An Analysis of the Decision Making Strategies of Selected School Administrators as Participants in Self-Funded Health Insurance

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LOYOLA UNIVERSITY CHICAGO

AN ANALYSIS OF THE DECISION MAKING STRATEGIES OF SELECTED SCHOOL ADMINISTRATORS AS PARTICIPANTS IN SELF-FUNDED HEALTH INSURANCE

A DISSERTATION SUBMITTED TO THE FACULTY OF THE SCHOOL OF EDUCATION FOR THE DEGREE OF DOCTOR OF EDUCATION

DEPARTMENT OF EDUCATIONAL LEADERSHIP AND POLICY STUDIES

BY
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CHICAGO, ILLINOIS
JANUARY, 1996
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ACKNOWLEDGEMENTS

I wish to thank my advisor and mentor, Dr. Mel Heller, Professor of Educational Administration at Loyola University. His guidance and expertise motivated me through the dissertation process. Thank you to Dr. Edward Rancic, who encouraged me to seek my doctorate and served on the dissertation committee. Thank you also to Dr. Lou Gatta for serving on my dissertation committee.

I thank the ten administrators who graciously gave their time and participated in the study. Without their cooperation, the study could not have been possible.

A special thanks to my wife Jane and my four children, Aimee, Jim, Julie, and Tom for their encouragement and patience during my doctoral program.
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INTRODUCTION

The spiraling cost of health care is of paramount importance in every American business and household today. Americans have the most advanced medical technology and use it more often than most countries. Most of us enjoy a freedom in choosing medical care that is the envy of foreign countries. In fact, thousands of wealthy citizens from Japan, Germany, and Canada travel to the U.S. for medical care each year. Yet, medical insurance costs have caused many Americans to be outraged. Prior to 1980, most health costs were invisible to individuals because the costs were low and borne by employers or government agencies. Since 1990, the burden of the cost has begun to shift to individuals as companies try to share the burden by asking employees to pay higher deductibles and copayments and to contribute to their insurance premiums.\(^1\) According to a recent study by Alexander Consulting Group, over twice as many employers are shifting more health care costs to employees in 1991/1992 than they did in 1990. This increase of costs to employees has caused a cooperative venture to reduce medical costs.\(^2\)

Peter G. Peterson states that the high costs of health care have been caused by seven main factors:

Inflation: Health care inflation has consistently exceeded the general inflation rate by a wide margin.

Technology: Medical technology continues to make advances that are beneficial to consumers, but extremely expensive to maintain.

Cost Shifting: The U.S. Government programs such as Medicare and Medicaid are severely underfunded. To cover these costs, hospitals and providers shift the cost to the private sector. Since 1965, the year Medicare was instituted, the costs of federal health benefits have

soared from $1.8 billion to $250 billion or from 1.4% of the federal budget to 16.5% of the budget.

Aging Society: Nearly every measure of illness, disability and health care rises with age. Seniors comprise thirteen percent of our population, but account for thirty-seven percent of medical costs.

Lack of Health Care Marketplace: Only about fifteen percent of Americans are enrolled in Managed Care Programs, which promotes efficiency by negotiating lower physician and hospital rates. This has caused medical costs to be shifted to other payers who do not belong to a Managed Care Program.

Malpractice System: According to some estimates, unnecessary tests and treatments authorized by doctors to leave a paper trail contribute to twenty percent of physical expenditures. Our malpractice system discourages any cost saving innovation.

After the fact Intervention: The most cost effective way to ensure good health is preventive maintenance. Our health system emphasizes after the fact intervention. With modest life style changes, our national health could improve and reduce medical costs. The U.S. Public Health Department estimates that changeable lifestyle practices account for approximately fifty-four percent of all death from heart disease.\(^3\)

In 1980, health care spending totaled 215 billion dollars. Just ten years later, it exceeded 800 billion dollars and represented fifteen percent of the nation's economy. In 1993, the United States devoted 14.4 percent of its economy to health care. This number in dollars is equal to the size of Great

Britain's entire economy. By the end of the next decade, health care costs are projected to rise to 1.7 trillion dollars, over 18 percent of our economy.\footnote{Ibid., p. 120}

**PURPOSE OF THE STUDY**

The continued increase of health care cost has had a detrimental effect on the budgets of school systems across the nation. Vital dollars have been diverted from educational programs to pay the cost of our health care. It is easy to predict that the growing cost of health care will continue to increase unless an alternate proposal can address this high cost fringe benefit.

School systems can address this problem of high costs by considering self-funded health insurance and self-funded health cooperatives (pools) rather than traditional health programs. The advantages of this alternative are reduced administrative cost, elimination of carrier profit margin, lower risk charge, less overhead, cost and utilization controls, cash flow benefits, return on investments for reserves and, most importantly, the control of the plan design. In Illinois, the cost of a self-funded health plan ranges from twenty to thirty percent lower than a traditional health plan with a similar plan design.\footnote{Michael Chino, Assistant Superintendent, Orland Park, IL, Jan. 1994}

Each year, Illinois school administrators are held responsible by their community and local school board. Since school administrators manage the expenditures of a school district, it would be most appropriate to undertake a study which will give insight on how they utilize decision making strategies as participants in self-funded health insurance programs.

The purpose of this study is to analyze and draw conclusions about the decision making strategies selected administrators utilized in managing their school insurance plans. Analysis was focused on the knowledge of
school administrators who participate in self-funded insurance plans and their use of various decision-making strategies.

SAMPLE

The sample selected for this study is comprised of four Cook County suburban Chicago health insurance cooperatives representing forty-two school districts and twenty Cook County suburban school districts that utilize self-funded health insurance. Since location has a direct impact on the cost of health insurance, choosing suburban Cook County suburban school districts lessened the impact of health cost variations. A survey instrument was sent to the administrator who handles the health insurance in the sixty-two school districts in suburban Cook County, seeking pertinent information about the school district and participation in a follow-up interview. The sixty-two school districts were selected because they were identified as using the self-funded health process. Since there is no listing of school districts using the self-funding health process, a consultant from A.J. Gallagher submitted the names of school districts who used the self-funded process in suburban Cook County. Administrators in fifty-five school districts returned the survey and all volunteered to participate. Five school districts that were part of a self-funding cooperative and five that were not were selected for the follow-up interview. The sample included elementary, high school, special education districts, and provided a diverse cross section as to wealth and size.

Two limitations were utilized when selecting participants. The first was that the administrators had to be employed in their present capacity for at least two years and the second was that they have had at least two years experience with self-funded insurance. These limitations ensured that the
administrators had some knowledge of self-funded health insurance and that they had gone through at least one full year of the self-funding cycle.

**PROCEDURE**

The procedure of this study was to survey all sixty-two self-funded school districts as provided by James Murray, insurance consultant with A.J. Gallagher, Inc. Those school districts are listed in the appendix, noting the type of school district, gender of the administrator who handles the health insurance program, age, years of experience with self-funded health insurance, and job title.6

In order to carry out the purpose of the study, it was decided after a preliminary review of the literature and discussions with advisors and self-funded insurance professionals, that the face to face interview would allow for in depth answers and the ability to probe to obtain more thorough data than if a questionnaire was utilized. A list of eight questions was developed and submitted to each subject prior to the interview to assure him that there was no hidden agenda other than what had been communicated. In addition, since the respondents were almost equally divided among districts participating in a cooperative and districts not in a cooperative, one school district from each group was randomly selected to participate in a pilot interview. The interviewing procedure was utilized in the pilot interview to note clarity of questions, vague wording, concerns of the participants and for the researcher to practice the interviewing process.

The content validity of the interview questions was determined by the technique referred to as validation by experts. For this study, three insurance consultants, three school administrators, and three university

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professors of educational administration validated the questions. This group critiqued the survey instrument and interview questions noting the validity of the questions, vague wording, or ambiguities. Corrections were made as necessary. The structured schedule was used and the questions were reviewed during the pilot interview to determine that they provided insights in terms of the research questions. The first question in each set of questions sought concrete answers to determine knowledge of self-funded insurance and follow up questions sought the interviewer's rationale for his discussed action. In addition, a conscious effort was made to ensure that all questions related to the theoretical framework and to the literature review of this research.

Memoing was utilized after the interviewing and during the coding process. Memoing was especially helpful during the pilot process as this tool allowed an opportunity to revise and refine the research questions and coding instrument to provide more meaningful data.

The interviews were completed during the months of April and May 1995. The time was chosen because most health insurance plans are reviewed and rates set in February and March; therefore, all school districts had recently completed the process and had up-to-date information. The administrators participating in the study were contacted by telephone to arrange the interview and to discuss any concerns that they may have identified. All questions were sent prior to the interview so that the administrator could have time to think about and formulate answers to the questions. The questions utilized in the study are as follows:

QUESTION I: Are there specific stop loss provisions? At what level are they set? How did you set the specific stop loss margin?

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QUESTION II: Who is involved in the decision making process in relation to the school district's Health Insurance and what is their functions?

QUESTION III: How many plans do you offer? What is the cost of each? Single? Family? What procedures are followed to set rates for each plan?

QUESTION IV: Do you utilize an administrative agent? What is the yearly cost? How did you select the administrative agent?

QUESTION V: Whom do you utilize as a third party administrator? What is the cost for claims administration? How did you select the third party administrator? Do you have a performance contract for your third party administrator?

QUESTION VI: What procedures do you follow to ascertain employee satisfaction?

QUESTION VII: How do you determine your plan design? Do you have input in the plan design?

QUESTION VIII: At what level is your reserve set? Who set it? How did you arrive at this figure?

The interviews were transcribed and then coded utilizing Funkhouser's model of action decision making. The administrators' responses were analyzed to expose knowledge of the self-funded health insurance process and the decision making strategies that were observable and discussed. The comparison of decision making strategies from the literature provided a frame of reference for analyzing the data.

Patterns and categories emerged and the comparisons between and among categories were described. Connections between categories and
patterns were explored for meaning and were related to the theoretical framework of the study.

Philosophers have tried to answer the question of why people do what they do. While there has been speculation as to the impact of our innermost being on a moment to moment basis, what we do comes from individual decisions we make. Sociologists Talcott Parsons and Edgar Shils stated that, "before any action, a decision must always be made (explicitly or implicitly, consciously or unconsciously)." Existentialist philosopher, Jose Ortega y Gasset, stated it similarly, "At every moment of the day, I must decide what I am going to do the next moment; and no one can make this decision for me, or take my place in this."\(^7\)

At the operational level, one can observe what people are doing, but it is impossible to know what a person is thinking. Our minds process thoughts and ideas so rapidly that it is difficult to isolate thought processes. Feelings, perceptions, ideas and images come and go in seconds, and much of it happens below the surface of our awareness. Funkhouser describes a sequential decision model in which he explains that everyone may go through a six step thought process when making a decision. Following is a description of Funkhouser's model that was utilized in the coding of decision-making strategies that were observed in the interviews.

**Step 1: Is there a need for action?**

Some stimuli get a person's attention and bring a problem or concern to a level of awareness and ultimately to the decision. Most stimuli are ignored while others bring a reaction because of our life long learning process. If one decides that no action is necessary, the decision making process stops here. However, if it is decided that action is necessary we progress to Step 2.

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Step 2: Is there a choice if action is to be taken?

Once a person decides that some action is needed, the next decision is to determine if there is a choice. The decision maker must ask if there is one action available so compelling that he doesn't have to consider any others? Or, is he better off considering more than one alternative?

Frequently, when there is no choice, it is because the decision maker is not aware of other alternatives, all others look bad, or it suits our convenience to decide that there is no choice. The latter is often selected because people prefer to take the path of least resistance, even if there are viable alternatives. Some people do not make a choice because they don't want to and because decision making takes effort. If a person decides that they have no choice at Step 2, it means that they can skip Steps 3, 4, 5 and go directly to Step 6.

Step 3: Will a habitual course of action suffice?

Many people do many things out of habit. When one does this there is a need to make very few decisions. At this step one needs to determine if what they ordinarily do is going to be the best thing to do or will they be better off doing something else. If a person acts out of habit, Steps 4 and 5 can be skipped and go directly to Step 6. If the habit selection is not adequate, the person must go to Step 4 or 5.

Step 4: Reduction of alternatives to a "consideration set."

This stage requires one to narrow down the choices to a manageable number that is referred to as our consideration set. This step provides the most anxiety in decision making because it takes the most effort. It is at this step that unwanted alternatives are dropped from consideration. Once the alternatives are narrowed down to a few serious contenders, it is time to move on to Step 5.

Step 5: Choice of preferred course of action selected.
At this step the person weighs the value of the remaining alternatives. One must ask, "Is this what I ought to do or isn't it?" Once the best alternative is selected, the person may move to Step 6.

Step 6: Decision to take action.

Once a person arrives at this step, there is one possible alternative left. The person must select the best alternative at the time and the decision making process is completed.\textsuperscript{8}

The Action Decision Sequence

\begin{align*}
\text{Step 1} & \quad \text{Is there a need for action?} \\
& [\text{YES}] \quad [\text{NO}] \quad > \quad \text{No action taken} \\
& ^\wedge \\
\text{Step 2} & \quad \text{Is there a choice of actions to be taken?} \\
& [\text{YES}] \quad [\text{NO}] \quad > \quad \text{No action taken} \\
& ^\wedge \\
\text{Step 3} & \quad \text{Will a habitual course of action surface?} \\
& [\text{YES}] \quad [\text{NO}] \\
& ^\wedge \quad ^\wedge \\
\text{No action taken} & \quad < \\
\text{Step 4} & \quad \text{Reduction of alternatives to a "consideration set"} \\
& ^\wedge \\
\text{Step 5} & \quad \text{Choice of preferred course of action (behavioral intervention)} \\
& ^\wedge \\
\end{align*}

\textsuperscript{8}Ibid., pp. 69-79.
Health insurance has a jargon all its own. Much of it consists of cryptic messages and acronyms that are meaningless to the majority of subscribers. The following glossary lists many of the terms used in the health insurance industry and are used in this study.

**GLOSSARY**

**Administrative Services Only:** An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits, and other administrative functions for a self-insured group.

**Broker:** A sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies.

**Deductible:** The amount of covered charges you must pay before the plan pays benefits.

**Group contract:** An insurance contract made with an employer, or other entity that covers a group of persons identified as individuals by reference to their relationship to the entity.

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9Ibid., pp. 78-80
Health Insurance: Protection that provides payment of benefits for covered sickness or injury.

Premium: The fee paid on a regular basis (weekly, monthly, quarterly) for enrollment in a plan.

Risk: Any chance of loss.

Self - Insured plan: A program for providing group insurance with benefits financed entirely through the internal means of the policy holder, in place of purchasing coverage from commercial insurance carriers.

Standard Insurance: Insurance written on the basis of regular morbidity underwriting assumptions used by an insurance company and issued at normal rates.

Third Party Administrator: Administration of a group insurance plan by some person or firm other than the insurer or the policy holder.

Aggregate Attachment: The maximum amount of claims that an employee will have to pay in a given year.

Margin: The difference between expected paid claims and the actual claims paid. This is the risk the employer is accepting in his self - funded plan. The more risk the employer assumes, the less risk there is for the insurance company to bear and therefore the lower the Aggregate premium. Minimum margins apply to groups based on their size and other factors.
Stop Loss: Comes in two forms: Specific and Aggregate

Specific Stop Loss: The form of excess risk coverage that provides protection for the employer against a high claim on any one individual. This protection against abnormal severity of a single claim rather than abnormal frequency of claims in total. Specific Stop Loss is also known as Individual Stop Loss.

Aggregate Stop Loss: Provides a ceiling on the dollar amount of eligible expenses that an employer would pay, in total, during a contract period. The carrier reimburses the employer after the end of the contract period for aggregate claims.

Plan Document: Defines the benefits offered to the employees and is critical in determining liability under the Stop Loss coverage. Because the employer has great latitude in designing the plan, there may be elements in the document that are not included under the Stop Loss coverage. The covered portions of the plan document must be approved by the underwriter in order to effect the Stop Loss coverage. Changes in the plan document after its initial approval must be approved before their inclusion in the Stop Loss coverage.

Health Insurance: Protection that provides payment of benefits for covered sickness or injury.

HMO Health Maintenance Organization: An organization that provides a wide range of health-care services for a specific group at a fixed periodic
payment. The HMO is usually sponsored by the government, school district, employer, and other hospital - medical plans.

**PPO Preferred Provider Organization:** An organization that provides health care benefits for a specific group at a reduced cost. A substantial penalty is incurred when one utilizes a non-PPO medical provider

**Limitations of the Study**

Two limitations of this study were the size and the restricted geographical sample in which the author will base generalizations about decision making by school administrators. These limitations, however, can be viewed as a control since all the administrators are from public school districts with the same budgeting rules and procedures. Their financial resources were not reduced equally because of the range of dependence on local and state funding. All the sample districts were recently placed under the Property Tax Limitation Act, which mandates school districts in Suburban Cook County to limit their tax extensions to a five percent increase for the 1995 tax year and not more than five percent of the rate of inflation in subsequent years. A third limitation was the quality and accuracy of the data obtained from the interview. Although the face to face interview allowed the body language and voice inflection to be noted, there still was a concern that administrators responded with what they were supposed to do rather than what actually happened. These limitations were considered while conducting the study. In an effort to substantiate the responses, artifacts, such as the State of Illinois Report Card and health insurance documents, were requested and related back to the responses for credibility.
CHAPTER 2

Review of Related Literature

The purpose of this study is to analyze the decision making strategies selected school administrators use as participants of self-funded health insurance. The source of materials for the literature review varied. Textbooks, educational journals, professional training publications, health insurance brochures, and doctoral dissertations were investigated. For the purpose of this literature review, the research was divided into two distinct relevant sections. The first section presents the concepts of appropriate decision making, thereby developing the framework of this study. The second section reviews the history and related literature to health insurance and self-funded health insurance.

Decision Making

This section reviews selected theories of decision making and is organized as follows: management trends, classical decision making, intuition decision making, and group decision making.

Management Trends

In each decade, management has been characterized by a few descriptive themes as it relates to decision making. In the early part of the twentieth century, the "scientific management" movement proposed an analytic approach. In the 1930's, the "human relation movement" headed by Elton Mayo and Mary Parker Follett, emphasized the need to understand the psychology of work and workers. In the 1940's logistical needs of World War II promoted the "operatives research movement" that included intricate mathematical methods that included the first
electronic computer. In the 1950's, the systems approach emerged and analyzed organizations as units or wholes. In the 1960's and 1970's strategic planning surfaced and shed new light on financial planning and forecasting in the form of a carefully developed plan. Then in the 1980's, world trade competition promoted the Japanese management principles, most of which were originally developed in the United States. All of these movements have had a major impact on how managers arrive at a decision, and how the process of thinking and its relationship to decision making has emerged as a means of promoting successful decision making.  


MANAGEMENT THEMES THROUGH THE DECADES

1. Scientific Management (starting in early 1900s)
   - Universal principles of efficiency
   - Search for frictionless organizations
   - The rise of industrial engineering

2. Human Relations (1930s and following)
   - Hawthorne studies at Western Electric
   - Psychology of work and motivation
   - Participative management and job enrichment

3. Operations Research (1940s and following)
   - World War II needs and the advent of computers
   - Quantitative models of organizational problems

4. Systems Analysis (1950s and following)
   - Cybernetic perspective (building control systems)
   - Focus on dynamic interactions

5. Strategic Planning (1960s and 1970s)
   - Diversification and search for synergies
   - Redeployment of assets and restructuring

6. Japanese Management (1980s)
   - Quality control systems involving people
   - Novel approaches to inventory and production management

7. The Cognitive Perspective (1990s?)
Emphasis on understanding how people think
Recognition of errors made in managing information
Use of artificial intelligence technology

Classical Decision-Making

Classical decision-making theory is described as having clearly defined steps in a linear process. M. Chester Nolte, in his book, *An Introduction to School Administration*, selected readings explain several theories of classical decision-making. One theory developed by Herbert Simon describes one classical theory of decision making as comparison of three distinct phases. The first is finding occasions for making a decision. The second phase consists of finding possible courses of action, and the third phase is choosing among courses of action. Simon points out that the decision maker is a person at the moment of choice, ready to plant his/her foot on one or another route. Most images focus on the final moment that gives a false impression. They tend to ignore the whole lengthy, complex process of alerting, exploring and analyzing the activity prior to the final moment. This process accounts for a fraction of time and varies for each decision maker. The cycle of phases is, however, far more complex than this sequence suggests. Nevertheless, the three phases are often clearly discernible as the decision-making process unfolds.

The second theory is closely related to the stages in problem solving first described by John Dewey. They are

- What is the problem?
- What are the alternatives?

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Another classical theory of decision-making was Peter Drucker's model for decision-making. This model necessitates the decision-maker to have a clear understanding of the problem, know all the possible solutions, and from this knowledge, pick the best solution. Drucker's Model was closely followed in the United States and Japan and served as a benchmark during the 1970's and 1980's. This model consisted of five steps which are consistent with the classical model: 1) define the problem, 2) analyze the problem, 3) develop alternative solutions, 4) choose the best solution, and 5) implement the decision.

Dishy described a process utilizing a circle and dots. When considering a decision or action one unconsciously draws a circle around dots that represent the options which we believe are potential solutions. According to Dishy, this tool turns the process of free choice into a conscious activity and reminds us that for every action, choice or decision that we make, there is a circle full of alternatives. He also states that there is no perfect option, as each option has it advantages and disadvantages. If one seeks a perfect choice, he will find stress, frustration and inevitable disappointment. A good choice or decision is based upon intuition, solid experience and sufficient information. In the end, every choice is a calculated risk and no more than an educated guess.

Daniel Griffiths states that while decision making is a highly discussed topic, much of the discussion focuses on the process of how a decision should be made. However, Griffiths cautions that the process is best applied under ideal conditions in a stable environment. Griffiths summarizes the core components of a decision making procedure as follows:

12 Ibid., quoted in NOLTE p. 207
1. Recognize, define and limit the problem
2. Analyze and evaluate the problem
3. Establish criteria and standards by which a solution will be evaluated or judged as acceptable and adequate to the need
4. Define the alternatives
5. Collect data on each alternative
6. Apply evaluative criteria to each question
7. Select preferred alternatives
8. Implement choice
9. Evaluate choice.\textsuperscript{15}

In contrast, Katz and Kahn point out that day to day decisions, usually get made on an ad hoc basis, are oftentimes made by lower level managers, and their effect is as powerful as though a new policy had been developed by the formal leadership.\textsuperscript{16} Due to demands of time, data collection, resources and intelligence on decision-making, tend to subvert the step-by-step process as outlined by Griffiths. Charles Lindblom states that most decision making follows the process of "The Science of Muddling Through."\textsuperscript{17} Lindblom argues that decisions should be made on an incremental basis because, even if a mistake is made, an incremental step backward returns the system to its original position. Lindblom writes that incremental decision-making permits administrators to limit risk taking, ignore theory and theorists when convenient, and "fly by the seat of their pants."

The six basic characteristics of Lindblom's model are as follows:

1. Rather than attempting a comprehensive survey and evaluation of all possible alternatives, the decision maker focuses only on those policies that differ incrementally from existing policies.

2. Only a relatively few policy alternatives are considered.

\textsuperscript{15}Daniel E. Griffiths, Administrative Theory (New York, Appleton - Century - Crofts, 1959), p. 94.
\textsuperscript{17}Charles E. Lindlelom, "The Science of Muddling Through," Public Administration Review (1959) p.80
3. For each policy alternative, only a few "important" consequences are evaluated.

4. The problem confronting the decision maker is continually redefined: Incrementalism allows for countless ends-means and means-ends adjustments which, in effect, make the problem more manageable.

5. Thus, there is no one decision or "right" solution, but a never-ending series of attacks on the issues at hand through serial analyses and evaluation.

6. As such, incremental decision making is described as limited in scope and impact, geared more to the alleviation of present, concrete social imperfections than to the promotion of future social goals. However, Amitai Etzioni argues that there is a middle ground between the classical model and Lindblom's "muddling through." Etzioni refers to a middle ground theory as mixed scanning. He feels that the classical model has many weaknesses when applied to the real world, and points out that the incremental model is also flawed. Etzioni's mixed scanning suggests that the decision makers combine elements of the rational with the incremental and also provide a criterion under which one or the other is to be emphasized. Etzioni points out that:

...each of the two elements in mixed scanning helps to reduce the effects of the particular shortcomings of the other: incrementalism reduces the unrealistic aspects of rationalism by limiting the details required in fundamental decisions, and contextuating rationalism helps to overcome the conservative slant of incrementalism by exploring longer-run alternatives.

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18 Ibid., p. 81.
19 E. Mark Hanson, Educational Organizational Behavior. (Boston, Mass., Allyn and Bacon, Inc. 1979), p. 93.
Also, W. H. Weiss, in his book, *Decision Making for First-Time Managers*, describes and promotes a combination of classical and intuitive decision making in his practical approach to decision making. Weiss states there is no one best way to make all decisions and the steps of decision making invariably overlap. Conscious as well as unconscious factors influence many decisions and decisions made strictly on logic may be faulty. Although he stresses that there is no same way to always be successful in decision making, he suggests the following guidelines:

1. Concentrate on the objective of a decision you must make. Know what you want to achieve. Hold off making any decision until you are sure you know all that is involved.

2. Constantly reconsider the objective and be ready to change your approach if you sense that you should. Be flexible to the extent that you can readily adjust to new information. Changing circumstances may require you to make a new decision. To reverse or modify a decision does not mean you're inept as a decision maker.

3. Accept the advice and recommendations of others but rely on your own judgment and experience when it comes to making the decision. Don't automatically follow an expert's advice.

4. Give your hunch or intuition considerable weight. Hunches emanate from more than just facts and information; they should be considered along with the other bases of your decisions.

5. Be fearless and aggressive when making a decision. Meekness does not convey assuredness. Major changes can be made more easily than minor ones. Be sure your attack has been planned and well thought out.

6. See that your decision fits the particular circumstances and that you're not making it because such a decision worked before. It is risky to assume that two situations are identical and can therefore be handled the same way. Priorities, directions, and people change. You must judge each situation as separate and distinct from all others.

7. Consider the preferences of other people, including your boss and his or her boss. It is sheer folly to make a decision that conflicts with their thinking unless you have a very convincing argument to back it up.
8. Take your time, especially with important decisions. The more impact the decisions will have, the more time you should devote to them.

9. Be wary of selecting your first choice of alternatives. Experienced decision makers say that you can almost always find a better one. Consider as many alternatives as possible.

10. Be prepared to change course once you act. Decisions often trigger new problems, and the reactions to a decision can alter a situation greatly.20

**Intuition Decision Making**

Russo and Schoemaker state that most people make decisions intuitively, because they know of no other way and, therefore, achieve much less consistency than they generally suspect. Intuition is fine for small decisions like buying groceries and organizing your kitchen cabinets, but research has documented that a systematic process will result in better decisions than unaided intuition.21

All decision making depends on some use of intuition, since no one can frame an issue or gather information without it. Herbert Simon researched intuition and reported on its positive side effects. He stated that intuition is based on accumulated experiences and concerns for quick understanding of a situation without conscious analytical thought. He defines intuition as tacit knowledge.22

In contrast, Russo and Schoemaker reviewed the limits of intuition in their book *Decision Traps*. They state that when an individual relies on intuition or "gut feeling," to make a decision, the human mind processes some, but rarely all, of the information without an awareness of detail. The authors state that the major problem with using intuition is that it is often inconsistent. On a different day, the same person will decide differently, even when considering a clean-cut question.

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because intuition decision making is affected by alertness, interest, and the ability to focus on a specific situation.\textsuperscript{23}

However, Russo also stated that intuitive decision making does have a distinct advantage in that it takes less time than making a decision with a systemic process. It has value when one needs to process simple decisions because your mind can process your knowledge in a more complex and subtle way than if one would attempt to express it in a systemic process.

Russo and Schoemaker reported on the work of Hoffman, Slovic and Rorer who studied radiologists' use of intuition decision making. They found that people who make decisions intuitively achieve much less consistency and accuracy than they generally suspect. In one study, psychologists presented information to five radiologists extracted x-rays of ninety-six individuals. Each doctor was asked to evaluate the likelihood that a malignant stomach ulcer was present. A week later the doctors were presented with the same ninety-six cases in a different order. Again, the directions were to evaluate the likelihood that a malignant stomach ulcer was present. The psychologists compared the conclusions that the radiologists had reached on the same cases on different days. The results were tabulated using a scale of 0 to 1, with 1 indicating a perfect correlation and 0 meaning no correlation. The correlation ranged from .60 to .92. When the doctors reviewed the x-rays a second time, their second judgment differed to a significant degree from their previous conclusions. Studies like this suggest that advice to seek a second opinion before undergoing surgery is well founded.

In another study reported by Russo & Schoemaker, physicians examined 382 boys and found that forty-five percent of them needed a tonsillectomy. When another group of physicians examined only the boys judged healthy by the first

panel, they actually concluded that forty-six percent needed a tonsillectomy. A third panel examined the remaining 116 boys who had been judged healthy by the first two groups of physicians. The third group found an additional forty-four percent needed a tonsillectomy.24 Doctors and other professionals, such as accountants and school administrators, seldom realize just how much they rely on intuition decision making. Since most of the variations go unrecognized, it is probable that professionals are doing all they can to guarantee that they make the choices likely to produce good outcomes. Edward Russo suggests that people making decisions by intuition usually suffer from information overload, and have a difficult time applying simple rules consistently even with effort.25

Other authors support the intuition decision making process. Spencer Johnson advocates the use of intuition as a major part in decision making. He states:

"Your own unconscious knowledge based on your own personal experiences. It's what you somehow sense is right for you."26

Johnson further states that when a person uses intuition it is important to look at the feelings of the person making the decision. If stressed, the person is probably trying to force things to happen. If so, the decision arrived at will probably be poor and not attain the goal. On the other hand, if the person is probing questions and feels peaceful, he probably is making a decision based on truth which is recognized and if so, the results will be more effective. With time and experience one can improve intuition decision making. One must realize that

24 Ibid., 121-122.
feelings are personal guides, an internal mentor, that resides inside to show wisdom.  

W. H. Weiss, in his book, *Decision Making for First Time Managers*, states that intuition decision making is a dramatic and useful way of solving problems. In fact, he states that most of today's technical professionals, psychologists and consultants use it on a regular basis. He defines intuition as a case in which the mind rapidly performs the steps of induction and deduction in analytical thought below the level of conscious awareness. Intuition thinking differs from analytical thinking in that it does not proceed in careful, pre determined steps. Intuition involves the perception of the problem and leads to jumping about, skipping steps, and usually taking the shortest, quickest route to the answer. On the other hand, analytical thinking follows careful and deductive reasoning, often times with a process of induction and experimentation and frequently using mathematics, logic and cost analysis. The analytical user can document the steps leading to the answer. The intuitive thinker may have an answer, but usually there is no awareness of how the answer was arrived at or reached.

Weiss further states that the most successful decision makers believe that their best decisions have evolved from a combination of truth, logic and intuition. Some people are better at intuition decision making because they are perceptive, observant, cognizant and knowledgeable of human nature and the subject matter being discussed. Following are Weiss' suggestions on how to improve and assist your intuition decision making:

"Determine, first, whether you really have intuitive ability. Make a record of your hunches and grade them on how good they were. If the majority have worked out well, give more weight to your future

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hunches.

Recognize that you will still need basic facts and information before you can rely on your hunches. Intuitive thinking is a normal thinking process. It has nothing to do with mystical ceremonies of clairvoyance. You must thoroughly investigate every problem.

Watch for bias and prejudice from personal, subjective thinking. Don't confuse intuitive thinking with wishful, emotional thinking.

Prefer to use intuitive thinking and analytical thinking together. Depending on the problem, one or the other should predominate. It is not necessary that you give them equal weight in coming to your final decision."29

**Group Decision Making**

Group decision making is a process that grows out of individual and organizational needs. This philosophy is based on the belief that employees will take more pride and interest when they are allowed meaningful contributions. While the literature suggests that involvement can have a positive influence on decisions, many factors must be considered in evaluating its effect. Russo and Schoemaker discuss these factors in their book *Decision Traps*.30

As far back as 1979, Piper found that the group decision is superior to an individual's decision. In his study, Piper concluded that:

" 1) group discussion lead to better decision making
2) decisions made by participatory decision making are more correct than decision made by individuals
3) decisions made by either consensus or participatory are frequently more correct than the decisions of the best member of the group."31

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29Ibid., p. 100-101.
31Donald L. Piper, "Decision-Making: Decisions Made by Individuals vs. Those Made by a Group Consensus or Group Participatory* Educational Administration Quarterly 10* (Spring 1979) pp. 82-95.
John Carver, in his book, *Boards That Make a Difference*, the operation of non-profit and public boards to group decision-making. He states that while board members arrive at the table with dreams, visions and values, they spend the majority of time on less important, even trivial, items. Carver contends that the failures of governance are not a problem of people, but of process. The problems lie squarely in our approach to governance, including treatment of board job design, board staff relationships, chief executive roles, performance monitoring and virtually all aspects of the board-management partnership. According to Carver, governing boards have not been very efficient even in the best of situations. Drucker, writing of corporate boards, said, "There is one thing all boards have in common, regardless of their legal position. They do not function. The decline of the board is a universal phenomenon of this century."\(^{32}\) This book is an indictment of governance, and the group decision-making process. Carver describes the poor practices that intelligent, caring board members regularly exhibit.

Short-Term Bias. The "time horizon" over which concern and planning should take place is more distant at the governing level than anywhere else in the organization. Yet, we find boards dealing with far more than the near term and, even more dysfunctionally, with the past. Last month's financial statement gets more attention than an agency's strategic position.

Reactive stance. Boards consistently find themselves reacting to staff initiatives rather than acting proactively. Proposals for staff action and recommendations for board action so often come from staff that some boards will cease to function if called upon to create their own agendas.

Reviewing, Rehashing, Redoing. Some boards spend most of their time going over what their staffs have already done. "Eighty-five percent of our time was spent monitoring staff work," says Glendora Putnam, Boston, of a prominent national board. "We can't afford that. We have  

too much wisdom (to be put to use)" personal communication). Just keeping up with a large staff can take prodigious hours and even then can never be done fully. But the salient point is that reviewing, Rehashing, and redoing staff work--no matter how well accomplished--do not constitute leadership.

Leaky Accountability. Boards often allow accountability to "leak" board continues to relate officially with other staff, either giving them directions or judging their performance.

Diffuse Authority. It is rare to find a board-executive partnership wherein each party's authority has been clarified. A vast gray area exists. When a matter lies in this uncertain area, the safe executive response is to take it to the board. Instead of using this opportunity to clarify to whom the decision belongs, the board simply approves or disapproves. The event has been settled, but authority is less unclear as it was before.33

Many people seek a better solution to a problem by involving more people. Russo and Schoemaker found that involving more people, no matter how effective the members of the group, does not result in a better solution. In fact, while they state that groups are likely to outperform individuals, it is only to the extent that conflict arises and gets resolved through debate. When this occurs, it is likely group decision making fosters a better understanding of issues. When conflict, debate and resolution do not occur, groups are just as likely to err as individuals.34

Another concern with group decision making arises when groups of intelligent, well intentional people are not managed properly and the group agrees prematurely to the wrong solution. The group then gives each other positive feedback that fosters a false sense of rightness. This common experience keeps groups from looking at possible faults, or polarizes members into shifting to extreme positions of an issue. Thus, movement toward a rational decision becomes virtually impossible. Russo and Shoemaker clarify this view with the following example: John F. Kennedy, after his administration's invasion of Cuba stated.

33Ibid., pp. 10-12.
34Ibid., pp. 146-147.
"How could we have been so stupid?" Former Yale University psychologist Irving Jones, stated in his article in Psychology Today, that the decision makers in this process were some of the smartest people in America: Robert McNamara, Douglas Dillin, Robert Kennedy, McGeorge Bundy, Arthur Schlesinger, Dean Rusk, and others. They did not fail because of lack of intelligence; they failed because they allowed the group's cohesiveness and loyalty to dominate the decision making process.35

The Kennedy group is not the only group to make a major error while using participatory decision making. Irving Janis documents that similar mistakes were committed in the decisions that led to:

1) U.S. underestimation of Japan's intelligence before Pearl Harbor
2) The U.S. Invasion of North Korea during the Korean War
3) U.S. mismanagement of the Vietnam War
4) The Watergate Scandal

Janis analyzed group decision making and discovered common elements that lead to the error or errors:

1) **Cohesiveness** Members knew and liked each other and wanted to preserve the group's harmony
2) **Insulation** Errant groups were often making discussions they could not discuss their progress with outsiders
3) **High Stress** The importance of the decisions, its complexity and tight deadline, put groups under great pressure
4) **Strong Director Leadership** The head of the group clearly stated up front what he or she favored.36

Group decision making is popular today. Whether to involve others in the decision making process, whom to involve, when they should be involved, are all

36Ibid., pp. 148-149.
questions that must be addressed in relation to the decisions to be made. Aubrey and Felkins offer the following comments about group decision-making:

Group problem solving groups can be an asset for an organization. In many cases, teams that are understood by their leader can make better decisions than individuals. The authors point out that when factors such as increased amounts of information, error correction, and evaluation are teamed with group energy and cumulative ideas, good decisions may result. The power of the team in a participatory process comes from the diverse personalities and uneven knowledge, yet these factors can also bring a clash to the group. While the disagreement over issues and ideas is not bad in itself, the conflict of personalities can be difficult to manage. Team members bring different attitudes, level of experience and varied needs to the group. It is a challenge for these diverse people to work together unless much effort is put forth to cause the group to focus on group goals. Oftentimes hidden agendas and individual motives can cause problems and lead to conflict between the individuals and groups' goals.37

Participatory involvement evolved through a merging of behavioral and management science with quality control sciences. Chris Argyris and Renses Likert helped identify the need for cooperation and reaching organization goals. Likert lists three primary characteristics which foster effective management:

1) Supportive relationships
2) Group decision making and group methods
3) High performance goals

Others like Douglas McGregor, Fredrick Herzberg and A.H. Maslow have contributed to this theoretical base. McGregor's theory is the fundamental attitude required for employee involvement. McGregor affixed the Y label to managerial assumptions that recognized the intellectual and creative potential of the average human being. Quality teams use this theory by involving people at all employee levels in resolving problems. The opposite assumption, which McGregor calls Theory X, is that employees are lazy, do not like to work, and do not want to take responsibility.38

Stephen Covey, in his book entitled Principle-Centered Leadership, encourages including stakeholders in decisions. According to Covey, decision makers need to see a balanced picture and receive information in a user friendly manner. Covey repackages the classic problem solving process with the addition of what he identifies as a feedback loop. He describes the loop as follows:

1) Gather data
2) Diagnose data
3) Select and prioritize your objectives
4) Create and analyze alternatives
5) Make a decision
6) Plan the action steps to carry out decision
7) Implement the plan
8) Study the results and go back to Step 1

Jeremy Main reports in Aubrey & Felkin's book that there is no clear cut formula for the participation process. He points out the differences of methods and open disagreement among the leading experts in quality and productivity. He states that the field is infused with jargons, slogans, statistics, and varying support for the theory of group decision making. In spite of the confusion with group decision-making, he believes participation is a simple concept based on information sharing, collective decision making and mutual trust. He highlights the following points about group decision-making:

1) Participatory decision making is not a new concept, it has been practiced for many years in various forms.
2) Collective knowledge and resources appear to bring a better decision, one that is more realistic with fewer errors in logic and design.
3) Each organization must consider participation involvement in terms of its own goals, values and culture.
4) Participation is collective power, produced by the group taking responsibility for quality and productivity.

The field of leadership is continually attempting to develop rational responses to complex problems. Some of the responses put forth are inviting and fruitful. Because educational management is rooted in a rational model of planning, coordinating, programming, budgeting, and organizing, attempts to utilize such strategies can only be achieved by manipulating the formal characteristics of the organization. Manipulation of the formal characteristics of an organization is only possible by comprehending the power of the many reference possibilities when power of reference points is understood. Reference points, such as unions, philosophy, policy, side effects, and community power structure can have an enormous impact on a decision. The successful decision-maker needs to consider the many reference points elaborated upon by M. P. Heller. Heller argues that these reference points are powerful and have a powerful influence on all decisions that school administrators must face. Lack of awareness of reference points and the inability of an administrator to recognize and deal with them are major causes of poor decision-making and ultimately poor administrative performance.41

Self Funded Health Insurance

History of Health Insurance

People have tried many ways to protect themselves from the cost of illness. From the earliest times, the artisans of Imperial Rome used the first known system of health protection by contributing money to assist families of members who were ill or injured. The purpose of this money was to assist the family until the family bread winner was able to return to work. Today, this type of coverage would be referred to as disability insurance.42

41 M. P. Heller, Professor, Loyola University, Chicago - Leadership 465; October, 1994.
The depression of the 1930's caused many people to be unable to pay medical bills. Hospitals and doctors were greatly impacted and many faced the same financial difficulties experienced by the rest of the nation. From 1930 to 1933, 400 hospitals had closed due to bankruptcy. Since so many people were unable to pay their medical bills, the third party evolved as a means to fill this void. The first third-party medical insurance was developed at Baylor University in 1929. This plan covered the medical expense of teachers in Dallas, Texas. The Baylor Plan was considered the model for other third party plans, such as Blue Cross plans. It was the first time people prepaid premiums in exchange for payment of hospital services.\footnote{Health Insurance Association of America, "Group Health Insurance I" (Chicago, New York, Washington: HIAA, 1976) p. 8.}

In the early 1930's most hospital plans, like the Baylor plan, involved an agreement with one hospital. By the later 1930's most third party plans gave the insured choices of hospitals. At about the same time, private insurance companies emerged and provided medical coverage for surgery, and group medical expenses at a low price.\footnote{Ibid., p. 8.}

The participation of the United States in World War II resulted in many governmental controls, including price freezes. Companies sought to keep good workers and replaced high salaries with more medical health benefits. During this period most workers were covered by a traditional plan offered by a private insurance such as the well-known Blue Cross/Blue Shield Plan. Blue Cross/Blue Shield plans developed as a non profit corporation operating under special laws that protected them from state premium taxes. Blue Cross contracted with specific hospitals and paid them a certain fee for services. Because of the number of consumers covered by Blue Cross, their payments to hospitals were much lower than those negotiated by private insurance companies and so they became very
appealing to companies and workers. Also, Blue Cross traditionally accepted all who applied for enrollment, regardless of age or health, and premiums were based on the group experience rather than on an individual's health or age. In addition to the Blue Cross plans, other plans were available in this time period. Aetna and Metropolitan were insurance companies that offered individual and group health insurance. The premiums for these companies were higher than those of Blue Cross because of the higher premium taxes and because of the smaller number of consumers covered by the plan. In an effort to remain competitive, these traditional companies relaxed policy limitations such as pre-existing conditions and health history clauses that excluded coverage for medical conditions that were previously covered by the policy.45

Risk Management

A self-funded plan is an arrangement whereby employers pay directly for the health care services rather than paying premiums to an insurance company. This type of plan results in a risk by the corporation or school district providing the insurance plan. Since most school districts provide health benefits for their employees, utilizing the self-funded plan can reduce health benefit costs. The basic principles of so called risk management requires the administration in charge of the self-funded plan to evaluate the amount or risk that is to be assumed in exchange for the premiums paid. The higher the risk factor, the higher the premium. When insurance is no longer a risk transfer, but simply the exchange of premium dollars, the medical costs will be much higher than if school districts assumed some risk. The risk is expressed in a dollar amount of coverage that the school district is willing to accept before a certain coverage is accessed. The risk level in self-funded insurance is referred to as the specific stop loss margin. The

specific stop loss margin can be set at any amount, but the usual and customary level is between $50,000 and $100,000. Michael Chinino, Assistant Superintendent in charge of finance suggests that school districts or corporations utilize a sequential decision-making strategy when setting the specific stop loss margin. According to Chinino, setting the specific stop loss margin is crucial to the success or failure of the self-funded process because it sets the level that the school district or corporation is liable. The amount above the specific stop loss margin is paid by the specific stop loss carrier and sets the maximum exposure for the school district or corporation.\[46\]

Employers can integrate creative health plan designs to curtail health costs by utilizing managed care providers like Preferred Provider Organizations and Health Maintenance Organizations. These managed care providers give various discounts when employees utilize their services and facilities. PPO's and HMO's costs are lower than traditional indemnity plans. Foster and Higgens projected the costs of HMO's and PPO's to be between $183 to $224 lower in cost than traditional plans. The following chart illustrates these differences.\[47\]

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\[47\]Foster Higgins, 1994, National Survey on Employer Sponsored Health Plans, 1993, Chart as appears in Medical Benefits, March 15, 1994, p. 1
The 1950's saw a great increase in medical benefits. Many users negotiated for dental, vision and life insurance. In addition, insurers began to expand coverage which led to the major medical benefit.

The 1960's saw the U.S. Government enter the health field as a third party by paying health costs for the aged and the poor. The Social Security Act of 1965 established a medical program for the poor and the elderly. The first program, Medicare, was a government supported medical program that covers a large percentage of hospitals and medical expenses for individuals over the age of sixty-five. Medicaid was the second medical federally subsidized program that paid medical and hospital expenses for low income families based on a federally determined income level. Unlike Medicare, Medicaid is administered by each state with specified federal guidelines.48

In the 1970's, the cost of medical expenses skyrocketed. Americans saw six hundred dollars added to the cost of a car to pay for the average auto worker's health insurance plan. Also, the average suburban school district spent eight percent of its annual budget on health insurance. While it was less expensive to

provide health coverage than a pay raise in the 50's and 60's, by the middle of the 1970's medical insurance became so expensive it became the objective of most companies to reduce the plan design. Because of the high cost, health benefits have been referred to as "free lunch" and the "silent paycheck." The 1970's is the decade when the health care cost problem was identified.49

In the 1980's and the 1990's health care costs have continued to rise causing employers to seek ways to shift the cost to the employee while maintaining the high health benefits that are demanded by employees. As medical costs take a larger dollar amount from individuals and corporations, especially those like school districts, who are experiencing a decline of revenue due to tax caps and voter resentment to higher taxes. School district cost increases are exceeding revenue increases, thereby causing teacher negotiations to be more strained as teacher and school boards argue over the shrinking revenues. Carol Mitchell, Chief Business Official in Evergreen Park school system, states that, "While teacher groups may be willing to accept a lower percentage of raise, there is a strong reluctance to reduce health coverage." 50

Current Status of Health Insurance

In the past five years, America has been experiencing a health insurance revolution. The traditional health insurance plan is structured in a set manner and is the most prevalent type of plan utilized in the United States. Hogue, Jensen and Urban describe the traditional plan as follows:

1. A client pays benefits on a fee for service basis. This means that, after care is given, charges are presented to the insurer for payment. Payments increase with the number of services provided.

49 Ibid., p. 309
50 Carol Anderson, Chief Business Manager, Evergreen Park School District 124, Interview May 10, 1995

37
2. Patient (employee) complete freedom to chose the provider. There is no restraint on where or from whom medical care is provided.

3. The plan is structured to pay for brief medical and surgical episodes with little emphasis on preventive care and little attention to effective management of chronic illness.\(^{51}\)

Many alternatives have been designed which, oftentimes, lower the costs by limiting choices, removing the fee for service while promoting preventive care and case management of chronic illness. This change has brought about some confusion as employees are asked to choose from among HMO's, PPO's, IPA's, CMP's and EPO's. In the past, most employees knew names like Blue Cross/Blue Shield and Aetna and are today confused by the acronyms which are often times misunderstood.\(^{52}\)

A variation of contracting with outside insurers is referred to as a self-funded insurance plan. Rather than purchasing insurance, the company or school district pays benefits from specified revenue or a trust fund. These funds are used to pay for incurred medical expenses for covered employees. In the past years, self-funded plans were common with large employers, especially those with five hundred or more employees. Because of the cost saving benefits and state mandate relief, many small employers have begun to utilize self-funded health insurance. As of 1993, The Health Association of America, reported that the majority of large companies in the United States are covered by self-funded health plans. On the other hand, most small companies are covered by the traditional health plan.\(^{53}\)

In 1993, employers reported a single-digit increase in health benefit insurance costs, which is the lowest, in the past five year period. The low increase is primarily due to the movement toward managed care and the increase in


\(^{52}\)Ibid., p. 53.

competition in the health managed field. During this five year period, an increase in employee contributions has also been evident. Employee contributions for single coverage averaged three hundred dollars in 1993, up from two hundred seventy-five dollars the previous year. The total increase for employer and employee in 1993 was eight percent. The U.S. Department of Health and Human Services publishes a yearly estimate of the growth of health spending in the U.S. The following chart illustrates the increase in health spending.\textsuperscript{54}

\begin{center}
\begin{tabular}{c}
\hline
\textbf{Chart I-2 Growth In Health Care Spending} \\
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\end{tabular}
\end{center}

The above statistics show that health care costs are a continually growing percentage of the U.S. economic output, and as much as twice the percentage of our major industrial competitors, such as Germany and Japan. In 1994, U.S. health care spending was 150 percent of the gross domestic product, almost 5 percentage points higher than 1984. Currently, the U.S. spends almost two times more on health care than on education. If the health care costs continue to increase at the same rate, it could be $1.5 billion by the year 2000, which will be approximately 1/6th of the U.S. economy.

In 1994, school districts in the State of Illinois paid 87.9\% of the single premium for teachers. Cook County school districts paid 92.81\% of the individual

premium. Seventy-five percent of school districts in Cook County contribute some amount toward family premiums, while 38% of school districts in the rest of the state contributed toward family premiums. While the percentage of employee contributions was higher in 1994 than in 1993, the cost for school district continues to increase.55

Types of Health Insurance

The two types of health insurance are group and individual coverage. Group insurance provides a set coverage to a group of individuals who work for a particular company or belong to a specific organization or association. The vast majority of health plans sold by commercial carriers is group insurance whereby, small, medium and large employers pay for all or a portion of the cost of the medical coverage. Usually this coverage is extended to the employees and their dependents.

The plan designs vary as employees negotiate the limits of the coverage which includes hospital costs, surgery expenses, physician's expenses and major medical expenses. The cost of the plan is directly dependent on the level of coverage and the experience of the group.

A large employer can lessen the cost of the plan by absorbing some of the risk and self insuring. Also, managed care options like PPO's, HMO's, and EPO's can be included in the plan and may result in fifteen to twenty percent savings to the plan. On the other hand, smaller employers have less capacity to spread the risk and lower the cost of the plan and the result is much higher premiums.56

Individual health insurance plans are available to individuals and their dependents. Because there is no ability to spread the risk, the cost is very high and usually the level of coverage is lower than those of group plans. Specified limits

are imposed on hospital expenses, surgical expenses, physician expenses and major medical expenses. Managed care options are available with individual plans, but the savings are usually less than those of group plans. With this type of plan the individual owns and pays directly for the coverage. Unlike group insurance, the plan is portable and the individual retains it even when changing employment unlike group insurance.57

Portability is important to those who intend to leave an employer or work as an individual contractor. Some insurance experts recommend that small businesses utilize individual medical plans rather than taking out a small group policy because of the impact of catastrophic costs on the premiums.58

Funding Health Benefits

Fifteen years ago, most school districts provided for employee benefits through traditional insurance programs. These insurance carriers were responsible for the administration of the program, establishment of premium and reserve levels, and payment of claims. In an effort to control rising costs, school districts began examining ways to economize and improve cash flow without sacrificing health coverage, budget consideration and bargaining agreements. Location and plan design have an effect on the way a health plan is funded. For many school districts the alternative to providing a quality plan design that is cost effective was self-funding. Until 1974, self-funded plans were obstructed by stringent state laws that required school districts to be licensed as insurers when they funded their own health plan. The passage of the Employee Retirement Income Security Act in 1974 (ERISA) removed those restrictions and self-funding is now one of the fastest growing areas in the employee benefit industry. With a self-funded plan, a

57Ibid., pp. 6-7.
58Ibid., pp. 2-3.
The school district can usually reduce operating costs significantly and maintain control of reserves. The reserve may be held in a trust to produce interest thereby reducing the overall expense to the employer and employee, or the reserve may be placed in an interest-bearing bank account. 59

With the traditional approach of funding a health plan, approximately 24% is allocated for administration, overhead and commission. Approximately 61% is allocated to cover anticipated claims and the remaining 15% set aside to cover emergency or unexpected claims. If the claims exceed the 61% level, the premium is increased and if claims fall below the 61% level, the net amount reverts to the insurance company as profit. This type of plan has 100% fixed costs, which requires a fixed premium each month. 60

With a self-funded approach, the fixed cost is approximately 12% and includes a specific stop loss coverage. The specific stop loss insurance is purchased as added protection against an excessive number of claims and catastrophic claims over a specific dollar amount and is paid to a specific stop loss carrier. According to Joseph Ruffero, self funded health consultant, most self funded plans set their specific stop loss margin between $50,000 and $100,000. The lower the specific stop loss margin is set, the higher the cost of the coverage for the employer or school district. Specific stop loss coverage usually costs between $15.00 to $20.00 per employee for the month for $100,000 stop loss margin. Unlike a fully insured plan, approximately 80% of the premium dollar is available for claims cost. During periods when a plan experiences less than expected claims, the surplus funds revert back to the corporation or school district reserve fund and is available for future use. Another advantage of the self-funded

60 Ibid., Presentation
process is that all available funds are reinvested and earn interest for the self-funded entity.\textsuperscript{61}

Joseph Ruffero compared the traditional approach to funding health insurance to self-funded approach as follows:

<table>
<thead>
<tr>
<th>The Traditional Approach</th>
<th>Self-Funded Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fully Insured</strong></td>
<td></td>
</tr>
<tr>
<td>9% Administration</td>
<td>3% Administration</td>
</tr>
<tr>
<td>10% Profit and Overhead</td>
<td>9% Stop Loss</td>
</tr>
<tr>
<td>15% Emergency Reserves</td>
<td>15% Emergency Reserves</td>
</tr>
<tr>
<td>61% Allowance for Claims</td>
<td>72% Allowance for Claims</td>
</tr>
<tr>
<td>5% Commission</td>
<td></td>
</tr>
</tbody>
</table>

\{ FIXED COST 100\% \} \hspace{1cm} \{ FIXED COST 12\% \}

An analysis of the foregoing comparison reveals that with the traditional approach, the fixed costs total 24\% of the premium, while with the self-funded approach, the fixed costs total twelve percent of the premium. In addition, sixty-one percent is available for claims with the traditional approach, while seventy-two percent is available with the self-funded approach. Since the corporation or school district insurance liability is a combination of claims costs and fixed costs, the self-funded approach is superior because of the lower fixed cost and more funds available for claims payment.

According to Edward J. Emering, among the advantages an employer may achieve under a self-insured program are

\textsuperscript{61} Ibid., Presentation
1. Enhanced control over plan operations, encouraged, in part, by the psychological impact of assuming risk and in part through the unbundling, or unpacking, of the various service components of a traditional group insurance contract.

2. Ability to select independent service providers to replace all or some of the services previously provided by the carrier while retaining other functions "in house."

3. Elimination of carrier retention (overhead) charges and premium taxes.

4. Immediate recognition of gains from favorable claims and/or investment experience and reduced administrative costs.

5. Flexibility in the manner in which gains or losses are converted, actuarially, into cost leveling adjustments.

6. Flexibility in the types and amounts of cash flow stop loss coverages purchased. These coverages are of two distinct types: (1) specific, which places a ceiling on individual or family-unit claims in any plan year; and (2) aggregate, which places a ceiling on the total claims for the entire group in any plan year. It should be noted that many larger employers forego the use of these coverages entirely, but with the increasing trend of small employers opting to self-insure the use of these coverages and the number of markets available for placement of such coverages has increased dramatically. Naturally, you might expect, there are some disadvantages.62

Emering cautions that a large number of disadvantages apply to employers, especially those with less than one hundred employees. Among the disadvantages to be considered are

1. The unavailability of pooling or risk sharing with other employers. The risk reverts totally to the employer, with the exception of any cash flow stop loss coverages.

2. The multitude of service providers you may have to deal with, including actuaries, lawyers, insurance brokers and claims administrators.

3. The employee/participant perception of the fact that all benefit guarantees are now based on the "good faith and credit" of the employer.

4. The inability to completely duplicate the features of an insurance program, such as the post-termination of employment individual policy conversion privileges.

5. The inability to find a carrier willing to accept any existing conditions that occurred during the intervening period of self-insurance, upon a subsequent decision to "reinsure" the plan.63

In reality, a school district that selects to self insure is actually going into the insurance business. Most school districts hire an insurance company or third party administrator to perform, manage, process and monitor claims. The money

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63Ibid., pp. 4-5.
used to pay claims is the employer's and the third party administrator is responsible for prompt and efficient claims processing. In addition to a third party administrator, some school districts elect to secure the services of an insurance company to serve as consultants or brokers. This company is referred to as an administrative agent. Many use the terms consultants and brokers interchangeably; there is a major difference in the two. Consultants are retained to advise and recommend the best course of action for a set fee. On the other hand, brokers usually advise and recommend, and their fee is usually based on commission. The usual and customary fee for insurance brokers is between fifteen and twenty percent.64

The ability of a school district to self-insure is directly related to the size of the district. Many school districts have merged to form self-insurance health cooperatives and cooperatives have sprung up across the U.S. Sidney W. Stolz, insurance consultant supports the use of cooperatives for school districts,

"Volume talks, hospitals and providers are making better deals for groups that bring more patients to the table and fill their beds. A small school district of 100 employees could have its reserves wiped out by one catastrophic claim. On the other hand, a school district with 1,000 employees would be able to withstand many claims. By developing self insurance cooperatives, school districts greatly increase their risk as the large number causes claims to have less impact on their reserves."65

Hogue and Jensen caution that even with the right numbers, school districts can fail to save money. Claims management, reinsurance, benefit design and employee satisfaction must be thoroughly understood in order for self-insurance to be cost effective. They suggest that school administrators not view self-funding as a panacea to the high cost of health coverage.66

64Ibid., p. 5.
65Lindsay, Drew Small Districts Eye "Pools" as Remedy, Education Week (September 7, 1994: p. 21-24
Michael Sheridan, Assistant Superintendent for Finance, in Lansing, Illinois, cautions school districts who are considering the self-funded process. Sheridan states that a thorough knowledge of self-funding and the role of the third party administrator is a must, prior to entering into an agreement to utilize self-funding. While he is a proponent of the self-funding concept, Sheridan cautions that the lack of self-funding knowledge on the part of school administrators can lead to financial and legal chaos. If an administrator is not familiar with determining a plan document, setting the specific stop loss margin and establishing a pertinent reserve level, the school district can have a large financial exposure. Sheridan described the services and the average costs of a third party administrator as follows:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>FEE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processing medical claims</td>
<td>$7.00 - $18.00 each employee per month</td>
</tr>
<tr>
<td>Processing dental claims</td>
<td>$1.00 - 3.00 each employee per month</td>
</tr>
<tr>
<td>Plan loading/start up cost</td>
<td>$0 - $6.00 per employee</td>
</tr>
<tr>
<td>Hospital case management</td>
<td>$1.00 - $2.50 each employee per month</td>
</tr>
<tr>
<td>HMO/PPO fee</td>
<td>$2.00 - $3.50 each employee per month</td>
</tr>
<tr>
<td>Plan document development</td>
<td>$2,000 - $5,000</td>
</tr>
<tr>
<td>Printing of booklets</td>
<td>$1.00 - $2.00 per booklet</td>
</tr>
<tr>
<td>COBRA Administration</td>
<td></td>
</tr>
<tr>
<td>Monthly Computation</td>
<td>$.25 - $.75 each employee per month</td>
</tr>
</tbody>
</table>

The foregoing presentation points out the range of fees that are charged by third party administrators. As Sheridan points out, school administrators who are

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67Michael Sheridan, Presentation to South Suburban Benefit Cooperative, October 1994, Orland Park, IL

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responsible for their school districts health plan should be aware of the self-funding terminology and the fee range.

**Program Administrative Services**

Many corporations and school districts elect to secure the services of insurance consultants. The range of services varies and can be provided by one individual or from large consulting enterprises. Edward Emering lists the many services that a program administrator can provide:

A. **Actuarial Consulting Services**

Actuarial services could include all of the following:
1. Attendance at all regularly scheduled meetings of the Trustees.
2. Consultation with legal counsel, financial accountants and other agents of the program, as required. Litigation support is available for additional fees.
3. Periodic consultation with the Trustees with regard to administering, evaluating and reviewing the plan of benefits.
4. Routine telephone consultation throughout the plan year.
5. Assistance with the resolution of claim problem issues, as required.
6. Review and calculation of the proper incurred, but not reported (IBNR) claims reserve, which will be certified in a formal letter to become an integral part of the program's annual financial statement.
7. Review of all regular Third Party Administrator (TPA) reports on claims payment and management including the TPA's lag reports on actual claim payments.
8. Development of actuarial cost estimates for proposed benefit modifications.
10. Development of medical trend data in support of the annual underwriting review and pricing.
11. Coordination of any independent performance audit of the TPA's services.
12. Assistance with the development of employee plan booklets (Summary Plan Descriptions).

B. **Program Administration Services**

These services would include all of the following:
1. Maintenance of the minutes for up to six formal meetings of the Trustees and subsequent distribution of such records to each Trustee.
2. Scheduling and planning of up to six regular Trustee meetings.
3. Preparation and distribution of meeting agenda books for up to six formal meetings of the Trustees.
4. Coordination of the printing and distribution of employee plan summary booklets.
5. Review of all stop loss claims and coordination of the re insurer's processing to insure appropriate reimbursement to the program.

C. Underwriting Services

These services would include all of the following:
1. Annual review of each any submission risks and development of specific pricing parameters for the coming year.
2. Review of any new submission risks and development of specific pricing parameters for such risks.
3. Application of gross actuarial data on demographics and trends to specific program applications.
4. Coordination of the final rate making process with the underlying actuarial data.
5. Review and development of annual aggregate and specific stop loss pricing for the program.

D. Additional Services

Accounting and Financial, which would typically include:
1. Preparation of quarterly financial statements consisting of a balance sheet and income and expense summaries.
2. Recording all premium contributions.
4. Preparation of the program's annual operating budget and cash flow.
5. Assistance with the annual financial audit and compilation of the program's annual financial report including compliance with GASB-10.

Marketing, which could range in magnitude from minimal to very aggressive assistance and might include the following:

1. Preparation of a detailed marketing plan and strategy.
2. Development of appropriate program marketing materials.
3. Periodic calls and visits with prospect school districts to review and explain the SSBC's program.
4. Coordination of potential new risk pricing with the actuarial and underwriting group.
5. Preparation of detailed marketing reports and summaries to be provided at the meetings of the Trustees.
6. Attendance and support at state or regional conferences which are deemed to provide a marketing opportunity.68

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Selection of Third Party Administrator

Self-insured benefit plans can help contain health insurance costs, eliminate state mandated premium taxes and promote employer control of the plan's management, if the plans are managed with expertise and care. Ed Emering, senior actuary and insurance consultant, states that a most important part in accomplishing the goal is by selecting a competent third party administrator. Emering lists the following key issues to consider in the selection of a third party administrator:

Business Reputation: How long has the administrative organization been in business? How many offices does the organization operate?

References: Contact as many references as possible, especially school districts or corporations that have left the third party administrator.

Scope of Services: How many support services does the TPA offer? In payment, investigation can provide any of the following services. In addition to the normal services of claims processing, payment investigation can provide any of the following services.

Benefit Surveys: Will the TPA keep you informed of medical trends? What is the TPA's history in regard to keeping current and able to adjust the changes in the medical field?

Acceptance: How do local doctors and hospitals rate the TPA? What public relation strategies do they have in place?

Personalization: Is the TPA able to customize services to meet your needs? Can you use your plan design or must you use their design?

Growth: Can the TPA accommodate growth? How will growth affect their performance?

Claims administration: What is their history of processing claims? What audit capabilities do they have internally? Are claim files available for independent audits?69

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The increase in the number of self-funded insurance plans has resulted in an unbundling of the traditional support services associated with group insurance programs. Employers now request additional legal and actuarial services and claims processing services. Most critical to the successful operation of a self-funded plan is the skill and care with which it is administered. The selection of a third party administrator (claims processor) requires significant consideration on the part of the employer.

**Selection of Insurance Administrator**

Selecting the insurance administrator is difficult because a school district or company must determine if it wishes to secure the services of a consultant or a broker. Both have the capacity to recommend a course of action, but the broker is allowed to receive a commission which is ultimately paid by the employer and employees with higher insurance premiums. Michael Sheridan, Assistant Superintendent of Finance in Lansing School District 171, strongly recommends that school districts hire insurance consultants in place of brokers so that the school district receives the maximum savings.70 James Sandner, credited with writing the self-funding guidelines for the State of Illinois describes the role of the consultant as follows:

1. Attendance at regularly scheduled meetings of the Trustees.

2. Review and reporting on general health care legislation and trends.

3. Review of the underlying plan document and periodic recommendations for updates and/or modifications.

4. Review of underlying insurance treaties and policies and advice on appropriateness of stop loss coverage levels and premiums.

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70Michael Sheridan, Assistant Superintendent, Lansing School District 171
5. Review of third party claims payer agreements and assistance with contract negotiations.

6. Periodic actuarial review of the plan's underlying reserves.\(^{71}\)

**Performance Guarantees**

In an effort to encourage performance of third party administrators, it is suggested that school districts utilize performance guarantees. Guarantees mandate that the third party administrators perform at a specified level or risk loss of their monthly fee. James Murray, insurance consultant, describes a typical performance guarantee for a third party administrator often referred to as a claims processor:

The third party administrator will agree to several performance guarantees for the school district and place a portion of their fees at risk. The third party administrator will guarantee the following:

1. A financial accuracy rate of ninety-eight percent (98%);
2. A claim payment accuracy rate of ninety-five percent (95%);
3. A claim processing accuracy rate of ninety percent (90%);
4. A ten (10) work day (14 calendar day) claim turnaround time for ninety percent (90%) of all submissions.\(^{72}\)

**Health Plan Communication**

Katzoff, McCally and Cohen point out that effective communication with participants and providers is an effective strategy in conducting a successful health care cost containment plan. It is essential to review and update employee communication materials on a regular basis. The goal of the communication

\(^{71}\)James Sandner, Consultant, Sandner & Emering, Inc., Chgo., IL
\(^{72}\)James Murray, Consultant, A.J. Gallagher, Itasca, IL
program should be to let employees know that the company goal is to provide them with quality health care while maintaining the rate of health care increases to a manageable level. Communication should be in a variety of formats, such as brochures, letters, payroll stuffers, and meetings. These communications should address employee concerns and let employees know the cost of the plan and allow them to be involved in helping manage costs.\textsuperscript{73}

**Summary**

This chapter has presented a brief review of literature connected to decision-making in general and in the self-funded health process. It began with the discussion of management trends and the classical decision-making models. The decision-making models describe the process which are used to administer self-funded health insurance plans and in all decision making. The next section discussed the literature on intuitive decision-making and group decision making. Both methods have contributed processes for facilitating decisions, both in health insurance and in every day decision making. Finally, the chapter concludes with a brief summary of literature on health insurance and specifically, on the components of self-funded health insurance. The complicated nature of health insurance necessitates the need for effective decision-making strategies as well as an understanding of the process. From the research has come the present emphasis on health insurance cost control. Prior to evaluating a health plan and utilizing decision-making strategies, knowledge of the plan and process is vital. The research has documented the need to understand the intricate workings of the self-funded process and the effect on costs. When it comes to evaluating a health plan and the potential for savings through cost containment, remember knowledge is power.

CHAPTER 3

Presentation and Analysis of the Data

Surveys were sent to the sixty-two school districts in suburban Cook County that were identified as utilizing the self-funded process. Ninety percent of the administrators surveyed returned the survey completed, and all agreed to participate in the follow-up interview. Of the 55 who returned the survey, fifteen were superintendents, twelve were assistant superintendents, and twenty-eight were business managers. Three of the respondents were over fifty-five years of age, eighteen were between the ages of forty-nine and fifty-four, twenty-four were between forty-three and forty-eight; six were between thirty-eight and forty-two and three between twenty-six and thirty-seven. Seven of the fifty-five were female, two of whom are included in the study. The average years of experience with a self-funded health insurance program was 6.5 years.

The sample providing data for this dissertation is five administrators from a health insurance cooperative and five administrators not in a cooperative utilizing the self-funded health concept. Three of the ten were superintendents, two were assistant superintendents, and five were business managers. All administrators are employed in public school districts that are located in suburban Cook County and range in size from 550 pupils to 5,300 pupils. Three of the school districts are high school districts and seven are elementary school districts. The assessed valuation of the sample districts varied from a low of $106,000,000 to a high of $1,832,000,000. All administrators had at least two years in their present position and their experience with self-funding health insurance ranged between two years to fourteen years.
Interview Questions

The data presented are organized and analyzed by the eight sets of questions asked in the interview. The initial question in each set seeks knowledge of self-funding health insurance and was followed by a question seeking the rationale for the decision making strategy utilized. Each administrator received a copy of the questions prior to the interview and all were very cooperative and willingly shared verbal and written information. In fact, many of the administrators had prepared notes and compiled artifacts in preparation of the meeting.

The set of questions is as follows:

QUESTION I: Are there specific stop loss provisions? At what level are they set? How did you set the specific stop loss margin?

QUESTION II: Who is involved in the decision making process in relation to the school district's health insurance and what are their functions?

QUESTION III: How many plans do you offer? What is the cost of each? Single? Family? What procedures are followed to set rates for each plan?

QUESTION IV: Do you utilize an administrative agent? What is the yearly cost? How did you select the administrative agent?

QUESTION V: Whom do you utilize as a third party administrator? What is the cost for claims administration? How did you select the third party administrator? Do you have a performance contract for your third party administrator?

QUESTION VI: What procedures do you follow to ascertain employee satisfaction?

QUESTION VII: How do you determine your plan design? Do you have input in the plan design?

QUESTION VIII: At what level is your is your reserve set? Who set it?
Presentation and Analysis of Data by Question

Each administrator who participated in the study was guaranteed anonymity and each is represented by a letter. The responses to each question are analyzed, compared and contrasted to reveal categories, similarities, and patterns. There were many similarities, contrasts, and patterns that surfaced in the responses of the administrators to the interview questions. The ten administrators represented dissimilar beliefs about health insurance and decision making, resulting from their different ages, various stages in their professional careers, and different levels of involvement in the health insurance process. The questions, presentation of the data, and analysis follow:

I: Are there specific stop loss provisions? At what level are they set? How did you set the specific stop loss provision?

The first question was to state at what level the specific stop loss was set and to describe the rationale for setting it at that level.

Three of the ten administrators have specific stop loss margins below $35,000, three had margins set at $50,000, two at $100,000 and two administrators did not know at what level the specific stop loss margin was set. The three administrators who had specific stop loss margins set below $35,000 did not have any input in the determination of the specific stop loss. They stated that the margin was set by the insurance consultant/broker and they assumed that it was set at the most cost effective level. Possibly if school administrators had a better understanding of the specific loss theory they could have negotiated a better premium. Also if the administrators had a working knowledge of the self-funded process they could have asked questions to determine if the specific stop loss was set correctly and if the premiums were within the normal limits as set by the health
insurance industry. The specific stop loss rates for the premiums exceeded the normal limits in seven out of the ten school districts in the sample. It appears that the health insurance broker set the rate that he thought the district would pay, and therefore put the school district at the mercy of the broker.

Two of the three administrators who had specific stop loss margins set at $50,000 reported that they did not have any input in determining the margin and again, like the three previous administrators, assumed that the consultant/broker had set it at the most cost effective level. Elementary school administrator D had followed a prescribed actuarial procedure for determining the best specific stop loss level for his district. Administrator D stated that he had an actuarial study conducted on the claims experience of the school district. He reviewed the results with the actuary and his superintendent and selected the most cost effective specific stop loss margin. Because of the results of the actuarial study, he elected to raise the specific stop loss margin to $75,000, which did result in a $60,000 yearly savings to the school district. If an administrator has a working knowledge of the self funded process he can request actuarial studies which will allow him to make more cost effective decisions.

The two administrators who reported that they had specific stop loss margins at $100,000 arrived at that margin by different means. School administrator I arrived at this margin after an actuarial study by an actuary consultant and the recommendation of the health cooperative's consultant. The procedure involved the cooperative's insurance consultant presenting three options with accompanying rationale, and the reviewing of the options by the cooperative's governing board. Administrator I stated that this discussion usually takes between two to four hours before a consensus is reached. School district A stated that the specific stop loss was set at $100,000 by the consultant/broker because of a long relationship and trust.
Two of the administrators did not know at what level the specific stop loss margin was set. Upon probing, it was divulged that they assumed it was set by the health insurance consultant. If an administrator is not aware of and involved in the setting of the specific stop loss margin he has in effect proclaimed to the insurance broker that he can charge whatever he deems appropriate, this ineptness allows greedy insurance brokers to charge excessive premiums.

In summary, three of the administrators arrived at their specific stop loss margin after following a classical decision-making procedure. For example, administrator D, as previously reported, analyzed the data, in a logical, sequential manner. The administrator collected the data, analyzed them, established criteria and standards, and selected the preferred alternative. Conversely, five of the administrators did not review or critique the recommended stop loss margin and accepted the level recommended to them by their consultant/broker. The specific stop loss cost per covered employee was higher than the cost for the three school districts that followed a classical decision making strategy.

Determining the specific stop loss margin is a very important aspect of a self funded process. The stop loss margin specifies the amount of risk a school district or cooperative is willing to assume and the level of risk has a direct impact on the premium. Only three administrators reviewed these variables that impacted the specific stop loss margin and set the margin at the most cost effective level. Seven administrators did not review the margin level and it was set without a rationale. Edward Emering, insurance actuary, states that along with determining the desired risk level, the specific stop loss margin has a great impact on the fixed cost of the total health plan. Allowing another party to set the specific stop loss margin relinquishes control of the health program to an outside party.74

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school district that sets a specific stop loss margin without an actuarial study and rationale is most likely to fail.

The school administrators that utilized an actuarial study and analyzed the data in a predetermined manner had the lowest specific stop loss cost per employee. The administrators that utilized intuitive decision making or allowed another party to set the specific stop loss margin, had the highest cost per employee. Three of the five administrators who were part of a cooperative followed a predetermined procedure and had a rationale for setting the specific stop loss margin. Only one of the five administrators, not part of a cooperative, followed a predetermined procedure and had a rationale for the specific stop loss margin.

### Specific Stop Loss Margins

<table>
<thead>
<tr>
<th>School District</th>
<th>Specific Stop Loss Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100,000</td>
</tr>
<tr>
<td>B</td>
<td>50,000</td>
</tr>
<tr>
<td>C</td>
<td>Not specified</td>
</tr>
<tr>
<td>D</td>
<td>50,000</td>
</tr>
<tr>
<td>E</td>
<td>25,000</td>
</tr>
<tr>
<td>F</td>
<td>35,000</td>
</tr>
<tr>
<td>G</td>
<td>35,000</td>
</tr>
<tr>
<td>H</td>
<td>75,000</td>
</tr>
<tr>
<td>I</td>
<td>100,000</td>
</tr>
<tr>
<td>J</td>
<td>50,000</td>
</tr>
</tbody>
</table>

The foregoing chart reviews the specific stop loss margin for the ten school districts. Seven of the margins were set without any rationale or were simply a
guess. This manner of setting a specific stop loss margin is detrimental to the cost effectiveness of a self-funded plan. Failure to set the most cost effective stop loss margin results in a higher premium and the school district absorbing more costs than necessary. While all Cook County school districts are under a tax cap and with less funding from the State of Illinois, it would be prudent for school administrators to review areas like the specific stop loss margin which has the potential to save a school district a substantial amount of money. The money saved can then be utilized in other areas and also can make the superintendent look good in the eyes of the Board of Education.

The literature states that the setting of the specific stop loss margin is crucial to the effective operation of a self-funded health insurance program. Only three of the administrators who supervised the self-funded health insurance program had an understanding of the impact of the specific stop loss margin on the cost of the health program. Of the remaining seven administrators no one demonstrated a knowledge of the importance of the specific stop loss on the cost of the health program. In fact, the seven administrators who had specific stop loss margins below $75,000 had no idea of why it was set at that level, and paid a higher premium each year without any rationale for the increase.

Although all the administrators knew that the specific stop loss was a part of the self-funded process only four stated that they felt comfortable about questioning their broker/consultant about the specific stop loss. The literature states that health insurance is filled with health jargon which is not understood by the general public. Seven of the ten school administrators who handle health insurance did not understand the insurance terminology and therefore allowed the insurance broker/consultant to make decisions for them.

II: Who is involved in the decision making process in relation to the school district’s health insurance and what are their functions?
The second question was to determine who made the decisions regarding the district health program and what position did they hold in the school district.

All of the administrators stated that they were responsible for the health insurance program in their school district. While the percentage of time spent on health insurance related business was reported to be between 1% and 10%, all were responsible to share their decision making with others. The five business managers reported that they made the majority of decisions regarding health insurance and kept their superintendents informed on a regular basis. In fact, all business managers stated that they sought input and utilized participatory decision making with their superintendents before making most decisions.

The two assistant superintendents who were responsible for the health insurance made most decisions and kept their superintendents informed. They did state that they sought approval from their superintendent when they were reviewing premiums, consultant performance, and other facets of self funding that they thought should be shared with the superintendent.

The three superintendents who were responsible for the health insurance made all decisions about the health insurance program in their school district and stated that they kept the Board of Education informed of their actions.

While the Board of Education must ultimately approve the expenditures for a school district health program, it did so upon the recommendation of the administrator in the school district. Eight of the ten administrators stated that the Board of Education accepted the recommendation of the administrator and assumed that he was recommending the most cost effective program for the school district. Two administrators stated that their Board of Education was very involved in the decision making part of the health program. The Board of Education requested insurance financial reports which included present costs and
projected costs. The two administrators stated that the Board of Education was more concerned with the final cost of the program rather than the process of self-funded insurance. There appears to be a need for superintendents to educate their board members in the area of insurance.

The literature states that most Boards are well intentioned, but do not function effectively because they do not have the knowledge to make good decisions. The two boards who demanded to make the final decision regarding health insurance did so without any knowledge of self-funded health insurance. In reality the administrators were sharing information with their board and not involved in participatory decision-making. The fallacy is that Boards of Education and administrators felt that a good decision was reached because many people were involved. Also the approval and acceptance by the Board of Education promoted a false sense of understanding and expertise on the part of the Board of Education. The administrator, in turn, felt a sense of accomplishment after the Board of Education approved his recommendation. This cycle can continue with decisions being made without any rationale and knowledge base.

### Health Decision Makers

<table>
<thead>
<tr>
<th>District</th>
<th>Position</th>
<th>Decision Maker</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Business Manager/Superintendent</td>
<td>Shared</td>
</tr>
<tr>
<td>B</td>
<td>Asst. Superintendent/Superintendent</td>
<td>Shared</td>
</tr>
<tr>
<td>C</td>
<td>Business Manager/Superintendent</td>
<td>Shared</td>
</tr>
<tr>
<td>D</td>
<td>Superintendent</td>
<td>Self</td>
</tr>
<tr>
<td>E</td>
<td>Superintendent</td>
<td>Self</td>
</tr>
<tr>
<td>F</td>
<td>Superintendent</td>
<td>Self</td>
</tr>
<tr>
<td>G</td>
<td>Bus. Mgr./Supt./Bd. of Ed.</td>
<td>Shared</td>
</tr>
<tr>
<td>H</td>
<td>Assistant Superintendent/Superintendent</td>
<td>Shared</td>
</tr>
<tr>
<td>I</td>
<td>Bus. Mgr./Supt./Bd. of Ed.</td>
<td>Shared</td>
</tr>
<tr>
<td>J</td>
<td>Business Manager/Superintendent</td>
<td>Shared</td>
</tr>
</tbody>
</table>
In summary, the business managers and assistant superintendent made decisions only after conferring with their superintendents or immediate superiors. While this appears logical, the business managers and assistant superintendents were sharing and seeking advice from another person with a limited knowledge base of self-funded insurance. Involving additional people in the decision-making process does not guarantee that a good decision will be made. In fact, a group of uninformed people making the decision hinders the decision making process. Whereas, some of the literature supports participatory decision making, making a decision without a knowledge base and without active participation in the discussion is basically sharing of information and not participatory decision making. Russo and Schoemaker state that involving more people does not necessarily lead to a better solution to a problem. In fact, they state that groups are likely to outperform individuals only to the extent that they foster debate. When this occurs, they state that it is likely a group decision fosters a better understanding of the issues. The three superintendents responsible for the health program in their school district made the final decision and kept their Board of Education informed. Whereas, the three superintendents in the study had some knowledge of health insurance, almost all decisions were made by how they felt or by intuition.

Three of the administrators utilized the services of a consultant to arrive at decisions. Seven of the administrators arrived at a decision by seeking advice from a person without a knowledge base in self-funded health insurance or just by selecting what they thought was the best choice. In short, these administrators were utilizing intuition to make a decision.

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All administrators, with the exception of the three superintendents, conferred with at least one other person before making a decision. All felt that they were utilizing participatory decision-making. None of the administrators gave evidence that the members of the group had any knowledge of health insurance, but felt obligated to share the information with someone prior to making a decision. While most administrators assumed that the school district was involving staff in the decision-making process, they were simply sharing information with others.

The administrators involved in a health cooperative made the decisions in the same manner as administrators not involved in a cooperative. All administrators shared information with at least one other person. Only one of the administrators gave evidence that any members of the group had any knowledge of health insurance. While the administrators in health cooperatives felt some security with the team concept, most realized that power played a big part in the decision making process. If an administrator lacks the power to influence voters he will have to accept the decisions that were approved by the group. Some administrators like to use group decision-making in the event that the wrong decision is made and so all the blame will not rest on their shoulders. Although this view was not voiced by any of the respondents, this group approach to decision making can be a valuable ploy for school administrators.

III: How many plans do you offer? What is the cost of each? Single? Family? What procedures are followed to set rates for each plan?

The third question was to have the administrators describe how many plans they offered, the cost of each plan, and the procedure utilized to set the premiums for each plan.
Eight of the ten administrators stated that they had the common 80/20 plan and a managed care plan. An 80/20 plan is a medical plan in which 80% of the claim is paid by the employer and 20% is paid by the employee. Six of the managed care programs were Preferred Provider Organization plans and two were Health Maintenance Organization plans. Two administrators stated that they did not offer a managed care program because it was not recommended by their insurance consultant.

The premiums for the ten school districts varied from $134.00 per month to $281.92 per month for single coverage. The family coverage ranged from $417.00 per month to $653.00 per month. Upon further probing, it was noted that the school districts with higher premiums also had higher fixed costs. These school districts were paying higher than average rates for their specific stop loss coverage, third party administration, and had a higher cost for their administrative agent.

Procedures varied in how the premiums were set. Six of the administrators stated that the premiums were determined by the administrative agent or third party administrator without any input from the school district. Four administrators stated that they had a set procedure for rate setting. Three of the four school districts who followed a prescribed rate setting procedure were part of a cooperative and described the rate setting as participatory. While the administrators described the rate setting as participatory, it was noted that two or three of the members controlled the process. Participating in a cooperative does not ensure that all participants have equal voices in the final decision.

Foster and Higgins project the cost of HMO's and PPO's to be between $183 to $224 lower than a traditional plan. The two school districts that were not

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offering a managed care program opted not to do so because it was not recommended by their brokers. In addition, these school districts had rates 5 to 10% higher than the other school districts in the study. Although the literature states that managed care is a way of curtailing the rising medical costs, some administrators were not aware of this fact or did not venture to explore the possible value to their school district. The fact that the broker did not propose managed care options is very questionable. With the high premiums and high commissions of these brokers, one could conceive that the broker was taking unfair advantage of the health administrators and the school districts.

<table>
<thead>
<tr>
<th>School District</th>
<th>80/20 Plan</th>
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Four of the administrators followed a prescribed procedure for rate setting but two did so without a review and audit of the plan designs. In reality, the two school districts that did not review and audit the plan design set their rate by
intuition because it was not based on facts and past experience but on how they felt at the particular moment.

The six administrators who had rates set by the administrative agents or the third party administrators without their input relinquished control of the health program. Since the school administrators were not presented with a plan design audit and experience of the enrolled employees, the cost effectiveness of the plan design cannot be determined and there is no way of knowing the real cost of the health program. In short, these school districts do not know if they are really getting what they are paying for or if the product has any value. When the rates are set by the broker there is no incentive to recommend lower premiums. In fact, if the premiums are higher it will result in the broker receiving more compensation.

All of the school districts offered the traditional health plans whereby the school district pays 80% of the cost and the employee absorbs 20% of the cost. The traditional plan costs more than a Preferred Provider Plan or a Health Maintenance Plan. DePriest reports that the cost of Preferred Provider Plans or other managed care programs are approximately 17% less than traditional plans.\(^\text{77}\) Three of the school districts did not offer a Health Maintenance Plan or Preferred Provider Plan or other managed care plan, thereby eliminating a possible cost savings for their school district. In addition, only three of the school districts were offering incentives to motivate employees to change to a less costly plan. Even though health insurance takes a large part of school district budgets, school administrators are not creating or reviewing alternatives to contain health costs. The type of health programs that a school district conducts is directly related to the cost of the health plan, level of coverage, and the expansiveness of the coverage. Little awareness was evident by school administrators to relate the cost of the

\(^{77}\text{Pamela S. DePriest, 1995, Proposal for South Suburban Benefit Cooperative, chart in Section 8, p. 4.}\)
districts' health insurance to the costs that make up the premium. Not all administrators were aware of how the cost of their health program compared with other similar groups. In fact, the range of premiums for a single health premium was 100% and 56% higher for the family premium, within the sample. The range of premiums is due to the various costs that make up the premium. For example, if a school district is paying a higher than average premium for the specific stop loss or it is placed too low, it will drive the premium upward. The knowledge of the self funding relationship of components and the impact on plans and costs was not evident in the interviews.

The literature states that managed care programs can save a school district approximately 17% per year, yet three school districts did not offer a managed care program and one other school district was not promoting the managed care concept. While many excuses were presented as to why a managed care program was not offered, the real reason appeared to be a lack of knowledge of health trends, cost to support these trends, and a lack of in service of staff. If school districts are to control health care costs, a progressive in service program dealing with health care and health trends is necessary. While most administrators reported a resistance from teachers and unions to change, few had any plan in place to address teacher and union resistance to changing the health plan. Most administrators did not present any documentation of educating their employees about the benefits of alternative health plans and challenges in health care. According to the respondents, most employees want more coverage for less cost and believe there are magic remedies that will allow them to have high quality health care and save money. The search for magic remedies is usually just another way of making excuses and avoiding the need to choose.
IV Do you utilize an administrative agent? What is the yearly cost? How did you select the administrative agent?

The fourth question was to determine if school districts utilized an administrative agent, the cost of this service and to describe how the administrative agent was selected.

Eight of the ten administrators utilized an administrative agent either individually or through a health cooperative. Of the eight, one knew the exact amount paid to the administrative agent. Two administrators stated that they knew the approximate cost of the administrative agent and the remaining five did not know what amount the administrative agent was paid. The reason for not knowing the cost of the administrative agent may be because some school districts utilize brokers while others utilize consultants. While the services provided by each is similar, the cost difference is significant. Brokers charge a fee plus a commission, which is usually between 15%-20% for all policies that they procure. By comparison, consultants charge a flat fee and therefore have more incentive to seek the lowest possible premiums for a school district. Conversely, brokers have little incentive to seek the lowest possible premiums because that would result in lower commissions for them. The literature states that the range of commissions paid to brokers is between 15% to 20%. The insurance industry has been successful in highlighting the increasing medical costs as the main reason for high medical premiums. It appears that the issues confronting the health industry concern insurance profits rather than high medical costs. Health administrators need to question and critique health insurance contracts and policies to determine the actual broker compensation.

The cost of a self-funding health program is directly related to the fixed costs. The cost of the administrative agent for the sample ranged from $20,000 to $400,000 per year, depending on whether the agent is a consultant or a broker.
Upon probing the five administrators that did not know the cost of their administrative agent, it was determined by an examination of the health insurance contracts and monthly payments that the cost of the administrative agent was over $100,000 per year. All of the administrative agents for these five school districts were brokers and were paid a fee plus commission on the specific stop loss policy, aggregate stop loss policy and life insurance policy.

School administrators recommend contracts to Boards of Education regularly. Five administrators in the study recommended contracts to their Board of Education that paid a commission to brokers between 15% - 20% for all the policies procured. These same services were available for much less. The higher costs were primarily due to the fact that administrators did not know the difference between a broker and consultant. Also, administrators were not aware of insurance terminology and did not seek clarification of contracts, which resulted in much higher costs to the school district. If school administrators had the health contracts reviewed by attorneys who specialize in the health industry, the chance of excessive commissions would most likely be lessened. Only two of those interviewed took advantage of this type of expertise.

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Five of the school districts who had administrative agents did not demonstrate a working relationship with the administrative agent and accepted the yearly recommendations without questions. Since school administrators did not demonstrate a thorough knowledge of health insurance it is surprising that they do not utilize the services of a health consultant rather than a broker. The research states that consultants are much more cost effective than brokers, yet most school districts have retained the services of brokers. Many administrators reported that they retained their insurance broker because they had a long term relationship. This long term relationship could lull school administrators into a sense of false security; administrators tend to accept the recommendations of a broker without question. This situation could allow greedy brokers to make excessive fees at the expense of the school district.

The research has stated that while health insurance does not need to be bid, utilizing the bid process for securing the services of a consultant or broker could prove very fruitful. Administrators have been reluctant to bid this service and this fact is well known in the insurance industry. The three school districts who utilized the bid process and interviewing process paid one half of the amount paid in the districts who did not utilize the bid process. In addition, the three school districts who utilized consultants paid one fourth of the costs in comparison to those districts that utilized a broker.

There was no pattern of how school districts secured the services of an administrative agent. Two school districts hired agents because they were referred by other school districts or professional organizations. While the experts in self-funded health insurance recommend detached agents, only three school districts followed this advice.

A pattern that emerged was that school administrators favored service over costs. Six of the ten administrators stated that they were content with the service
and did not review or question the cost of the Third Party Administrator. All six stated that if the service declined, they would consider changing the Third Party Administrator. None of the six mentioned the need to gain employee input in the formal systematic manner. If employee input is not sought on a regular basis, how are employers going to be aware of poor service.

V  **Whom do you utilize as a third party administrator? What is the cost for claims administration? How did you select the third party administrator?**

The fifth question was to determine if the administrator utilized a third party administrator, the cost of this service and to describe how the third party administrator was selected.

All administrators stated that they utilized the services of a third party administrator to process the health and dental claims. The costs varied from $7.50 for each employee per month to $15.00 for each employee per month. Four of the administrators stated that they bid this service on a regular basis, but not less than every two years. The four school districts that utilized the bid process for the TPA service had the four lowest costs. The six school districts that did not bid out the TPA service had rates higher than the average. During the past two years, third party administrators costs have actually been lower because of the influx of more companies providing this type of service and the advances and uses of technology. According to Donald Long, third party administrator, the average cost of third party service is well under $10.00 per month per employee.\(^7^8\)

Three of the school districts developed specifications for services required of third party administrators and requested bids. The three administrators stated that the services and costs of TPA bids were reviewed and compared and the company that provided the prescribed services at the lowest costs was selected.

\(^7^8\)Donald Long - Interview, April 17, 1995
Four of the administrators remained with the present TPA because they were recommended by the district's administrative agent. Three of the administrators stated that they remained with the present TPA because they had a long relationship and because claims were being processed in a timely fashion.

All administrators were concerned about the costs of the TPA, yet only two had demanded a performance contract for the third party administrator. While performance contracts vary, most require that the TPA guarantee processing claims at prescribed rate and at a prescribed accuracy rate or lose a percentage of the monthly premium. Without a performance contract, school districts have little recourse if a TPA does not process their claims accurately or processes them slowly.

School districts are required to bid items over $10,000. Although there is much debate on whether a school district is required to bid health insurance
services, Tony Ficarelli, health insurance attorney, strongly recommends that this service be bid. Ficarelli states that by bidding the health service, a school district can ensure the best price for the services sought because the health services market is changing rapidly.

The range of costs of TPA services is $7.35 per employee per month to $14.00 per employee per month. This range represents a 100% difference from the lowest cost to the highest cost.

While three of the school districts had TPA specifications, the remaining seven were not aware of any job descriptions or specifications for the Third Party Administrators. While school systems' financial management is a topic of concern at the state and local level, it seems that paying a price for an unknown product or service is questionable financial management.

All of the school districts had Third Party Administrators, but only two school districts evaluated the performance of the TPA. The research states that consultant review of the TPA services and a regular audit of the services can promote good services and content consumers. While auditing firms are readily available, only two school districts conducted an audit on a regular basis. Administrative agents do not recommend audits because reduce program costs reduces commission. It was apparent from the comments of those interviewed that those strategies that promoted cost reductions were seldom mentioned or promoted by insurance brokers.

Insurance experts state that the average cost for the third party administrator is under $10.00 per person per month. Yet, six of the school districts in the study paid more than $10.00 and upon questioning and probing it was stated many times that school districts did not want change any part of the insurance program.

Tony Ficarelli, Interview, May 24, 1995
VI: What procedures do you follow to ascertain employee satisfaction?

The sixth question sought to determine the procedures that school administrators utilize to ascertain employee satisfaction with the school district health program.

All administrators stated that they follow up on all staff concerns dealing with health insurance. While one administrator stated that he had not received one complaint this school year, six of the administrators stated that they received two to three complaints each month and they usually took a considerable amount of time to resolve. Three administrators stated that they have received approximately 4-6 complaints each month. Reliance on complaints from the staff is a reactive posture. In something as important and worthy as health insurance the absence of a proactive, systematic approach to staff satisfaction is questionable. While most are resolved easily, some take a great deal of time, which includes telephone calls and, on occasion, meetings with the third party administrator.

While all administrators stated that their respective teacher's union had involvement into insurance concerns, only one administrator stated that he had a process in place to ascertain employee satisfaction. Administrator C meets with the school district's finance committee every other month and utilizes the format to respond to employee health insurance concerns. Two other administrators stated that they had yearly meetings with the staff to discuss and respond to insurance concerns. Marie Furmanski, Manager for Long Claim Services, suggests regular meetings with employees promotes satisfaction. She recommends twice a year face to face meetings and bi-monthly newsletters which provide timely insurance pointers.80

80 Marie Furmanski, Long Claim Service, Matteson, IL, Interview, April 17, 1995
Since all administrators agreed that health insurance was a constant concern of the staff, it seems that it would be reasonable that health administrators monitor the health insurance process. Regular monitoring of the school district's health insurance program could allow dissatisfied staff members an opportunity to seek a solution to their insurance concerns. While insurance mishaps can be frustrating and time-consuming, a regular monitoring program can prove very effective in lessening the stress and time needed to resolve concerns. In addition, regular monitoring ensures that employees and the school district are receiving the level of service they are paying for. Yet only three school districts had any means of communication with their employees during a school year. This lack of communication could promote an adversarial relationship with employees and increases the risk of resentment from staff and students.

Upon further explanation and exploration with the administrators in the sample, a pattern of dealing with employee concerns emerged. Administrators tended to react to employee concerns when they were presented to them. Only two administrators demonstrated a proactive stance and disseminated regular newsletters to all employees reviewing and clarifying employee health concerns.

Since eight of the administrators did not have employee health satisfaction surveys in place they increased the possibility of upsetting their employees when health problems occurred. For most people, there are few situations that are more personal, more capable of making them very happy or miserable. Since health insurance matters, or any kind of health care coverage, involves both one's health and one's money, it can be very aggravating when claims are not paid or health services are not rendered. Although health care is very expensive, and provided free or at a low cost to employees, poor administration of the health program can cause employers to be the recipient of the employee's wrath.
In analyzing the time spent on insurance related business, there seems to be little difference in how an administrator understood or handled the districts insurance program. In fact, in some districts the insurance related questions were handled by clerks who had little knowledge of the insurance plan. Most clerks were able to send forms while questions dealing with unpaid claims and health coverage were forwarded to administrators in charge of health insurance in the school district. Most insurance concerns and questions appeared to deal with unpaid claims and percentages of claims paid. While administrators were aware of some of the problems, few had a mechanism in place to help employees deal with these health insurance problems. Only through prodding during the interviews did the administrators realize the impact of side effects such as, low employee morale, possible teachers union grievances, and issues for the Board of Education. While most Boards of Education do not have the expertise to resolve health insurance problems, they may be confronted with this situation if problems emerge.

VII: How do you determine your plan design? Do you have input in the plan design?

The seventh question sought information about how the plan design was determined and who had input in the plan design.

Six of the administrators stated that the plan design has remained the same for the last six years. When changes had been contemplated, they were discussed with the teachers' union and, if accepted, the plan design was adjusted. Three of the administrators stated that the plan design in place was recommended by the administrative agent and had not been changed for at least ten years. In contrast, one administrator stated that his plan design was a matter of concern at all contract negotiations.
All administrators stated that the teachers had varying degrees of input in the plan design. Six administrators reported that the health plan design was part of the negotiated contract in their school district. Four reported that the teachers had input in the plan design, but that the plan design was not part of their teachers' contract. Even though the teachers had input in the plan design, six administrators stated that all plan design changes emanated from the administrative agent. Anthony Ficarelli, self-funded attorney, stated that the plan design must be carefully analyzed because it describes the level of services to be provided.\textsuperscript{81} It is equivalent to a health contract. Two of the administrators stated that their plan design was reviewed on a regular basis for cost effectiveness. The remaining eight administrators did not have any remarks concerning the development of the plan design.

The plan design of a health program states the level of services to be provided to employees and has a direct bearing on the cost of the program. Only two administrators had a mechanism in place to review and address the cost and service of the health plan. School administrators who were not reviewing and auditing the plan design on a yearly basis were purchasing a health plan that may not be meeting the employee needs and may not be cost effective.

While administrators reported that teachers had input in the plan design, clearly the major decisions were made by the administrators. While the teachers' unions wanted to maintain what services they presently had, a review by a competent insurance consultant could reveal a higher level of benefits for less costs. However, in no instance was this service sought. Allowing teachers without a thorough understanding of health insurance to dictate the plan design is relinquishing the cost control of the health program.

\textsuperscript{81}Anthony Ficarelli, Attorney - Scariano, Kula, Ellch & Himes, Chicago, IL, Interview - May 16, 1995.
There have been many changes in the health field in the past ten years. Those school districts that have retained the same plan design during this time are demonstrating a lack of health knowledge, medical treatment and medical cost controls.

**VIII: At what level is your reserve set? Who set it? How did you arrive at this figure?**

The eighth question was to determine if a school district had a reserve, who set it, and how it was established.

Four administrators stated that they did not have a reserve. Four administrators stated that the reserve level was determined by the administrative agent after a thorough evaluation of the premium and the projected expenses. The actual figure was set at three months of premium. Two administrators stated that the reserve level was set by the cooperative board after a study by the administrative agent.

Edward Emering, insurance consultant, recommends that self-funding school districts maintain a reserve of at least three months of premiums. He states that this reserve is necessary to guarantees that all expected claims can be paid. He cautions that any entity that has set a lower reserve level risks the possibility of chaos.82

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Six of the school districts had reserves set at the industry recommended level of three months of premiums. These reserves ensure that these school districts will usually have sufficient funds to pay medical claims. Operating a health plan without an adequate reserve leaves the school district open to financial vulnerability and will cause a school district to use funds designated for educational purposes to pay health insurance claims. The four districts without adequate reserves can be in a dangerous financial situation. Administrators who supervise health insurance plans who are not aware of current medical trends and costs will have a difficult time calculating an accurate medical reserve. With the passing of the tax cap legislation, school districts need to find ways of freeing up funds for the education fund and escalating medical claims can negatively impact the education fund. For example, if a school district experiences an increase in medical claims, and if the reserves are depleted, the claims must be paid from the
educational fund. This necessity then leaves the educational fund with less monies to pay teacher and staff salaries and to purchase curricular supplies. Conducting a self-funding health plan without an adequate reserve or no reserve restricts the school district to the self-funding process. If a district without a reserve wishes to move to a traditional health plan, the cost would be prohibitive because the school district would have to pay the premiums plus the cost of claims for at least 120 days. The six districts with adequate financial reserves may be able to pay substantial insurance claims. The four districts without this reserve are courting danger.
CHAPTER 4

Summary, Conclusions, Recommendations and Suggestions for Further Study

One of the costliest segments of a school district's budget is employee health insurance. Studying how administrators make decisions in supervising this segment of the budget contributes to the knowledge needed for effective administration. In an effort to ascertain what decision making strategies school administrators were utilizing in relation to employee health insurance, three superintendents, two assistants, and five business managers were interviewed in suburban Cook County. The districts were similar in that they were public schools with the same budgeting guidelines. They differed in that two were high school districts, seven were elementary districts, and one was a special education cooperative. The three women and seven men represented a wide range of experience with self-funding health insurance from 2 to 14 years.

The wealth of the school districts varied primarily due to their assessed valuation. The assessed valuation ranged from $106,000,000 to $1,832,000,000. All school districts were recently placed under the State of Illinois tax cap which limited tax increases to 5%, or to the consumer price index, depending which is lower.

Data were gathered through structured interviews, which lasted from 65 to 135 minutes. The eight major questions were developed to ascertain knowledge of self-funding health insurance and the decision-making strategies utilized. Much probing and interaction were necessary to
reveal answers to the questions. The questions follow:

QUESTION I: Are there specific stop loss provisions? At what level are they set? How did you set the specific stop loss margin?

QUESTION II: Who is involved in the decision making process in relation to the school district's health insurance and what are their functions?

QUESTION III: How many plans do you offer? What is the cost of each? Single? Family? What procedures are followed to set rates for each plan?

QUESTION IV: Do you utilize an administrative agent? What is the yearly cost? How did you select the administrative agent?

QUESTION V: Whom do you utilize as a third party administrator? What is the cost for claims administration? How did you select the third party administrator? Do you have a performance contract for your third party administrator?

QUESTION VI: What procedures do you follow to ascertain employee satisfaction?

QUESTION VII: How do you determine your plan design? Do you have input in the plan design?

QUESTION VIII: At what level is your reserve set? Who set it? How did you arrive at this figure?

Conclusions
There are eight conclusions resulting from this study:

• Administrators displayed a lack of knowledge of the intricate workings of self-funding health insurance.
The first conclusion evolved from the questions dealing with the specific stop loss provisions, the determination of the plan design and the setting of the reserve level. While some of the decision-making procedures were evident, the lack of knowledge on how self-funding insurance works lessened the effectiveness of the process. Oftentimes, administrators in the sample allowed consultants to develop the plan design, set the specific and aggregate stop loss, and determine the reserve level. While administrative agents have the technical knowledge necessary for the success of a self-funding plan, some administrative agents blatantly abused the client and broker relationship by charging exorbitant rates that exceeded the health insurance standard. School districts should retain the final decision-making authority to ensure fiscal integrity. When the administrative agent dictates the program, the school district relinquishes the control and the cost of the program to an outside agent. An analogy would be to hire a personal financial planner and turning the earnings to him and having him dictate the various expenditures. Certainly, a personal financial planner has merit, but the level of involvement must be determined so that he does not have excessive power and total control of ones funds.

- Administrators, in general, were very content with the present decision making process that was utilized with their self-funding health insurance.

The second conclusion evolved from the question dealing with determining the specific stop margin, plan design, the plans offered and the selection of the third party administrator. The majority of administrators
were accustomed to allowing the administrative agent to recommend these important aspects of the self-funded process. Allowing the administrators to recommend these important aspects of the self-funded process can be due to the relative newness of the concept and the amount of time and expertise necessary to adequately supervise the totally self-funding program. In addition, the majority of administrators assumed that they were utilizing participatory decision making because they involved other people in the decision making process. In reality the business managers and assistant superintendents were sharing information, because the others involved lacked a knowledge basis of health insurance.

- **Administrators in self-funded health cooperatives and administrators not in cooperatives voiced satisfaction with the self-funded process, even though they did not have a good understanding of the intricate workings of the self funded process.**

The third conclusion emanated from all the questions. All the administrators were satisfied that they were in a self-funding program rather than in a more costly traditional program. The administrators stated that they were satisfied with the present cost of the insurance program but failed to evaluate and monitor the health program on a regular basis. The fact that eight of the ten school districts have had one administrative agent and the same Third Party Administrator since they have utilized the self-funded process verifies the fact that the administrators had become complacent and unwilling to make a change. Since this study was undertaken, three of the school districts in the sample have changed administrative agents and TPA's and two others are considering a change.
- Administrators were not aware of the total cost of health programs and specifically the cost of their administrative agent.

The fourth conclusion emanated from the question seeking information concerning the use and cost of an administrative agent. While eight of the school districts utilized an administrative agent, only two were reasonably aware of the cost of this service. Insurance consultants/brokers have fostered this condition by the use of terms used exclusively in the insurance business. Also, the insurance industry has viewed the school health business as a lucrative market and, while medical costs and insurance premiums have risen, so have their commissions and fees. The fees charged by the administrative agents were exorbitant and were not openly revealed to school districts. The subservient attitudes of school administrators has led to this relationship. The operation of a school district health program is very complicated and needs to be continually monitored if costs are to be controlled. The private sector has demonstrated the ability to change and control health costs by utilizing self-funding health insurance as well as self-funding in the areas of liability and workers' compensation.

- Administrators utilized intuitive decision making models most frequently when making decisions concerning self-funding health insurance.

The fifth conclusion evolved from the answers from all the questions. The majority of decisions were a guess or made by intuition. While intuitive decision making is of value in many situations, research has shown that in-depth, careful analysis and logical decision making are superior when working with detailed concepts like those present in self-funding.
health insurance. The study raised the question of when and how often did the administrators utilize intuitive decision making as compared to the classical decision making process. While five of the administrators were part of a cooperative, it was evident that more people involved in the decision making does not necessarily result in better decisions as evident by the high premiums. Two of the respondents stated that many of the decisions in the cooperative were swayed by the more powerful and influential board members. This influence results in a situation in which the individual school district did not have as much input as it may have liked. Participatory decision making was mentioned often by all business managers and assistant superintendents, yet it was not participatory decision making, but rather a sharing of information. The weakness of this process was that they were seeking input from other administrators, namely superintendents, who did not have a knowledge base in the area of self-funding health insurance. Furthermore, most business managers felt that utilizing participatory decision making concept was valuable in itself, even though all administrators participating may not have a knowledge of self-funding insurance. The administrators stated that they needed to follow the chain of command and report to their immediate supervisor.

- **Administrators did not have a structured and ongoing process in place to measure staff evaluation of the school district's health program.**

The sixth conclusion evolved from the question dealing with how administrators assessed employee satisfaction with their health program. Nine of the ten administrators did not have any mechanisms in place to handle and resolve employee health related concerns. They spent the
majority of their time attempting to resolve the same type of health related concerns throughout each school year. They paid attention to insurance problems on a quasi-crisis basis rather than on an analysis of and a solution to the issues and circumstances causing the problem. Yet only one district utilized a formal systematic process to measure the satisfaction level of the staff.

- School administrators who were part of the health cooperative did not have a better understanding of the self funded process than school administrators who were not part of a cooperative.

The seventh conclusion emanated from the answers to all the questions. Administrators who were part of a self funded cooperative demonstrated a similar understanding of the self-funded process as administrators who were not part of a health cooperative. Administrators in a self-funded pool attended regular and more frequent meetings than the administrators not in a self funded pool and no difference in their understanding or expertise was demonstrated.

- The cost of health insurance is usually the second largest item in a school district budget and receives less attention than it dictates.

The eighth conclusion evolved from an analysis of all questions. Administrators stated that health insurance costs were a large part of the education fund, but devoted between 1 to 10% of their time to health insurance issues. The administrators tended to utilize the insurance industry's projected trend increase as the guide to medical cost increase.
The insurance industry publishes a medical trend yearly and this projection has been followed by school administrators as they set premiums.

**Recommendations**

- Administrators, superintendents, and school board members need to be informed and become more knowledgeable about health insurance in general and specifically for self-funding health insurance. School districts need to make an informal and consensus selection of the decision-making process they wish to follow when dealing with health insurance. These decisions need to be implemented and reviewed regularly, in order to effect real change. The administrator responsible for health insurance and the school superintendent need to provide the leadership and support if a school district is to provide a cost effective and efficient insurance program. School administrators who deal daily with the self-funding program need to become familiar with intricate workings of the process. School business associations and the business community oftentimes sponsor workshops dealing with self-funded health insurance programs which can prove to be beneficial to school administrators. The administrators in charge of the health program and the staff that works with the program must make an effort to stay abreast of this ever-changing market.

- School administrators must be cautious, yet not intimidated, when dealing with representatives of the insurance industry. Oftentimes educators are not aware of the bottom line approach that is used in the business community and are victims of industry jargon and scare tactics. School districts should consider developing cooperatives to provide specific stop loss, aggregate stop loss, TPA services, life insurance, dental insurance, and prescription service. This format will eliminate the broker's commission and will result in a 20 to 40% savings to school districts.
School districts need to develop a procedure to seek the feelings of the school district employees in relation to the district's health program. Since the school district usually absorbs the majority of the cost of the health program, a regular assessment should be utilized to measure the cost effectiveness of the health program. Regularly scheduled meetings and newsletters focused on employee concerns should be part of a school district's health program.

School districts need to bid the administrative agent, third party administrators, and specific stop loss insurance. The bidding process forces competition. The lack of competition among insurance companies has allowed insurance companies to control the health insurance market. Conducting regular bidding of health insurance will cause insurance companies to change the manner in which they do business and put the customer first.

School administrators need to keep current and seek pertinent information from reliable sources in the medical and insurance industry.

School administrators should develop medical trends for their own school district or cooperative by analyzing and authorizing actuarial studies which would provide the data for determining trends.

Suggestions for Further Study

This study could be repeated utilizing different regions of the State of Illinois and comparing health costs, health services, and health plan design.
• It would be interesting to study the similarities and differences in health, liability, and workman's compensation entities that use the self-funded concept.

• While this study included school districts from health cooperatives and school districts not in health cooperatives it would be valuable to compare the costs, plan designs, and health services of the various health cooperatives by size and location.
Dear School Administrator:

With great enthusiasm, I request your participation in a research study that promises to be an important contribution in the understanding of decision making strategies utilized in self-funded health insurance. I feel that this study should provide significant data for school administrators when investigating or participating in a self-funded health program. To complete this research, your assistance is needed to:

- complete and return the enclosed questionnaire
- sign consent form to participate in face to face interview concerning self insurance

All statements will be held in absolute confidence. Your responses will only be used as research data, Confidentiality will be maintained by utilizing a letter code. The interview will probably take about 25-30 minutes and the 8 questions will be sent to you prior to the meeting so you will have an opportunity to review them. A copy of the final results will be mailed to you.

Thank you for your assistance and participation. Please return the questionnaire and this permission slip in the stamped, self-addressed envelope.

I agree to participate in this study. Please send me a copy of the questionnaire.

__________________________
Name of Participant

__________________________
Address

__________________________
Phone Number

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An Analysis of the Decision Making Strategies School Administrators use as Participants in Self-Funded Health Insurance

Administrator Questionnaire

1. Type of School District (please check one response)
   _____ A. Elementary (K-8)
   _____ B. High School (9-12)
   _____ C. Unit (K-12)
   _____ D. Other (Please specify)

2. Number of students in your school district for the 1994-95 school year.

3. In what year did your school district begin using the self-insurance concept?

4. What was the assessed valuation of your school district for the 1994-1995 school year?

5. What is your current job title?

6. What is your gender?  ___Female  ___Male

7. What is your age?  ___25 and under  ___43 - 48
   ___26 - 36  ___49 - 54
   ___37 - 42  ___over 55

8. How many years have you worked with the self-insurance program?

9. Would you be willing to participate in a follow-up interview concerning self-funded health insurance?
QUESTION I: Are there specific stop loss provisions? At what level are they set? How did you set the specific stop loss margin?

QUESTION II: Who is involved in the decision making process in relation to the school district's Health Insurance and what are their functions?

QUESTION III: How many plans do you offer? What is the cost of each? Single? Family? What procedures are followed to set rates for each plan?

QUESTION IV: Do you utilize an administrative agent? What is the yearly cost? How did you select the administrative agent?

QUESTION V: Who do you utilize as a third party administrator? What is the cost for claims administration? How did you select the third party administrator? Do you have a performance contract for your third party administrator?

QUESTION VI: What procedures do you follow to ascertain employee satisfaction?

QUESTION VII: How do you determine your plan design? Do you have input in the plan design?

QUESTION VIII: At what level is your reserve set? Who set it? How did you arrive at this figure?
WORKS CITED


Aubry, Charles A. and Patricia K. Felkins. (Teamwork: Involving People in Quality Productivity and Improvement, 1988)


DePriest, Pamela S.. 1995, Proposal for South Suburban Benefit Cooperative, chart in Section 8, p. 4.


Emering, Edward. Consultant, Sandner and Emering, Inc


Furmanski, Marie. Long Claim Service, Matteson, IL, Interview, April 17, 1995

Griffiths, Daniel E. Administrative Theory (New York, Appleton - Century - Crofts, 1959)
Hanson, E. Mark. *Educational Organizational Behavior*. (Boston, Mass., Allyn and Bacon, Inc. 1979)

Health Insurance Association of America, "Group Health Insurance I" (Chicago, New York, Washington: HIAA, 1976)

Heller, M. P. Professor, Loyola University, Chicago - Leadership 465; October, 1994.


Kohut, George, "1994-95, Teacher Salary Settlements" by the Illinois Association of School Administrators, March, 1995


Lindsay, Drew. *Small Districts Eye "Pools" as Remedy*, Education Week (September 7, 1994)

Long, Donald - Interview, April 17, 1995


Murray, James, A.J. Gallagher Insurance Consultant, Oct. 25, 1994

Piper, Donald L. . "Decision-Making: Decisions Made by Individuals vs. Those Made by a Group Consensus or Group Participatory Educational Administration Quarterly 10 (Spring 1979): pp. 82-95.


Sandner, James, Consultant, Sandner & Emering, Inc., Chgo., IL

Sheridan, Michael, Presentation to South Suburban Benefit Cooperative, October 1994, Orland Park, IL.


Wyatt's Proprietary Compare Date Base, Washington, D.C., 1994