

School Employees Health Care Board Third Annual Health Insurance Cost Report
2011

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Abstract

Ohio law requires the School Employees Health Care Board (SEHCB) to prepare and disseminate to the public an annual report on the status of health plan sponsors' effectiveness in making progress to reduce the rate of increase in insurance premiums and employee out of pocket expenses, as well as progress in improving the health status of school district employees and their families under O.R.C. 9.901(G)(7). This report fulfills the former duty (that of cost measurement), while a separate survey currently in the field will fulfill the latter duty (that of health status measurement).

The survey instrument that yielded the data analyzed in this paper was constructed in such a way as to provide evidence on the effectiveness of published SEHCB best practices and to identify potential best practices in utilization and cost management. This report demonstrates the success of current SEHCB best practices in the relatively modest cost increases in the school district and educational service center health insurance market from January 1, 2010, to January 1, 2011, and sheds light on the importance of the continuing work of the SEHCB in best practice development. The SEHCB best practices as currently codified in the Ohio Administrative Code are referred to in the body of the report and summarized in Appendix E.

Introduction

The Ohio State Employment Relations Board (SERB) distributes an annual health insurance benefit and cost census to all public employers under its statutory authority to provide information to the state in regards to salaries, benefits and working conditions of public employees under O.R.C. § 4117.02(K)(5). Similarly, Ohio law requires the School Employees Health Care Board (SEHCB) to prepare and disseminate to the public an annual report on the status of health plan sponsors' effectiveness in making progress to reduce the rate of increase in insurance premiums and employee out of pocket expenses, as well as progress in improving the health status of school district employees and their families under O.R.C. 9.901(G)(7). Since 2009, SERB and SEHCB have worked in concert to distribute one census survey that fits the needs of both state organizations in order to reduce governmental costs at the state and local levels and reduce the reporting burden on local governments.

The results of this effort yield two studies, one published by SERB and one by SEHCB. This paper was authored by Jon Brescia, Esq. with revisions and by members of SEHCB and its Advisory Committee. The SEHCB has final responsibility and approval for the contents of this Report.

Survey Design and Methodology

A modified version of the survey instrument utilized by SERB and SEHB in 2010 was deployed through the Zarca Interactive online data collection service in December 2010. Data collection proceeded through February 2011. Results were downloaded into PASW® Statistics (v.18) for validation and analysis. Standard research procedures regarding data management (Alreck & Settle, 2004; Ott, 1993) and screening (Mertler & Vannatta, 2002) were followed.

As with previous years, both school districts and other public employers were queried about their health insurance¹ benefits, their internal policies, and other elements of their institutional frameworks that might bear on the design, procurement, administration or evaluation of health insurance benefits. This year, the survey instrument was sent to 1,359 public employers, 719 of which were public school districts and educational service centers. The general response rate for all employers was 898/1,359 (66%), while the response rate for school districts and educational service centers was 531/719 (74%). This report addresses responses from school districts and educational service centers only.

¹ Please note that, for the benefit of the reader, the word "insurance" is used broadly in this report. While "insurance" technically refers to paying an insurer to mitigate risk, the term is expanded here to include self-insured plans that assume their own risks.

Summary of Findings

At the outset, employers were asked to identify whether they offered any of several basic categories of fringe benefits: medical, pharmaceutical, dental and vision insurance, as well as flexible spending accounts (Section 125 plans). Of the 719 employers surveyed, 100 percent ($n = 529$) offered some form of medical insurance; 99 percent ($n = 525$) offered prescription drug insurance; 98 percent ($n = 513$) offered dental insurance; 69 percent ($n = 363$) offered vision insurance; and 77 percent ($n = 399$) offered some form of a flexible spending account. In addition, 48 percent ($n = 248$) encouraged employees to voluntarily seek health care coverage elsewhere, while 24 percent ($n = 123$) reported having a mandatory spousal carve-out policy, requiring spouses with access to health care through their own employer to enroll in that employer's plan.

Past SEHCB benefit and cost surveys have noted that basic procurement principles have not been employed by this market. The SEHCB has developed and implemented best practices to address these items beginning March 19, 2012 (see Appendix E). In the 2011 survey, employers were asked about the nature of their procurement processes. Of those who responded, 26 percent ($n = 133$) indicated that existing law, policy, or regulation required them to use a formal competitive bidding process when procuring health insurance plans. When asked whether they retained the services of a broker, agent, or consultant in the procurement of health insurance plans, 78 percent ($n = 400$) of employers responded affirmatively. The median compensation for brokers, agents or consultants was \$35,100. Finally, 53 percent ($n = 269$) of respondents indicated that they had a formal labor-management health insurance committee in place.

Employers were also questioned about the quantity and type of plans offered to employees. Of those responding, 39 percent ($n = 143$) offered two or more plans. Regarding the prevalence of certain standard plan types, preferred provider organization plans were the clear majority, constituting 77 percent ($n = 624$) of all plan types reported. In descending order of plan type share, the remaining types were: consumer driven health plans at 10 percent ($n = 82$), traditional plans (e.g., base medical and major medical, comprehensive major medical plans) at 7 percent ($n = 56$), health maintenance organization plans at 4 percent ($n = 28$), and point of service plans at 2 percent ($n = 14$).

School districts were also asked questions about the first four SEHCB best practices, the implementation of which began in January 2010 on a rolling schedule keyed to the expiration of collective bargaining agreements. Seventy-nine percent ($n = 419$) indicated that they had all four of the best practices in some fashion. The practice-by-practice breakdown is as follows: 95 percent ($n = 476$) affirmed the existence of a wellness program; 93 percent ($n = 467$) affirmed the existence of a disease management program; 97 percent ($n = 481$) affirmed that employees have access to specialty networks for complex conditions; and 94 percent ($n = 509$) affirmed that they had conducted a dependent eligibility audit at some point during the past three years.

As regards loss financing methods, 75 percent ($n = 574$) of plans were self-insured, while the remaining 25 percent ($n = 189$) of plans were fully insured. At the employer level, 89 percent ($n = 301$) of employers with self-insured plans chose to procure health care benefits through a joint purchasing organization, while 56.9 percent ($n = 74$) of employers with fully insured plans chose to procure, administer and evaluate their plans independently.

In ascending order of market share, the top three insurance carriers (those who provide fully insured plans) were Anthem Blue Cross and Blue Shield, Medical Mutual of Ohio, and United Healthcare; in the same order, the top three plan administrators (those who administer self-insured plans) were Medical Mutual of Ohio, Allied Benefits Systems, and Anthem Blue Cross and Blue Shield.

Premium costs for medical plans with bundled prescription drug coverage (wherein medical and prescription drug insurance were offered under one plan) were broken into single and family rates, then further broken into employer and employee contributions. The median single premium for such plans was \$467 while the median family premium was \$1,205. Median employee contributions to single and family premiums were \$43 and \$120, respectively. Median employer contributions to single and family premiums were \$419 and \$1,062, respectively. Thus, as of January 1, 2011, the per-employee-per-year (PEPY) cost of medical and prescription coverage was \$10,542, an increase of 1.08 percent over 2010 rates.

Medical insurance plans can be divided into traditional (base medical and major medical plans, comprehensive major medical plans) or managed care (preferred provider organizations, health maintenance organizations, point of service plans, and consumer driven plans) categories. The majority of the school district and educational service center markets offer medical managed care plans, and most include prescription drug insurance coverage included with such benefits.

The most common type of prescription drug plan offered to employees was a formulary-based tiered co-pay plan. In particular, a three-tiered co-pay structure (i.e., generics in Tier 1, formulary brand names in Tier 2, and non-formulary brand names in Tier 3) accounted for 48 percent ($n = 374$) of the listed pharmaceutical plan types. The median retail co-payments for the three-tiered structure were \$10 for Tier 1, \$20 for Tier 2, and \$35 for Tier 3. The median mail co-payments for the three-tiered structure were \$20 for Tier 1, \$40 for Tier 2, and \$60 for Tier 3. Cost savings through tiered, formulary-driven pharmaceutical drug insurance plan designs are targeted in a series of SEHCB best practices that become effective in 2012 (see Appendix E).

Of those employers offering separate dental plans, the median single premium cost was \$38. The median family premium was \$80. The median employee contributions were \$2.40 and \$6.82 for single and family plans, respectively. The per-employee-per-year (PEPY) cost of separate dental plans was \$774.84.

Of those employers offering separate vision plans, the median single premium cost was \$9. The median family premium was \$80. The median employee contributions were \$1 and \$2 for single and family plans, respectively. The per-employee-per-year (PEPY) cost of separate vision plans was \$165.81.

Of employers who responded, 78 percent ($n = 399$) offered flexible spending accounts (Section 125 plans). Of those offering flexible spending accounts, 72 percent ($n = 293$) offered a premium-only pass-through plan; 83 percent ($n = 356$) offered a medical and dental account; and 79 percent ($n = 328$) offered a child or dependent care account. Twenty-eight percent ($n = 232$) offered all three benefits.

Health Insurance

Employee Coverage, Eligibility and Participation

When employers offer health insurance benefits to their employees, they must determine when newly hired employees become eligible to exercise those health plans (i.e., when an employee's rights and responsibilities under these plans vest). Eligibility considerations cleave primarily along the employee's status as full-time or part-time. For full-time employees, eligibility is generally marked by one of the following temporal designations: 1) the date of hire, 2) the first day of work, 3) the first day of the month following the date of hire, or 4) a period exceeding 30 days from the date of employment (indicating, for example, the existence of a fixed "open enrollment" period). For part-time employees, a common measure of eligibility—in addition to sometimes being a measure of premium contribution percentages—is the number of hours worked per week or, alternatively, per day.

In addition to considerations of full-time and part-time coverage, employers have two enrollment alternatives available: employee waivers and spousal carve-outs. Employee waivers are generally voluntary, but in some rare cases employers go beyond incentivizing waivers, requiring the employee to take third-party insurance as primary. While spouses may also be incented to elect primary coverage under another health care plan, it is more common to see the spouse being actively "carved out" of the plan using a requirement to elect primary coverage under another available plan, typically through that spouse's employer. While fully insured plans seem to be prohibited from using these "working spouse" provisions (*see* ORC §§ 3901.21(m) and (v)), preemption under the Employee Retirement Income Security Act of 1974 (ERISA) appears to allow self-insured plans to include such provisions.

For the employers in this dataset, the full-time offer rate was 100 percent ($n = 528$), while the part-time offer rate was 76.2 percent ($n = 390$). When asked about the timing of employee eligibility, 38.5 percent ($n = 181$) of employers reported that employees were eligible on the date of hire; 31.7 percent ($n = 149$) were eligible on the first day of work; 24.5 percent ($n = 115$) were eligible were eligible on the first day of the month following hire; finally, 3.6 percent ($n = 17$) were eligible after 30 or more days.²

Employers were asked whether they incentivized or required employee waivers and, if incentives were offered, what the dollar amounts of those incentives were. Responses indicated that 48.4 percent ($n = 248$) of employers offered an incentive for employees to waive coverage, while 1 percent ($n = 5$) of employers required employees to waive. The median reported waiver incentives were \$1,125 and \$1,600 for single and family plans, respectively.

Employers were also asked about their policies regarding spousal coverage and "working spouse" provisions. In contrast with the 'incentive to mandate' ratio found when examining employee waivers, 24 percent ($n = 123$) of employers required the spouse to take insurance elsewhere, while an additional 1.8 percent ($n = 9$) levied a penalty if the spouse refused to take insurance elsewhere. Only 9 percent ($n = 46$) of employers merely incentivized spouses to elect coverage elsewhere.

² Federal health care reform limits the waiting period for health plan benefits to 90 days or less beginning in 2014 (PPACA, Title 1, Subtitle C, Section 2708). This provision is applicable to grandfathered and non-grandfathered plans. As the data demonstrates, this provision will not impact the existing practices of school districts and educational service centers in the state of Ohio.

Formal Procurement Process

As stewards of public funds, government entities are often required to follow a formal, written procurement process when acquiring goods or services in the course of doing business. Procurement processes are instituted with two major goals in mind: preventing graft and using market competition to arrive at the lowest practicable price for a given good or service. The implementation of formal procurement processes to provide cost savings and accountability are recommended by both academics and professional organizations (see, for example, American Bar Association, 1979; 2007; National Association of State Purchasing Officials, 2001).

While Ohio's state and local governments are bound to a lengthy and highly particular catalogue of procurement policies, formal health insurance procurement processes for school districts and educational service centers in Ohio were not required until the SEHCB developed and implemented a best practice on the subject. Thus, while certain elements of procurement may be governed by statute (e.g., ORC § 9.833 defines how self-insured health insurance benefits may be provided by certain public employers, touching frequently on procurement or issues tangential to it), public school districts are largely free to design (or not) their own procurement processes until 2012 (see Appendix E). When asked whether law, regulation, or policy required their organization to adhere to a formal, written procurement process that required, at a minimum, the use of competitive bidding, twenty-six percent ($n = 133$) of employers responded affirmatively.

Health Insurance Placement

While school districts may procure insurance directly using only their own individual expertise, they may instead prefer to employ a broker, agent, or consultant when casting about for a new policy. When school districts were asked if they worked with a broker, agent, or consultant when procuring insurance plans, 78.1 percent ($n = 400$) responded affirmatively; 61 percent ($n = 244$) maintained a written contract with their broker, consultant, or agent. Of those employers who indicated they worked with a broker, agent, or consultant, 69.6 percent ($n = 218$) provided compensation as a flat fee. Seven percent ($n = 22$) provided compensation as a percentage of the total medical premium value. Only one percent ($n = 3$) of employers used a combination of a flat fee and a percentage of the premium. Troublingly, 15.7 percent ($n = 49$) of those using a broker, agent, or consultant indicated that they did not know the method by which they provided compensation. This year, the median annual compensation amount reported was \$35,000, making the per-employee-per-year (PEPY) cost of hiring a broker, agent, or consultant \$260.

Joint Purchasing Arrangements

As in previous years, employers were surveyed about their use of joint purchasing arrangements. The phrase "joint purchasing arrangement" refers to several types of entities: consortia (O.R.C. § 9.833), Councils of Government (O.R.C. § 167), Multiple Employer Welfare Associations (29 U.S.C. § 1002) and Voluntary Employee Beneficiary Associations (I.R.C. § 501(c) (9)). Taken together, 43 such entities have been found to be doing business with Ohio's public school districts, of which 72 percent ($n = 31$) have filed financial audits with the Auditor of State.³ Those arrangements which had not submitted a

³ This figure was derived by running a series of search strings run through the Auditor of State's website on May 5th, 2011.

financial audit were referred to the Auditor of State in 2009 and 2010; no response has yet been received from that office regarding the reason(s) behind these missing financial audits. As should be apparent, financial audits form the backbone of accountability for public funds.

Regarding participation rates, 76.3 percent ($n = 389$) of districts that responded indicated that they participated in some form of joint purchasing arrangement. The top three joint purchasing arrangements in order by share of total districts were OMERESA, Stark County COG, and SWOEPC (see Appendix D). Mann-Whitney U tests were performed to examine the differences in single and family premium distributions between school districts that participated in joint purchasing pools ($n = 383$) and those that did not ($n = 116$ for single, $n = 115$ for family). For single premium values ($n = 499$), the results of the test indicated a statistically significant difference ($p < .001$, $z = -4.003$) between those districts engaged in joint purchasing and those not so engaged. For family premium values ($n = 498$), the results of the test also indicated a statistically significant difference ($p < .001$, $z = -6.391$) between those districts engaged in joint purchasing and those not so engaged.

The SEHCB has published a number of best practices to address various issues involved with the administration and accountability of joint purchasing arrangements which take effect in 2012 (see Appendix E). These rules were derived by taking the results of previous iterations of this cost survey, creating a catalogue of the joint purchasing arrangements in which schools participate, and examining their financial audits. Based on both the paucity of audits noted in the past and the lack of upper-end regulation on reserves (the O.R.C. only specifies minimum reserve requirements), the aforementioned financial regulations were devised and promulgated. For a full list of joint purchasing arrangements and their latest financial data and other related information, see Appendix D.

Labor-Management Health Insurance Committees

Before turning to the results, it is worth noting that the political and legal situation in Ohio may moot this year's discussion of labor-management health insurance committees (LMHICs) and, further, eliminate future inquiries about employers' use of them. On March 31, 2011, Governor John Kasich signed Senate Bill 5 into law.⁴ This bill and the referendum movement that has sprung up in opposition to it work in concert to cloud the future of bargaining for health care benefits. While all of the benefits of an LMHIC are not destroyed when health care is removed from the bargaining table, there is little doubt that the primary procedural benefits are nullified.

Labor-management health insurance committees are, as the name implies, a joint effort by labor and management to clear up insurance-related bargaining issues prior to the expiry of the existing collective bargaining agreement. By working during the term of the contract, more time can be devoted to investigating issues, weighing alternatives, and building a consensus, streamlining the regular negotiations process when it arrives. When school districts were asked whether they had LMHICs in place, 52.6 percent ($n = 269$) responded affirmatively. LMHIC development is addressed in an SEHCB best practice that goes into effect in 2012 (see Appendix E).

⁴ http://www.dispatch.com/live/content/local_news/stories/2011/03/31/31-kasich-sign-sb5.html.

Worksite Wellness Programs

Worksite wellness programs are attempts to marry the convenience of on-site services for employees with the health benefits associated with wellness programs. While the wellness program best practice mandated by the SEHCB does not require on-site services, such services certainly count toward measurements of district implementation. Further, by strongly endorsing participation while simultaneously increasing ease of access to wellness program components, employers should see increases in employee participation rates, a critical measure of the effectiveness of any wellness program.

A comprehensive worksite health promotion program, as defined by Healthy People 2010, contains five elements: health education, supportive social and physical environments, integration of the organization's worksite program into its structure, programs like employee assistance programs and other programs to help employees balance work and family, and worksite screening programs (U.S. Department of Health and Human Services, 2000).

The majority of employers (58.7 percent ($n = 300$)) said they had some form of active worksite wellness program. When asked which components (if any) of a comprehensive worksite health promotion program they had, the most commonly reported component was a screening program (e.g., blood pressure, blood cholesterol, etc.) (52.2 percent), followed by a supportive social and physical work environment (e.g., policies against tobacco and alcohol use, classes on nutrition and fitness, etc.) (48.7 percent), health education (e.g., education or counseling opportunities relative to physical activity, nutrition, injury prevention, etc.) (46 percent), related programs (e.g., employee assistance, work/family programs, occupational safety and health programs) (27.3 percent), and integration of the worksite wellness program into the organization's structure (e.g., dedicated staff, office or budget) (19.8 percent).

Those organizations' worksite wellness programs that possessed all five components represented 14.4 percent ($n = 76$) of employers responding. While there is a plethora of studies that demonstrate the importance and promise of such programs for cost management and health status improvement, an excellent review is offered by Goetzel and Ozminkowski, 2008.

Medical Insurance Plans

Best Practices

While specific measurements of school district compliance rates can be found in the SEHCB's annual compliance report available at <http://sehcb.ohio.gov/>, general questions about the existence of best practices in the schools were answered by respondents to this survey, as well. Seventy-nine percent ($n = 419$) indicated that they had all four of the best practices in some fashion. The practice-by-practice breakdown is as follows: 95 percent ($n = 476$) affirmed the existence of a wellness program; 93 percent ($n = 467$) affirmed the existence of a disease management program; 97 percent ($n = 481$) affirmed that employees have access to specialty networks for complex conditions; and 94 percent ($n = 509$) affirmed that they had conducted a dependent eligibility audit at some point during the past three years.

Medical plan choice

Employers were asked about the number of plans made available to employees as of January 1, 2011. Of those responding, 64.3 percent ($n = 341$) offered one plan; 18.1 percent ($n = 96$) offered two plans; 15.7 percent ($n = 83$) offered three plans; and 1.9 percent ($n = 10$) offered four or more plans.

Medical insurance plan designs

Next, employers were asked about the types of plans they offered. Using a plan-level analysis, the most commonly reported plan type was the preferred provider organization (PPO), making up 77.6 percent ($n = 624$) of all reported plans. The next most common plan type was the high deductible health plan (HDHP), making up 10.2 percent ($n = 82$) of reported plans. Traditional indemnity plans, major medical plans, and other conventional medical plans made up 6.9 percent ($n = 56$) of plans. Rounding out the types of plan offerings were health maintenance organizations (HMOs) and point of service (POS) plans, constituting 3.5 percent ($n = 28$) and 1.7 percent ($n = 14$) of plans, respectively. Table 1 illustrates the distribution of plan types across the various employer types. Note that percentages will not total exactly 100 due to rounding.

Table 1: Medical Plan Type by Employer Type

Medical Plan Design	City	Local	Ex Vil	JVSD	ESC	Total	Percent
Traditional Plan	15	28	1	6	6	56	7%
Preferred Provider Organization	150	336	39	44	55	624	78%
Point of Service	8	4	2	0	0	14	2%
Health Maintenance Organization	6	14	3	3	2	28	4%
High Deductible Health Plan	23	38	6	9	6	82	10%
Total	202	420	51	62	69	804	100%

Enrollment and risk stratification

Employers were questioned about the enrollment rates in their medical plans. Enrollment responses were broken into a variety of categories, the chief measures being single and family enrollment categories. The dividing of enrollment into different levels is rooted in an understanding of risk and probability. A lone individual is less likely to incur as many costs as a family of six, all other things being equal. Thus, the division of enrollment into levels (or “risk stratification”) allows costs to be assigned in proportion to the level of risk associated with a contract that covers one, two, three or four or more persons.

Survey responses indicated that three types of risk stratifications were in use. The chief division of enrollment levels was the two-tier plan, which type constituted 85.8 percent ($n = 688$) of plans. Three- and four-tier plans were employed at substantially lower rates, constituting 5.9 percent ($n = 47$) and 8.4 percent ($n = 67$) of plans, respectively. Thus, when comparing benefit costs, per-employee-per-year costs provide a tighter estimate of costs than single and family health insurance premium or funding rates.

Take-up rates

Using the enrollment data provided by respondents, the median take-up rate (i.e., the number of employees enrolled in a plan divided by the number of employees eligible for the plan) for medical plans was 70.8 percent ($n = 788$).

Based on prior research (Gabel et al., 2003; Holahan, 2003; Kaiser Family Foundation, 2007), there exists a link between medical plan take-up rates and the associated premium contribution costs to employees. To see if various cost sharing elements or utilization costs bore meaningfully on the take-up rates in public schools, a nonparametric test of bivariate association, Kendall's Tau, was performed at the plan level.

This year, no significant correlation was noted between the premium cost to employees and plan take-up rates. As with previous years, however, a significant negative correlation between take-up rates and in-network single (Tau: $-.055$, $p = .034$, $n = 765$) and family (Tau: $-.059$, $p = .023$, $n = 766$) maximum out of pocket costs, further confirming the findings of the Ohio Education Association (Gascon, 2008) and the School Employees Health Care Board (Gascon, 2009; Gascon, 2010).

Loss financing

When providing a medical plan to its employees, an employer must choose its loss financing strategy. Self-insured plans rely on an internal funding structure, one in which the risk of loss remains with the employer. Fully insured plans transfer the risk of loss to a third-party insurer.

Which loss financing strategy is chosen depends on a complex and particularized balancing of risk estimates against the amount of loss an organization is capable of absorbing (Olivieri and Pitacco, 2011). If an employer completes a risk assessment that can determine with reasonable certainty the expected loss for a particular risk or risks, the employer is then able to judge how much risk (if any) to retain and how much (if any) to transfer. Additionally, the employer may endeavor to offset some amount of risk through other means (e.g., changing internal policies to avoid certain risks partially or entirely). Finally, an employer may opt to pool its risk in the form of a joint purchasing arrangement, a strategy whose primary aim is the stabilization of risk via the law of large numbers.

Employers were queried on their choice of loss financing strategies, to which 71.6 percent ($n = 348$) reported that they were self-insured, while 28.4 percent ($n = 138$) reported that they were fully insured. Of self-insured employers, 89.1 percent ($n = 301$) chose to pool risk in the form of a joint purchasing organization, while 56.9 percent ($n = 74$) of fully insured employers chose to stand alone.

A Mann-Whitney U test was performed to examine the differences in single and family premium distributions between health care plans that were fully insured ($n = 187$) and those that were self-insured ($n = 573$ for single and $n = 572$ for family). For single premium values ($n = 760$), the results of the test indicated a statistically significant difference ($p < .001$, $z = -4.739$) between self-insured and fully insured plans. For family premium values ($n = 759$), the test also indicated a statistically significant difference ($p < .001$, $z = -7.698$) between self-insured and fully insured plans.

Market share of medical insurance plan administrators

According to the Department of Insurance website at <http://www.ohioinsurance.gov/>, 531 health and life insurance companies and 29 health insuring corporations are authorized to do business in the state of Ohio. Additionally, 423 third-party administrators are licensed to do business in the state of Ohio. Tables 2 and 3 display the market share of self-insured and fully insured plans. As in the past, these tables demonstrate that the fully insured market is less competitive than the market for third party administrators, with the top two insurers controlling over 60 percent of the market. In contrast, one must combine the market shares of the top four companies in the self-insured market to exceed 60 percent of market control.

Table 2: Self-Insured Market Share

Medical Administrator	Self-Insured	
	<i>f</i>	Percent
Medical Mutual of Ohio	196	30.6
Allied Benefit Systems	100	15.6
Anthem Blue Cross & Blue Shield	72	11.2
Employee Benefit Mgmt Corp	27	4.2
Benefit Services, Inc.	26	4.1
CoreSource	24	3.7
Self Funded Plans, Inc.	20	3.1
United Healthcare of Ohio	17	2.7
Other	159	24.8

Table 3: Fully Insured Market Share

Medical Administrator	Fully Insured	
	<i>f</i>	Percent
Anthem Blue Cross & Blue Shield	89	34.2
Medical Mutual of Ohio	75	28.8
United Healthcare of Ohio	48	18.5
Kaiser Permanente	10	3.8
Paramount Heath Care	8	3.1
Other	24	11.6

Medical health insurance premium and funding levels

Medical insurance premiums (or funding levels, in the case of self-insured plans) are reported each year as a major measure of overall health care costs, as analyses of plan utilization and its attendant effects have proved unworkable thus far. The SEHCB will continue to investigate opportunities to conduct such studies. The scope of this survey, however, did not include such inquiries.

Medical insurance premiums (or funding levels, in the case of self-insured plans) are reported each year as a measure of overall health care costs. Table 4 shows aggregate and categorical breakdowns of premium costs for medical plans in which pharmaceutical coverage was bundled into the cost of the medical premium ($n = 753$).

Table 4: Premium Costs by Categories

		<i>n</i>	Single			Family		
			Employee	Employer	Total	Employee	Employer	Total
BOE Region*	0 - Central	76	\$ 53	\$ 449	\$ 525	\$ 195	\$ 1,137	\$ 1,346
	1 - Southwest	82	47	398	443	136	1,015	1,154
	2 - West Central	65	47	401	461	133	1,064	1,201
	3 - Northwest	70	35	384	418	100	999	1,080
	4 - North Central	103	43	420	445	100	1,017	1,082
	5 - South Central	40	42	525	618	160	1,278	1,474
	6 - Southeast	29	53	553	602	213	1,360	1,559
	7 - East Central	97	43	385	428	104	976	1,040
	8 - Northeast	68	35	400	427	87	1,047	1,112
Employer Type	City	159	\$ 38	\$ 429	\$ 461	\$ 100	\$ 1,061	\$ 1,198
	Local	348	43	410	445	114	1,039	1,158
	Ex Vil	43	41	401	454	109	994	1,114
	JVSD	48	45	419	469	130	1,056	1,184
	ESC	63	53	397	445	166	956	1,130
Plan Design*	Traditional	50	\$ 43	\$ 401	\$ 436	\$ 104	\$ 988	\$ 1,060
	PPO	509	45	418	471	121	1,053	1,199
	POS	13	38	468	532	108	1,139	1,469
	HMO	20	42	394	427	122	1,079	1,205
	HDHP ¹	34	27	375	428	91	969	1,066
	HDHP ²	32	21	358	400	90	980	1,072
Joint Purchasing*	No	101	\$ 49	\$ 453	\$ 515	\$ 136	\$ 1,182	\$ 1,349
	Yes	291	43	410	448	115	1,031	1,154
Loss Financing*	Fully Insured	174	\$ 49	\$ 443	\$ 496	\$ 143	\$ 1,135	\$ 1,304
	Self-Insured	489	43	406	445	106	1,007	1,094
Aggregate		662	\$ 43	\$ 412	\$ 448	\$ 114	\$ 1,039	\$ 1,159
¹ No employer contribution to employee account								
² Employer contribution to employee account. Median contributions were \$1191 for single plans and \$2073 for family plans.								
Asterisk (*) denotes statistical significance ($p < .05$, two-tailed)								

In Table 4, plan numbers (n) represent the lowest number of medical insurance plans for which data in that category were available. Typically, an accompanying table for medical plans that carve out prescription drug coverage would be provided, but insufficient data was reported for any meaningful analyses to be performed. Employer and employee contribution amounts will not sum to the total premium amounts listed, as each figure represents the median of its own distribution. As noted below the table, an asterisk (*) denotes statistical significance (where $p < .05$).

Kruskal-Wallis tests were performed to compare the differences in single and family medical premium distributions when grouped by Board of Education region, plan type, and employer type. For plans grouped by board of education region, significant results were noted in both single ($\chi^2 = 163.990$ (8, $n = 765$), $p < .001$) and family ($\chi^2 = 169.479$ (8, $n = 764$), $p < .001$) medical premium categories. For plans grouped by plan type, significant results were again noted for both single ($\chi^2 = 48.296$ (5, $n = 802$), $p < .001$) and family ($\chi^2 = 43.125$ (5, $n = 801$), $p < .001$) medical premium categories. Finally, for plans grouped by employer type, no significant differences were found.

From this distribution, a per-employee-per-year (PEPY) cost can be identified by multiplying the number of single medical contracts by the product of the employer's share of the single medical plan premium or funding level multiplied by 12, adding it to the number of family medical contracts by the product of the employer's share of the family medical premium or funding level multiplied by 12 and dividing that sum by the total number of employees on the medical plan. Thus, for 2011, the PEPY cost of medical and prescription drug plans was \$10,542. Please note that the PEPY value just provided applies only to medical plans which have pharmaceutical coverage bundled in the cost of the premium and does not include any other costs attendant to providing or administering health care benefits.

Table 5 details the patient cost management strategies employed by school districts and educational service centers in 2011. As has previously been noted, this market is dominated by preferred provider plans. Managed care plans typically include co-payment fees associated with visits to doctors' offices, emergency rooms (if not admitted), and urgent care centers. For managed care plans in this dataset, the median doctor's office visit co-payment was \$15; the median emergency room visit co-payment was \$75; and the median urgent care center visit copayment was \$20. Table 5 displays the median figures for other variable costs related to utilization.

Utilization and cost management

Employers were asked whether or not they engaged in any of 12 interventions designed to mitigate cost increases. Five hundred and thirteen employers responded. Of the catalogued responses, the chief interventions employed by respondents were, in descending order of application: increasing the number of preventive services (10.6% ($n = 63$)), increasing medical plan premium contributions (33.8% ($n = 201$)), and increasing medical insurance cost sharing (11.4% ($n = 68$)). Thus, the predominant means of controlling costs in 2011 continue to be increasing employee costs.

Table 5: Patient costs embedded in medical plans

Utilization Costs by Plan Model		<u>Median</u>
Managed Care Plan Usage Costs		
Single Deductible		
	Network	\$ 150
	Non-Network	\$ 300
Family Deductible		
	Network	\$ 300
	Non-Network	\$ 600
Single Out of Pocket Maximum		
	Network	\$ 900
	Non-Network	\$ 1,550
Family Out of Pocket Maximum		
	Network	\$ 1,700
	Non-Network	\$ 3,000
Traditional Plan Usage Costs		
Deductible		
	Single	\$ 100
	Family	\$ 200
Out of Pocket Maximum		
	Single	\$ 600
	Family	\$ 1,200

Prescription Drug Plans

When asked about their prescription drug plans, employers were invited to respond according to the type of co-pay structure that they employed, ranging from a single tier (more accurately, no tier structure whatsoever) to four tiers (i.e., generic, preferred brand, non-preferred brand, and biologic/cosmetic). The most commonly reported plan design was the 3-tiered pharmaceutical plan, which constituted 48.4 percent ($n = 374$) of all prescription plans. Under this style of plan, the median retail copayments were \$10 for generic drugs, \$20 for preferred brand drugs, and \$35 for non-preferred brand drugs. The median mail order co-payments for this style of plan were \$20 for generic drugs, \$40 for preferred brand drugs, and \$60 for non-preferred brand drugs. The reader should bear in mind that mail order prescriptions are typically written for a 90-day supply, while retail prescriptions are typically written for a 30-day supply.

Employers were also asked about any cost management policies that might attach to their pharmaceutical plans. First, employers were asked if their pharmaceutical plans excluded one or more classes of drugs from coverage. Based on responses to this question, 87.1 percent ($n = 634$) of pharmacy plans excluded one or more classes of drugs from coverage. Second, employers were asked whether or not their pharmaceutical plans contained a prior authorization feature for specific drugs or drug classes. Responses showed that 64.2 percent ($n = 471$) of plans require prior authorization in certain situations. Third, employers were asked whether their pharmaceutical plans required step therapy, which prevents an end-run on the plan's formulary structure. Responses showed that 56.5 percent ($n = 284$) of plans contained a step therapy requirement. Finally, employers were asked if their pharmaceutical plans levied a penalty (or ancillary charge) for electing to take a brand name drug when a generic equivalent was available. Responses showed that 50.6 percent ($n = 350$) of plans contained such a penalty clause.

Table 6: Prescription drug cost management options

Rx Plan Design & Premiums			<i>n</i>	<i>p</i>	<i>z</i>
Mann-Whitney <i>U</i> Test Results					
Exclusion of Certain Drug Class(es)					
	Single		726	0.161	-1.402
	Family		725	0.184	-1.328
Prior Authorization Feature					
	Single		732	0.124	-1.539
	Family		731	0.213	-1.246
Step Therapy Feature					
	Single*		502	0.005	-2.808
	Family		502	0.095	-1.671
Penalty or Ancillary Charge					
	Single*		689	< .001	-3.779
	Family*		689	< .001	-4.818
* Denotes statistically significant result ($p < .05$, two-tailed)					

Next, Mann-Whitney *U* tests were run on single and family medical premiums (or funding levels) and each prescription drug cost management practices identified above. The results showed a significant difference in single premiums when measured according to the presence or absence of step therapy requirements; the same cannot be said of family premiums. Significant differences were also noticed in both single and family premiums depending on whether or not a penalty or ancillary charge attached when choosing a brand name drug over an available generic alternative.

Table 6 demonstrates that the most effective cost management provisions embedded in a pharmaceutical plan may be a mandatory generic plan with a penalty for choosing a brand-name drug when a generic is available and a step therapy program which requires a health care provider to begin drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more

costly or risky therapy only if necessary. See Appendix E for the SEHCB best practices which begin to address these issues.

Dental Insurance Plans

Dental insurance covers a variety of oral care situations, from orthodontic care to restorative maxillofacial surgery. Of those responding, 97.7 percent ($n = 513$) of employers offered dental insurance coverage to their employees. The median single premium for those plans was \$37.61. The median family premium for those plans was \$79.63. Employees contributed \$2.40 and \$6.82 for single and family plans, respectively. The median per-employee-per-year (PEPY) cost for dental insurance in 2011 was \$775.

Dental plans were overwhelmingly self-insured (69.5 percent ($n = 338$)), while the minority were fully insured (30.2 percent ($n = 147$)). The top three dental plan administrators (regardless of loss financing method) were Medical Mutual of Ohio (22.8 percent), CoreSource (12.3 percent), and Delta Dental (10.5 percent).

Dental coinsurance is generally divided into coverage classes. Employers were asked to report coinsurance levels under the prevailing four-class structure. In-network, Class 1 services like diagnostic and preventive care were covered at 100 percent ($n = 454$); Class 2 services such as oral surgery were covered at 80 percent ($n = 448$); Class 3 services ($n = 451$) like major restorative care and Class 4 services ($n = 438$) for orthodontic care were both funded at 60 percent.

The median in-network deductibles for single ($n = 362$) and family ($n = 398$) plans were \$25 and \$50, respectively. Additionally, some employers reported a per person deductible, for which the median was \$25 ($n = 199$). The median annual maximum benefit per covered person was \$1,500, while the median annual maximum benefit for orthodontia (adult and child combined) was \$1,000.

Vision Insurance Plans

Vision insurance covers a variety of optical issues, from examinations to the fitting of glasses and contact lenses. When asked whether they offered vision coverage at all (as a component of medical or dental coverage, or as a stand-alone plan), 69.1 percent ($n = 363$) of employers responded affirmatively. Of those employers reporting a stand-alone vision plan, the median single premium was \$9 ($n = 292$), and the median family premium was \$20 ($n = 296$). The median employee contributions for single and family premiums were \$1 and \$2, respectively. The median per employee per year (PEPY) cost for vision plans in 2011 was \$166 ($n = 281$).

Regarding loss financing, 55.7 percent ($n = 186$) of plans were fully insured, while 44 percent ($n = 147$) of plans were self-insured. The top three administrators (irrespective of loss financing method) were VSP (40.5 percent ($f = 147$)), Medical Mutual of Ohio (14.9 percent ($f = 54$)), and Medical Benefits (2.5 percent ($f = 9$)).

Employers were asked about the frequency with which certain benefits were eligible for coverage under their vision plans. Table 7 below summarizes those findings.

Table 7: Vision Plan Benefits by Frequency

Vision Plan Benefits by Frequency	Annual		Biannual	
	<i>f</i>	Percent	<i>f</i>	Percent
Vision Exam	284	85.5	48	14.5
Single Vision Lenses	237	74.1	83	25.9
Bifocal Lenses	234	74.1	82	25.9
Trifocal Lenses	232	74.1	81	25.9
Frames	137	43.1	180	56.6
Contacts (Elective)	236	73.8	84	26.3
Contacts (Necessary)	234	75.2	77	24.8

Flexible Spending Accounts

Flexible spending accounts (Section 125 plans) provide a vehicle for funding health care and dependent care expenses in the context of an employee benefit program. If the employer requires employee premium contributions, a flexible spending account should be offered to employees. A number of expenses can be paid for through such accounts. In the context of health care expenses, these may include dental services, hospital services, insurance premiums, prescription drugs, dental services, travel expenses to receive medical care, and vision care, to name a few. Qualified medical expenses are updated each year in IRS publication 502; IRS publication 503 details expenses that are qualified annually for dependent care expense reimbursement.

FSA funding occurs through the employer or the employee. In the case of the former, employers contribute a uniform amount to employees’ accounts. In the case of the latter, a salary reduction agreement is negotiated. In both cases, however, the decision to set a contribution or salary reduction amount is implemented once a year, though changes during the year are possible under certain federal rules.

According to the catalogue of responses, 77.9 percent ($n = 399$) of employers offered a flexible spending account. Regarding the type of account, 72 percent ($n = 293$) offered a premium-only pass-through plan; 83 percent ($n = 356$) offered a medical and dental account; 79.2 percent ($n = 328$) offered a child and dependent care account; 28.4 percent ($n = 232$) offered all three types.

Coverage can be further examined in terms of duration and employer contributions. Of the accounts offered, 68.2 percent ($n = 257$) had twelve-month terms, while 31.6 percent ($n = 119$) had 14-month terms. Regarding contributions, 10.4 percent ($n = 39$) of accounts noted employer contributions, of which the median single and family contributions ($n = 31$) were \$400 and \$600, respectively.

Longitudinal Analysis: Three Years of Scrutiny

With the completion of the 2011 cost survey, three years of data were available for a comparative analysis of health insurance costs in the school district and educational service center market. With three distinct points to chart, longitudinal comparisons became available, allowing us to chart short-term trends. First, as a basic measure of costs, the median premiums, employer contributions, employee contributions, and per employee per year (PEPY) costs were placed side-by-side for brief, easy comparisons. Note that the dollar values are unadjusted figures unless otherwise noted.

Table 8: Median Medical Costs: Unadjusted Three-Year Comparison

Median Medical Costs:	<u>2009</u>	<u>2010</u>	<u>2011</u>
A Three-Year Comparison*			
Median Employee Premium Contribution			
Single	\$ 38	\$ 40	\$ 43
Family	\$ 100	\$ 114	\$ 120
Median Employer Premium Contribution			
Single	\$ 384	\$ 406	\$ 419
Family	\$ 962	\$ 1,023	\$ 1,062
Median Total Premium Costs			
Single	\$ 420	\$ 446	\$ 467
Family	\$ 1,078	\$ 1,141	\$ 1,205
Median PEPY Costs	\$ 9,668	\$ 10,176	\$ 10,542
<i>*Unadjusted dollar values rounded to nearest whole dollar</i>			

While the unadjusted dollar values were interesting by themselves, a more accurate gauge of the rate of increase could be made with inflation-adjusted figures. Using the Consumer Price Index for Urban Consumers (CPI-U), the dollar figures were adjusted for inflation, after which rates of increase were noted on an annual basis. The previous comparison table was then modified to display the new results.

Table 9: Median Medical Costs: Adjusted Three-Year Comparison

Median Medical Costs:	2009*	2010*	Increase	2011	Increase
A Three-Year Comparison			2009-2010		2010-2011
Median Employee Premium Contribution					
Single	\$ 40	\$ 41	3.56%	\$ 43	5.17%
Family	\$ 104	\$ 117	12.16%	\$ 120	3.01%
Median Employer Premium Contribution					
Single	\$ 400	\$ 416	4.03%	\$ 419	0.69%
Family	\$ 1,002	\$ 1,048	4.63%	\$ 1,062	1.33%
Median Total Premium Costs					
Single	\$ 437	\$ 457	4.48%	\$ 467	2.25%
Family	\$ 1,123	\$ 1,169	4.14%	\$ 1,205	3.08%
Median PEPY Costs	\$ 10,070	\$ 10,429	3.56%	\$ 10,542	1.08%
Unadjusted Annual CPI-U Medical Care Index	--	--	3.4%	--	3.3%

**Values adjusted to 2011 dollar value using Consumer Price Index, rounded to nearest whole dollar*

The data in Table 9 demonstrates that public schools’ health care costs in the state of Ohio have been increasing, but even in the year where the increase outstripped the CPI measure, it did so by only a fraction of a percent. The latest measure of increase, 1.08 percent, was less than half that measured by the CPI.

This paper demonstrates the progress that school districts and educational service centers have made in collaboration with the efforts of the School Employees Health Care Board and its Advisory Committee, and point towards a bright future for utilization and cost management designed to decrease employer and employee costs and increase the health status of school district and educational service center employees and their dependents.

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Appendix A: Precision of Estimates

Surveys attempt to make certain assertions about population characteristics based upon samples generated within them. The sample size needed to estimate p with a bound on error B was estimated using Equation 1:

Equation 1

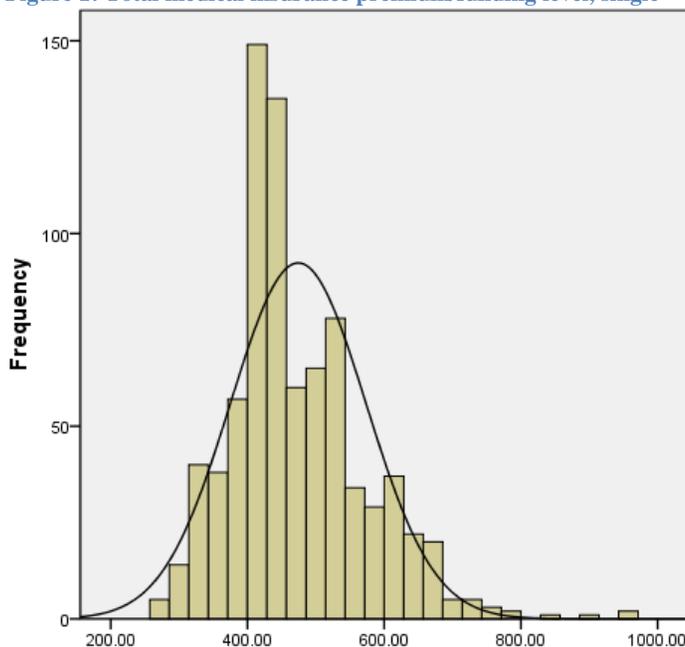
In (1), $q = 1 - p$ and $D = B^2/4$. The bound (B) utilized was .05, while p was replaced with the most conservative estimate, .5. Solving for n generated a required sample size of 258, while the sample size of the survey was 620, so the sample estimates produced herein could be considered as representative of the Ohio school district and educational service center population.

Appendix B: Measures of Central Tendency and Probability Distributions

Most health insurance studies include data on premium averages. Employing such a measure of central tendency expressly implies that premiums are normally distributed- a unimodal, symmetric shape with 95 percent of all observations falling within two standard deviations of the mean of the distribution. In such cases, measures of a distribution's skew, a numerical description of the distribution of scores around a mean, will approach 0. Similarly, measures of a distribution's kurtosis, or the extent to which scores in a distribution are peaked, will approach 0. It is well established that many economic variables possess non-normal distribution traits such as outliers, pronounced skew and gaps or clusters (Moore & McCabe, 1999), as do many health care variables (Pett, 1997).

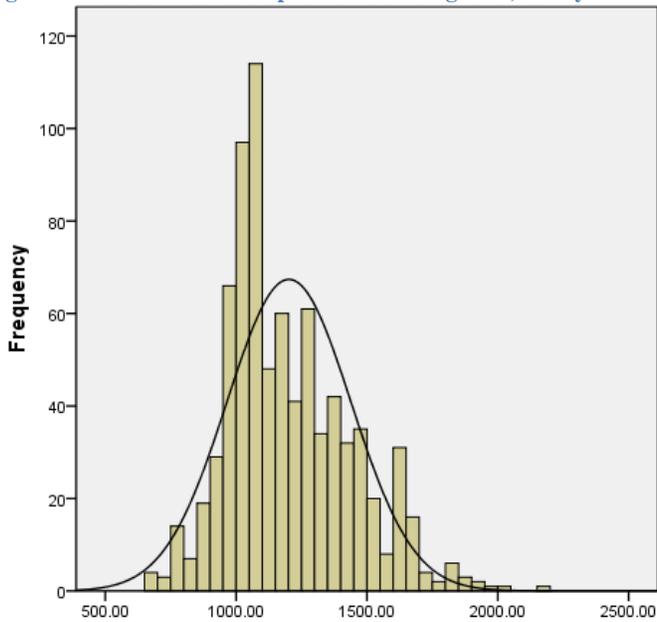
Cost is clearly an economic variable and would be likely to demonstrate one or more anomalies indicative of non-normal distributions. Using the mean as a measure of central tendency in such distributions puts the center of the distribution farther out in the long tail than the median (or midpoint) of the distribution. Thus, the median was used as a measure of central tendency as appropriate (i.e., when a skewness value was observed to be more than twice its standard error). An illustration of the most germane distributions can be found in Figure 1 (single total medical insurance premium or funding level) and Figure 2 (family total medical insurance premium or funding level). In both figures, a normal curve has been placed over the distribution to offer a visual placeholder to judge normality. As can be readily observed, both distributions are positively skewed with costs piled up on the left-hand side of the graph; in these distributions, the mean is 'pulled' to the right by virtue of a few high values and is larger than the median or midpoint of the distribution.

Figure 1: Total medical insurance premium/funding level, single



In Figure 1, the mean is \$474, the standard deviation is 105, the median is 445, the skewness value is .921, and the kurtosis statistic was 1.621. Given the level of skew, the distribution was observed to be non-normal.

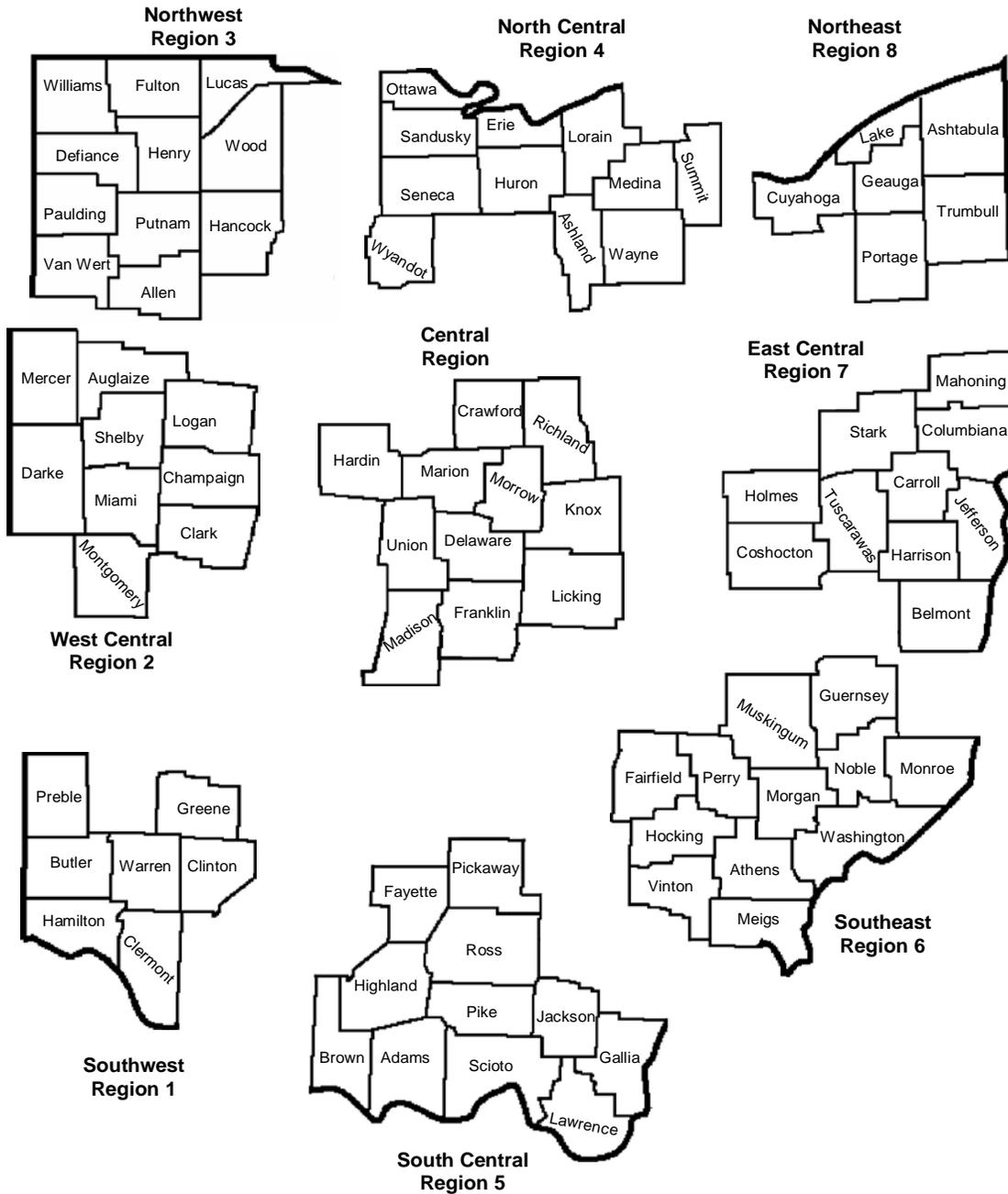
Figure 2: Medical insurance premium/funding level, family



In Figure 2, the mean is \$1,202, the standard deviation is 237, the median is \$1,148, the skewness value is .705, and the kurtosis statistic is .351. Again, given the level of skew, the distribution was observed to be non-normal.

Appendix C: Board of Education Regions

Boards of Education Regions



Appendix D: Joint Purchasing Arrangement Chart

Financial Audits of Ohio School District Consortia Filed with Auditor of State of Ohio as of May 2011						
Original List from School Employees Health Care Board Second Annual Health Insurance Cost Report, 2010						
Joint Purchasing Arrangement	Estimated Number of Members	Date of Audit Report	Accounting Method	Reserves in Excess of IBNR	Reserved Funds	IBNR Estimate and Other Liabilities
Allen County Schools Health Benefit Plan	12	6/30/10	Modified Cash	\$2,116,737	\$4,243,943	(\$2,127,206)
Ashtabula County Schools Council of Governments	7	6/30/10	Cash	\$7,479,649	\$9,109,649	(\$1,630,000)
Athens County School Employees Health and Welfare Benefit Association	6	No audit; Form 990 (2009)	Accrual	\$3,577,752	\$4,474,607	(\$896,855)
Brown County School Benefits Consortium	6	6/30/10	Cash	\$943,774	\$980,299	(\$36,525)
Butler Health Plan	7	No audit; Form 990 (2009)	Accrual	\$13,607,993	\$23,033,845	(\$9,425,852)
Central Ohio Health Care Consortium	8	12/31/09	Accrual	\$2,569,300	\$3,129,016	(\$559,716)
Champaign, Delaware, Marion, Union, School Employee Welfare Benefit Association Consortium	9	No audit; Form 990 (2009)	Accrual	\$3,772,280	\$6,548,237	(\$2,775,957)
Clermont County Insurance Consortium	6	6/30/10	Cash	\$2,718,738	\$5,721,297	(\$3,002,559)
East Ohio Schools Employees Insurance Consortium (*established reserve with OME-RESA in FY09)	7	9/30/10	Accrual	\$3,277,402	\$3,678,402	(\$401,000)
Greater Cincinnati Insurance Consortium	13	6/30/09	Cash	\$10,279,789	\$14,949,689	(\$4,669,900)
Hancock County Schools Health Benefit Fund	9	9/30/10	Modified Cash	\$405,617	\$1,605,540	(\$1,199,923)
Hardin County School Employees' Health Welfare Benefit Plan and Trust	6	No audit; Form 990 (2009)	Accrual	\$2,381,812	\$3,172,762	(\$790,950)
Health Care Benefits Program of Lake County Schools Council	11	6/30/10	Accrual	\$5,065,857	\$7,753,857	(\$2,688,000)
Huron-Erie School Employee Insurance Association	13	6/30/10	Accrual	\$11,622,499	\$14,873,499	(\$3,251,000)
Lake Erie Regional Council of Governments	17	6/30/10	Cash	\$8,137,335	\$11,112,335	(\$2,975,000)
Logan County Schools Benefit Plan Association	3	No audit; no Form 990				
Mahoning County School Employees Insurance Consortium	12	6/30/10	Cash	\$6,814,787	\$8,604,487	(\$1,789,700)
Mercer Auglaize Employee Benefit Trust	13	No audit; no Form 990				

Joint Purchasing Arrangement	Estimated Number of Members	Date of Audit Report	Accounting Method	Reserves in Excess of IBNR	Reserved Funds	IBNR Estimate and Other Liabilities
Northern Buckeye Education Council	41	6/30/08	Cash	\$13,553,329	\$17,169,329	(\$3,616,000)
North Central Ohio Joint Self-Insurance Association	8	No audit; no Form 990				
Ohio School Benefits Cooperative	15	6/30/10	Cash	\$1,953,176	\$2,981,176	(\$1,028,000)
OME-RESA Health Benefits Consortium	75	6/30/09	Cash	\$69,322,856	\$83,158,856	(\$13,836,000)
Paulding County Insurance Consortium	2	No audit; no Form 990				
Pickaway County Public Employees Benefit Program	3	No audit; no Form 990				
Portage Area School Consortium Health & Welfare Insurance Pool	19	6/30/09	Cash	\$8,016,489	\$10,997,587	(\$2,981,098)
Preble County Schools Regional Council of Governments	6	6/30/10	Cash	\$4,242,005	\$5,652,648	(\$1,410,643)
Putnam County Schools Insurance Group	11	12/31/09	Cash	\$4,867,148	\$6,002,495	(\$1,135,347)
School Employees Insurance Consortium (Ross County)	3	6/30/10	Cash	\$532,650	\$2,044,450	(\$1,511,800)
San-Ott Insurance Consortium	9	7/31/10	Cash	\$4,042,327	\$5,797,327	(\$1,755,000)
Scioto County Schools Council	9	6/30/09	Cash	\$3,977,829	\$6,238,129	(\$2,260,300)
Shelby County Schools Consortium	6	No audit; no Form 990				
South Central Ohio Insurance Consortium (associated with OME-RESA)	13	6/30/10	Accrual	\$18,563,289	\$21,663,289	(\$3,100,000)
Southwestern Ohio Educational Purchasing Council (EPC)	55	6/30/10	Accrual	\$3,227,923	\$12,198,923	(\$8,971,000)
Stark County Schools Council Of Governments	70	6/30/10	Modified Cash	\$56,266,189	\$69,203,189	(\$12,937,000)
Suburban Health Consortium	11	9/30/10	Accrual	\$11,112,411	\$16,221,411	(\$5,109,000)
Summit Regional Health Care Consortium	6	No audit; no Form 990				
Trumbull County Schools Employee Insurance Benefit Consortium	15	6/30/09	Modified Cash	\$4,248,616	\$6,089,062	(\$1,840,446)
Van Wert Area School Insurance Group	5	9/30/09	Cash	\$2,938,936	\$3,863,936	(\$925,000)
Wood County Schools Health Insurance Consortium	8	No audit; Form 990 (2009)	Accrual	\$3,497,707	\$6,639,050	(\$3,141,343)
Wyandot Crawford Health Benefit Plan	6	No audit; Form 990 (2009)	Accrual	\$2,283,481	\$3,455,953	(\$1,172,472)
TOTALS				\$297,417,682	\$402,368,274	(\$104,950,592)

Appendix E: SEHCB Best Practices

In the 2007 biennial budget bill signed by the Governor of Ohio, all health insurance plans offered by school districts and educational service center employees fell under the jurisdiction of the School Employees Health Care Board (SEHCB). The SEHCB, with the assistance of its Advisory Committee, was created to perform seven functions as listed under O.R.C. § 9.901(G):

1. Adopt and release a set of standards that shall be considered the best practices to which public school districts shall adhere in the selection and implementation of health care plans.
2. Require that the plans the health plan sponsors administer make readily available to the public all cost and design elements of the plan;
3. Work with health plan sponsors through educational outlets and consultation;
4. Maintain a commitment to transparency and public access of its meetings and activities;
5. Promote cooperation among all organizations affected by this section in identifying the elements for the successful implementation of this section;
6. Promote cost containment measures aligned with patient, plan, and provider management strategies in developing and managing health care plans;
7. Prepare and disseminate to the public an annual report on the status of health plan sponsors' effectiveness in making progress to reduce the rate of increase in insurance premiums and employee out of pocket expenses, as well as progress in improving the health status of school district employees and their families.

Accordingly, school districts and educational center health insurance plans must be in compliance with SEHCB best practices. For those health insurance plans that are issued or renewed after January 1, 2010 or after the expiration of any applicable collective bargaining agreement after that date, the following best practices apply:

A. Wellness Program Best Practice

1. All health care plans offered to employees by a school district and subject to O.R.C. § 9.901 shall include a wellness or healthy lifestyle program. For the purposes of this rule, the term 'wellness or healthy lifestyle program' means a program that consists of a combination of activities that are designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, encourage modifications of his or her health status, and enhance his or her personal well-being and productivity, with a goal of preventing illness and injury.
2. The required components of an acceptable wellness or healthy lifestyle program under this rule specifically include but are not limited to:

- a. Conducting an initial evaluation of historical claims experience if available to specifically identify health conditions that are modifiable and preventable through health improvement, health management, and patient compliance.
 - b. A personal health assessment tool capable of providing an accurate and comprehensive baseline of population health status. The personal health assessment must:
 - i. be available in multiple formats including both online and paper media
 - ii. be reasonable in length
 - iii. capture modifiable and non-modifiable risk factors
 - iv. assess an individual's confidence and readiness to change, potential barriers to change, and include quality of life measures
 - v. capture current contact information and preferred means of contact
 - vi. generate a personalized report for the individual that addresses lifestyle changes they can make to improve their health and reduce risks
 - c. Conduct a biometric screening at the health plan sponsor location(s) of choice. Screening must include:
 - i. cholesterol levels
 - ii. diabetic risk assessment
 - iii. blood pressure
 - iv. body mass index (BMI), including recording of height and weight and body composition
 - d. Provide proactive, ongoing support and education for individuals with lifestyle health risks, such as tobacco use, obesity, high blood pressure, high cholesterol, and high stress. This support and education must:
 - i. include access to personalized health coaching
 - ii. be available in multiple formats, including telephone, email and the internet
 - iii. be provided by qualified professionals
 - e. Include processes or programs that encourage the highest levels of participation possible at the onset of the program, make it attractive to enroll in the program at any time and to keep participants engaged throughout the duration of the program.
 - f. Provide regularly scheduled reports to the plan sponsor demonstrating the impact of the program in aggregate, including:
 - i. personal health assessment completion rates
 - ii. outcome-oriented metrics such as reductions in BMI, smoking cessation rates and other quantifiable improvements in behavior
1. The use and disclosure of health information collected through health risk assessments shall respect patient confidentiality and may not be used or disclosed for any purpose other than allowed by state or federal law to improve the health status of participating members.

2. Each health care plan sponsor subject to O.R.C. § 9.901 shall furnish to the Board evidence of its compliance with this rule. Upon ascertaining the wellness program's suitability and compliance with the minimum criteria as set forth, the Board shall certify the compliance of the health plan sponsor and its wellness program.
3. Any health care plan or vendor providing wellness or healthy lifestyle programs to employees of public school districts shall provide health plan sponsors with evidence that its wellness program meets the minimum criteria as set forth in this rule within sixty days after receiving a written request for such information from the health plan sponsor.

B. Disease Management Best Practice

1. All health care plans offered to employees by a school district and subject to O.R.C. § 9.901 shall include a disease state management program. For the purposes of this rule, the term 'disease state management' means a program that includes both education and support activities designed to increase individuals' awareness and understanding of their disease(s), promote voluntary behavior change, improve self-care, with the goal of preventing or managing complications associated with targeted chronic diseases.
2. The required components of an acceptable disease management program under this rule specifically include:
 - a. An initial evaluation of plan history and claims if available to specifically identify the prevalence of diseases amenable to disease state management interventions.
 - b. Identification, classification and tracking of defined patient populations.
 - c. Patient education and involvement in self-care techniques.
 - d. Drug management and protocol adherence.
 - e. Feedback to physicians on the progress of patients in the program.
 - f. Integration of the services provided and the sharing of information with the health plan's employee wellness or healthy lifestyle program.
3. A disease state management program offered under this rule shall address chronic diseases, including but not limited to asthma, cardiovascular diseases, diabetes, chronic obstructive pulmonary disease and morbid obesity if such diseases have been identified as being prevalent in the population being served.
4. A disease state management program under this rule must provide the health plan sponsor with regular reports documenting the impact of the program in aggregate, specifically including but not limited to participation rates and satisfaction, disease-specific clinical outcomes and financial outcomes.
5. Each health care plan sponsor subject to O.R.C. § 9.901 shall furnish to the Board evidence of its compliance with this rule. Upon ascertaining the disease state management program's suitability and compliance with the minimum criteria as set forth, the Board shall certify the compliance of the health plan sponsor and its disease state management program.

6. Any health care plan or vendor providing disease state management services to employees of public school districts shall provide health plan sponsors with evidence that its disease state management program meets the minimum criteria as set forth in this rule within sixty days after receiving a written request for such information from the health plan sponsor.

C. Access to Institutions and Providers Demonstrating Superior Healthcare

1. All health care plans offered to employees by a school district and subject to O.R.C. § 9.901 shall include access to institutions and providers offering demonstrated clinically superior health care for complex medical conditions.
2. Complex medical conditions may include but need not be limited to:
 - Transplantation (solid organ, blood and bone marrow)
 - Cancer
 - Chronic Kidney Disease
 - Congenital Heart Disease
 - Infertility (if a covered condition)
 - Neonatology
 - Morbid Obesity
 - High Risk Pregnancy

All health care plans offered to employees by a school district and subject to O.R.C. § 9.901 shall be required to use objective, measurable criteria to evaluate participating institutions and providers

All health care plans offered to employees by a school district and subject to O.R.C. § 9.901 shall provide the health plan sponsor access to the evaluations of all participating institutions and providers so long as the release of specific information is not in breach of any agreement between an institution or provider and the health care plan.

Each health plan sponsor subject to O.R.C. § 9.901 shall furnish to the Board evidence of its compliance with this rule and the Board shall certify the compliance of the health plan sponsor.

Any health care plan or vendor providing access to institutions and providers offering demonstrated clinically superior health care for complex medical conditions shall provide health plan sponsors with evidence that the institutions and providers meet the minimum criteria as set forth in this rule within sixty days after receiving a written request for such information from the health plan sponsor.

D. Dependent Eligibility Audits

1. All health plan sponsors offering health care plans subject to O.R.C. §9.901 shall undertake periodic dependent eligibility audits.

2. The aggregate results of each dependent eligibility audit shall be furnished by each health plan sponsor subject to O.R.C. §9.901 to the School Employees Healthcare Board.
3. Each health plan sponsor subject to O.R.C. § 9.901 shall furnish to the Board evidence of its compliance with this rule, and the Board shall certify the compliance of the health plan sponsor.

For those health insurance plans that are issued or renewed after March 19, 2012 or after the expiration of any applicable collective bargaining agreement after that date, the following best practices also apply:

E. Transparency Best Practice

1. All health care plans offered to health plan sponsors shall be evaluated, negotiated, procured, and administered in a transparent manner. Transparency requires public disclosure of all costs a health care plan or a health plan sponsor pays to or receives from any person or entity related to the designing, procuring, administering, and evaluating a public school district's health care plan.
2. Any school district that is a member of a joint-purchasing arrangement shall:
 - a. Only participate in a joint purchasing arrangement that is audited at least biannually in accordance with the Generally Accepted Government Auditing Standards (GAGAS) in the United States and submits such information to the Board; and
 - b. Only enter into an agreement with any joint purchasing arrangement that holds cash and cash equivalents in a separate interest-bearing account in a financial institution authorized to do business in the State of Ohio; and
 - c. Only participate in a joint purchasing arrangement that invests its funds in accordance with the requirements of Chapter 135 of the Revised Code; and
 - d. Only participate in a joint purchasing arrangement that requires plan fiduciaries to be trained as such at least triennially.

F. Cost Containment Best Practice

1. Each school district or educational service center that procures its health care plans independently or each joint purchasing arrangement that procures health care plans on behalf of school districts or educational service centers shall participate in a formal, competitive procurement process for health insurance coverage and, if appropriate, health consulting services no less than every 3 years (except in cases of financial exigency) and no more than every 5 years.
2. Each health plan sponsor shall:
 - a. Employ a tiered pharmacy plan incorporating a drug formulary;
 - b. Include in their health care plans that generic drugs must be dispensed where applicable in order for the health care plan provisions to apply, unless:

- A less expensive option is available; or
 - A physician has indicated that the prescription is to be dispensed as written and that drug is a covered drug under the benefit plan.
3. Each health plan sponsor shall establish or maintain a labor-management health benefits committee. The committee will have the responsibility of reviewing all health benefits related issues including but not limited to benefits design, costs, and communications to district personnel. The Committee will make recommendations to the superintendent, all school employees and school employee organizations regarding health benefits and costs. The Committee will consist of certified, classified and administrative personnel. The Committee shall receive labor-management health benefits committee training triennially by the School Employees Health Care Board (SEHCB) or an SEHCB-approved training organization.
 4. All health plan sponsors that maintain a self-insured health care plan shall reserve funds as advised in an actuarial report to the health plan sponsor by an actuary who has achieved the designation of Member of the of the Academy of Actuaries. The reserve amounts will include IBNR (Incurred but not Reported) claims plus no more than 30% of expected annual claims. Amounts over the aforementioned reserve levels shall be returned to the member districts in accordance with the governing documents for the health care plan. Amounts under the aforementioned reserve levels shall be billed to the member districts in accordance with the governing documents for the health care plan. The specific methodology for setting reserve levels must be disclosed to the board under O.A.C. § 3306-3-02.

G. Certification of Compliance

1. Each health plan sponsor offering health care benefits to persons employed with the public school districts of this state shall furnish to the board evidence of its compliance with all best practices as established by this chapter. Upon ascertaining compliance with the criteria as set forth, the board shall certify the compliance of the health plan sponsor.
2. Any health care plan or vendor providing programs or services to employees of public school districts of this state pursuant to best practices as required by these rules shall provide health plan sponsors with evidence that such programs or services meet the minimum criteria as set forth in this rule within sixty days after receiving a written request for such information from the health plan sponsor.
3. Each health plan sponsor that provides health insurance through a self-insured plan shall provide, at least once every other fiscal year, to the board a copy of its biannual audit and the actuarial report on the reserves required in O.A.C. § 3306-2-04(G).