



April 30, 2007

The Honorable Ted Strickland
Governor of the State of Ohio
The Statehouse
Columbus, OH 43215

Dear Governor Strickland:

Section 9.901(N) of Am. Sub. H.B. 66 directed the Department of Administrative Services (DAS) to assess the feasibility of pooling health benefits for persons employed by public institutions of higher education. Through a competitive bidding process, DAS selected Mercer Health and Benefits to help assess the environment. The report that DAS received from Mercer is attached to this letter and is also being provided to the Speaker of the House of Representatives and the President of the Senate, as stipulated in Section 9.901(N).

The Mercer report is a high-level overview of the health care environment in higher education institutions, with an assessment of the issues they face and recommendations for possible solutions. Mercer was selected last year by the School Employees Health Care Board (SEHCB) to collect and analyze data and make recommendations about improving the health care delivery system for K-12 school districts in Ohio. Given that DAS's responsibility was a feasibility study, the higher education study did not involve the same level of data collection and analysis required by statute for the K-12 study.

While there are some differences in the structure of school districts and colleges and universities, Mercer found that both groups are experiencing many of the same problems related to health care. Health care costs are rising at a rate that exceeds available revenues, purchasing powers are eroded by small risk pools, and proven health management strategies are not being used consistently. Utilizing the earlier Mercer report on school districts, the SEHCB, in its report for K-12 school districts, suggested that maintaining the status quo would produce uncontrollable increases in school budgets. Without changes, school services would be seriously impacted. The SEHCB recommended for K-12 school districts that through the establishment of best practice standards, the implementation of transparent processes and other actions, health care could be improved and savings could be generated.

DAS agrees with Mercer that this same situation faces colleges and universities, and that there is room for improvement in the way money is spent for health care. Strategies for improvement are summarized below and are detailed in the attached Mercer report.

With the knowledge of the K-12 analysis, supplemented by additional data from the higher education institutions, Mercer has demonstrated the potential for savings to be realized on health care expenditures for higher education institutions. Mercer estimates the annual savings to range from \$7.5 million to roughly \$10 million if all recommendations are implemented. The savings can be produced, according to Mercer, by using a number of options, but can also be enhanced with statewide purchasing of select benefits and full disclosure of appropriate data.

After reviewing the report, DAS and Mercer met to discuss the report. In discussions, Mercer confirmed these key points:

- Mercer is not recommending a “pooling” approach for plan design or shared risk purposes. There are not meaningful savings to be achieved, and different stakeholders would oppose pooling for these purposes. An exception may be the opportunity that exists for smaller higher education institutions to partner with larger higher education institutions located within the same geographic region. (i.e. Columbus State Community College and the Ohio State University)
- Consistent with the K-12 recommendations, Mercer strongly recommends:
 - 1) Statewide purchasing of select benefits including but not limited to: pharmacy benefits, health management services, stop loss, and ancillary benefits.
 - 2) Requiring transparency and full disclosure of relevant health care data.
 - 3) Implementation of best practice standards.
- Mercer recommends the elimination of indemnity plans, perhaps with “wrap networks” to provide better discounts on health care services.

DAS has considered the various strategic options for cost containment and health status improvement, as outlined by Mercer. DAS agrees with Mercer and is not recommending the pooling of health care benefits for the employees of higher education institutions except for the possibility noted above for smaller higher education institutions. DAS does not believe the pooling of health care benefits is necessary to achieve the desired outcomes.

Mercer has proposed a comprehensive group of initiatives for cost savings. DAS agrees with many of the proposals, specifically:

- To require Health Plan Sponsors to fully disclose all relevant health care data, making them more readily available to the public.
- To develop and implement standards – or best practices – for all Health Plan Sponsors. These standards, examples of which are cited on page 10 of the Mercer report, should improve efficiencies, quality of health benefits management, and reduce the rate of increase in health insurance premiums paid by Health Plan Sponsors. DAS agrees with those recommended steps that do not require pooling (i.e. removal of indemnity plans, best practice networks, improved ASO arrangements).
- To pursue the feasibility of statewide purchasing of select benefits that offer demonstrable economies of scale, such as – but not limited to – population health management and prescription drug programs. This is a practice that is broadly employed in the private sector and by many public purchasing programs. Combining higher education and K-12 employees in such programs would achieve additional meaningful savings.

DAS recognizes the need to balance the process for successful change and the potential for cost savings. DAS believes that statewide purchasing of select benefits, implementation of standards for best practices, and increasing transparency of results are the right things to do and can be combined with the retention of collective bargaining rights and improvement in the health status of higher education institution employees.

At this time, DAS recommends that the existing School Employees Health Care Board and Advisory Committee engage in serious conversations with the Chancellor of the Ohio Board of Regents on how to best incorporate potential higher education healthcare savings in conjunction with the work of the SEHCB.

Unlike the K-12 study, the higher education study was simply a high-level feasibility report. Although a detailed review similar to the K-12 analysis could be performed, it is recommended that a detailed analysis of higher education institutions not be conducted because nearly all of the findings would be duplicative of those offered in the original K – 12 study. While a detailed analysis would provide additional detail, it is our collective belief the additional detail would not change our recommendations.

My staff and I stand ready to assist you with this important initiative. If you have any questions or need additional information, please let me know.

Sincerely,



Hugh Quill
Director

Attachment: Mercer Feasibility Report on Higher Education

CC: Speaker Jon Husted, Ohio House of Representatives
President Bill Harris, Ohio State Senate
Chancellor Eric Fingerhut, Ohio Board of Regents
Dr. Stephen Loeb, Chairman, School Employees Healthcare Board
Nancy Kelly, Deputy Director of Human Resources, Dept. of Administrative Services
Dirk Raderstorf, Acting Administrator, Office of Benefits Administration

April 16, 2007

Report to the State of Ohio
Department of Administrative Services,
Benefit Administration Services
A feasibility study of Ohio public higher education
institution employees' health care benefits

MERCER

Health & Benefits

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Background

The Ohio General Assembly adopted HB 66 which included section 9.901 of the Ohio Revised Code that created the School Employees Health Care Board (the Board) to develop a plan to pool the health benefits of Ohio public school employees. Mercer was retained to provide recommendations for the development and implementation of an approach to pool the employee benefits offered to Ohio school employees. Mercer's report and recommendations were submitted to the Governor and Legislature on December 20, 2006. The School Employees Health Care Board report was subsequently submitted on January 30, 2007. These recommendations are pending further legislative action.

HB 66 also called for the Ohio Department of Administrative Services (DAS), Benefits Administration Services (BAS) to assess the feasibility of pooling benefits among persons employed by public institutions of higher education. Public institutions of higher education include state universities and colleges, state community college districts, community college districts, university branch districts, technical college districts, and municipal universities.

DAS/BAS identified the need to engage an independent objective consulting partner to analyze this feasibility. On January 5 2007, DAS released a Request for Proposal to identify a health services research and consulting firm to analyze health care benefits of institutions of higher education and to make recommendations. The Request for Proposal was structured to identify a consulting partner to help achieve this goal.

The RFP specified that the consultant produce and provide a final report by April 16, 2007 to the Department of Administrative Services (DAS) and Benefits Administration Services (BAS), not to exceed 20 pages. The final report must address the consultant's recommendations about whether it is feasible to achieve the following four items specified in Section 9.901 of the Ohio Revised Code:

1. Designing multiple medical plans to cover persons employed by public institutions of higher education that achieve an optimal combination of coverage, cost, choice and stability; and include both the state and regional preferred provider plans, set employee and employer premiums and set employee plan co-payments, deductibles, exclusions, limitations, formularies and other responsibilities
2. Maintaining reserves, re-issuance and other measures to insure the long-term stability and solvency of medical plans
3. Providing appropriate health care information, wellness programs and other preventive health care measures to medical plan beneficiaries
4. Coordinating contracts for services related to medical plans

Consistent with the RFP the report is organized in the following sections:

- Background
- Methodology of Review
- Assumptions and Current Data
- Cost/Savings Analysis
- Recommendations and Other Considerations
- Funding Information
- Projected Implementation Timelines

This report is submitted in fulfillment of the request for proposal. In addition, ORC 9.901 requires DAS/BAS to submit a written report to the Governor, Speaker of the House of Representatives and the President of the Senate no later than April 30, 2007. Mercer Health & Benefits wishes to thank the School Employees Health Care Board and the contributing higher education institutions for their cooperation and assistance in the preparation of this report.

Methodology of Review

This analysis is based upon research gathered from existing survey data and from information provided directly by the colleges and universities. In order to effectively analyze the current benefits offered by these institutions Mercer used data from the 2006 Mercer Survey of Employer Sponsored Health Plans and leveraged previous research conducted on behalf of the Ohio School employees to provide a framework for discussing the assumptions and cost/savings analysis. Additional data was collected and analyzed using the following steps:

- Interviews with representatives of two and four year public institutions
- Collection of data directly from four-year public institutions through a customized questionnaire and health plan survey
- Collection of data for two-year public institutions by survey data provided by HR leaders of the community colleges
- Analysis of data and recommendations

Interviews

At the request and recommendation of BAS, Mercer conducted phone interviews of a representative group of individuals knowledgeable of the benefits offerings among higher education. Calls were made with representatives of the Ohio Association of Community Colleges, the Inter-University Council, Ohio State University, Ohio University, University of Toledo, Sinclair Community College, University of Cincinnati, Columbus State Community College, and Miami University. Calls were made to seek input on the following questions:

- What efforts at pooling have been taken in Ohio?
- Please tell us about your understanding of the pooling opportunities in Ohio.
- What sources exist for understanding the benefits being offered? e.g. existing surveys, e-mail requests, etc.
- What barriers to success exist?

Observations from these interviews note the following:

- Participants pointed out the differences in approach and scale of existing university and college benefit plans as contrasted with the K-12 schools
- Significant concern exists that pooling approaches must recognize the local nature of the populations
- Healthcare delivery is local and must reflect and include school based delivery systems including medical colleges, hospitals, managed care organizations, and student health services

- Smaller schools may find economies of scale from joint procurement with larger schools. Some purchasing initiatives already exist in local markets as well as through school-based organizations (e.g. IUC)
- It was observed that the managed care networks used by the largest universities may already be close to optimal so incremental savings from improved network arrangements will likely flow only to the smaller schools.
- Considerable concern exists that risk pooling will create winners and losers and inhibit successful change
- Plan designs need to be flexible to recognize the preference by some schools to steer employees to in-house services
- Concerns exist about the impact on collective bargaining contracts and transition processes and the need to allow flexibility of plan design
- There is considerable interest in optimizing population health management approaches and best practice plan administration

Four-Year Data Collection

Mercer contacted the Ohio Inter-University Council (IUC) and explained the feasibility study and the data collection process. The IUC provided Mercer with a list of names and email addresses for HR representatives from the 4-year schools that are members of the IUC. Mercer contacted HR representatives from 13 public 4-year institutions and sent each an email with a detailed explanation of the study and the data collection process and a customized automated questionnaire. The data requested in the questionnaire were:

- Total # of eligible employees, total # of covered employees, and total # of union employees
- Employee enrollment by plan type
- Health plan costs for 2005 and 2006
- Type of funding
- Current vendors
- SPDs or link to websites to collect additional benefit information

Mercer relied upon the data as provided by the various responding organizations. Mercer did not perform an audit of the data and cannot opine as to the quality of the data. All data capture processes involve some level of human error and inconsistency. However, Mercer did apply a number of reasonability tests to best reflect the apparent intent.

Community College Data Collection

Mercer received data from 22 out of 23 two-year institutions. The following is a list of the 23 institutions from which Mercer requested data. The numbers in parentheses correspond to the map in the Appendix.

- Belmont Technical College (1)
- Cincinnati State Technical and Community College (3)
- Columbus State Community College (5)
- Edison Community College (7)
- Jefferson Community College (9)
- Lorain County Community College (11)
- North Central State College (13)
- Owens Community College (15)
- Rio Grande Community College (17)
- Southern State Community College (19)
- Terra State Community College (21)
- Zane State College (23)
- Central Ohio Technical College (2)
- Clark State Community College (4)
- Cuyahoga Community College (6)
- Hocking College (8)
- Lakeland Community College (10)
- Marion Technical College (12)
- Northwest State Community College (14)
- James A. Rhodes State College (16)
- Sinclair Community College (18)
- Stark State College of Technology (20)
- Washington State Community College (22)

Mercer requested data from 13 Four-year institutions. Of the 13 institutions, Mercer received survey responses from nine institutions. The following is a list of the 13 institutions from which Mercer requested data:

- University of Akron
- Central State University
- Cleveland State University
- Miami University
- Ohio University
- University of Toledo
- Youngstown State University
- Bowling Green State University
- University of Cincinnati
- Kent State University
- Ohio State University
- Shawnee State University
- Wright State University

Assumptions and Current Data

Mercer analyzed cost and benefit data reflecting 22 of the 23 community colleges and 9 of the 13 four-year universities. The community college data is clearly representative of the benefits offered by those institutions. Some concern exists regarding the extrapolation of data from the four year college respondents to the non-respondents due to the geographical disparity and small sample size. However for the purpose of the overall cost estimate and relative savings projections, it is believed that the data shown in this report provides a fair assessment of the opportunities, though the savings projections referenced cannot be inputted to individual schools. The estimated cost savings accruing to any school is a function of underwriting variables including current demographics, plan design, vendors, and provider mix.

	Four-Year Universities	Two-Year Universities	Total
Total Schools	13	23	36
Assumed Covered Employees	52,275	6,462	58,737
Assumed 2006 Cost	\$457,099,000	\$56,190,000	\$513,289,000
Average Cost Per Employee	\$8,744	\$8,695	

Cost/Savings Analysis

The following section presents a cost/savings analysis generated based on data submitted by the two-year and four-year institutions. All costs in this section reflect medical and prescription drug expenses as reported by the responding two-year and four-year institutions. Data assumptions were used for institutions that did not respond to the survey. Additionally, a \$1,300 cost PEPY for RX was assumed and administrative cost percentages were based on tiers set up by group size. On this basis, the estimated total healthcare (medical and pharmacy) expenditures incurred by the Ohio public universities in 2006 is approximately \$513 million.

Total healthcare costs vary significantly across the universities. Among the four-year colleges for instance, costs range from a low of \$6,691 per employee per year to a high of \$14,244 per employee per year. With further time and access to data other potentially correlating factors such as demographics could be identified that may contribute to this variability. In the interviews with college representatives, it was observed by the college representatives that the average age and union make-up of the colleges varies significantly.

While it was previously theorized that the costs among larger schools may be lower due to their market clout or economies of scale, this fact was not observed in the data. Average costs of two-year colleges were \$8,695 per employee per year and average costs of four-year colleges were \$8,744 per employee per year.

Based upon Mercer's work with colleges and other employers across Ohio, other possible contributing factors to the cost variation should be noted. Provider costs and utilization vary by market. These patterns are influenced by factors beyond the scope of this analysis but could include managed care reimbursements, access to care, demographics, community health status, benefit plan design, market competition, participation in health management programs, access to tertiary and teaching hospitals, and cost allocation methods used by hospitals and providers affiliated with the colleges.

The analysis presents savings in the following areas:

- Removal of Indemnity Plan
- Best Network Practices
- Fully Insured Risk Charge
- Premium Tax
- Eliminate Broker Commissions
- Improved Administrative Services Only (ASO) Arrangements
- Other Areas of Savings

Low, medium and high range estimates are provided to recognize the inherent variability associated with projections based upon uncertain variables and assumptions and are noted on the following page.

Resulting Breakout of Costs:	Four-Year Universities	Two-Year Universities	Total	
Medical	\$ 350,167,000	\$ 40,771,000	\$ 390,938,000	76.2%
Rx	\$ 67,958,000	\$ 8,401,000	\$ 76,359,000	14.9%
Admin	\$ 38,974,000	\$ 7,018,000	\$ 45,992,000	9.0%
TOTAL	\$ 457,099,000	\$ 56,190,000	\$ 513,289,000	100.0%

State of Ohio

	4-Year Universities	2-Year Universities	Total	Low Savings	Medium Savings	High Savings
University Medical Plan Costs						
Total Schools	13	23	36			
Assumed Covered Employees	52,275	6,462	58,737			
Assumed 2006 Cost	\$ 457,099,367	\$ 56,189,949	\$ 513,289,316			
Resulting Breakout of Costs:						
Medical	76.2%	\$ 350,167,000	\$ 40,771,000	\$ 390,938,000		
Rx	14.9%	\$ 67,958,000	\$ 8,401,000	\$ 76,359,000	◀ Assuming a \$1,300 PEPY for Rx	
Admin	9.0%	\$ 38,974,000	\$ 7,018,000	\$ 45,992,000	◀ Admin % based on tiers set up by group size	
TOTAL	100.0%	\$ 457,099,000	\$ 56,190,000	\$ 513,289,000		
Removal of Indemnity Plans:						
Enrollment in Product	1,019	12	1,031	1.8%	1.8%	1.8%
Cost reduction due to Implementing Discounts				35.0%	40.0%	45.0%
Overall Population Savings				\$ 2,402,000	\$ 2,745,000	\$ 3,088,000
Best Network Practices:						
Enrollment Advantaged by switching to "Best In Market" discounts	1,589	224	1,813	3.1%	3.1%	3.1%
Cost reduction due to Implementing Discounts				10.0%	15.0%	20.0%
Overall Population Savings				\$ 1,207,000	\$ 1,810,000	\$ 2,413,000
Fully Insured Risk Charge:						
Fully Insured Premium	\$ 3,218,000	\$ 24,111,000	\$ 27,329,000			
Insurer Profit Margin %				2.0%	3.0%	4.0%
Overall Population Savings				\$ 547,000	\$ 820,000	\$ 1,093,000
Premium Tax:						
Fully Insured Premium	\$ 3,218,000	\$ 24,111,000	\$ 27,329,000			
Premium Tax Rate				2.0%	2.0%	2.0%
Overall Population Savings				\$ 547,000	\$ 547,000	\$ 547,000
Eliminate Broker Commissions:						
Assumed Current Commissions (% of Premium)				1.5%	1.5%	1.5%
Fully Insured Premium	\$ 3,218,000	\$ 24,111,000	\$ 27,329,000	\$ 27,329,000	\$ 27,329,000	\$ 27,329,000
Overall Population Savings				\$ 410,000	\$ 410,000	\$ 410,000
Improved ASO Arrangements:						
Current ASO Expense (% of Premium)	8.5%	12.5%	9.0%	9.0%	9.0%	9.0%
Assumed ASO Expense (% of Premium)				8.5%	8.5%	8.5%
Overall Population Savings				\$ 2,362,000	\$ 2,362,000	\$ 2,362,000
Overall Medical Plan Savings:				\$ 7,475,000	\$ 8,694,000	\$ 9,913,000
% of Total Cost				1.5%	1.7%	1.9%
Other Items with Potential Savings:						
1. Improved Prescription Drug Contract (deeper discounts, higher rebates, lower admin)						
2. Reduced stoploss coverage by pooling risk with a larger group						
3. Improved plan implementation and administration through reducing number of plans offered						

Recommendations and Other Considerations

Legislation was enacted calling for a feasibility study of providing health care benefits to Ohio public colleges and universities. It was postulated that risk could be mitigated and economies of scale could be created. It has been observed that most insurance companies and other risk managers (e.g., large plan sponsors with 1,000 or more employees) utilize the law of large numbers to mitigate and manage the risk inherent in medical insurance coverage. The 2006 Mercer National Survey of Employer-Sponsored Health Plans documents this practice. The larger the risk pool, the more predictable the claims experience. Therefore, as risk pools increase in size, the cost of risk management decreases since insured margins, stop loss premiums, and other risk management expenses are mitigated and/or eliminated.

With few exceptions, Ohio higher education does not pool employee benefits. Schools are free to join pools or remain autonomous, though in Ohio, there has been very limited experimentation with pooling. The Inter-University Council had limited success with the pooling of pharmacy benefits, challenged by the inability to enforce participation and inhibit the erosion of the risk pool. However, there have been some statewide, regional, and local efforts to pool purchasing of a broad range of products and services, including property & casualty insurance.

Public higher education institutions in the State of Ohio cover approximately 59,000 employees. Aggregating these employees in some form could theoretically create a risk pool sufficiently large to generate administrative cost savings, economies of scale in purchasing, and predictability of expenses. However, the incremental savings accruing to already large risk pools (as is found among some of the largest Ohio universities) may not be of significant size to merit a single pool approach. Other approaches and alternatives may be preferable in light of the preferences indicated by the higher education institutions.

Previously stated requirements to pooling in Ohio include the following:

- Pooling approaches must improve affordability – Pooling strategies should produce meaningful results
- Standards should be developed around plan administration, plan design, eligibility, financing, vendor management, and distribution
- The process must be data driven – Mercer was instructed to gather data from public higher education institutions and other relevant organizations to create a robust, credible set of information from which decisions could be made
- The approach must produce long-term cost management
- Pooling strategies should consider the opportunity to improve the health of employees through enhanced access to information and improved health management efforts
- The approach should reflect the viewpoints of the affected constituencies
- Improved health plan effectiveness and efficiency would lead to better health and improved outcomes in education

Pooling approaches are designed to drive greater adoption of best practices through control and influence created by larger risk pools. As the risk pool grows in size it gains capacity for driving best practice benefits delivery and economies of purchasing. With respect to healthcare however, it has been observed in Ohio that managed care networks are not necessarily optimized through the use of a single vendor. Instead, contracting with the best practice network or providers in a given region generates the greatest overall savings. This impact is felt even more by colleges that predominantly have employees residing in the community and using local providers or even the facilities of the school for healthcare services.

Recognizing that many of the larger four-year schools have maximized many of the efforts towards cost-control, purchasing power, etc, it is suggested that the pooling approach revolve more around smaller institutions finding economies from joint purchasing with larger institutions. These practices are frequently in use today as smaller institutions partner with their larger local brethren to buy other services. Clusters of regionalized institution employee health pools could be established around geographic regions. Smaller schools would be clustered into zones or regions with a larger school positioned at the core.

Central to the success of any pooling effort is the sharing and analysis of healthcare data. Even with independent, though sizeable risk pools, the combined data set of claims experience from all colleges would provide a richer source for analyzing the health trends of the college employee population. A centralized data warehouse should be considered for the creation of tailored health management approaches and to permit ongoing management of these costs.

The role of the pools is primarily for centralized procurement of services. The pool may consist of a few institutions who uniformly agree to contract with managed care organizations for network and claims administration services. Where appropriate and available, network options including healthcare facilities and providers available through a partnering school should be preferred.

It should be noted that the plan design options offered to the respective schools need not be mandated. Given the complexity of multiple collective bargaining agreements and differences in competitive markets, each school may prefer to retain the ability to negotiate plan features such as deductibles or coinsurance that are unique to the needs of each institution, and as discussed later, mandating plan designs may not generate desired cost savings that offset the expected turmoil of the change.

Savings attributable to pooling can be realized by eliminating existing indemnity plans, utilizing optimal provider networks, migrating to self-funded plan approaches that eliminate risk charges and premium taxes, eliminating brokerage commissions, improving administrative service arrangements, and implementing optimal health management, pharmacy benefit management, and ancillary plan procurement. These opportunities are explored further.

Removal of Indemnity Plan

There still exist traditional indemnity plan offerings among the options available to college employees. These plan approaches do not take advantage of provider discounts available through the use of provider networks. Frequently these plans are maintained to accommodate employees and dependents living outside of the local managed care network area, but occasionally are maintained to accommodate collectively bargained plan requirements. In either event, eliminating the indemnity plan options and replacing with a choice of network plan options will generate savings.

A common challenge, as referenced above, is the ability to offer plan discounts out of the local market area. Frequently the most cost effective network option for the local employees is not the most cost effective option outside of the local market, leaving the out-of-area employees with limited access to network providers, if any. In the theme of pooling, it may be advantageous to create a non-Ohio network option to be available to all Ohio schools. This approach may also be used to address the needs of colleges located in parts of the state with no proximal four-year colleges with whom to leverage pooling opportunities.

Best Network Practices

As was observed in the K-12 analysis, different insurance companies and managed care networks have strengths in different Ohio markets. There is no single network offering the deepest discounts in all areas of the state. In fact, the costs charged back to the universities from their own providers may be competitive with or better than the discounts available externally. Based upon this premise, it is observed that most larger universities are already taking advantage of the optimal network arrangements in their local markets. Some savings can be derived where this is not necessarily the case, though the order of magnitude of savings is not as significant as seen in the K-12. In fact, the bulk of the savings opportunity, on a percentage savings basis, will be realized by the smaller colleges and universities.

Network access should also be considered from a best practice perspective. Contracting networks should be held to procurement standards stipulating the number of primary care, specialists, and hospitals to be accessible to employees residing within the geographic region and throughout the state. Access to trauma facilities, transplants, and other tertiary care services must be assured and should reflect best practice measures developed by organizations such as NCQA.

Fully Insured Risk Charge

Colleges that currently offer fully insured plans incur risk charges by the insurance company to assume the liability for potential fluctuations in claims in excess of the insured premiums. In self-funded plans, this charge may be non-existent, or partially assumed through the purchase of stop loss insurance. In this analysis, savings are conservatively estimated based upon the number of lives currently covered by fully insured plans, and discounted to assume stop loss coverage is offered by the larger pool.

Premium Tax

As with the risk charges, fully insured plan expenses include State premium taxes based upon the insured premiums. Moving the fully insured plans into self-funded arrangements eliminates the premium tax liability of two percent of the currently insured premium.

Eliminate Broker Commissions

Commissions, overrides, and other forms of compensation are traditionally paid to producers (brokers and agents). An advantage of aggregating lives is that the expense of connecting plan sponsors to administrators/insurers is minimized. In essence, the “middle man” is eliminated and/or replaced by professional advisors. Professional advisors can provide more objective and sophisticated advice on a contractual fee basis evident to the college, improving transparency of the total expenses.

Under the proposed approach, commissions, overrides, contingent commissions and other payments, trips, and awards from insurance carriers related to the benefits offered through the colleges will be eliminated. This does not preclude colleges from entering into direct contractual fee arrangements for services with brokers, consultants, or advisors. No Ohio statutory or administrative rules appear to *prevent* the payment of commissions on a fee basis, or to *require* override or other commissions to be paid to insurance brokers (Section 3905.18 Ohio Revised Code). Anecdotally, the larger schools appear to be less likely to use brokers and to see commissions included within their current costs. Smaller districts may again see the greater benefit of this strategy.

Improved ASO Arrangements

Streamlining plan administration may offer additional savings opportunities. Because of the wide difference in covered populations between schools, process improvements can be offered to effectively administer eligibility of employees and dependents. It has been observed that colleges are frequently the largest employer in a given community and as such, often offer more generous benefit plans than smaller local employers. Consequently, colleges may be covering individuals who may have access to other coverage. Strategies for steering dependents off of the college’s plan include the use of spousal surcharges and dependent eligibility audits. An ancillary benefit of improved eligibility monitoring is the impact upon tuition reimbursement plans for staff and their dependents. As dependents (or staff) are identified who may not meet dependent eligibility requirements in the health plan, their eligibility for participation in tuition reimbursement plans should also be questioned.

Just as size matters in the procurement of health care, size also matters when dealing with the administrative requirements of claim administration. Size enables demands for best practice approaches to administrative functions and service expectations. With size there is also the responsibility for ongoing vendor management activities that:

- Satisfy fiduciary responsibilities to safeguard plan assets
- Provide independent assessment of performance of vendor
- Identify opportunities to lower costs and improve service
- Increase negotiating leverage

Claim administration requirements are not limited to how a claim is processed. Claim administration covers a number of functions that must all be working in concert to enable the administrator to deliver efficiently and effectively on service commitments. Standards should be developed on best practices dimensions and performance monitoring metrics that we have observed in the administrative environment in claims appeals, customer services, processing, and client relationships. While Mercer does not suggest a requirement for selection of a single claim administrator, regional procurement of a common vendor is expected to result in lower overall administrative expenses as a percent of total costs.

Plan Design

Given the variance in costs and the broad range of cost drivers, it cannot be inferred that there is a single existing benefit plan model in place today that is optimally suited to be replicated in all other schools. Plan designs currently in place offer a wide range of employee choices, including differing network models (HMOs, PPOs, Health Savings Accounts) and plan features (deductibles, copays, coinsurance). The differing plan designs and plan features actuarially create different levels of employee cost sharing – the higher the deductibles or copayments, the lower the overall cost to the employer.

For the purpose of this analysis, it was suggested that multiple options of plans could be offered. Indeed, the wide variation in designs suggests that more commonality in design could be created. For instance, a Low, Middle 1, Middle 2 and High Plan approach in which the Middle plan pricing was structured near the median and the Low and High Plans were set at the end points of the current range could be offered resulting in no overall impact upon claim costs. This approach simply rationalizes and limits the number of plan options to reflect the current “typical” plans. If the intent of the legislation is to generate cost savings to the colleges, simplification of the plan designs will have only modest impact. Therefore the cost savings attributable to the Low/Medium/High approach will derive solely from administrative cost savings associated with this simplified approach. To maximize this furthermore, it is assumed that the insurance companies and/or plan administrators offer reduced administrative fees reflecting the simplicity and consistency of approach.

An effort to create four mandated plan designs as suggested by HB 66 therefore creates the following issues:

- Any four plan designs will require significant change to existing collective bargaining agreements. Transitioning from the current plans to new options would need to be staged or legislation enacted to override current contracts. This has been seen to be unpalatable to the stakeholders.
- Creating four new plan designs creates winners and losers. Previous efforts by the SEHCB produced reluctance by both the Board and unions to permit this.
- Creating a model plan of four options that has a relative cost value equivalent to the plans currently offered will, by definition, not generate any cost savings. Cost savings will only accrue to the degree plans are implemented that have a lower overall value to the plan participant or shift costs to the individual.

- Cost savings can be achieved through the implementation of best practice plan and health management, as discussed in later sections and including maintenance of eligibility, underwriting, reserve setting, selection of managed care networks, claim administrators, and health management vendors

Alternatively, plan designs can be redesigned to shift greater costs to employees, thereby lowering college costs. It is likely that this will encounter significant resistance by the unions and their membership. In the analysis of the K-12 schools, there was no appetite for shifting costs to employees or creating “winners and losers.” However, if it is the intent of the Legislature to reduce costs through plan design changes, significant savings can be achieved to the degree there is a willingness to shift costs to employees. For the purpose of this analysis, it was presumed this was not the legislative intent.

Lastly, the current plans offered by many of the colleges do not take advantage of some current approaches to benefit delivery, including the use of account-based plans such as Health Savings Accounts (HSA) and Health Reimbursement Arrangements. Frequently offered under the term “Consumer Directed Health Plan” (or CDHP), these programs are structured to create changes in healthcare behavior. Designed correctly, these programs allow for preventive care to be covered on a first dollar basis. Other covered services may be subject to a higher deductible or paid through an account funded by the employee or employer, in the case of an HSA. This design has been observed to influence the purchase of discretionary care such as the use of brand name drugs, specialists, or emergency care for non-emergent conditions. Colleges may benefit from consistent guidance on the design and pricing of these models as a plan option available to employees.

Pharmacy Benefits

The four-year colleges have previously participated in a voluntary collectively purchased pharmacy benefits pool offered by the IUC. Over time, participation in this approach has eroded as institutions have opted out of the plan. The voluntary nature of the pool inherently leads to adverse selection as already large institutions may find it to be preferable to stand alone and retain the flexibility to negotiate independently while remaining competitive. As with most pool approaches, the smaller entities typically derive a greater benefit from the enlarged scale of the pool.

Mercer believes that that a mandatory single pool statewide plan for pharmacy benefits would be the best overall approach to benefit all colleges and generate short and long term program savings. A mandated single pool approach will drive critical mass into the program and provide the leverage required to negotiate the most competitive contractual terms. The State of Ohio colleges could leverage the IUC model and extend the offering to the community colleges. Success of this effort is only anticipated if the program is legislated to be mandatory.

The administration of pharmacy benefit services occurs behind the scenes, and is often transparent to members, which will help ease the transition to a pooled approach. A mandatory prescription drug collective would be awarded via a competitive bid to a carve-out pharmacy benefit manager (PBM) or use the existing IUC vendor relationship. In order to complete a competitive bid process

updated data from current carriers regarding participation, communication, level of programming and cost would be needed to supplement previously submitted information. The list below outlines several initial recommendations for pharmacy:

- Collection of pharmacy plan participation and claims experience from all colleges to facilitate the procurement process
- PBM procurement for Prescription Drug Collective – including formal kickoff to define goals, objectives, key stakeholder responsibilities, timing, procurement process, scoring criteria, etc., development and release of the Request For Proposal (RFP), evaluation of proposals, “best and final” negotiations, finalist interviews, site visits, contract negotiations, and vendor award
- Develop a plan of action around the plan termination dates, or a strategy to facilitate a vendor change mid-contract
- Implementation assistance is recommended to facilitate a smooth transition
- Proactive plan oversight including clinical and utilization management support

One of the best practices in today’s dynamic pharmacy market is to hire a Pharmacy Director to serve this oversight role. Pharmacy Directors are common in jumbo corporations, managed care organizations, and group purchasing collectives. It is the Pharmacy Director’s responsibility, whether a single dedicated individual or consulting firm, to provide proactive and comprehensive prescription drug program oversight and management that is clinically grounded and experience-based.

A potential drawback to the PBM carve-out is frequently cited by managed care organizations (MCO). It is argued that keeping the access to the drug data with the managed care organization permits the MCO to access the pharmacy claims experience in a more timely manner, enhancing the health management and outreach opportunities by the MCO. Optimally this should occur and efforts to carve-out the Pharmacy benefit must recognize the need to report this data back to the MCO, claims administrator and/or health management vendors.

Mercer estimates that a voluntary prescription drug collective could save new participating schools from 1% to 3% of their current prescription drug spend. Existing participants might see only marginal improvements in savings as the pool gains size and market clout, permitting renegotiation with existing vendors.

Health management

A more active health, disease and care management program could be developed for the colleges and universities. In the surveys of higher education, participation in wellness programs was relatively low among the 2 year colleges (only 4 of the 23 colleges reported having a wellness program). These programs have grown dramatically over the past three years and are now mainstream cost containment strategies at the majority of larger plan sponsors. It is recommended that a consistent approach to gathering health information through the use of health risk assessments be initially considered. The effectiveness of the use of these tools can be further enhanced through leveraging biometric screening techniques, health coaching, and analysis of the data generating from these tools. In the analysis of the K-12 schools it was projected that 3% or greater savings annually are possible, though these savings would not materialize until year two or likely year three. An initial investment would also be required to start such a program.

Beyond the question of immediate cost savings, progressive health management programs targeted at the needs of the employee population are recommended. Disease management programs focused on managing chronic conditions such as diabetes, asthma, and heart disease are commonly offered by managed care organizations and specialty vendors. Care management strategies focusing on the acute catastrophic cases offer potential savings if combined with steerage to centers of excellence specialized in the management of those cases. Ohio universities offer medical schools and hospitals with nationally recognized expertise in managing a broad variety of conditions. It was also noted by some universities that there is potential for leveraging the resources of existing in-house university health, wellness, and disease management programs.

The key to success of these programs presumes access to data that captures health information in a timely manner, feeds that data to providers for appropriate intervention, and produces population based data for future decision making by providers, individuals, and employers. As stated before, strict confidentiality to personal health information is to be assured at all levels.

Ancillary Benefits

Unlike healthcare benefits that are delivered locally, ancillary benefits such as life insurance, accidental death, dental, personal accident, vision insurance, and disability insurance can be jointly purchased to deliver lower costs to the colleges and employees. As with the pharmacy benefits, a single joint procurement of these benefits will create significant purchasing mass and savings to the colleges. Quantification of these savings is outside of the scope of this report, though 5%- 10% savings have been seen to be achievable in other joint purchased efforts by other colleges.

Funding Information

Medical plan sponsors manage risk through a combination of techniques. For plan sponsors with only a few hundred employees, the medical plan is often fully insured. Larger plan sponsors use a self-insured approach with low levels of ISL (individual stop loss) insurance as well as ASL (aggregate stop loss) coverage in some cases. These plan sponsors take on more risk and experience more volatility year to year in exchange for what are, on average, lower overall costs. As the group size increases, self-insurance becomes more prevalent. For the largest size groups, the prevalence and/or level of stop loss coverage (ISL and ASL) diminishes. Funding approaches among Ohio universities generally tracks this pattern. Within the 23 responding two-year schools, seven offered self-funded plans. Within the four-year schools, eight of the nine respondents offer self-funded plans.

The implementation of a self-funded pooled option for colleges currently fully insured can produce savings in the reduction of administrative costs through economies of purchasing, elimination of premium taxes, and lower risk charges. Since the fully insured schools tend to be smaller, the percentage savings is greater to these institutions.

However, this presumes that self-funding of the colleges on a stand-alone basis is an optimal approach – it is not necessarily so and is contingent upon the institution's ability to manage the variable cash flow in a self-funded environment. In order for the smaller schools to benefit from the savings projections while mitigating the greater cyclicity of claims expenses, these institutions would need to participate in a common risk pool with other schools. This pooling could take different forms, but at a minimum should optimally include a total risk pool of 10,000 covered employees. At this level, the need for stop loss coverage diminishes and internal risk charges can be fairly calculated and allocated. A single state-wide risk pool could achieve this scale. Alternatively, regional pools could be structured around the largest institutions already at this level. For instance, risk pools could revolve around the largest schools with inclusion of the smaller school within their proximal area (area to be determined). In the event a common pool is used, reserve requirements consistent with current legislation guiding public employers under ORC sec. 9.833 provide an effective template for reporting reserves. In addition, minimum reserve requirements are recommended that would fund a minimum of 2.5 months of expected claims. A customized transition plan to fund this level will be required to recognize existing funding status of self-funded plans and the migration of fully-insured plans to a self-funded pool.

The pool would commonly procure services for network administration, claims administration, risk pooling, and support services, while leaving plan design to the discretion of each local institution. This approach permits the leveraging of the enhanced scale of the combined entities while recognizing the unique demographic, cultural, and labor market situations of the different colleges.

Projected Implementation Timeline

As requested by DAS, the following high level implementation timeline provides approximate timing required for implementation of the proposed recommendations. This timetable presumes a start after required legislation is enacted and that the required staff support and funding can be provided to DAS.

Communications

Confirmation of approach
Invitation to participate in governance
Notification to colleges of timeline and data needs
Data request and compilation
Procurement processes

MONTHS 1-3

Governance

Enabling legislation authorizes creation of pools
Pool governance processes and representation developed
Pool operating parameters established
Advisors identified– legal, actuarial, consulting

MONTHS 1-3

Networks

Plan administrator/network procurement
Out of area network procurement process
Analysis of vendor options'
Vendor selection

MONTHS 2-4

Pharmacy Benefits

Pharmacy benefit manager RFP
Analysis of vendor options
Vendor selection

MONTHS 2-4

Stop Loss/Reserving

Stop loss plan requirements developed
Stop loss procurement
Vendor selection (if necessary)
Risk pool funding and banking approach developed
Fund balance target established and individual college rates developed

MONTHS 2-6

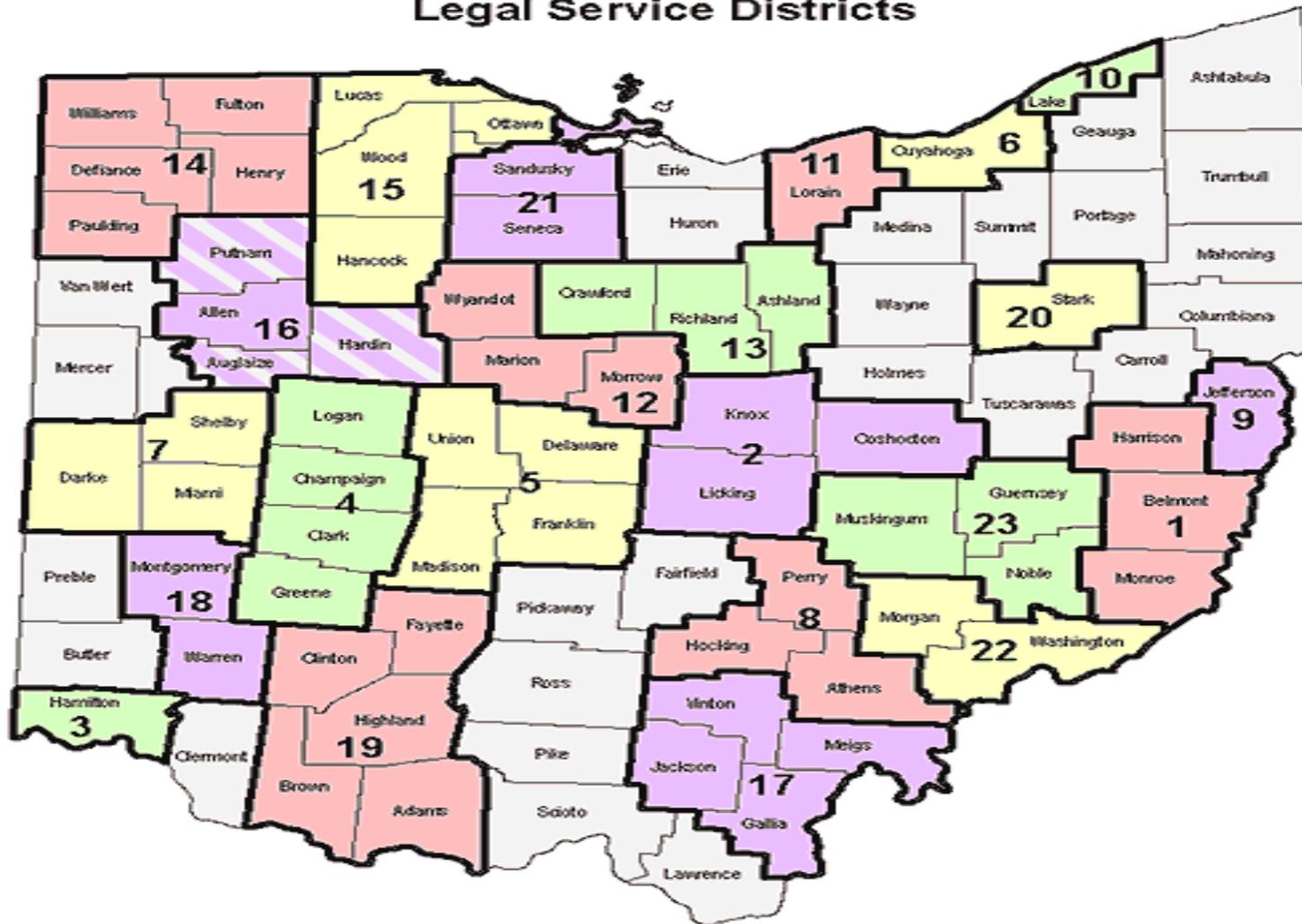
Ancillary Benefits

Identify/confirm benefits
Ancillary benefit procurement process

MONTHS 2-4

Appendix

Ohio Community and Technical College Legal Service Districts



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Health & Benefits

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