Stacey Cockroft

From:	Stacey Cockroft
Sent:	Wednesday, April 22, 2020 1:47 PM
To:	Anne McCabe; Dave Jones; David Brighton; Dylan Hooper; Elizabeth Hayes; Jimmy Love; Joel Burns; Jordan Chilson; Matt Fischer; Stephanie Bohrnsen; Vaughn Dosko
Subject:	Specific Stop Loss 3/31/2020

Good Afternoon,

Below is the specific stop loss report effective 3/31/2020. Please note the first two members have been lasered, so there will be no reimbursement for those individuals. The third member has not went over the $250,000 threshold yet.

Subscriber	Total Amt	Amt over Spec	Amt Requested	Amt Reimbursed	Non Reimbursed Expenses	Amt Open
1 ***LASERED***	$ 421,837.57					
2 ***LASERED***	$ 408,659.86					
3	$ 218,382.98					
	$ 1,048,880.41	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Thanks,

Stacey Cockroft

Kenai Peninsula Borough School District

Employee Benefits Manager

148 N. Binkley St. Soldotna, AK 99669

Phone: (907) 714-8879 Fax: (907) 262-9645

scockroft@kpbsd.k12.ak.us

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Traditional & HDHP (HRA) - July 1, 2019 through December 31, 2019

Kenai Peninsula Borough School District

Health Care Committee Monthly recap
as of March 31, 2020.

Reserve Account	As of 6-30-18	As of 6-30-19
Employee Share	471,065.27	750,000.00
Employer Share	1,572,408.17	2,418,648.76

FY20 Monthly Contribution - Traditional	
Employee Share *	469.36
Employer Share	2,659.73
	3,129.09

FY20 Monthly Contribution - HDHP	
Employee Share *	302.34
Employer Share	1,713.29
	2,015.63

This document is provided to the Health Care Committee as a work paper to recap the contributions to and expenditures from the Health Care Plan each month. It is to be used primarily as an aid in estimating costs of the plan to determine if changes should be made in employee contribution amounts. Every effort is made to provide current and accurate information, but this information is not audited until after the end of the fiscal year.

	Number of Employees	YTD Employees		Current Month Obligations	YTD Obligations	Contributions Current Month Collected	Contributions YTD Collected
Employees							
KPEA Employees	-	1,687		-	791,810.32	-	790,871.60
KPEA Employees - HDHP	-	1,672		-	505,512.48	-	503,214.71
KPEA Repay EE Reserve							
KPESA Employees	-	953		-	447,300.08	-	443,075.82
KPESA Employees - HDHP	-	1,083		-	327,434.22	-	327,286.42
KPESA Repay EE Reserve							
Administrators	-	113		-	53,037.68	-	53,507.04
Administrators - HDHP	-	225		-	68,026.50	-	68,933.52
Admin Repay EE Reserve							
Board Members	-	6		-	2,816.16	-	3,519.50
Board Members - HDHP	-	18		-	5,442.12	-	4,950.00
Board Repay EE Reserve							
Exempt Employees	-	61		-	28,630.96	-	28,659.60
Exempt Employees - HDHP	-	97		-	29,326.98	-	29,931.66
Exempt Repay EE Reserve							
Affordable Care Act **				-	0.00	-	
ACA Empl Repay EE Reserve							
Total Employees on Payroll	-	**5,915**		-	**2,259,337.50**	-	**2,253,949.87**
COBRA Payers (FY20 = $2534.08)	-	11		-	28,532.47	-	28,532.47
COBRA HD Payers (FY20 = $1886.06)	-	10		-	19,030.48	-	19,030.48
Total Employees	-	**5,936**	**Total**	-	* **2,306,900.45**	-	**2,301,512.82**

* Current month employee obligations are a calculation of "Number of Employees" eligible for health care coverage during that month times the "Employee Share" (shown in the upper right corner of the sheet).

** Affordable Care Act (ACA) coverage is offered to employees once eligibility is determined. Eligiblity is based on number of hours worked during the measurement period.

	Number of Employees	YTD Employees	Current Month Obligations	YTD Obligations	Contributions Current Month Collected	Contributions YTD Collected
Employer						
Employer share	-	2,820	-	7,500,438.60	-	5,638,586.69
Employer share - HDHP	-	3,095	-	5,302,632.55	-	4,887,372.29
Total			-	**15,109,971.60**	-	**12,827,471.80**

+ Employee Share Split	**FY20 Contribution Traditional**	**469.36**	**Subtotal**	-	1,319,633.56
	Cobra	**2,534.08**	**Subtotal**	-	28,532.47
				-	1,348,166.03
	FY20 Contribution HDHP	**302.34**	**Subtotal**	-	934,316.31
	Cobra HD	**1,886.06**	**Subtotal**	-	19,030.48
				-	953,346.79

Expenditures

Since the health care plan is self-funded, both employee and employer contributions are collected and bills are paid from the accumulated funds.

	TRADITIONAL		HDHP	
Claims	**Current Month**	**Year-To-Date**	**Current Month**	**Year-To-Date**
Health Care Claims paid by TPA (Rehn)	547,774.01	8,892,405.59	285,937.87	4,539,624.44
Prescription Claims paid by Caremark	-	2,025,151.61	-	540,006.38
HRA	-	-	-	167,348.39
HSA	-	-	-	
Total Claims Paid	547,774.01	10,917,557.20	285,937.87	5,246,979.21
Administration				
TPA (Rehn) fees and costs	-	124,404.44	-	-
TPA (Rehn) HRA fees and costs	-	-	-	157,263.21
Aetna Administration Fees	-	60,706.72	-	66,678.64
Consultant Fees	-	14,111.85	-	15,488.13
Stop Loss Premiums	-	797,193.41	-	875,763.76
RX Health	-	-	-	-
Affordable Care Act Fee	-	22,082.83	-	23,903.89
Total Administration	-	1,018,499.25	-	1,139,097.63
Total Claims plus Administration	547,774.01	11,936,056.45	285,937.87	6,386,076.84
Adjustments				
Stop Loss reimbursements	-	(2,383,308.73)	-	-
Prescription Rebates	-	(261,640.81)	-	(144,430.54)
Health Care Claims refund	-	-	-	-
Claims reimbursements	(550.00)	(4,150.00)	-	(750.00)
Other adjustments	-	-	-	-
Total Adjustments	(550.00)	(2,649,099.54)	-	(145,180.54)
Total Expenditures	547,224.01	9,286,956.91	285,937.87	6,240,896.30

Obligations/Contributions

Health care obligations and contributions provide employee and employer amounts of health care contributions using different calculation methods.

Obligations are estimates of funds that employees and the district will be obligated to contribute, based on the plan year (July through June).

Returning employees are covered by the health care plan for the entire plan year, meaning the 12 month period July through June; both employee and employer are obligated to pay for 12 months of coverage. New employees pay for coverage from date of hire through June, the end of the plan year. If an employee works at all during a month, both employee and employer pay for the entire month of coverage.

Actual Contributions made by employees and benefits paid by the employer during the payroll process are shown on the sheet in the columns labeled "Collected." The division of payments is governed by the Collective Bargaining Agreements and Memorandums of Understanding between the district and the employee groups.

Employee-paid contributions are deductions from payroll checks. Employees who work 12 months make contributions each pay period. Many school district employees do not work 12 months, so contributions are collected for those employees during the 9 month period from September through May.

For this reason, contributions are generally larger than obligations for September through May and contributions are generally smaller than obligations for June, July and August.

The "Collected" columns show what is actually available for paying health care costs. The "Obligations" show what is estimated to be available by month, based on number of employees at the current rate of contributions.

Traditional & HDHP (HRA) - July 1, 2019 through December 31, 2019

Kenai Peninsula Borough School District
Healthcare Expenditures Split
as of March 31, 2020.

Traditional Plan	
YTD Participants	2,820
Net Expenditures	9,286,956.91
ER - Employer portion (85%)	7,893,913.37
EE - Employee portion (15%)	1,393,043.54
Total ER & EE Expenditures	9,286,956.91

HDHP (HRA)	
YTD Participants	3,095
Net Expenditures	6,240,896.30
ER - Employer portion (85%)	5,304,761.86
EE - Employee portion (15%)	936,134.45
Total ER & EE Expenditures	6,240,896.30

Traditional Summary

Through Current Month	YTD EXP	YTD REV	REV Less EXP
Employer	7,893,913.37	5,638,586.69	(2,255,326.68)
Employee	1,393,043.54	1,348,166.03	(44,877.51)
Totals	9,286,956.91	6,986,752.72	(2,300,204.19)

HDHP (HRA) Summary

Through Current Month	YTD EXP	YTD REV	REV Less EXP
Employer	5,304,761.86	4,887,372.29	(417,389.56)
Employee	936,134.45	953,346.79	17,212.35
Totals	6,240,896.30	5,840,719.08	(400,177.22)

Traditional

Obligation per Employee FY20		Year-to-date
469.36 EE/2659.73 ER Split	3,129.09	3,129.09
Monthly Cost per Employee - ER		2799.26
Monthly Cost per Employee - EE + Cobra		493.99
		3293.25
Current Variance		(164.16)

HDHP (HRA)

Obligation per Employee FY20		Year-to-date
302.34 EE/1713.29 ER Split	2,015.63	2,015.63
Monthly Cost per Employee - ER		1713.98
Monthly Cost per Employee - EE + Cobra		302.47
		2016.44
Current Variance		(0.81)

Obligations indicate the funds that will be accumulated per employee per month. Expenditures are amounts that have been paid through the plan.

A positive number for "current variance" represents the amount per employee per month that is estimated to be collected above the amount spent year-to-date. A negative number represents the amount of expenditures (per employee per month) that are more than what is estimated to be collected for payment of those expenditures.

HDHP (HRA & HSA) - January 1, 2020 through June 30, 2020

Kenai Peninsula Borough School District
Healthcare Expenditures Split
as of March 31, 2020.

YTD Participants	2,940
Net Expenditures	4,195,029.25
ER - Employer portion (85%)	3,565,774.86
EE - Employee portion (15%)	629,254.39
Total ER & EE Expenditures	4,195,029.25

Through Current Month		YTD EXP	YTD REV	REV Less EXP
Employer		3,565,774.86	7,282,395.20	3,716,620.34
Employee		629,254.39	1,303,933.84	674,679.45
	Totals	4,195,029.25	8,586,329.04	4,391,299.79

Obligation per Employee FY20			Year-to-date
	369.67/2094.82ER Split	2,464.79	2,464.79
Monthly Cost per Employee - ER			1212.85
Monthly Cost per Employee - EE + Cobra			214.03
			1426.88
	Current Variance		**1,037.91**

Obligations indicate the funds that will be accumulated per employee per month. Expenditures are amounts that have been paid through the plan.

A positive number for "current variance" represents the amount per employee per month that is estimated to be collected above the amount spent year-to-date. A negative number represents the amount of expenditures (per employee per month) that are more than what is estimated to be collected for payment of those expenditures.

JDOLAW
JERMAIN DUNNAGAN & OWENS, P.C.
3000 A Street, Suite 300 • Anchorage, Alaska 99503
tel 907.563.8844 • fax 907.563.7322 • www.jdolaw.com

To: Dave Jones, Acting Superintendent
Heath Care Program Committee Members

From: Saul R. Friedman, School District Attorney

Re: Legal Opinion Regarding the Powers and Authority of the Health Care Program Committee and Subcommittee

Dated: April 21, 2020

You asked if the Health Care Program Committee ("HCPC") has the power/authority to change the employee contributions from a one tier, consolidated rate structure to a four tiered rate structure, divided into separate contribution amounts for Single, Single + Spouse, Single + Child(ren), and Single + Spouse + Child(ren), referred to as the Family tier. In my opinion, for the reasons set forth below, it does not.

You also asked if the Health Care Subcommittee has the power to make that change separate from the HCPC. Similarly, it is my opinion that it does not. My reasons follow.

For purposes of this opinion letter, I am citing to Article 27 of the KPESA CBA. The language of that Article is the same as the language in Section 10 of the KPEA CBA. In analyzing your questions, the overriding factor is that the HCPC and its Subcommittee exist solely because the parties to the CBAs established those committees by negotiating their existence and authority, with each CBA being ratified by both the School Board and the association memberships. Therefore, each committee's power/authority cannot be greater than what the parties intended in the CBAs. That intent is determined through the language of the contract and the parties' negotiating history.

In Article 27, fifth paragraph, p. 45, the HCPC is granted identified, but limited, powers. Specifically, the HCPC is "empowered to determine health care benefits different from benefits in place ..." That paragraph further authorizes the HCPC to "determine and control the health care program...during the term of this agreement including but not limited to the following: benefits and coverage provided, cost containment measures, preferred provider programs, co-payment provisions...."

The third paragraph on p. 45 similarly acts as a limit on the authority of the HCPC where it addresses the voting procedure for the HCPC. Committee votes are allowed on matters that "could impact the costs and benefits of the health care program or on any matter that would requires a change in the Summary Plan Description."

Relevant language on page 47 creates the Health Care Subcommittee to "determine the employee contribution amount" separately for the Traditional Plan and the high deductible health plan ("HDHP") when each existed concurrently, and currently for just the HDHP, the only plan available to the District's eligible employees as of January 1, 2020.

Contract analysis shows that the identified powers do not include the authority to adopt a tiered rate. First, the term "employee contribution amount," contractually located within the language relating to the Subcommittee, does not appear in the language quoted above relating to the power/authority of the HCPC, or stating the matters on which it can vote. The lack of use of that term is significant, considering that the amount of District and employee contributions has historically been the primary and most contentious bargaining topic between the parties. The parties' decision not to use that terminology reflects an understanding that District and employee contributions are not "benefits and coverages," are not "cost containment measures," and are not "preferred provider programs." As will be discussed below, they are also not "co-payment provisions."

Rather, Article 27 identifies the employee monetary responsibility for their share of Plan expenses at the bottom of page 46 as "employee's contributions" or just "contributions." Those contributions are the employee's share of "premiums." That is the term used in the middle of page 46 to describe the total of the District and employees' contributions.

The HCPC has never sought to change the percentage split of the "premium" between the District and employees, currently 85%-15%, nor suggested that it has the authority to do so. The HCPC cannot change the current 85%-15% contribution percentage because those rates are also not "co-payment provisions." Rather, co-payments establish an individual employee's share of health care facility or provider billings for services to that employee or dependents. They are not employee premium contributions. Premium contributions can only be changed through bargaining.

The Summary Plan Descriptions ("SPD") for the prior Traditional Plan and the current HDHP use the term "co-insurance" to describe the employee's share of his/her billings from health care facilities and providers. In my opinion, the term "co-payment provisions" in the CBA is synonymous with the SPD's "co-insurance" language. Therefore, a change to the employee premium contribution amount is not a change to the SPD's co-insurance percentages regarding individual billings, or the CBA's "co-payments" regarding such billings. Such employee co-insurance or co-payments are separate and distinct from their 15% premium contribution to total Plan costs.

During my review of relevant documents, I located a September 2019 Health Insurance FAQ on the District's website that discusses "co-pay" as "The employee portion of the Health Care premium..." The individual employee amount of $4,436.04/year or $367.67/month, when multiplied by the eligible employees, equals the anticipated 15%

total employee contribution. The purpose of that specific FAQ is to inform employees of the actual dollar amount of their annual/monthly contribution, an amount not set in the CBA. The FAQ also uses the term "premium," as does the CBA. In my opinion, the FAQ's use of the term "co-pay" in conjunction with "premium," but not the term "contribution," is of little significance to the interpretation of the relevant CBA language, and does not supplant or modify the CBA's "employee contribution amounts." The employee premium contribution amount is not a "co-payment provision."

Also important is the bargaining history. The lack of a multiple tiered employee contribution rate was the result of bargaining that included discussions of multiple tiers. The end result was a single (composite) tier payable by each employee. There was no discussion or intent that this determination by the bargaining teams could be later changed by the HCPC, nor was language added to the contract granting the HCPC with this express authority. Moreover, such a change would represent a significant and substantial departure from what the teams bargained at the table. A change to a four tiered employee contribution rate could have employees with families contributing three times what a single employee contributes. When the Public Education Health Trust (PEHT) provided proposed four tiered premium rates to the District for FY 19, its Plan F medical rates were $1,034/month for the single tier and $3,143/month for the family tier. Plan F is the PEHT's most comparable plan to the District's HDHP. If PEHT Plan F with its four tiers had become the District's health plan, an employee only in Plan F would be paying 15% of $1,034/ month, or $155.10/month. A family tiered employee in Plan F would be paying 15% of $3,143/month or $471/month, three times more than the individual employee.

Lastly, the CBA allows the Subcommittee to "determine the employee contribution amount." That language does not empower the Subcommittee to change the employee 15% share of Plan costs. The Subcommittee cannot possess more authority than the HCPC. What that language allows is for the Subcommittee to set the anticipated total amount of that 15% share and determine the employees' payroll deduction for that share of the Plan's premium. That payroll deduction is the same amount for all enrolled employees. If that set monthly amount was too low after the Plan's total costs are determined at the end of the Plan year, use of the Employee Health Care Reserve Account can make up the difference. If set too high, the overpayment may be credited against subsequent year employee contributions. The point is that the Subcommittee needs the power to change that payroll deduction amount during the Plan year as annual projections of Plan costs change. That is an important, but limited, empowerment to benefit the enrolled employees.

In conclusion, the CBA does not authorize either the HCPC or the Subcommittee to change the single tier (composite) employee contribution amount paid by each enrolled employee to four different monthly employee contribution amounts. For such a drastic change to take place after ratification by the membership of a one tiered system, the CBA language must state clearly and unambiguously that such power has been granted. In my opinion, the language does not come close to meeting that standard.

LANDYE BENNETT
BLUMSTEIN LLP
ATTORNEYS

MEMORANDUM

TO: Glenn Bafia, Executive Director and Josh Yeh, Uniserv Director
NEA-Alaska

FROM: Kim Dunn

DATE: April 21, 2020

RE: Legal Opinion on Healthcare Provision

KPEA has asked for a legal opinion on the Health Care Program Committee's (HCPC) authority to implement a tiered structure of benefits. The HCPC is made up of appointees from three unions, employees appointed by the Superintendent, and administration advisors, but does not itself represent any one union. It has the general authority to make recommendations to the Kenai Peninsula Borough School District with respect to the District's health plan.

For purposes of this opinion, I assume that the broker/consultant has presented a tiered structure for the HCPC to consider, that the District administration favors a tiered structure for cost containment, and that some KPEA/KPESA members will object to a tiered structure.

The issue of the HCPC's authority is two-fold:

(1) Does the HCPC have the power to review and recommend a tiered structure to the District?

Answer: **Yes**, based on the most current language describing the HCPC's role.

(2) Would the District have the power, with the HCPC's approval, to implement a tiered structure under Section 210 of the CBA, without first negotiating that change with the affected unions?

Answer: **No.** There is no evidence of delegated power to change material CBA provisions.

Both questions turn on the question of delegation. While both answers could change with evidence of contrary bargaining intent, the answer to question (2) appears to be clear based on the terminology used between 2009 and 2012 and unchanged 8 years later.

LBB

MEMORANDUM
April 21, 2020

Background. The health committee language in KPEA's CBA has changed and expanded over the last several years.[1] Tiered rates have been addressed twice, in the 2003-2006 and 2009-2012 CBAs, and both times the Committee played some role in addressing costs.

The 2003-2006 CBA required the committee to review tiered rates as a potential cost savings. The 2003-2006 CBA listed 3 cost control options to consider, with one being "establishing dependent charge to cover/reduce cost of co-pay." The assignment specified that the "membership would include affected groups with voting to reflect their percentage of the total pool, but could vote their share proportionally." The District's contribution was capped, and another provision stated: "A determination of any additional employee and/or dependent co-payment shall be made annually, in May for the subsequent year." (Underlines added). The 2003-2006 agreement was explicit in addressing tiering for dependents. In contrast, the next CBA covering 2007-2009 made no reference to tiers.

In 2009, the District and KPEA negotiated a 3-year contract that required tiered benefits to start in FY 2012, and gave the committee the power to decide employee monthly costs and dependent costs.

In 2012, the parties bargained to impasse, in part because of health benefit disputes and KPEA's objection to tiered benefits. Arbitrator Katie Whalen issued an advisory determination favoring KPEA/KPESA's health plan proposals, recommending that the parties eliminate tiered benefits and drop the 50/50 split for health care costs over the caps. Whalen's decision was explicitly based on economic conditions present at the time, including high health care cost increases and wage status. There was no question that the unions had been reluctant to accept a tiered structure in 2009 and were opposed to adopting tiers in 2012.

The final CBA, most likely signed weeks after Whalen's decision, eliminated the tiered structure, as shown in the deletion below:

2009 Language with 2012 Changes Noted in Red:

> ~~Effective FY 10 and FY 11, b~~Benefits are afforded to the employee, spouse and all eligible dependents~~. Effective FY 12, health benefits are afforded to employees only. Effective July 1, 2011 employees may elect to have dependent and/or spouse coverage per the following rate schedule:~~

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[1] In 1999-2002, the "Health Insurance Committee" provision was two sentences long, and required the committee to determine and control benefits, co-payments and cost-saving measures during the term of this Agreement." It guaranteed KPEA the same number of members as "any other bargaining unit," not less than 3. The 2007-2009 agreement added the Director of Human Resources as the Plan Administrator and defined the committee as having 9 members. The committee was required to adopt bylaws and hold monthly meetings.

The 2012 bargain also made major changes to the health care committee provisions, more formally defining its composition and operation in two new paragraphs, including a provision specifying that the Superintendent would appoint 3 employee members, for a total of 11 members (compared to the previous 9). The language addressing the Committee's function was both broadened and narrowed:

> ~~A health care cost committee~~ The Health Care Program Committee shall be empowered to determine health care benefits different from benefits in the plan in place on January 1, 2013. The committee ~~shall~~will determine and control the health care program for all District employees covered by the program during the term of this agreement including but not limited to the following~~; setting the amount of employee monthly contributions and dependent coverage costs,~~:[2] benefits and coverage provided, cost containment measures, ~~evaluating and deciding the outcome of appeals, regulating use of the health care cost reserve account~~preferred provider programs, co-payment provisions, evaluating other health insurance programs, and implementing any wellness measures it deems beneficial to employees and the health care program. The District shall not be required to adopt changes made by the HCPC which would result in violations of established laws or regulations.

Impact of the 2012 Language Changes.

The first issue is whether the CBA prohibits tiering by the surviving sentence: "Benefits are *afforded* to the employee, spouse and all eligible dependents" (emphasis added). By itself, the phrase is not crystal clear, because the word "afforded" can mean to supply, provide or to offer an opportunity. This ambiguity means that contract intent is determined by context and background.

The evidence shows that the parties used the word "afforded" to mean *provide*, not to offer or make available through election. In the 2009 version of the CBA, the language explicitly stated that benefits were only "afforded to employees," and not to spouse and dependents, when the tiered structure was effective. In the first two years before FY 2012, the term "afforded" meant to *provide*. Similarly, Arbitrator Whalen's decision referred explicitly to KPEA's proposal to eliminate tiered rates and to instead "afford" coverage to spouse/dependents. After Whalen's recommendation, the parties used the phrase "afforded" in a consistent manner.[3] Thus, absent

[2] This deletion removed language that first appeared in the 2009-2012 agreement, along with the tiered structure applicable to the third year of the contract.

[3] Documents presented to Whalen would disclose in greater detail how the union used the term "afforded" in late 2012. The 2007-2009 CBA did not have any language regarding tiers or "afforded," with the term appearing apparently for the first time in the 2009-2012 agreement

other evidence, this phrase was intended to abolish tiers. I have no evidence to suggest the meaning of the phrase has changed since 2012.

At the same time, this limitation does not preclude the HCPC from considering or recommending a tiered plan. The deletion of the language allowing the Committee to "set the amount of employee monthly contributions and dependent coverage costs" is consistent with the fact that the Committee was no longer *obligated* to address tiered or dependent costs. By itself, however, the deletion would not prohibit the Committee from evaluating tiered rates, given other changes to the Committee's role and the complexity of the economic issues bargained in 2012/2013. The list of allowed activities explicitly states that it is not intended to be an exclusive list of the committee's activities. And, the revised provision adds a new power to the Committee: to "evaluat[e] other health insurance programs."

Other language in the 2012 paragraph suggests an intent to expand the Committee's role. The name is changed from the "cost" committee to the "program" committee. The first sentence, although not completely clear, emphasizes the Committee's latitude to deviate from the benefits existing on the effective date of the contract.[4] The new sentence at the end of the paragraph (and repeated again in a later paragraph) acknowledges that the HCPC might even recommend changes that would potentially violate the law, hinting at broad authority to consider options, hear from experts, and evaluate programs.

Other provisions were added in 2012: the Committee was explicitly assigned only an advisory role on matters of Broker selection, TPA, and Stop-Loss insurance. A subcommittee of union representatives only was formed to determine the "employee contribution amount" and to determine use of the employee's healthcare reserve account. This subcommittee formation confirms the HCPC's revised scope in 2012, and the role of the Superintendent's 3 appointees and advisors.

Without additional information, I can't assess the extent to which the Committee revisions may be a consequence of Whalen's advice that the parties adopt the District's proposal to create a health care Task Force. According to Whalen's description, the Task Force proposal and reserve fund changes were geared toward re-balancing the interests of the administration and the employees. Although there is no actual Task Force identified in the 2012 CBA, its concepts may have been integrated into the revised Committee role and structure. An individual with knowledge of the negotiations following Whalen's decision could shed more light on this question.

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[4] The current CBA retained the dates first referenced in the 2015-2018 CBA, obscuring what they mean in today's CBA. At least in 2012, the original sentence cited benefits provided in "January 2013," referring to the plan that was in place at the time the parties finished bargaining, several months after the last contract expired.

In the absence of bargaining notes, I conclude that the Committee has substantial latitude to consider and recommend options for the benefit of employees. If the consultant, District or union committee members sought to make major changes to the existing health program, for example, the Committee would be the natural place to start "evaluating" program options. Again, this conclusion could be rebutted by evidence that the HCPC was intended to have a more limited role, or that the parties have rejected a broader role in the last 8 years.

This does not mean that the Committee's recommendations would legally bind the three unions who appointed members to the HCPC. A Committee recommendation to alter the expressly bargained requirements of the health plan as set-out in the CBA would be largely advisory to the District. The requirement that benefits be afforded to spouses and dependents is a material element of the CBA, which can't be changed unilaterally by the District.

In other words, while the HCPC's evaluative and advisory power is broad, the HCPC has no authority to bargain on behalf of bargaining units. As Elkouri states generally, even union committees lack the power to alter CBA provisions:

> Arbitrators have strictly required a showing of authorization or ratification by the union membership of any action of a union committee that changes the terms of the collective agreement. "To hold otherwise would mean that a local Union committee meeting with management could dissipate the contractual benefits of its membership without its approval." For this reason, a union field representative cannot change [a CBA] unless such authority is clearly vested in the representative by the union membership."

Consequently, if the HCPC concluded that a tiered design would benefit employees, the District could then propose to negotiate with each of its 3 unions. Whether the District would have any obligation to attempt negotiations, is a question outside the scope of this opinion. Education unions can formally establish health committees to engage in bargaining and to address reopeners, but the KPEA CBA does not contain the needed language to grant that power.

Please let me know if you have any questions or if additional documentation is available.

(Full text of the 2009 Health Plan provision is quoted below).

MEMORANDUM
April 21, 2020

2009 – 2012

The District health care program is self-funded. Program costs are solely a product of administrative expenses and actual claims experience.

A health care cost committee shall determine and control the health care program for all District employees covered by the program during the term of this agreement including but not limited to the following; setting the amount of employee monthly contributions and dependent coverage costs, benefits and coverage provided, cost containment measures, evaluating and deciding the outcome of appeals, regulating use of the health care cost reserve account, and implementing any wellness measures it deems beneficial to employees and the health care program. The committee will be composed of up to nine (9) members and KPEA will be entitled to at least three (3) Association representatives on the committee. The Director of Human Resources will be the plan administrator.

The committee shall annually review by-laws in September of each year unless the committee deems that an alternate time would be better. The committee will meet monthly unless this is changed by the committee members in accordance with the committee's by-laws.

Only permanent and permanent part-time employees who currently work four (4) or more hours per day are eligible for year-round health care benefits.

The District will make contributions to the health care program for each participant on a 12-month basis as follows:

FY10 950.00 per eligible employee per month
FY11 975.00 per eligible employee per month
FY12 975.00 per eligible employee per month

Employee participants will make contributions to the health care program on a 12- month basis as follows:

FY10 175.00 per eligible employee per month
FY11 200.00 per eligible employee per month
FY12 200.00 per eligible employee per month

Effective FY 10 and FY 11, benefits are afforded to the employee, spouse and all eligible dependents.

Effective FY 12, health benefits are afforded to employees only.

Effective July 1, 2011 employees may elect to have dependent and/or spouse coverage per the following rate schedule:

Dependent Coverage: $5.00 per month per dependent
Spouse Coverage: $10 per month
Family Coverage (spouse and dependents): $30 per month

Employees who have elected no spousal and/or dependent coverage may, during open enrollment, add that coverage.*

Effective FY 10, all permanent and permanent part-time employees who work four (4) or more hours per day are required, as a condition of employment, to participate in the KPBSD health plan.

Effective FY 11 and 12, all permanent and permanent part-time employees who work six (6) or more hours per day are required, as a condition of employment, to participate in the KPBSD health plan.

Employees first hired with the District on or after July 1, 2010, for at least 4 hours per day or .50 FTE, but less than 6 hours per day or .75 FTE, may opt out of health care coverage altogether. The choice to opt out will be made upon initial employment and will be irrevocable* unless a person is rehired after employment has been terminated more than 1 school year.

*Guidelines involving "qualifying event" and "pre-existing conditions" will be followed in accordance to the health plan document.

http://www.kpbsd.k12.ak.us/employees.aspx?id=10156

All funds deposited into the health care account in excess of actual expenditures will be placed in the health care cost reserve account to be used only to offset future health care cost increases.

Expenditures in excess of available health care cost account reserves shall be borne equally between the District and all eligible employees. Should health care costs remain below the negotiated monthly cap per employee for a twelve (12) month period, any such savings shall be applied to the reserve account to offset future year expenses and/or provide additional benefits.

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The District agrees to work with the health plan committee to provide reasonable time for meetings and provide adequate support including an expert health care consultant for plan design. Administrative leave will be provided for all participants.

The District shall maintain a "reward" system to protect the plan from inaccurate charges by Service Providers. The District and employee shall evenly divide any monetary benefits resulting from the correction of such charges. Errors made by the plan administrator are ineligible for this reward.

A flexible benefit account program, under the provision of Section 125 of the Inter