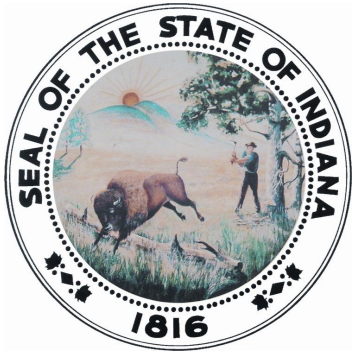

June 30, 2010

State of Indiana

Analysis of Health Insurance Benefits for Public Employees

MERCER

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Consulting. Outsourcing. Investments.

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Executive summary

Background

Pursuant to the 2009 budget bill, *SECTION 494 effective, July 1, 2009,* the State Budget Agency is required to oversee a review of the current state of employee healthcare insurance for the State of Indiana, school corporations and public universities. Mercer Health and Benefits (Mercer) was selected by the Budget Agency to gather data and conduct an analysis of healthcare benefits offered by the above entities. Throughout this document the term "public schools" will be used to refer to Indiana public school corporations and public universities collectively, unless otherwise noted.

An integral step in this analysis was the collection of data from public schools and the vendors (for medical, drug, dental and vision benefits). The budget bill directed public schools to provide the data needed to complete the review to the Budget Agency and its appointees. Mercer, in its capacity as the Budget Agency's appointee for the purposes of this evaluation, conducted the data gathering stage of the project during March and April of 2010. The following were potential findings and outcomes that were anticipated as a result of this initiative:

1. An inventory of the current benefit program in terms of plan designs, overall costs, funding, risk management, networks utilized etc. and how these attributes compare relative to benchmarks
2. An assessment of opportunities for more efficient procurement of healthcare benefits
3. The feasibility of implementing a more uniform and cost effective healthcare benefit offering to public school employees

The State of Indiana conducted an extensive RFP in 2009 to determine the optimal healthcare network and administrator going

forward for 2010. Since this market check was just performed, Mercer's professional opinion is that the State of Indiana's healthcare offering to State employees is currently optimized. Additionally, the State's plan designs and contributions are within an optimal range relative to benchmark.

Sources of potential savings

Insurance companies and other risk managers (e.g., large plan sponsors) utilize the law of large numbers to mitigate and manage the risk inherent in healthcare benefits. The larger the risk pool, the more predictable the experience. Therefore, as risk pools increase in size, the cost of risk management decreases as insurance margins, stop loss premiums and other risk management expenses are mitigated and/or eliminated. In addition to group size advantage, other areas of opportunity for savings exist and are described below. The savings are reflective of the active population only and do not include pre-or post 65 retirees.

Group size advantage	▪ By combining public schools into a common benefit program, management savings can be achieved through economies of scale in procurement, more efficient management of risk and consistent application of best practices and best-in-class vendors. ▪ On average, there are 300 enrolled employees in public school plans and 5,200 employees enrolled in the seven public university plans. Aggregating all public schools and State employees would create a risk pool estimated to be approximately 150,000 enrolled employees. With a risk pool of this size, significant savings are possible through a number of dimensions which are described below.
Plan design	▪ Plan design features such as deductibles, copayments and coinsurance influence the total cost of a healthcare plan both through the utilization of services as well as the net amount paid by the plan sponsor. ▪ On average, public schools cover a higher portion of services through plan design than the State's PPO plan (and higher than benchmark). By requiring public schools to move into the State plan, savings can be achieved though increased cost sharing through plan design.
Employee contributions	▪ Employees participating in healthcare plans often share in the cost of the plan through employee contributions. ▪ On average, public school employees contribute less for healthcare coverage compared to the State plan (and less than benchmark). By requiring public schools to move into the State plan, savings can be achieved through increased employee contributions.

Provider networks	▪ Development and management of provider networks are critical competencies of medical, dental and vision vendors. Contractual arrangements with providers allow vendors to provide considerable savings through discounts vs. the "retail" pricing encountered outside of networks. ▪ Currently public schools use a variety of vendors, some of which do not have competitive discounts. By requiring the use of a best-in-class vendor(s), savings can be realized through increased discount arrangements and increased use of in-network providers.
Prescription drugs	▪ Currently, the State and public universities utilize aggregate purchasing power through the Indiana Aggregate Prescription Purchasing Program (IAPPP). ▪ Savings can be achieved through the IAPPP's preferred pricing relative to the current public school pharmacy arrangements by extending the IAPPP to all public schools.
Funding arrangements	▪ Depending upon the size of the organization, there is a need to transfer the risk of large and unpredictable claims. This is done via fully insured plans and for self insured plans through stop loss coverage. ▪ By pooling public schools under the State plan, savings can be achieved by self insuring this risk, thus eliminating profit, risk margins and overhead which vendors build into the rates. This can be as much as 25% of the entire rate. ▪ For public schools that are already self insured, more competitive stop loss rates will be available if this coverage is purchased through the State. Alternatively, if public schools are required to participate in the State plan, the need for stop loss coverage will be eliminated.
Producer compensation	▪ Typically, there are fees associated with brokers and/or consultants who manage procurement of healthcare vendors and provide plan management services. ▪ By consolidating the public school employees, producer compensation costs could be greatly reduced or eliminated with improved value.
Premium taxes	▪ Fully insured plans pay insurance premium taxes to the State to help fund the costs of State regulation and oversight of the insurance industry. ▪ By pooling public schools under the State plan, savings can be achieved by self insuring the risk, thus eliminating premium taxes that are built into the fully insured rates. ▪ While this would be a cost savings to public schools, the State of Indiana would experience a revenue decline. For this reason, we are not estimating savings as a result of eliminating premium taxes.

Consumerism	▪ The State of Indiana has realized favorable experience due to the introduction of Consumer-Driven Health Plans (CDHPs) as evidenced through a recently completed (May 2010) comprehensive analysis. Currently these plans are generally not offered to public school employees. ▪ By requiring participation in the State benefit options, a CDHP will be an option available to the public schools resulting in favorable employee behavior change. Similar to the State's experience, public school employees enrolling in Consumer-Driven Health Plans (CDHPs) can be projected to reduce the long-term costs by approximately 10.7% in addition to the other savings mentioned in this report.
Avoidance of costs (fines etc.) **Non-compliance with federal laws**	▪ Today plan sponsors often unknowingly violate Federal Statutes regarding issues such as 5500 filings, proper development of COBRA rates, discrimination testing rules etc. Department of Labor audits are random but can result in substantial fines. Smaller plan sponsors are most often at risk due to lack of expertise and compliance resources. Recently passed Federal Laws such as The Mental Health Parity Act as well as The Patient Protection Act (Health Care Reform) will make future compliance requirements even greater. ▪ Consolidation of risk pools and more global management of benefit programs provide economies of scale and also can assure a more rigorous review. The bottom line is better compliance, fewer fines and a lower cost of assuring compliance vs. the current state.

Additional opportunities for savings not highlighted in this report include the following:

- Life insurance and AD&D
- Disability
- COBRA
- Flexible Spending Accounts (FSA)
- Benefit administration
- Payroll
- Health management programs
- Consumerist behavior
- Increased opt outs resulting from alternate plan selection i.e., coverage through spouse plan
- 401k
- Pension

In this report Mercer presents the following four scenarios for consideration. Mercer has estimated a projected annual cost savings and a summary table of advantages and disadvantages for each scenario.

<table>
<tr><th colspan="4">A Range of Options</th></tr>
<tr><th>Scenario 1: Required Provider Network</th><th>Scenario 2: Required provider network, stop loss procurement and broker/consultant</th><th>Scenario 3: Required participation in State benefit programs; employee contribution autonomy</th><th>Scenario 4: Required participation in State benefit program including employee contributions</th></tr>
<tr><td>▪ Preferred medical, dental and vision vendors based on current provider relationships, services and pricing
▪ Negotiated discounts and improved pricing based on leverage and volume
▪ Improved contract and servicing terms
▪ Individual school contracts</td><td>▪ Coordinated vendor management, procurement and strategic plan design services
▪ Common Insurers
▪ Individual school plan design & employee contribution setting maintained
▪ Local servicing of administrative, experience monitoring and compliance needs
▪ Requirements regarding reinsurance procurement and fees paid to producers and advisors (brokers and consultants)</td><td colspan="2">▪ Coordinated vendor management, procurement and strategic plan design services
▪ State of Indiana plan design options
▪ Common administrative standards, benefits platform and data analytics across public schools
▪ Coordinated vendor management, procurement and strategic plan design services
▪ Introduction of consumerism into the program resulting in improved employee engagement and behavior change
Contribution autonomy | State contribution methodology</td></tr>
<tr><td>Minimum</td><td colspan="2">Savings</td><td>Maximum</td></tr>
<tr><td>Less</td><td colspan="2">Governance</td><td>More</td></tr>
</table>

Scenario 1: Required provider network

Estimated annual savings: $77 million

In this scenario, there would be requirements regarding which provider networks are utilized. The savings generated from this scenario are a result of improved discounts and administrative fee changes relative to the current medical vendor arrangements. There will be a slight increase in administrative fees since best-in-class medical vendors typically charge higher amounts than third-party administrators. All public school employees would be allowed, but **not required**, to participate in the plans offered to State of Indiana employees.

Advantages	Disadvantages
Some cost savings	Removes some local decision making
Future potential procurement leverage	Some vendors would lose market share

Scenario 2: Required provider network, stop loss procurement and broker/consultant

Estimated annual savings: $118 million

In this scenario, there would be requirements regarding which provider networks are utilized, how insurance and reinsurance is procured and a single, preferred broker and consultant arrangement. The savings generated from this scenario are a result of improved discounts and reduced administrative fees relative to the current medical vendor arrangements. Additionally, the cost of broker and consultant compensation will be significantly reduced by consolidating the current services with a single, best-in-class partner. All public school employees would be allowed, but **not required**, to participate in the plans offered to State of Indiana employees.

Advantages	Disadvantages
Significant cost savings	Removes some local decision making
Procurement leverage	Some vendors would lose market share
Ability to implement and scale health management programs	Insured reinsurance coverage would be greatly reduced
Ability to scale and manage risk more efficiently	Requires monitoring to ensure compliance with requirements
Stabilizes annual volatility	
Eliminates some redundant expenses and duplicative resources	
Moves towards best-in-class results	

Scenario 3: Required participation in State benefit programs; employee contribution autonomy

Estimated annual savings: $229 million

In this scenario all public school employees would be **required** to participate in the healthcare plans offered to State of Indiana employees. Public schools would continue to use their current employee contribution methodology. Public schools would fund the Health Savings Account at the same level as State employees. The savings generated from this scenario are a result of improved efficiency with regards to purchasing, reduced broker/consultant compensation and changes to plan design which may result in cost shifting. The savings would be projected to grow annually in future years at inflationary levels.

Advantages	Disadvantages
Significant cost savings	Removes local autonomy
Maximum procurement leverage	Local staff resources would need to be repositioned
Ability to implement and scale health management programs	Some vendors would lose market share
Ability to scale and manage risk more efficiently	Insured reinsurance coverage would be greatly reduced
Provides a platform for uniform and equitable benefit offerings	
Reduces annual volatility in costs at the individual entity level	
Eliminates redundant expenses and duplicative resources	
Facilitates best-in-class results	
Bargaining negotiations would be modestly simplified	
Efficiency in compliance with new regulations	
Access to consumer based health plans	

Scenario 4: Required participation in State of Indiana benefits program including employee contributions

Estimated annual savings: $454 million

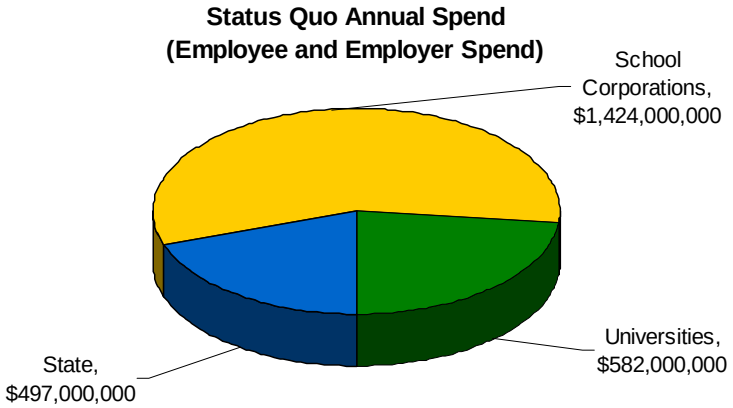
In this scenario all public school employees would be **required** to participate in the healthcare plans offered to State employees and have the same employee contribution levels as the State plan. Public schools would fund the Health Savings Account at the same level as State employees. The majority of the savings generated from this scenario are a result of increased employee cost sharing through higher contributions. Other sources of savings include purchasing efficiency, plan design changes, reduced broker/consultant compensation and increased consumerism. The savings would be projected to grow annually in future years at approximately the rate of medical inflation as compared to the current state.

Advantages	Disadvantages
Maximum cost savings	Removes local autonomy
Maximum procurement leverage	Local staff resources would need to be repositioned
Ability to implement and scale health management programs	Some vendors would lose market share
Ability to scale and manage risk more efficiently	Insured reinsurance coverage would be greatly reduced
Provides a platform for uniform and equitable benefit offerings	
Reduces annual volatility in costs at the individual plan sponsor level	
Eliminates redundant expenses and duplicative resources	
Facilitates best-in-class results	
Bargaining negotiations would be modestly simplified	
Efficiency in compliance with new regulations	
Access to consumer based health plans	

- Note: In 2010, five public schools voluntarily elected to participate in the State plan. Of those that joined the State's program, 86% have enrolled in the CDHP options. Overall the five schools are projected to save approximately $3,600 per enrolled employee in 2010. For the 598 enrolled employees across the five school corporations, this equates to 2010 savings of $3.5 million or 41% compared to the 2010 forecast prior to joining the State plan.

Savings projections

The table below identifies the sources and magnitude of the projected savings under each scenario. The pie chart to the right illustrates the current total annual employee and employer spend for 2011 and 2012 of $2.5 billion by the State and public schools.



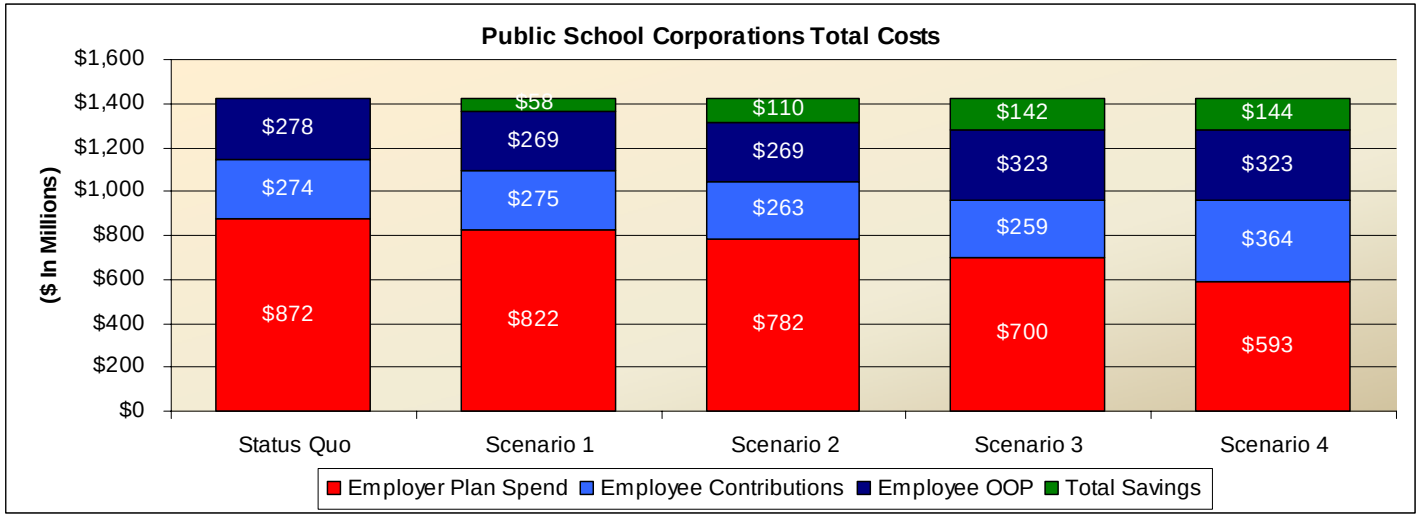
Annual Savings Opportunity - Public School Corporations and Public Universities				
	Scenario 1	**Scenario 2**	**Scenario 3**	**Scenario 4**
Medical claims (provider networks)	$81,000,000	$81,000,000	$81,000,000	$81,000,000
Prescription drug claims (PBMs)	N/A	N/A	$13,000,000	$13,000,000
Administrative/overhead fees	($7,000,000)	$18,000,000	$31,000,000	$31,000,000
Stop loss premium	N/A	$13,000,000	$13,000,000	$13,000,000
Producer compensation	N/A	$3,000,000	$7,000,000	$9,000,000
Dental and vision	$3,000,000	$3,000,000	$3,000,000	$3,000,000
Employer Efficiency Savings	**$77,000,000**	**$118,000,000**	**$148,000,000**	**$150,000,000**
Plan Design and Contribution Savings[1]	**$0**	**$0**	**$81,000,000**	**$304,000,000**
Total Employer Savings	**$77,000,000**	**$118,000,000**	**$229,000,000**	**$454,000,000**
Employee Efficiency Savings	**$14,000,000**	**$26,000,000**	**$31,000,000**	**$31,000,000**

[1] See pages 14 and 15 for additional detail

Additional opportunities for savings not specifically included in these projections, but likely to produce more savings, include:

- Consumerist behavior (up to 10.7% based upon previous State of Indiana case study dated May 20, 2010)
- Increased opt outs resulting from participants electing coverage from other household sources
- Consistent health management programs, improved legal compliance, further procurement leverage, (e.g. life and disability)

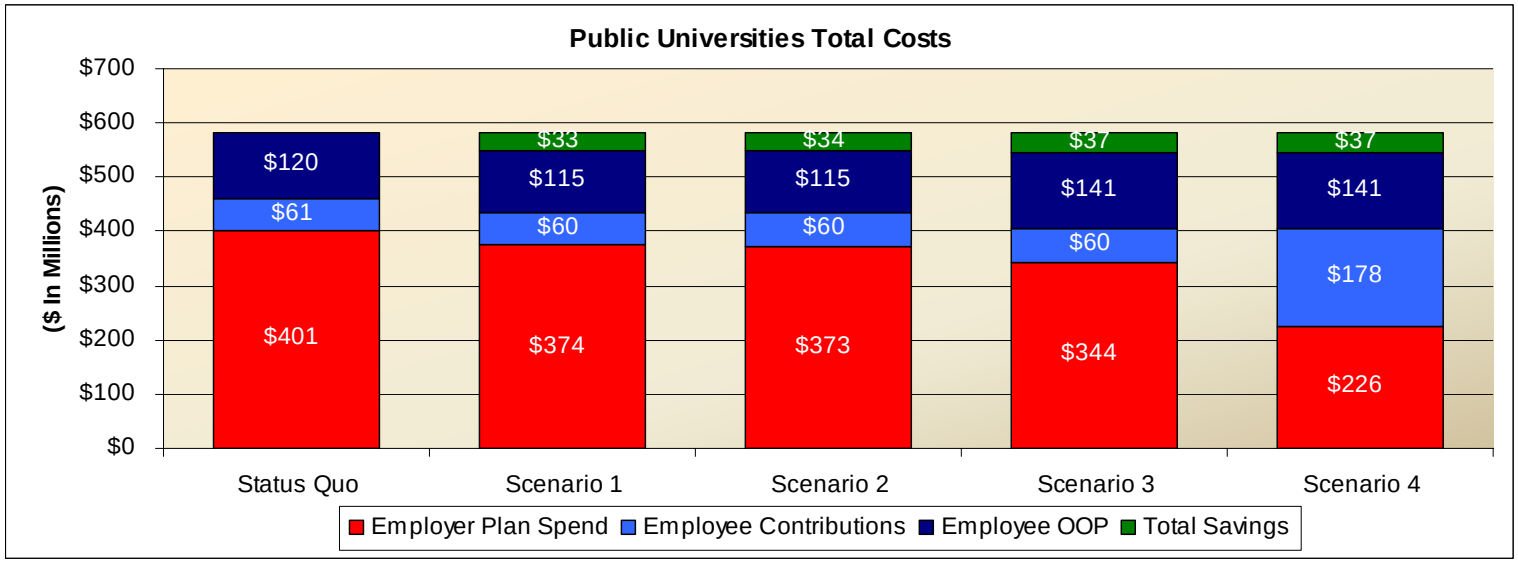
The table below displays the savings opportunities for public school corporation employees and employers under each scenario.



Annual Savings Opportunity - Public School Corporations				
	Scenario 1	**Scenario 2**	**Scenario 3**	**Scenario 4**
Medical claims (provider networks)	$55,000,000	$55,000,000	$55,000,000	$55,000,000
Prescription drug claims (PBMs)	N/A	N/A	$13,000,000	$13,000,000
Administrative/overhead fees	($7,000,000)	$18,000,000	$29,000,000	$29,000,000
Stop loss premium	N/A	$12,000,000	$12,000,000	$12,000,000
Producer compensation	N/A	$3,000,000	$6,000,000	$8,000,000
Dental and vision	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Employer Efficiency Savings	**$50,000,000**	**$90,000,000**	**$117,000,000**	**$119,000,000**
Plan Design and Contribution Savings[1]	**$0**	**$0**	**$55,000,000**	**$160,000,000**
Total Employer Savings	**$50,000,000**	**$90,000,000**	**$172,000,000**	**$279,000,000**
Employee Efficiency Savings	**$8,000,000**	**$20,000,000**	**$25,000,000**	**$25,000,000**

[1] See pages 14 and 15 for additional detail

The table below displays the savings opportunities for public university employees and employers under each scenario.



Annual Savings Opportunity - Public Universities				
	Scenario 1	**Scenario 2**	**Scenario 3**	**Scenario 4**
Medical claims (provider networks)	$26,000,000	$26,000,000	$26,000,000	$26,000,000
Prescription drug claims (PBMs)	$0	$0	$0	$0
Administrative/overhead fees	$0	$0	$2,000,000	$2,000,000
Stop loss premium	N/A	$1,000,000	$1,000,000	$1,000,000
Producer compensation	N/A	$0	$1,000,000	$1,000,000
Dental and vision	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Employer Efficiency Savings	**$27,000,000**	**$28,000,000**	**$31,000,000**	**$31,000,000**
Plan Design and Contribution Savings[1]	**$0**	**$0**	**$26,000,000**	**$144,000,000**
Total Employer Savings	**$27,000,000**	**$28,000,000**	**$57,000,000**	**$175,000,000**
Employee Efficiency Savings	**$6,000,000**	**$6,000,000**	**$6,000,000**	**$6,000,000**

[1] See pages 14 and 15 for additional detail

2

Sources of medical/pharmacy plan savings

Group size advantage

The type of funding of healthcare benefits impacts the typical plan sponsor's per capita costs. Generally, smaller groups fully insure their plans (transfer of risk to the insurance carrier) and while this is prudent from a risk management perspective, it does create higher overall costs. These additional costs come largely from insurer profit margins, risk charges, commissions, premium taxes and state mandated benefits. These additional costs can be avoided if a group has enough lives to self insure their benefit risk. In the market, it is common for groups with less than 500 lives to be fully insured. However, the larger the group the more likely the group is to be self insured. The decision is often a tradeoff between expected lower costs with higher volatility of costs (self insuring) vs. the certainty of annual costs but at a known higher total cost (fully insured). The table below shows how costs for public schools vary by group size, adjusted for differences in plan design.

Medical Costs by Group Size

School Size	Number of Schools	Medical Costs PEPY	Plan Adjusted Costs PEPY[1]
0-49 EEs	16	$12,423	$13,239
50-99 EEs	55	$11,276	$10,964
100-249 EEs	96	$10,744	$10,312
250-499 EEs	42	$11,625	$10,990
500-999 EEs	22	$11,889	$11,143
1000+ EEs	17	$11,981	$10,783
Incomplete Data	42	ID	ID
Public School Corporation Total	**290**	**$11,669**	**$11,013**
Universities	**7**	**$10,860**	**$10,229**
State Plan	**1**	**$11,140**	**$11,140**

[1] Adjusted for differences in plan design, but not for demographic, geographical or health risk differences

Medical/pharmacy plan design

Today, public schools provide healthcare benefits almost exclusively through PPO/POS plans. The table below shows the types of plans offered by public schools. 95% of the predominant plans (the plan with the most enrollment) are PPO/POS plans while consumer-driven health plans (CDHPs) with either HSAs or HRAs are the most predominant plan for less than 4% of public schools. Most public universities offer multiple medical plans but PPO/POS plans have the most enrollment. As demonstrated through the State's favorable experience in the CDHPs, increased enrollment in these plans represents an opportunity for improvement and future savings for public schools.

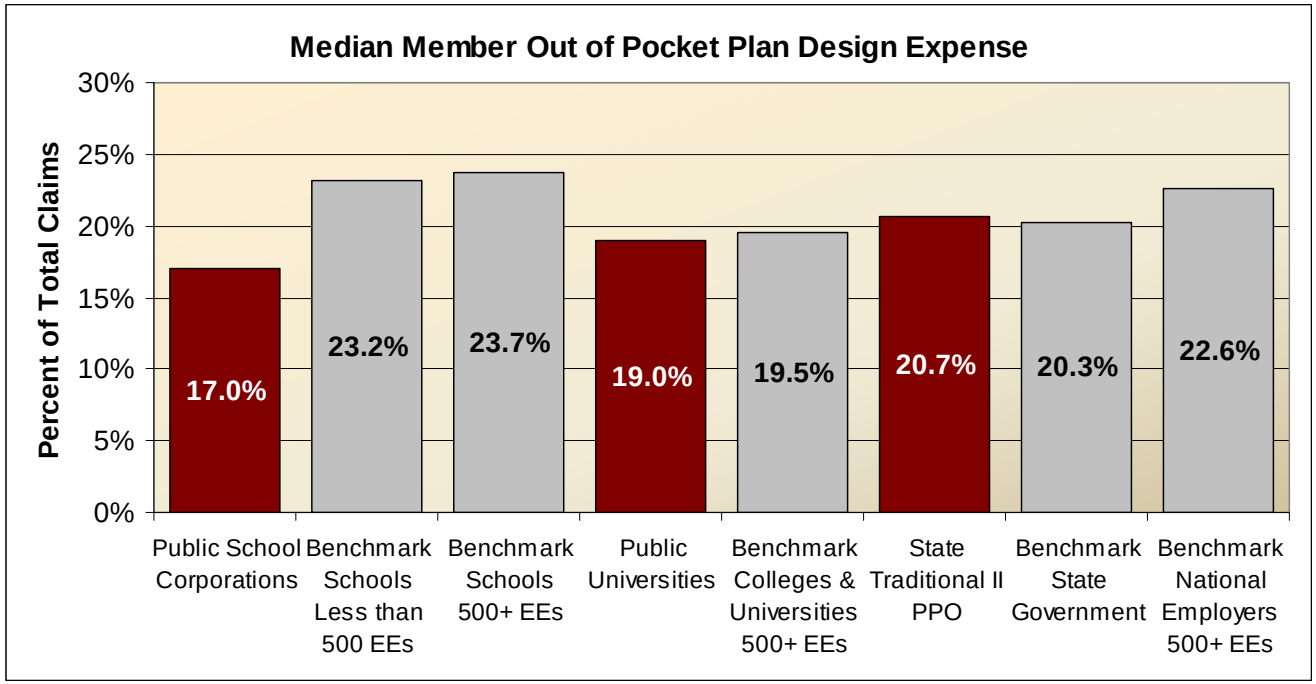
Medical Plan Types			
Plan Design	Number of School Corps	Public Universities [1]	State Employee Plans
PPO/POS	262	6	1
HMO/EPO	5	1	1
CDHP with HSA	8	0	2
CDHP with HRA	2	0	0
Incomplete Data	13	0	0
Total	**290**	**7**	**4**

[1] Plan with the most enrollment

Participant out of pocket provisions (deductibles, copays, coinsurance, out of pocket maximums, etc.) vary across the public school entities. In general, public school corporations offer the same plan design to both their certified and non-certified populations, but there are some public school corporations that have different offerings. 21 of the 277 respondents indicated that they offer different plan designs. The following table summarizes key plan design elements and how they vary for each organization.

Medical/Pharmacy Plan Design Summary					
	School Corp Certified Plans			University Plans	State Traditional II
In-Network Plan Design	25th Percentile	Median	75th Percentile	Median	PPO
Single Medical Deductible	$200	$325	$500	$250	$500
Family Medical Deductible	$400	$650	$1,275	$750	$1,000
Single Out of Pocket Maximum	$700	$1,500	$2,000	$2,500	$2,000
Family Out of Pocket Maximum	$1,500	$3,000	$5,000	$5,000	$4,000
Primary Care Physician Copay	$15	$20	$25	$20	20%
Inpatient Coinsurance	10%	20%	20%	20%	20%
Retail Generic Rx Copay	$6	$10	$10	$10	$10

The majority of public schools offer plans that have lower employee out of pocket plan design costs than the plans offered to State employees. For example, the Traditional II PPO plan offered to State employees has a single medical deductible of $500, and 75% of public schools have a deductible less than or equal to $500. Using the school-reported plan design information, Mercer compared the public schools out of pocket plan design expense to the State's Traditional II PPO and results from Mercer's 2009 Mercer National Survey of Employer-Sponsored Health Plans. The results are stratified in the following table.

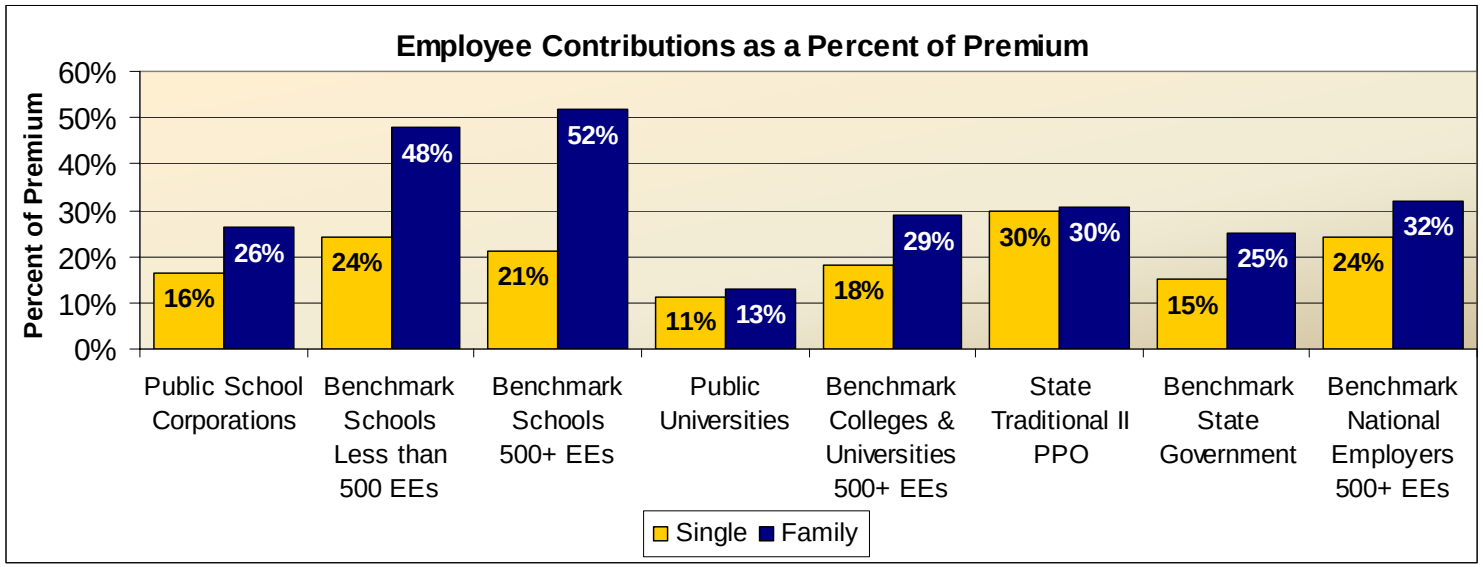


- In general, public schools have a more generous plan design than the State Traditional II PPO and benchmark.
- The average value of public school plans is 3.7% higher than the State Traditional II PPO plan and 6.2%-6.7% higher than the benchmark for schools
- The average value of the University plans is 1.7% higher than the State Traditional II PPO plan and 0.5% more generous than the benchmark for universities

Under Scenarios 3 and 4, if all new public school entrants to the State plan elect the Traditional II PPO, public school costs would be reduced by $81 million annually through increased employee out of pocket plan design expense. This estimate is expected to increase with medical trend. Realistically, not all employees will elect coverage in Traditional II PPO, but will enroll in one of the CDHPs options instead. These plans have higher deductibles and out of pocket maximums than the Traditional II PPO, so this savings estimate would increase as more employees enrolled into the CDHPs. However, the CDHPs have lower employee contributions which would ultimately offset this additional savings.

Employee contributions

According to the 2009 Mercer National Survey of Employer-Sponsored Health Plans, schools require higher employee contributions as a percent of premium for family coverage as compared to single coverage. Indiana's public schools are similar to the benchmark in relation to the difference between single and family contributions, but on average require lower contributions than benchmark as shown in the following table.



Most public schools also require lower employee contributions, as a percent of premium, than the State requires from its employees for the Traditional II PPO plan. If all new entrants to the State plan elect the Traditional II PPO, this would reduce public school costs (through increased employee contributions) by $223 million annually ($105 million for public school corporations and $118 million for public universities). Realistically, not all employees will elect coverage in the Traditional II PPO, but will enroll in one of the CDHPs instead. These plans have lower employee contributions, which will reduce the estimated savings. However, this reduction in savings is offset by the State's CDHP plan designs (deductibles, coinsurance, etc.) that require more cost sharing (through plan design) than the public school options. While there are significant savings opportunities from modifying employee contributions, the savings are a result of cost shifting from the public schools to the employee.

Medical provider networks

Today a number of different networks are utilized by public schools. The following table shows how participant enrollment varies by carrier network and Indiana metropolitan statistical area (MSA). Healthcare purchasing is currently done at a local level, and some vendors are stronger than others in each geographical region. One advantage of an aggregated procurement is the ability to optimize the networks utilized to maximize access to providers and leverage best in market contractual discounts for all participants at the local market level. Mercer estimates that there is an opportunity to optimize the use of networks within the State of Indiana. If network use was optimized for all participants as noted above, Mercer estimates that a total savings of $95 million annually could be achieved.

Medical Plan Enrollment by Geography								
MSA	**Aetna**	**Anthem**	**CIGNA**	**Humana**	**UHC**	**Welborn**	**Other[1]**	**Total**
Bloomington, IN	0	18,604	0	0	193	0	580	19,377
Cincinnati-Middletown, OH-KY-IN	0	1,574	0	251	92	0	0	1,917
Columbus, IN	0	2,445	0	0	46	0	1,644	4,135
Elkhart-Goshen, IN	0	3,441	531	0	145	0	1,561	5,678
Evansville, IN-KY	0	1,123	0	0	0	1,492	298	2,913
Fort Wayne, IN	0	6,449	0	0	0	0	3,683	10,132
Gary, IN	551	9,663	577	0	271	0	1,840	12,902
Indianapolis-Carmel, IN	0	28,885	449	322	1,829	0	12,204	43,689
Kokomo, IN	0	3,885	867	0	146	0	893	5,791
Lafayette, IN	0	3,147	11,411	0	972	0	144	15,674
Louisville/Jefferson County, KY-IN	0	3,657	0	1,797	0	0	178	5,632
Micropolitan, IN	0	1,965	0	0	0	0	1,661	3,626
Muncie, IN	0	4,532	0	0	30	0	4,604	9,166
South Bend-Mishawaka, IN-MI	0	327	2,620	0	0	0	0	2,947
Terre Haute, IN	0	3,414	1,389	0	181	0	0	4,984
Total	**551**	**93,111**	**17,844**	**2,370**	**3,905**	**1,492**	**29,290**	**148,563**
Annual Medical Claim Savings - Public School Corporations[2]								**$64,000,000**
Annual Medical Claim Savings - Public Universities[2]								**$31,000,000**

[1] Represents a variety of third party administrators (TPAs) using rental networks
[2] Based on Mercer's market knowledge of network discounts and survey respondent information

Prescription drugs

Today the State of Indiana efficiently leverages the procurement of prescription drugs for the State and public universities through the Indiana Aggregate Prescription Purchasing Program (IAPPP). By including the public school corporations in this pharmacy contract, savings will be realized through improved pricing and contractual terms. The projected savings are only applicable under Scenarios 3 and 4 due to the following requirements:

- The current IAPPP's Pharmacy Benefit Manager (PBM) must be the exclusive provider of Rx benefits
- Eligibility is received from a single source
- Reporting and invoicing is produced at the group level for plans with less than 1,500 employees
- The coverage must be self-funded
- The State of Indiana plan designs must be utilized

Pharmacy Benefit Management (PBM) Summary				
School Size	**PBM**	**No PBM**	**Total**	**Savings**
0-49 EEs	2	13	15	$54,000
50-99 EEs	18	39	57	$645,000
100-249 EEs	22	73	95	$2,326,000
250-499 EEs	13	30	43	$2,455,000
500-999 EEs	10	14	24	$2,536,000
1,000+ EEs	3	14	17	$5,005,000
Incomplete Data			39	$260,000
Total	**68**	**183**	**290**	
Annual Rx Claim Savings - Public School Corporations				**$14,000,000**
Annual Rx Claim Savings - Public Universities[1]				**$0**

[1]The financial arrangement of those universities not in the IAPPP is being reviewed to determine if additional cost savings could be realized.

Funding arrangements

Medical plan sponsors manage risk through a combination of techniques. For plan sponsors with only a few hundred employees, the medical plan is often fully insured. In the long run this is the most expensive funding arrangement and is often dictated by the carrier's underwriting requirements. However, for smaller groups this is the most fiscally prudent approach since few small organizations can manage the cash flow implications of a few very large claims. Larger plan sponsors use a self insured approach with varying levels of individual stop loss (ISL) insurance as well as aggregate stop loss (ASL) coverage in some cases. These plan sponsors take on more risk and experience more volatility year to year in exchange for what are, on average, lower overall costs. Stop loss insurance helps contain volatility and risk, in essence insuring only large claims. As group size increases, self-insurance becomes more prevalent as compared to fully insured arrangements and as groups get larger, the level of stop loss coverage (both ISL and ASL) diminishes. For example, the State of Indiana has approximately 30,000 enrolled employees and does not have stop loss coverage. Given the size of the State plan, the risk of large claims is retained. For groups this size and larger, this is typical. The table below details the current funding arrangements of Indiana public schools. It is interesting to note that many of the smaller public school corporations are currently self insured using both ISL and ASL to protect against adverse claims experience.

Count of School Corps by Medical Plan Funding Type

School Size	Fully Insured	Self Insured			Incomplete Data	Total
		ISL Only	ASL Only	ISL and ASL		
0-49 EEs	16	0	0	5		21
50-99 EEs	16	0	1	47		64
100-249 EEs	29	4	2	65		100
250-499 EEs	12	2	2	27		43
500-999 EEs	5	1	0	17		23
1,000+ EEs	7	1	0	9		17
Total	**85**	**8**	**5**	**170**	**22**	**290**

Funding arrangements (fully insured)

Insurance carriers charge a "premium" when they take on a group's risk and provide coverage. Mercer collected historical claim, premium and enrollment information from the medical plan administrators for each public school to analyze the portion of premium that has historically been used to pay for claims versus overhead. Overhead can be broken into several categories: administrative expense, profit margin, risk charge, premium tax, broker/consultant compensation and other expenses. The following table summarizes the historical loss ratios and average overhead per employee per month (PEPM) that the fully insured public schools have experienced. Overall, these groups have had an 86% loss ratio, which means 14% of premium paid is overhead. On a self insured basis, Mercer expects the State to be able to administer coverage for schools with significantly less overhead.

Fully Insured Overhead Comparison - Medical						
		Average	Current Average	Competitive Market Fees - PEPM		
School Size	N	Loss Ratio	Overhead PEPM	Scenario 2	Scenario 3	Scenario 4
0-49 EEs	15	75%	$238	$40	$30	$30
50-99 EEs	13	77%	$223	$40	$30	$30
100-249 EEs	24	79%	$206	$40	$30	$30
250-499 EEs	9	79%	$204	$40	$30	$30
500-999 EEs	4	72%	$273	$40	$30	$30
1000+ EEs	8	92%	$73	$40	$30	$30
Total	**73**	**86%**	**$137**	**$40**	**$30**	**$30**
State Plan		**96%**	**$39**			
Annual Insured Overhead Savings - School Corps[1]				**$33,000,000**	**$37,000,000**	**$37,000,000**
Annual Insured Overhead Savings - Universities[1]				**$0**	**$0**	**$0**

[1] Based on Mercer's market knowledge and carrier respondent information

Funding arrangement (self insured)

While 30% of the public schools are currently fully insured, the remaining 70% are self insured with some form of stop loss coverage, ISL and/or ASL. Under Scenarios 3 and 4, there would be no need for stop loss coverage, since the total risk pool would be large enough to self insure the catastrophic claims. Most of the premium spent on stop loss coverage today is for ISL coverage. Eliminating this coverage under Scenarios 3 and 4 is projected to save $11 million annually. This savings is a result of eliminating the overhead charged by insurers which typically ranges from 17% to 25% of premium. Under Scenario 2 where the State sets up a stop loss pool to insure individual school corporations, the same savings from reduced overhead can be achieved; however, additional staff resources and actuarial and underwriting expertise would be needed to administer and maintain the stop loss pool which would offset a small portion of the savings opportunity.

Individual Stop Loss Summary							
		ISL Deductible			ISL Monthly Premium PEPM		
School Size	Number of School Corps	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
0-49 EEs	5	$200,000	$150,000	$150,000	$37	$50	$50
50-99 EEs	47	$200,000	$150,000	$100,000	$37	$47	$81
100-249 EEs	69	$200,000	$122,500	$100,000	$37	$71	$83
250-499 EEs	29	$168,750	$140,000	$100,000	$45	$51	$76
500-999 EEs	18	$175,000	$125,000	$100,000	$33	$55	$75
1,000+ EEs	10	$237,500	$175,000	$151,250	$25	$34	$48
Total	**178**	**$194,000**	**$137,000**	**$104,000**	**$38**	**$57**	**$78**
Annual ISL Premium Retention Savings - Public School Corporations							**$10,000,000**
Annual ISL Premium Retention Savings - Public Universities							**$1,000,000**

Under Scenarios 2, 3 and 4, the need for ASL coverage will be eliminated. The following table summarizes the usage of ASL coverage by public school corporations today. Based on the school survey, Mercer estimates that public schools spend $5 million in ASL coverage each year. Unlike ISL coverage, it is rare that ASL reimbursements occur. Therefore, the full premium amount is assumed to be a savings opportunity.

Aggregate Stop Loss Summary			
School Size	Number of School Corps	Average Premium PEPM	Enrollment
0-49 EEs	5	$9.83	175
50-99 EEs	48	$10.93	3,319
100-249 EEs	67	$7.48	10,935
250-499 EEs	29	$10.85	11,415
500-999 EEs	17	$3.90	14,441
1,000+ EEs	9	$4.86	17,845
Total	**175**	**$6.65**	**58,130**
Annual ASL Premium Savings - School Corporations			**$5,000,000**
Annual ASL Premium Savings - Public Universities			**$0**

In general, as group sizes increase, lower administrative fees are able to be negotiated with medical plan administrators. Currently, public schools are paying administrative fees in the range of $30 - $40 PEPM. The $30 PEPM fees are very competitive with what Mercer would expect the State could achieve with a leveraged procurement. The following table summarizes the estimated impact to administrative fees paid by schools currently self insured.

Self Funded Administrative Fees - Medical				
		Competitive Market Fees		
Group Percentile	Current Administrative Fee	Scenario 1	Scenario 2	Scenarios 3&4
25%	$30.91	$40.00	$40.00	$30.00
50%	$34.90	$40.00	$40.00	$30.00
75%	$40.27	$40.00	$40.00	$30.00
State Plan	$39.30			
Annual Fee Savings - School Corps[1]		**($9,000,000)**	**($9,000,000)**	**$1,000,000**
Annual Fee Savings - Universities[1]		**$0**	**$0**	**$2,000,000**

Producer compensation

Public schools were asked to disclose the amount of money they paid to producers annually. The reported information for producer compensation (consulting fees, commissions, overrides, bonuses and contingent commissions) was often inconsistent between the schools and the carriers, and sometimes incomplete. Some types of producer compensation are not transparent, as it is "baked into" the fees and/or premiums. However, the following table summarizes the compensation that was reported.

Producer Compensation Summary[1]						
	Self Insured		Fully Insured		Combined	
School Size	Number of Schools	Producer Compensation PEPM	Number of Schools	Producer Compensation PEPM	Number of Schools	Producer Compensation PEPM
0-49 EEs	5	$34.25	12	$27.95	17	$29.80
50-99 EEs	47	$9.28	11	$20.38	58	$11.38
100-249 EEs	70	$8.52	18	$16.80	88	$10.22
250-499 EEs	27	$8.70	10	$8.56	37	$8.66
500-999 EEs	19	$4.99	3	$9.76	22	$5.64
1000+ EEs	10	$2.94	3	$8.28	13	$4.17
Subtotal	**178**	**$5.16**	**57**	**$7.87**	**235**	**$5.82**
Incomplete Data					55	
Total	**178**	**$5.16**	**57**	**$7.87**	**290**	**$5.82**
Self Insured Producer Compensation Savings - Public School Corporations[2]						**$4,000,000**
Self Insured Producer Compensation Savings - Public Universities[2]						**$0**

[1] Producer compensation was reported by both the public school and their plan administrator. The highest reported compensation is shown above

[2] Savings from reducing producer compensation for fully insured plans is already included as retention savings

The average commission expense was $5.82 PEPM which equates to 0.6% of projected total spend. This is below market levels (1%-4% based on group size), therefore Mercer expects there is significant unreported producer compensation. Contingent commissions and override arrangements between brokers and insurance carriers were not reported consistently. Commissions are also commonly paid for stop loss insurance, as well as for placing life and disability coverage, which can also be subject to efficiencies gained through consolidation of vendors and producers.

In Scenarios 2, 3 and 4, these producer expenses would be significantly reduced since these services would be covered under the State of Indiana benefit program. In Scenario 2 these expenses would be reduced by way of transparency and compensation guidelines. In Scenario 1 these expenses would continue as they currently occur.

Premium taxes

Premium taxes only apply to the fully insured groups. In Scenarios 3 and 4 the current state premium taxes would be eliminated. However, while this would be a cost savings to public schools, the State of Indiana would actually experience a revenue shift. Revenue historically received by the Department of Insurance would be reclassified as a cost savings to public school funding. For this reason, the elimination of premium taxes is not included in the results in the Executive Summary.

Consumerism

The State introduced the first Consumer Drive Health Plan (CDHP) offering in 2006 along with the existing health plans. Mercer was asked to validate the sources of savings and overall experience of the two CDHP Plans compared to the remaining PPO. The CDHPs have achieved significantly lower cost than the PPO.

- The total average cost for the PPO was $12,317 compared to $5,462 for CDHP1 and $9,444 for CDHP2
- The two CDHPs had combined savings of 10.7% per year and are projected to save $17-23 million for the State in 2010
- Additionally, state employees and their families enrolled in the CDHPs are projected to save $7 to $8 million in 2010
- Both CDHPs had lower than average age populations, but a higher average family size compared to the PPO
- Individuals who moved to either CDHP option had reduced utilization and intensity of services

Additional savings not quantified in this report could be significant for public schools if the behavior changes, resulting in healthier individuals, and lower claims costs, carry over to that population if enrolled in the State's CDHP options.

3

Sources of potential dental and vision plan savings

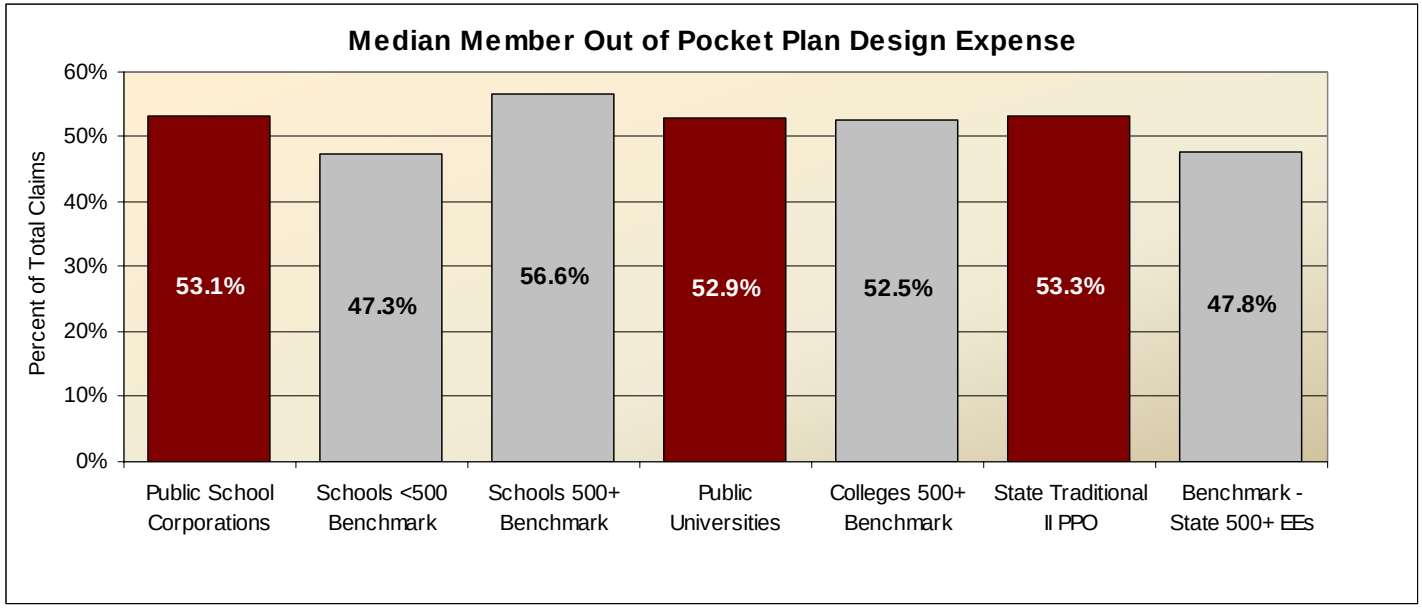
Similar to medical, there are savings opportunities available for the dental and vision plans currently offered, although the total opportunity is modest compared to medical and prescription drug plans. Today, it appears that approximately 30% of public schools offer dental and vision plans on a voluntary basis. In a voluntary offering, employees are offered access to insurance but pay the entire cost of the program. In these situations no plan sponsor savings are possible. There are some leveraged procurement opportunities if dental and vision coverage were consolidated to one or two vendors. However, due to the small premium amounts and the level of voluntary coverage, the projected savings are estimated to be only approximately $2 million each year for 2011 and 2012. These savings would only be available under a Scenario 3 or 4 type of program structure.

Dental Plan Types - Certified Plans			
Plan Design	**Number of School Corps**	**Public Universities [1]**	**State Employee Plans**
DPPO	131	4	1
Indemnity	30	1	0
DHMO	7	1	0
Other	31	0	0
Incomplete Data or Voluntary Coverage	91	1	0
Total	**290**	**7**	**1**

[1] Most enrolled plan

Dental Plan Design Summary					
	School Corp Certified Plans			University Plans	State Dental
Plan Design	25th Percentile	Median	75th Percentile	Median	Plan
Single Deductible	$0	$50	$50	$50	$50
Preventive Care Coinsurance	0%	0%	0%	0%	0%
Basic Restorative Coinsurance	20%	20%	20%	20%	20%
Major Restorative Coinsurance	40%	50%	50%	20%	40%
Orthodontia Coinsurance	50%	50%	50%	50%	40%
Annual Plan Maximum	$1,000	$1,000	$1,500	$1,200	$1,000
Orthodontia Lifetime Maximum	$500	$1,000	$1,200	$1,000	$1,125

Public schools have a similar plan design cost share for dental as the State plan and the College/University benchmark (53% employee cost share through plan design). Cost share through plan design is slightly more with Indiana public schools relative to Schools under 500 employees and slightly less than schools with over 500 employees.



Dental Plan Enrollment by MSA						
MSA	**BCBS**	**CIGNA**	**Delta Dental**	**Guardian**	**Other**	**Total**
Bloomington, IN	417	17,648	0	538	1,166	19,769
Cincinnati-Middletown, OH-KY-IN	0	0	397	0	815	1,212
Columbus, IN	354	0	0	0	1,673	2,027
Elkhart-Goshen, IN	536	556	1,154	0	1,455	3,701
Evansville, IN-KY	0	0	0	0	1,101	1,101
Fort Wayne, IN	3,547	0	154	0	2,488	6,189
Gary, IN	1,355	0	369	1,637	3,343	6,704
Indianapolis-Carmel, IN	980	0	14,680	543	6,512	22,715
Kokomo, IN	0	886	454	162	1,253	2,755
Lafayette, IN	0	0	402	250	1,624	2,276
Louisville/Jefferson County, KY-IN	0	0	3,258	171	1,443	4,872
Micropolitan, IN	96	0	229	0	1,874	2,199
Muncie, IN	410	0	1,480	19	806	2,715
South Bend-Mishawaka, IN-MI	0	0	2,738	0	0	2,738
Terre Haute, IN	0	0	1,718	0	1,489	3,207
Total	**7,695**	**19,090**	**27,033**	**3,320**	**27,042**	**84,180**
Annual Dental Claim Savings - Public School Corporations[1]						**$1,500,000**
Annual Dental Claim Savings - Public Universities[1]						**$300,000**

[1] Based on Mercer's market knowledge of network discounts and survey respondent information

Vision Plan Administrator			
Plan Design	**Number of School Corps**	**Public Universities**	**State Employee Plans**
EyeMed	5	0	0
Spectera	6	0	0
VSP	106	2	0
Other	75	2	1*
Incomplete Data or Voluntary Coverage	98	3	0
Total	**290**	**7**	**1**

* Anthem Blue View Vision Select

4

2010 health care reform legislation

After more than a year of debate, President Obama signed comprehensive federal health care reform into law on March 23, 2010. The law, called the Patient Protection and Affordable Care Act (PPACA), is intended to expand coverage while building upon and strengthening the private, employer-based health insurance system. The PPACA has many components—from new reporting requirements, taxes and fees to major structural changes such as insurance reforms, employer and individual mandates, and state insurance exchanges—phasing in over many years. Every employer-sponsored health plan will be impacted.

All employers must respond on several fronts. In the short term, employers need to comply with the provisions of PPACA that will become effective first, generally January 1, 2011 for most public school plans. In addition, the State and public schools need to begin assessing the longer term impact of federal health care reform on its health plans. Making this more difficult, a flurry of guidance is expected from government agencies clarifying various aspects of PPACA. Keeping up to date with regulatory developments will be difficult, but essential.

While the purpose of the opportunity analysis conducted does not account for any changes from PPACA, it is important to think about the impact this reform legislation will have on any plan offerings. Our summary of health reform changes found in this document highlights only these key issues affecting design and plan costs in 2011. Note that there are many other administrative issues related to compliance, and many requirements in future years.

Short-term impact

The health care reform provisions that are effective within the next year include:

- Coverage must be extended to age 26 to employees' adult children (regardless of whether tax dependent, student, married or residing with employee) without access to other employer coverage
- Extend tax-free treatment for employer-provided health care benefits to an employee's child until end of the year in which child turns age 26 (employer can also decide to end coverage on the 26th birthday)
- Pre-existing condition exclusions for dependent children under age 19 are prohibited
- Overall lifetime plan maximums are prohibited
- Annual limits for essential health benefits are restricted
- The cost of over-the-counter medications will no longer be reimbursed from medical plans, FSAs or HSAs
- Note that certain mandates may apply sooner for employer plans that are not "grandfathered". There has been no guidance on how an employer would lose grandfathered status. Should a public school be deemed as losing grandfathered status, the following provisions would also apply:
  - Provide mandated preventive services with no cost-sharing
  - Establish and provide notice of internal and external appeals procedures
  - Emergency services coverage
    - Cannot be limited to in-network providers
    - Cannot include higher cost-sharing for out-of-network providers
    - Cannot require preauthorization
  - Plans requiring or providing for primary care physician designation
    - Must allow designation of any participating primary care physician or pediatrician
    - May not require preauthorization or referral for OB/GYN services
  - Insured plans cannot discriminate in favor of highly compensated individuals

There are two other provisions where the effective date is not clear:

- Auto-enrollment requirement
- 60-day advance notice to plan design changes

Long-term Impact

In the next few years, many more major changes under PPACA will become effective, including:

- "Shared responsibility" provisions requiring employers to offer affordable coverage meeting minimum standards to certain workers – or face potential penalties
- Excise tax on high cost health coverage
- Cap on health FSA contributions at $2,500
- Exchange for individuals and small businesses to purchase coverage
- Individual mandate to maintain health coverage – or face a penalty
- Employer vouchers for low-income employees to enable them to purchase insurance from the exchange

Although these changes (and many more) will be phased in, they will have a major impact on the entire U.S. health care system. **Having 300+ entities separately make the necessary changes for compliance is inefficient and it is likely there will be public schools that are not compliant.** Offering one standardized set of plans statewide (Scenario 4) will reduce this administrative burden.

5

Approach and methodology

Following an introductory letter to each school from the Department of Education and the State Budget Agency, jointly, the request for data was conducted in a two phase approach. In the first phase, a survey was released to school corporations, public universities and charter schools. In the second phase, a separate survey was released to medical/Rx, dental and vision carriers based on the responses from the schools.

The data inventory tracking tool contained information on the school corporations, universities and charter schools including number of certified vs. non certified employees and key contact information. This was the control source for tracking responses from schools and allowed Mercer to build the database requirements in order to store the received data. A survey was released to the schools and contained the following data elements:

- General Information
- Contact Information
- Employee Information
- Broker/Consultant Information
- Payroll/Enrollment System Information
- Consortium/Purchasing Group
- Retiree Medical
- Base Medical Plan for the most predominant active plan – certified vs. non certified, where applicable
- Base Dental Plan
- Base Vision Plan
- For the Base Medical, Dental and Vision plan, the survey collected the following information
    - Incumbent carrier

- Financial terms
- Enrollment
- Contributions
- Plan Design

Training was held for the school corporations and charter schools to clarify data elements that were being requested and the opportunity to ask questions was given. Individual outbound calls were placed to the universities to field questions and assist with completion of the questionnaire.

The following outlines the response rate from the school entities:

- School Corporations 290 out of 290 (100%)
- Public Universities 7 out of 7 (100%)
- Charter Schools 16 out of 32 (50%)
  Many charter schools were deemed ineligible for the survey due to their involvement with either an out-of-state management company or an existing parental unit, which provides insurance coverage through private sources.

Contact was also established with the administrator/officiate of each of fifteen unique Trusts or Consortiums, established in the State of Indiana. The fifteen organizations represent, collectively, 130 public school systems. The administrators were asked to endorse the schools' participation and, where appropriate, facilitate the completion of surveys from either the schools or carriers/vendors.

Based on the school responses, and their explicit authorization, carriers/vendors were identified to which subsequent surveys were sent. Data elements in the carrier request included the following:

- Policy information
- Consortium/Purchasing Group participation
- Broker/Consultant Compensation (Commissions, Overrides, Bonuses, etc.)
- Financial Terms
- Monthly Claims Figures
- Monthly Enrollment Figures

The following outlines the response rate from the carriers and vendors:

- 313 out of 321 Medical plans (98%)
- 147 out of 159 Dental plans (92%)
- 77 out of 82 Vision plans (85%)

A comprehensive validation process took place whereby all responses were peer reviewed for “reasonableness” in response. The completed school and carrier responses were reviewed for completeness, accuracy, and logic then subsequently entered into the database. If information was incomplete or required clarity, an outreach attempt was made to either the school or carrier.

Although the data collection process did NOT ask for protected health information (PHI), all information collected was treated in a HIPAA-compliant manner. Information from the data collection process will only be disclosed to individuals authorized by the Budget Agency deemed necessary to meet the legislative intent of the evaluation.

Qualifications and Caveats

The cost projections in this report are based upon the data collected from public schools, the carriers serving these schools, and data provided by the State of Indiana. Mercer did not audit any of the data but did perform reasonability tests and made numerous calls and outreaches to confirm and / or edit data which appeared to be inconsistent. Mercer also utilized its own proprietary databases and experience to confirm that the data provided and used in the analysis was reasonable. ***However, all estimates, based upon the information available at a point in time, are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate.***

All school corporations and public universities complied with the data request. However, the analysis of most data dimensions were based upon less than 100% of the responses due to various data issues. For most data dimensions, the analysis was based upon approximately 96% or more of the covered participating lives. Sizing estimates were made to account for the remaining lives.

Mercer believes that the estimates in this report are reasonable estimates for the purposes of making strategic and high level tactical decisions. However, as noted previously, all estimates are subject to variance and unforeseen events. Therefore, all projections need to be understood as having a plus or minus range to account for the many assumptions which were involved in each dimension of potential savings and future state facts which may prove different than assumed. Further, the projections in this report do not anticipate or forecast any impact which for may occur due to the recently passed Patient Protection and Affordability Care Act (PPACA). Most of the impacts of health care reform are scheduled to occur in 2014 and later. However, Mercer believes that the cost of compliance with PPACA will be significant for Indiana public schools in the current state. Another unquantified advantage of Scenario 4 in this report is the ability to efficiently and effectively comply with Federal and State regulations in the future.

Benchmark participants – Schools less than 500 EEs

ADRIAN PUBLIC SCHOOLS
ALEXANDER DAWSON SCHOOL
AMANDA-CLEARCREEK LOCAL SCHOOL DISTRICT
BACON COUNTY BOARD OF EDUCATION
BELOIT-TURNER SCHOOL DISTRICT
CAMDEN COUNTY BOARD EDUCATION
CARROLL CO SCHOOL DISTRICT
DETROIT COUNTRY DAY SCHOOL
DEXTER COMMUNITY SCHOOLS
DISTRICT 31 NEWMARKET
EVERGREEN PARK SCHOOL DISTRICT
FOULK PRE-SCHOOL & DAY CARE CENTER
GLEN ELLYN SCHOOL DISTRICT 41
GREENFIELD R-IV SCHOOL DISTRICT
GRUNDY CENTER COMMUNITY SCHOOL
HANOVER PUBLIC SCHOOL DISTRICT
HARRISON COMMUNITY SCHOOL
HERKIMER COUNTY BOARD COOP
KALAMAZOO VALLEY CMNTY COLLEGE
KLAMATH FALLS CITY SCHOOL DISTRICT
MAURICE RIVER TWP SCHOOL DST
MILBANK SCHOOL DISTRICT 25-4
MINERAL SPRINGS SCHOOL DST
MISSISSIPPI BEND AREA EDUCATION AGENCY 9
OUR LADY OF MERCY HIGH SCHOOL
QUAPAW PUBLIC SCHOOL
ROCKWELL-SWALEDALE COMM SCH
SCHOOL DISTRICT OF WHITE LAKE
SITKA SCHOOL DISTRICT
SOUTH HARRISON SCHOOL DIST R2
SOUTH SANPETE SCHOOL DISTRICT
SOUTHERN KERN UNIFIED SCHL DST
ST MATTHEWS EARLY EDUCATN CTR
ST. CLAIR SCHOOL DISTRICT
SUN RIVER VALLEY SCHL DST 55F
TONKAWA PUBLIC SCHOOL DISTRICT
TOWER HILL SCHOOL ASSOCIATION
WARREN COUNTY R-111 SCHOOL DST
WHITEFACE CNSLD IND SCHL DST

Benchmark participants – Schools 500+ EEs

ACADEMY SCHOOL DISTRICT TWENTY
ATLANTA BOARD OF EDUCATION
AUSTIN INDEPENDENT SCHOOL DST
BALTIMORE COUNTY PUBLIC SCHOOLS
BEDFORD COUNTY PUBLIC SCHOOLS
BLOOMINGTON PUBLIC SCHOOLS, SCHOOL DISTR
BOARD OF PUBLIC EDUCATION SCHOOL
BROOM-TIGOA BOARD OF COOP EDUC SVCS
CADDO PARISH SCHOOL BOARD
CAMDENTON R3 SCHOOL DISTRICT
CENTRAL CNSLD. SCHL. DIST. 22
CHARLES COUNTY PUBLIC SCHOOL
CITY OF PUBLIC SCHOOLS SUFFOLK
CITY OF VIRGINIA BEACH PUBLIC SCHOOLS
CITY SCHOOL DISTRICT
CLARKSVILLE-MONTGOMERY COUNTY
COLLEGE COMMUNITY SCHOOLS INC
COLUMBUS COUNTY GOVERNMENT
COMAL INDEPENDENT SCHOOL DST
COMPTON UNIFIED SCHOOL DST
CONSOLIDATED LIBRARY DST NO 3
COOK CNTY BOARD OF EDUCATION
CORPUS CHRISTI IND SCHL DST
CYPRESS-FAIRBANKS ISD
DEER VALLEY SCHOOL DST 97
DUVAL COUNTY PUBLIC SCHOOLS
EDUCATION CHICAGO OFFC
EL PASO COUNTY SCHOOL DST 11
EL PASO COUNTY SCHOOL DST NO 3
ELKO COUNTY SCHOOL DISTRICT
ESCAMBIA COUNTY SCHOOL BOARD
FLAGLER COUNTY SCHOOLS
FRANKLIN COUNTY PUBLIC SCHOOLS
FREMONT BOARD OF EDUCATION
HAZELWOOD SCHOOL DISTRICT
HESPERIA UNIFIED SCHOOL DST
HILLSBOROUGH COMMUNITY COLLEGE
HOUSTON INDEPENDENT SCHOOL DISTRICT
HURON VALLEY BOARD EDUCATION
IDAHO FALLS SCHOOL DISTRICT 91
JOHNSON CITY CENTRAL SD
KAMEHAMEHA SCHOOLS
KENTWOOD PUBLIC SCHOOLS
LEON COUNTY SCHOOL BOARD
LONG BEACH UNIFIED SCHOOL DIST
LOS ANGELES UNIFIED SCHL DIST
MENTOR EXEMPTED VILLAGE BRD. OF EDU.
MESA PUBLIC SCHOOL DISTRICT
MESQUITE INDEPENDENT SCHL DST
METROPOLITAN NASHVILLE PUBLIC SCHOOLS
MISSOULA COUNTY PUBLIC SCHOOLS
MORENO VALLEY UNIFIED SCHOOL DISTRICT
MT PLSANT CMNTY SCHL FUNDATION
MUSCOGEE COUNTY SCHOOL DST
NATOMAS UNIFIED SCHOOL DST
NEW KENT, COUNTY OF
NEWARK CITY SCHOOLS
NORTHSIDE INDEPENDENT SCHL DST
NORTHWESTERN OKLAHOMA STATE UNIVERSITY
OAK HILLS LOCAL SCHOOL DST
OAKLAND SCHOOLS
ORANGEBURG 5
OSSEO AREA SCHOOL
OSWEGO CMNTY UNIT SCHL DST 308
PLAINFIELD COMMUNITY SCHL CORP
PLANO INDEPENDENT SCHOOL DST
POUDRE SCHOOL DISTRICT
RACINE UNIFIED SCHOOL DISTRICT
RICHMOND PUBLIC SCHOOLS
RIVERVIEW GARDENS SCHOOL DIST
ROCHESTER CITY SCHOOL DISTRICT
ROCKFORD SCHOOL DST NUMBER 205
SALEM-KEIZER PUBLIC SCHOOL
SALINAS CITY SCHOOL DISTRICT
SCHOOL BOARD PINELLAS CNTY FLA
SCHOOL DISTR CITY HIGHLAND PRK
ST CHARLES PARISH SCHOOL BOARD
ST JOHN BAPTIST PARISH SCHL BD
ST JOSEPH SCHOOL DISTRICT
ST LANDRY PRH SCHL BD CNSLD 1
TERREBONE PARISH SCHOOL BOARD
TOLEDO PUBLIC SCHOOLS
TUCSON UNIFIED SCHOOL DISTRICT
UNIFIED SCHOOL DISTRICT 233
UNIFIED SCHOOL DISTRICT 259
WARREN COUNTY PUBLIC SCHOOLS
WASHOE COUNTY SCHOOL DISTRICT
WAUSAU SCHOOL DISTRICT
WEST DES MOINES COMMUNITY SCHOOLS
WHITTIER UNION HIGH SCHL DIST
WOBURN PUBLIC SCHOOLS

Benchmark participants – Colleges & Universities 500+ EEs

ADELPHI UNIVERSITY
ALFRED UNIVERSITY
ALVERNO COLLEGE
ART INSTITUTE OF CHICAGO
BALL STATE UNIVERSITY
BAYLOR COLLEGE OF MEDICINE
BOARD OF REGENTS OF THE UNIV SYS OF GA
BUCKNELL UNIVERSITY
CAREER EDUCATION CORPORATION
CASE WESTERN RESERVE UNIVERSITY
CLEVELAND STATE UNIVERSITY
COCHISE CNTY CMNTY COLLEGE DST
COLBY COLLEGE
COLUMBIA UNIVERSITY
CORINTHIAN COLLEGES, INC.
CORNELL UNIVERSITY
DAVENPORT UNIVERSITY
DAYTONA STATE COLLEGE INC
DUKE UNIVERSITY
DUQUESNE UNIV OF HOLY SPIRIT
EASTERN MICHIGAN UNIVERSITY
EDUCATION MANAGEMENT CORPORATION
FURMAN UNIVERSITY
GEORGE MASON UNIVERSITY
HARRISBURG AREA COMMUNITY
INDIANA UNIVERSITY
IRON MOUNTAIN INC
JAMES MADISON UNIVERSITY
LAFAYETTE COLLEGE
LAKELAND COMMUNITY COLLEGE
LEHIGH UNIVERSITY
LOS ANGELES CMNTY COLLEGE DST
LOYOLA UNIVERSITY OF CHICAGO
MARIST COLLEGE
MASSACHUSETTS INSTITUTE OF TECHNOLOGY
MEHARRY MEDICAL COLLEGE
MESSIAH COLLEGE
MIAMI DADE COLLEGE FOUNDATION
MIAMI UNIVERSITY
MICHIGAN STATE UNIVERSITY
MISSOURI STATE UNIVERSITY
NAZARETH COLLEGE
NEW MEXICO STATE UNIVERSITY
NEW YORK SCHOOL OF MEDICINE
NOVA SOUTHEASTERN UNIVERSITY
OAK RIDGE ASSOCIATED UNIVERSITIES
OBERLIN COLLEGE
OHIO UNIVERSITY
OKLAHOMA STATE UNIVERSITY
OREGON UNIVERSITY SYSTEM
PENN STATE UNIVERSITY
PRINCIPIA CORPORATION
PROVIDENCE COLLEGE
RENSSELAER POLYTECHNIC INSTITUTE
RIDER UNIVERSITY
ROCHESTER INSTITUTE OF TECHNOLOGY
SEATTLE UNIVERSITY
SETON HALL UNIVERSITY
TEACHERS COLLEGE, COLUMBIA UNIVERSITY
TEXAS A&M UNIVERSITY SYSTEM
TROY UNIVERSITY
TRUSTEES GRINNELL COLLEGE
TRUSTEES OF MT HOLYOKE COLLEGE
TRUSTEES OF SMITH COLLEGE
TULSA COMMUNITY COLLEGE
UNIVERSITY OF ALASKA
UNIVERSITY OF ARKANSAS SYSTEM
UNIVERSITY OF CINCINNATI
UNIVERSITY OF DAYTON
UNIVERSITY OF IOWA
UNIVERSITY OF KENTUCKY
UNIVERSITY OF MARYLAND
UNIVERSITY OF MINNESOTA
UNIVERSITY OF OKLAHOMA
UNIVERSITY OF PTTSBURGH-BENEFITS DEPT.
UNIVERSITY OF ROCHESTER
UNIVERSITY OF TOLEDO
UNIVERSITY OF UTAH
UNIVERSITY SYSTEM OF NEW HAMPSHIRE
UNIVERSITY WISCONSIN SYSTEM
VANDERBILT UNIVERSITY
WAYNESBURG UNIVERSITY
WEST VIRGINIA UNIVERSITY
WIDENER UNIVERSITY
WRIGHT STATE UNIVERSITY

Benchmark participants – State Government

ALABAMA STATE EMPLOYEES INSURANCE BOARD
CALPERS
COMMONWEALTH OF KENTUCKY
COMMONWEALTH OF VIRGINIA
EMPLOYEES RETIREMENT SYSTEM OF TEXAS
GROUP INSURANCE COMMISSION
KANSAS HEALTH POLICY AUTHORITY
MISSOURI CONSOLIDATED HEALTH CARE PLAN
NOPERS
OK STATE & EDUCATION EMP GRP INS BOARD
STATE OF ALASKA/DEPARTMENT OF ADMIN.
STATE OF ARKANSAS EMPLOYEE BENEFITS DIV.
STATE OF COLORADO
STATE OF DELAWARE - STATEWIDE BENEFITS
STATE OF FL., EMPLOYEE HEALTH INSURANCE
STATE OF INDIANA
STATE OF IOWA
STATE OF LOUISIANA OFFICE OF GROUP BENEF
STATE OF MAINE
STATE OF MINNESOTA
STATE OF MISSISSIPPI, DFA, OFFICE OF INS
STATE OF MONTANA
STATE OF NEVADA
STATE OF NEW HAMPSHIRE
STATE OF NEW JERSEY
STATE OF NORTH CAROLINA-STATE EMPLOYEES
STATE OF OHIO DEPT ADMIN SERVICES S
STATE OF OREGON
STATE OF RHODE ISLAND
STATE OF S.C. EMP. INSURANCE PROGRAM
STATE OF TENNESSEE DIVISION OF BENEFITS
STATE OF VERMONT
STATE OF WISCONSIN-EMPLOYEE TRUST FUNDS
STATE OF WYOMING EMPLOYEES GROUP INSUR
UTAH DEPARTMENT OF HUMAN RESOURCE MGMT
WA STATE HEALTH CARE AUTHORITY
WV PUBLIC EMPLOYEES INS AGENCY

MERCER

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