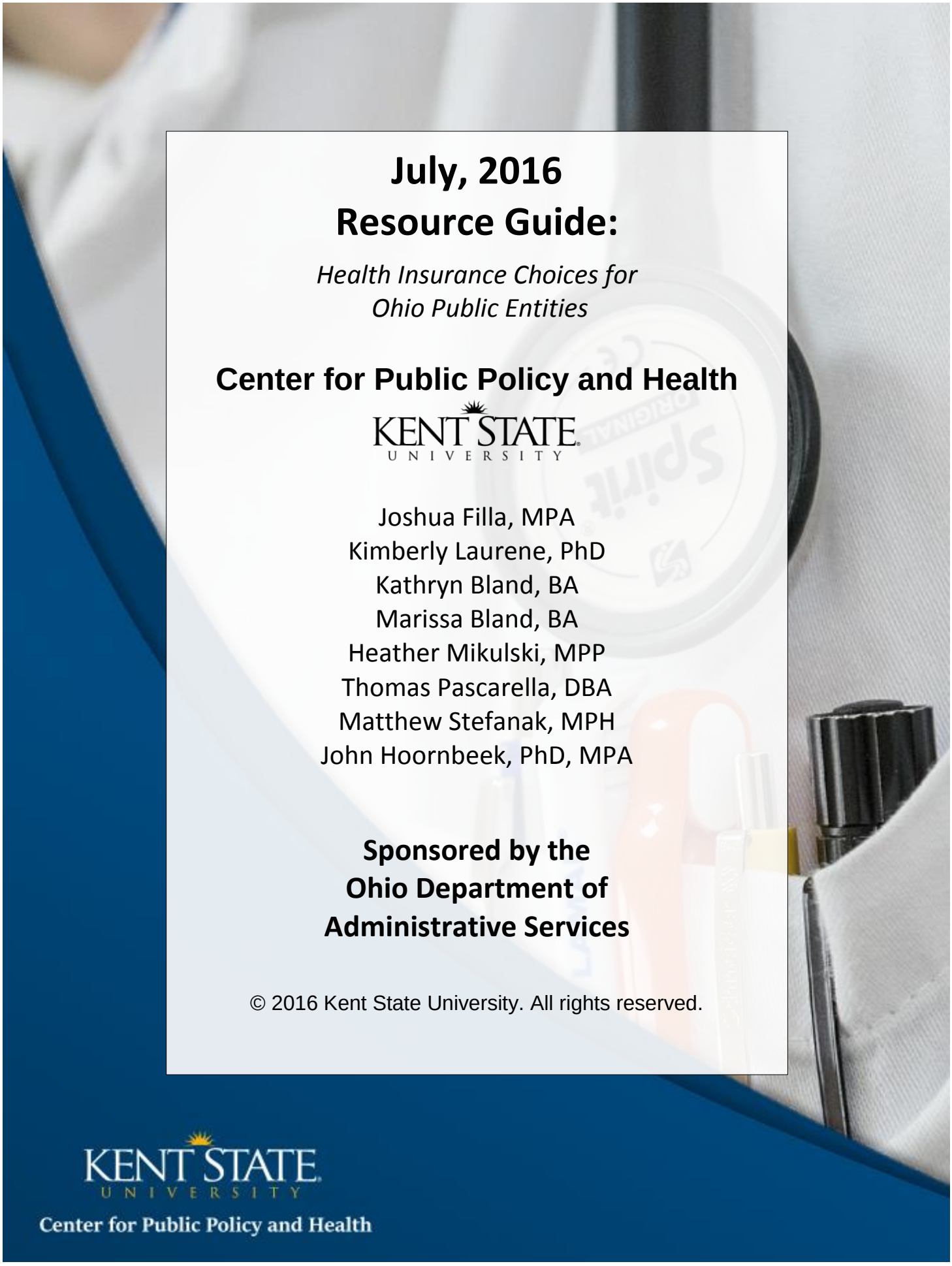

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Resource Guide:

Health Insurance Choices for Ohio Public Entities

Center for Public Policy and Health

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Disclaimer

While Kent State University (KSU), its Center for Public Policy and Health (CPPH), and the Ohio Department of Administrative Services (ODAS) have put in substantial efforts to ensure that this document contains helpful information for public entities in Ohio, judgments regarding health insurance purchases are ultimately a situation-specific matter and the responsibilities for which are best reserved to individual public entities. In addition, officials should keep in mind that the insurance industry and its accompanying regulations are constantly changing, and that the information presented in this document may become outdated based on actions taken by government or private industry in the future. This Resource Guide seeks to provide local officials with tools to help them make decisions regarding health benefit plans that they feel are best for their employees, their organizations, and the citizens they serve. Neither KSU nor ODAS can accept responsibility for consequences flowing from the individual choices made by Ohio public entities or others based on the information presented in this Resource Guide. Accordingly, neither KSU, ODAS, nor their respective officers, employees and/or agents, makes any warranty, express or implied, or assumes any legal liability or responsibility for the accuracy, completeness, or any use of this Resource Guide. Further, neither KSU, ODAS, nor their respective officers, employees and/or agents shall be liable for any direct, indirect, incidental, special, punitive or consequential damages which may result in any way from use of the information provided in this Resource Guide.

Note for Readers

The fields of healthcare and health insurance in Ohio are in the process of undergoing significant change, so information provided here may become outdated. While we have made efforts to provide updated information in this guide, readers are encouraged to supplement the information in this report with current or more recent information whenever possible.

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Introduction

This resource guide is designed to assist public entities in Ohio in making informed decisions about health benefits they provide for their employees. It also seeks to help public entities determine whether or not entering a health benefit consortium is appropriate for their organization. The public entities benefiting from the information contained herein include general purpose local governments such as counties, cities, villages and townships, as well as public colleges and universities, school districts, and special purpose governments of various kinds.

The cost of health benefits and the health services covered under a health benefit plan can seriously impact the health and wellness of public sector employees and their families. The costs of providing health benefits can also have major financial impacts on the public entities themselves, and those costs must be managed if the entity is going to sustainably operate to the benefit of those it serves. The complex insurance marketplace and its corresponding state and federal regulations are elements of decision-making processes that can become complicated and difficult to understand.

It is a good time for public officials to revisit how and where they purchase health benefits for their employees. Healthcare costs have been rising for decades, and controlling increases in health care costs has been an issue that public entities and their labor units have been working to address. In 2013, for example, state and local level health care spending rose to $64.9 billion – a 19.6 billion increase over the previous decade (Kaiser Family Foundation, 2015a). A national survey of local government officials found that 71% of respondents felt that "employee health care costs" were one of their top three operating concerns (International City/County Management Association [ICMA], 2011). The federal government enacted the Affordable Care Act (ACA) in March of 2010 and new requirements associated with this law have been taking effect since that time. It is important for public entity officials to understand that these and other changes in the health insurance market are likely to affect their health benefit plan options and choices over time.[1]

One important decision within the overall process of purchasing health insurance is for an entity to choose whether to purchase a health benefit plan individually or collaboratively through a health benefit consortium. Health benefit consortia are designed to pool the employees of participating entities to create a larger risk pool and achieve economies of scale through the collaborative administration of health benefits purchasing and claims management.

[1] The Affordable Care Act actually refers to two separate pieces of legislation — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Throughout this report, we use the "Affordable Care Act" (ACA) as shorthand for the cumulative changes made in both of these pieces of legislation.

This guide provides information on factors influencing the need for public entities to revisit where and how they purchase health benefits, as well as information on basic health benefit plan options and current health benefit purchasing practices of Ohio public entities. It also provides guidance on major steps and considerations that should be taken into account when public entities revisit where and how they purchase health benefit plans for their employees.

A listing of known health benefit consortia serving public entities in Ohio (Appendix A), a glossary of relevant terms (Appendix B), a description of the research underlying this Guide (Appendix C), a supplemental reading list (Appendix D), and a decision tool for public entities considering alternative health benefit options (Appendix E) can be found in this document's appendices.

The Basics of Health Benefit Plan Options

There are two primary forms of health insurance available for public entities to purchase: ***fully-insured health benefit plans*** and ***self-funded health benefit plans***. There are also two ways entities can purchase health insurance products: **individually** or through a ***health benefit consortium***. When entities participate in a health benefit consortium, they purchase health benefit plans collaboratively with other entities.

This section of this resource guide provides a brief overview of the different health insurance purchasing options available to public entities in the State of Ohio. For the options identified in the previous paragraph, each subsection provides a brief description of health benefit purchasing option, along with a short list of potential advantages and disadvantages associated with that option. The section closes with a brief overview of the health benefit purchasing plans chosen by a group of (relatively large) public entities in the state.

Fully-Insured Health Benefit Plans

Fully-insured plans are typically purchased from a state licensed insurance company. In fully-insured plans, premiums vary across employers based upon the employer size and employee population characteristics (MacDonald, 2009). The insurance premiums are essentially charges from the insurance carrier that are passed on as a fee for the coverage of benefits by that carrier (Fernandez, 2010). Premiums may vary based upon age and use of tobacco (Giovannelli, 2014). Employers are typically charged the same premium for each employee (MacDonald, 2009). In a fully-insured plan, the employer pays a per-employee premium to an insurance company and the insurance company assumes the risk of providing health coverage for insured events. The covered persons (i.e., employees

and dependents) are responsible to pay any deductible amounts or co-payments required for covered services under the policy (MacDonald, 2009).[2]

Potential advantages and disadvantages of fully-insured health benefit plans are described below.

Advantages:

- **Administrative Services Provided:** Typically, insurers offering fully-insured health plans provide administrative services to assist their clients (Manning & Napier, 2013). For example, applicable government fees tend to be incorporated into premium costs and are then paid by the insurance company, so the public entity does not need to worry about the administrative burdens of paying them.
- **Do Not Have to Pay Excess Claim Costs:** In any one year, the insurance companies providing fully-insured plans accept the risk of paying the public entity's claims, so the entity does not need to be concerned about excess claims in any one year (Filice, n.d.). Their up-front premiums are paid in part to get the insurer to pay for this risk.

Disadvantages:

- **May be More Expensive than Self-Funded Plans:** Fully-insured health benefit plans can be more expensive than self-funded plans in Ohio, in part because these plans are required to pay some fees that self-funded plans are not required to pay (National Insurance Services, 2012).
- **May Have Less Generous Health Benefits:** There are cases where fully-insured plans may have less generous health plan benefits than self-funded plans because self-funded plans can be designed with the flexibility to meet the needs of the employer and their employees (Manning & Napier, 2013).

Self-Funded Health Benefit Plans

Perhaps the main distinction between self-funded and fully-insured health plans is that self-funded health plans are not purchased through an insurance carrier like fully-insured plans. Instead, organizations with self-funded plans fund their own claims. In doing so, they may contract with a third party administrator (TPA) that assumes duties associated with procuring health benefits and

[2] Changes affecting fully-insured (and other) health benefit plans are occurring as a result of the ACA. These changes (which may affect the future calculation of premiums for fully-insured products) are discussed later in this report.

administering them (Fernandez, 2010). Self-funded plans may not be purchased through a state licensed insurance carrier, and these plans may not be subject to state regulations that apply to fully-insured plans (Fernandez, 2010). This is true in Ohio.

Potential advantages and disadvantages of self-funded health benefit plans are described below.

Advantages:

- **May be Less Expensive than Fully-Insured Plans:** Self-funded health benefit plans may be less expensive than fully-insured plans providing similar benefits because the premium for fully-insured plans is based on the maximum expected claims cost and the employer pays this fixed amount regardless of whether or not they incur the claims to account for the premium. In addition self-funded plans are not required to pay certain fees that fully-insured plans are required to pay (National Insurance Services, 2012).
- **May have more Generous Health Benefits:** Self-funded health insurance plans may be more generous in their benefits than fully-insured plans. At least in part, this may occur because they are not required to pay fees that fully-insured plans are required to pay (Manning & Napier, 2013), and may therefore be able to fund more generous health benefits for their employees.

Disadvantages:

- **May Have to Pay Excess Claim Costs:** In self-funded plans, the employer is liable for all claims within any given year, so they may find that they need to pay out additional funds at the end of the year that they have not anticipated (National Insurance Services, 2012). (However, this potential liability can be addressed by "stop loss" policies to protect the employer.)
- **Administrative Services Not Provided:** In self-funded plans, the employer is responsible for the administration of the plan and the payment of fees associated with it, so public entities using self-funded health plans often need to maintain greater administrative capacity than public entities purchasing fully-insured health benefit insurance policies (Employer Health Advisors, 2011).

Individually Purchased Health Benefit Plans

The traditional method of purchasing health insurance products is for employers to compare, select, and pay for their employees' health insurance plans individually, rather than in collaboration with other employers. Employers can select fully-insured products or self-fund their own coverage if they have the financial capacity needed to cover the costs of their employees' claims. Employers can also

work with licensed insurance industry representatives to compare and acquire insurance for their employees.

Potential advantages and disadvantages of individually purchased health benefit products are described below:

Advantages:

- **Complete Control of the Purchasing Process:** An employer has complete control of the purchasing process when they purchase health benefit plans individually. Employers have the ability to craft and/or purchase a plan that meets their specific financial situation and employee health needs (Field and Shapiro, 1993). This flexibility may not always be available through health benefit consortia because – in those cases – the needs of multiple employers must be taken into account.

- **Flexibility for Future Changes:** Employers are able to maintain flexibility to make future changes to where and how health benefits are purchased. This flexibility may be reduced when participating in a health benefit consortium (Wisconsin Association of School Boards, 2014).

Disadvantages:

- **Fewer Health Insurance Plan Options:** Employers, especially if they are small, are usually unable to offer individual employees the option to choose among several health benefit plans due to administrative burdens associated with having contracts for multiple health benefit plans (Wicks, 2002). However, health benefit consortia usually permit individual employees to select from an array of plans with which the consortium has negotiated contracts (Wicks, 2002).

- **May be more Expensive than Health Benefit Consortia Plans:** Individually purchased health benefit plans may be more expensive than plans purchased through a health benefit consortium. This may be particularly true for smaller employers who are not able to take advantage of increased purchasing power and the sharing of administrative costs that can occur with health benefit plans purchased through a consortium (Wicks, 2002).

Health Benefit Consortia (Purchased by a Group of Employers)

A health benefit consortium is a group of employers that join together to purchase health benefits for their employees. These consortia can purchase either fully-insured or self-funded health benefits for their employees, although many existing health benefit plans offered by consortia in Ohio are self-funded (see Table 1 below).

The specific forms of consortium organization and the plans offered vary depending on the needs of the members. Some operate as a closed group of similar entities, such as a consortium operated by a county Educational Service Center for local school districts. In fact, school districts have relied on health benefit consortia for many years in Ohio. Other consortia operate more like private businesses, advertise their products widely and seek to grow their membership. In some cases, a consortium may contract with a TPA to manage its members' claims.

Health benefit consortia also vary in the manner by which consortium members pay for the health benefits they receive. In a **"pooled"** consortium, every member organization pays an equal amount to support the consortium's operations based on the overall risk of the entire population of member organizations pooled together. In this case, the claims (and therefore costs) generated by each entity may not be widely known among the members. By contrast, in an **"allocated balance"** health benefit consortium, payment rates are based on individualized risk assessments for each member organization. Higher risk member organizations may pay more compared to other member organizations, and payments are based on the expenses of each participating organizational entity.

Advantages:

- **Achieve Economies of Scale:** Health benefit consortia help member entities achieve economies of scale, which – in combination with enabling use of self-funded health benefits – may reduce health benefit costs or enhance the generosity of benefits for participating entities. This means that smaller public entities participating in consortia may reap financial savings or enhanced health plan benefits similar to those achieved by larger employers who can spread risk over larger numbers of employees (Barro, 2011).

- **Service Benefits:** Health benefit consortia may also provide service benefits to participants who might not otherwise be able to administer their own self-funded health benefits due to a lack of capacity and resources. In these cases, public employers may be able to benefit from services provided by insurance professionals associated with TPAs without having to employ these kinds of professionals themselves.

Disadvantages:

- **May Need to Pay Terminal and/or Legacy Costs:** Members of health benefit consortia may be required to pay "terminal" and/or "legacy" costs incurred by their consortium. Terminal costs are funds owed by the consortia after it dissolves, and participating entities may be responsible for paying these costs (NYSSBA, 2009). Legacy costs are costs incurred by the consortia prior to an entity joining the group. In these cases, public entities may be responsible to assist in paying these costs after joining the consortium (NYSSBA, 2009).

- **May Have to Share Control of Their Health Benefit Choices:** Members of health benefit consortia inevitably cede some degree of control over their health benefit choices to other parties (Minnesota Life, 2009). In some cases, this may mean that they cannot gain precisely the benefit plans they desire. In other cases, past organizational claims histories or other characteristics of the organization's employee base may prevent them from getting optimal health benefit packages from the consortium in which they participate.[3]

All four of the options described above are used by public entities in Ohio. Table 1 provides a snapshot of the options used by public entities in Ohio who responded to a 2014 survey of Ohio public entities on their health insurance choices that was administered by the State Employment Relations Board (SERB, 2014B). The 2014 survey was sent to a sample of 1,327 public entities, and 1,231 of them were completed by administrators from the jurisdictions involved -- a response rate of 92.8% (SERB, 2014B). The 1,231 public entities provided data on 1,856 medical plans offered by their entity.

Table 1: Number of Health Benefit Plans Purchased by Ohio Public Entities for 2014

Purchasing Arrangement	Form of Health Benefit Plans*		Totals by purchasing arrangement
	Full-Insurance Plans	Self-Funded Plans	
Individual Health Plans	431	326	757
Jointly Purchased Health Plans (eg. "consortia")	158	915	1,073
Totals by plan type	589	1,241	**1,830**

Note. Medical plans do not total 1,856 due to missing data associated with the Purchasing Arrangement and Form of Health Benefit Plans questions in the 2014 SERB survey. Source: SERB 2014A.

[3] For additional information on the advantages and disadvantages of health consortia please see the report, "Adapting to the Changing Health Insurance Landscape: A Look at the Use and Effects of Health Benefit Consortia by Public Entities in Ohio (KSU-CPPH, 2016)." It is available on the ODAS and KSU-CPPH websites.

Additional information from this SERB survey is provided in Section IV, which provides readers with information on current health benefit choices of public entities in Ohio. However, it is worth noting here that the entities surveyed include relatively large numbers of K-12 school districts and larger public entities, so the figures here are not necessarily representative of all public entities in the state of Ohio. In Section IV, readers can access more detailed information on health benefit plan choices made by different kinds of public entities in Ohio.

Changes in the Insurance Market and how They Affect Public Entities

There has been a long-term trend of increasing health care costs in both the United States (U.S.) and Ohio. In the U.S., health care spending grew by 5.2% on average each year between 2000 and 2007, and 4.1% on average per year between 2007 and 2010 (Council of Economic Advisors, 2014). In Ohio, health care spending was $7,076 per capita with an annual growth rate of roughly 6% in 2009 (State Health Facts, 2015). At that time, premiums were projected to continue to grow eight percent per year (Multi State Plans, 2015).

These costs have potentially significant impacts on public entities in Ohio, which have already been dealing with stresses to their budgets due to the recent recession and cuts in external funding sources. At the same time, demands for quality services from constituents continue, and employee unions continue to seek quality health benefit packages from public employers. Health care costs can represent a significant amount of an entity's annual expenditures, so exploring ways to provide quality health care at the best price is an important process for public managers to undertake.

The ACA was passed into law by the federal government partially as a response to increasing health care costs. The law made a number of important changes to existing health insurance regulations and practices, and these changes have direct impacts on health benefit plans purchased by public entities in Ohio.

The Affordable Care Act (ACA) and Related Regulatory Changes: An Overview

The federal government enacted the ACA in 2010. Public entities need to understand key elements of the law, so they can both comply with its requirements and respond to its impacts on the overall health insurance market. Three key areas of focus in this regard are new requirements relating to community rating processes for establishing health benefit costs, new health-benefit plan requirements for employers, and new fee structures which affect the relative costs of different health benefit plan purchasing arrangements. Understanding these changes will allow officials from public entities to make better decisions related to purchasing health benefits for their employees.

Community rating requirements for insurance providers. A community rating is one way for insurance companies to calculate the cost of insurance for a group. To calculate a community rating, an insurer evaluates the risk factors of the entire market instead of any one individual employer, and premiums are set based upon the spread of that risk across the group (Centers for Medicare and Medicaid Services [CMS], 2013). As a result of recent regulations associated with the ACA, the Centers for Medicare and Medicaid Services' (CMS) now requires insurers to use new modified community ratings that are based on four factors: age, smoking status, family size and geographic area for group insurance health plans, within a community (CMS, 2015b). These four factors are then used to help determine premiums for insurance in that community. In Ohio, a community is defined by counties that are lumped together into 17 rating areas (CMS, 2015b). The community ratings rule is effective for plan years that started on or after January 1st, 2014.

Most large employers that are fully-insured or self-funded are exempt from being required to use the modified community ratings (National Association of Health Underwriters, 2015.; United HealthCare Services, Inc., 2013). For large employers, insurance providers may use "experience" rating, rather than "community" rating, to establish health insurance costs. Experience ratings are based upon an individual group (or employer's) claims history, not the pooled factors of the community within which they reside (CMS, 2015b).

Originally, the ACA increased the size threshold for "large group" health benefit markets to 101 employees starting in 2016 (it had been 51; CMS, 2014). However, the Protecting Affordable Coverage for Employees (PACE) Act of 2015 has subsequently changed the threshold for large group to those employers with 51 or more employees. The new (2015) law does appear to allow states to expand the definition of small employer to those with up to 100 employees. This would mean that employers with between 51 and 100 employees could be required to pay health benefit costs based on the new modified community rating regulations starting in 2016 in states which choose to expand the definition of "small" to include entities with up to 100 employees. This requirement could extend to public entities, and it would mean that public entities within this size range, which have previously been subject to experience rating, would then be required to have their health benefit costs established through the modified community ratings processes described above.

Smaller public entities may be affected negatively by community ratings if any of the factors upon which ratings are calculated (e.g. smoking status, age, family size, geographic regions) do not work in the favor of the entity (CMS, 2013). Small entities with a young and healthy workforce may also see premium increases due to the mandated restrictions leading to lower premiums for the less healthy and older workers (Hamilton, 2013).

If the state decided to expand the definition of small employers, it would be likely to affect health benefit costs for public entities. Employers should be aware of the potential for the threshold separating large and small employer categories to change in the future. In Ohio, the definition of small

employer is having 2-50 employees (ORC 3924.01), and at the time of this writing, we are unaware of any plans at the state level to change this definition.

ACA Requirements for Employers. The ACA contains a number of other requirements that may affect Ohio public entities as employers. A summary of some of these requirements is provided below.

- **Employer Shared Responsibility Provisions (Employer Mandate "Play-or-Pay")**: The Employer Shared Responsibility provision under the ACA states that employers employing 50 or more full-time employees (or a combination of full-time and part-time employees that is equivalent to 50 full-time employees) will fall under the Employer Shared Responsibility provisions (Internal Revenue Service, 2015). This is stated under the 4980H section of the Internal Revenue Code, which states that employees working more than 30 hours a week or 130 a month are to be provided minimum level of coverage by their employer or the employer will be subjected to fees (Internal Revenue Service, 2015).

  Public entities with 100 or more full-time equivalent employees (FTE) will need to insure at least 70% of their full-time employees by 2015 and 95% by 2016. Employers with 50-99 FTE will need to start insuring full-time employees by 2016 (Internal Revenue Service, 2015). The "play or pay" mandate does not apply to employers with 49 or fewer full time equivalent (FTE) employees. The mandate applies to all employers – including public entities -- with 50 or more FTEs. It also requires employers to (Internal Revenue Service, 2015):

  Provide Affordable Insurance: Coverage offered to employees must be considered affordable (i.e., an employee's share of the premium for employer-provided coverage cannot cost the employee more than 9.5% of that employee's annual household income).

  Provide Minimum Essential Value Insurance: Employer must provide minimum value insurance (i.e., a plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan).

- **Minimum Essential Health Benefits**: As noted above, employers of a certain size must provide insurance for their employees. Health plans in the individual and small group markets must provide a comprehensive package of items and services within at least the following 10 categories (healthcare.gov, 2015):
  - Ambulatory patient services
  - Hospitalization

- Maternity and newborn care
- Preventative and wellness services
- Emergency services
- Prescription drugs
- Rehabilitative services and devices
- Mental Health and substance use
- Laboratory services
- Pediatric Services

Health Benefit Plan Fees Under the ACA. The ACA also introduced a number of fees associated with the choice of health benefit plans, and the changing costs associated with them is likely to affect the desirability of different kinds of health benefit purchases for public entities. There are differences in fees associated with choosing a plan that is self-funded or fully-insured. Self-funded plans experience fewer fees from the ACA and do not have fees that are solely based on the size of the entity.

There are currently six fees (not including the penalty fees for not complying with the requirements discussed in the previous subsection) that have stemmed from the roll out of the ACA. As noted briefly above, different fees apply to self-funded and fully-insured health benefit plans. In addition to applicability by insurance type, whether or not a plan is "grandfathered" is also a factor contributing to the applicability of certain fees. A health insurance plan is "grandfathered" if it was created or purchased before or on March 23, 2010. Plans cannot be changed significantly or increase their costs to the employees to maintain their grandfathered status. Grandfathered plans are also exempt from providing preventative services at no cost to those enrolled in the plan or being subjected to rate reviews for premium hikes (Marketplace Options, 2015). The new fees under the ACA are briefly described below.

- **Patient Centered Outcome Research Institute (PCORI) Fee**: The PCORI fee is a fee on insurers which will assist the PCORI, a non-profit corporation created by the ACA, in giving patients a better understanding of prevention, treatment and care options available and in advancing the quality and relevance of evidence-based medicine to compile clinically effective research findings (PCORI, 2015). This is a temporary fee that is in effect from 2012 to 2019 (PCORI, 2015). The PCORI fee is applicable to fully-insured and self-funded plans (PCORI, 2015).

- **Transitional Reinsurance Fee**[4]: This fee funds the Transitional Reinsurance Program, which was established to stabilize premiums in the individual market both inside and

[4] The Ohio Attorney General's Office, ODAS, Warren County, and four state universities have filed a lawsuit in U.S. District Court calling into question the constitutionality of the Transitional Reinsurance Fee (Ohio, 2015). The lawsuit asserts that the Federal Government has overstepped its constitutional authority by levying broad

outside the State and Federal Marketplace and to cover administrative costs of operating the reinsurance program (CMS, 2015a). The transitional reinsurance program will collect fees from the contributing entities (health insurance issuers, self-insured groups, and multiple group health plans) to fund the reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual plans (eligibility based on total annual medical costs for covered benefits of an enrollee in an individual market plan (CMS, 2015c)), the administrative costs of the operation of the transitional program, and the General Fund of the U.S. Treasury for the 2014-2016 benefit years (CMS, 2015a). The fee is applicable beginning in 2014 to fully-insured and self-funded plans.

- **Market Share Fee**: The Market Share Fee is an annual fee on health insurers based on each insurer's market share of net annual health insurance premiums that are collected (Congressional Research Service [CRS], 2013). This fee funds the premium tax subsidies for low-income individuals and families that purchase insurance from the public exchanges (Medical Mutual, 2015). The fee is permanent and went into effect in 2014. The aggregate amount of fees to be collected across all users will be indexed to the overall rate of annual premium growth (CRS, 2013).

- **Risk Adjustment Fee**: The risk adjustment fee funds government cost to administer the Risk Adjustment Program. This program redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees to protect against adverse selection and risk selection in the individual and small group markets, inside and outside the exchanges by spreading financial risk across the markets (Kaiser Family Foundation, 2015b). This is a permanent fee that is applicable to non-grandfathered fully-insured plans in metal tier products (platinum, silver, gold and bronze) (Medical Mutual, 2015). In 2014, the fee is $1.00 per member per year (Medical Mutual, 2015).

- **Exchange User Fee**: The exchange user fee exists to help fund and support the federal exchanges (Medical Mutual, 2015). This fee is applicable to non-grandfathered fully-insured plans. The effective date is 2014 with the health insurance carriers being charged 3.5% of their premium for all business on a federal facilitated exchange (Medical Mutual, 2015).

- **Cadillac Tax:** The Cadillac tax is a permanent annual tax taking effect in 2020 that is placed on employers providing high-cost benefits through an employer-sponsored group health plan. This fee will help to finance the expansion of health coverage from the ACA's health insurance mandate. This tax is applicable to fully-insured and self-funded plans, regardless of grandfathered status. The fee amount is 40% of the cost of plans that exceed predetermined threshold amounts. For planning purposes, the

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tax assessments directly against State and Local governments and their instrumentalities. The term "fee" is used in this Guide only because the term was used in documents consulted in the development of this Guide. Its use here implies no comment regarding the lawsuit mentioned above. For more information on the State of Ohio's lawsuit please visit the Ohio Attorney General's website. At the time of this writing the fee is still being implemented by the Department of Health and Human Services.

threshold amounts are $10,200 for individual coverage and $27,500 for family coverage and will be updated when final regulations are issued (Cadillac Tax Fact Sheet, 2015). For example, an $11,000 individual plan would exceed the threshold by $800 ($11,000 - $10,200 = $800). Therefore, an $11,000 individual plan would pay an excise tax of $320 ($800 x 40% = $320) (Cadillac Tax Fact Sheet, 2015).

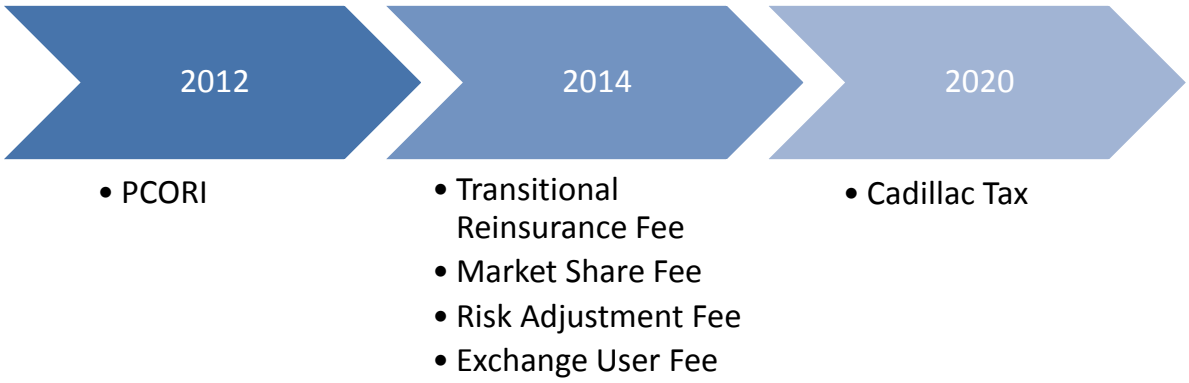
As stated above, the fees associated with the ACA are assigned via insurance type as well as based on the size of the public entity involved. Public officials may want to take these factors into consideration when choosing what type of health insurance to purchase. Figure 1 further illustrates how the fees are distributed based upon insurance type and size of the entity.

Figure 1: Applicable Fees and Taxes for Fully-Insured and Self-Funded Plans

Insurance Type	Government Entity Size	
	Small (100 or less Full-Time Employees)	**Large** (101 or greater Full-Time Employees)
Self-Funded	Patient Centered Outcome Research Institute Fee Transitional Reinsurance Fee Cadillac Tax	Patient Centered Outcome Research Institute Fee Transitional Reinsurance Fee Cadillac Tax
Fully-Insured	Risk Adjustment Fee Patient Centered Outcome Research Institute Fee Transitional Reinsurance Fee Market Share Fee Exchange User Fee Cadillac Tax	Patient Centered Outcome Research Institute Fee Transitional Reinsurance Fee Market Share Fee Exchange User Fee Cadillac Tax

The insurance fee effective dates vary in their start dates from 2014 to 2020. Local officials should pay attention to when certain fees and requirements apply to their public entity. Figure 2 illustrates the time point at which various fees are scheduled to become effective.

Figure 2: ACA Fee Timeline



Current Health Benefit Choices of Public Entities in Ohio

The health benefit plans carried by Ohio public entities are very diverse. There is no one health benefit plan to meet the needs of all entities. Entities vary by whether they individually purchase health benefits or purchase them through a health benefit consortium. In addition, health benefit plans differ based on whether they are fully-insured or self-funded plans. Furthermore, the desirability of the health benefit plans varies by the costs and benefits related to the plan.

The purpose of this section is to describe current health insurance plans chosen by public entities in Ohio, paying particular attention to practices that may differ across types of public entities (school districts, cities, etc.).[5] Data from the SERB 2014 annual survey of public entity officials' benefit purchasing practices are used to assess the prevalence of health benefit plans among different kinds of public entities.[6] By being aware of recent practices of different kinds of public entities, public officials can gain perspective on the range of health benefit choices being made by other public entities in the State of Ohio. The findings are presented in the narrative below and in Tables 2, 3, and 4.

[5] It is important to recognize that the sample of public entities surveyed by the SERB is biased toward larger public entities, by virtue of the Ohio Revised Code (ORC) language guiding its activities. The SERB survey also samples school districts disproportionately. Readers should be aware of these biases as they review the information provided.

[6] We also spoke with a small sample of officials from jurisdictions serving fewer than 5,000 people to supplement the analysis of the SERB data. Only 2/9 (22%) of the smaller jurisdictions offering health insurance to their employees were involved in a health benefit consortium.

Individual and Health Benefit Consortia Health Benefit Purchasing Arrangements

Table 2 displays the number of medical plans reported to SERB (2014A), which were purchased through health benefit consortia and the number that were purchased individually.[7] According to the data presented, 58% of the health benefit plans appear to be purchased through a health benefit consortium, while 42% of health benefit plans are individually purchased. When the type of health benefit purchasing arrangement is assessed by the type of public entity, schools appear as the only type of entity that selects health benefit consortia provided plans a majority (79%) of the time. When taking the number of eligible employees for health benefits into consideration, health benefit plans chosen by entities that have 51 to 100 eligible employees are much more likely to be purchased through a health benefit consortium (74%) than individually purchased (26%). While public entities that have less than 50 employees are slightly more likely to purchase health benefit plans individually (56%), entities with more than 101 employees are slightly more like to purchase health benefit plans through a consortium (55%).

Self-Funded and Fully-Insured Health Insurance. Ohio public entities' choices of self-funded and fully-insured health plans are reported in Table 3. The data in the table reveal that 68% of the health benefit plans purchased by public entities responding to the SERB survey are self-funded while 32% are fully-insured.[8] When the type of health benefit funding is broken down by the type of entity, health benefit plans chosen by schools, counties, and colleges/universities appear more likely to be self-funded (82%, 75%, and 65%, respectively) than fully-insured (18%, 25%, and 35%, respectively). However, townships, special districts (e.g., fire districts, regional transits, metro housing, and port authorities), and cities appear more likely to purchase fully-insured health benefit plans (76%, 75%, and 53%, respectively) than self-funded plans (24%, 25%, and 47%, respectively). When taking the number of eligible employees for health insurance into consideration, entities that have 50 or fewer employees are more likely to choose fully-insured (62%) than self-funded (38%) health benefit plans. However, larger entities appear more likely to choose self-funded health benefit plans (51 to 100 eligible employees: 66% self-funded and 101 or more eligible employees: 73% self-funded).

[7] Data reported from the SERB surveys may vary in sample size depending on the number of responses for individual questions in the survey.

[8] However, all of the smaller jurisdictions we interviewed (9/9) that offered insurance to their employees utilized fully-insured plans.

Table 2: Number of Medical Plans Offered by Ohio Public Entities by Total Sample, Jurisdiction Type, and Eligible Employees for Health Benefit Consortia and Individual Health Insurance

	Purchased through Health Benefit Consortia [# of medical plans (%)]	Purchased by Individual Public Entity [# of medical plans (%)]	Total (# of medical plans)
Total Sample	1075 (58%)	763 (42%)	1838
Jurisdiction Type*			
Schools	850 (79%)	232 (21%)	1082
Cities	86 (26%)	243 (74%)	329
Counties	56 (39%)	86 (61%)	142
Townships	52 (39%)	80 (61%)	132
Special Districts	16 (20%)	65 (80%)	81
Colleges/Universities	15 (21%)	56 (79%)	71
Eligible Employees			
0 to 50	120 (44%)	151 (56%)	271
51 to 100	249 (74%)	86 (26%)	335
101 and Higher	649 (55%)	526 (45%)	1175

Note. Totals and percentages are calculated across rows. Medical plans do not total 1,856 (the total number of plans identified in responses received to the 2014 SERB survey) due to missing data associated with the variables in the table.
* The State of Ohio is not included in jurisdiction type analyses, but it is included in the other analyses.

Table 3: Number of Medical Plans Offered by Ohio Public Entities by Total Sample, Jurisdiction Type, and Eligible Employees for Self-Funded and Fully-Insured Plans

	Self-funded [# of medical plans (%)]	Fully-Insured (# of medical plans (%)]	Total (# of medical plans)
Total Sample	1242 (68%)	591 (32%)	1833
Jurisdiction Type*			
Schools	883 (82%)	197 (18%)	1080
Cities	154 (47%)	172 (53%)	326
Counties	107 (75%)	36 (25%)	143
Townships	31 (24%)	100 (76%)	131
Special Districts	20 (25%)	61 (75%)	81
Colleges/Universities	46 (65%)	25 (35%)	71
Eligible Employees			
0 to 50	103 (38%)	166 (62%)	269
51 to 100	221 (66%)	112 (34%)	333
101 and Higher	861 (73%)	313 (27%)	1174

Note. Totals and percentages are calculated across rows. Medical plans do not total 1,856 (the total number of plans identified in responses received to the 2014 SERB survey) due to missing data associated with the variables in the table.
* The State of Ohio is not included in jurisdiction type analyses, but it is included in the other analyses.

Type of Health Benefit Purchasing Arrangement and Type of Insurance Funding. One can also view Ohio public entities' choices of health benefit purchasing arrangement by the type of benefit plan (fully-insured vs. self-funded) to better understand their health benefit purchasing practices (see Table 4). Half (50%) of the health benefit plans in the sample of plans reported by SERB (2014) were purchased from a health benefit consortium that is self-funded (50%). The next most common arrangement reported to SERB (2014) is having individual-insurance that is fully-insured (24%), followed by individual insurance that is self-funded 18%) and health benefit consortia that are fully-insured (9%).

Across the various types of public entities, schools appear most likely to participate in a health benefit consortium that is self-funded (72%). Townships appear to be most likely to purchase a fully-insured health plan through a consortium (24%). Counties (44%) and colleges/universities (45%) appear most likely to purchase health benefits individually and be self-funded, while cities (43%), townships (52%), and special districts (62%) appear most likely to purchase insurance individually and be fully-insured.

One can also view health benefit purchasing practices in Table 4 based on public entity size. "Medium" sized public entities appear most likely to participate in a health benefit consortium that is self-funded (51 to 100 eligible employees: 60%). Larger public entities with 101 or more eligible employees reported purchasing health benefit plans through consortia that are self-funded 49% of the time. By contrast, public entities with 50 or fewer eligible employees appear most likely to purchase insurance individually and be fully-insured (47%).

Table 4: Number of Medical Plans Offered by Ohio Public Entities by Total Sample, Jurisdiction Type, and Eligible Employees for Type of Health Insurance Purchasing Arrangement by Type of Funding

	Purchased through Health Benefit Consortia		Purchased by Individual Public Entity		Total [# of medical plans]
	Self-funded [# of medical plans (%)]	Fully-Insured [# of medical plans (%)]	Self-funded [# of medical plans (%)]	Fully-Insured [# of medical plans (%)]	
Total Sample	915 (50%)	158 (9%)	326 (18%)	431 (24%)	1830
Jurisdiction Type*					
Schools	778 (72%)	71 (7%)	105 (10%)	125 (12%)	1079
Cities	55 (17%)	30 (9%)	99 (31%)	141 (43%)	325
Counties	43 (30%)	13 (9%)	63 (44%)	23 (16%)	142
Townships	20 (15%)	32 (24%)	11 (8%)	68 (52%)	131
Special Districts	5 (6%)	11 (14%)	15 (19%)	50 (62%)	81
Colleges/Univ's	14 (20%)	1 (1%)	32 (45%)	24 (34%)	71
Eligible Employees					
0 to 50	81 (30%)	39 (15%)	22 (8%)	127 (47%)	269
51 to 100	200 (60%)	49 (15%)	21 (6%)	63 (19%)	333
101 and Higher	577 (49%)	70 (6%)	283 (24%)	241 (21%)	1171

***Note*. Totals and percentages are calculated across rows, and percentages do not add to 100% in all cases due to rounding. Medical plans do not total 1,856 (the total number of plans identified in responses received to the 2014 SERB survey) due to missing data associated with the variables in the table.**

* The State of Ohio was not included in jurisdiction type analyses, but the State of Ohio was included in the other analyses.

Making Health Benefit Choices: Steps and Considerations for Public Entities

This section provides an overview of a process public entity officials can consider for exploring potential changes to their health benefit plans. It also focuses specifically on providing information relevant to assisting public entities in determining whether or not joining a consortium is right for their unique situations.

Major Steps and Considerations in Purchasing Health Benefit Plans

Like many significant decisions made by public officials, it is useful to think of decision-making about health benefit choices as consisting of a number of key steps. And, for each step, there are considerations to be addressed as it is undertaken. In this context, public entity officials may want to consider viewing their health benefit plan choices as growing from a systematic process of information collection, alternative identification and evaluation, and decision-making and management. The information provided here is thus presented around six key steps, all of which are subject to multiple considerations.

The key steps envisioned for making health benefit choices by public entities are:

1) Assessing and understanding the needs of the public entity and its stakeholders;
2) Identifying professionals and resources that can help officials understand their needs, and assist them in identifying and evaluating their options;
3) Identifying health benefit plan options to consider;
4) Comparing promising options identified in step 3;
5) Making a decision based on the public entity's needs and those of its stakeholders, and;
6) Assessing, evaluating, and adjusting choices over time.

The subsections that follow provide information relevant to proceeding through each of these steps, as well as key considerations associated with each of them. In addition, in Appendix E, readers will find a decision-making tool that may be of use to them in comparing health benefit plan options and deciding on a health benefit plan that best meets their needs.

Step 1: Assess and Understand Needs

Each public entity will have its own set of needs and circumstances related to employee health benefits. In this regard, public entity officials should consider:

- Their employees' demographic make-up and past health claims. This matters when considering plan types and how community or experience rating systems would be likely to impact premium costs. In addition, understanding employee health needs will allow officials to make decisions about what types of health programs and services should be covered by the health benefit plan(s) they purchase.

- Their budgetary constraints. What type of health benefit costs can their entity's budget support?

- What stakeholder groups would be impacted by health benefit decisions and how would they be impacted. Potential stakeholders include public employees and their families, taxpayers, and labor unions. Is there an employee-management health committee that should be consulted?

Health Benefit Committees Are Often Established through Collective Bargaining Agreements

- The KSU-CPPH project team reviewed 285 collective bargaining agreements (CBA's) in the Ohio SERB's online database.

- Of the 285 CBA's reviewed, 136 (48%) included provisions establishing a labor-management Health Committee.

- What does the entity's current health benefit plan look like? Is it a fully-insured plan or a self-funded plan? Is it purchased individually or through a consortium? What are the employees required to pay toward their coverage? What is the plan's total cost? What does the plan cover and provide for employees?

- How much latitude does the public entity's official leadership have to make changes in their health benefit plans? What relevant ordinances and/or requirements regarding health benefit plan changes need to be considered? What collective bargaining agreements are in place that might affect decisions regarding changes in health benefits?

Public Entities Must Often Work with Others in Making Health Benefit Purchasing Decisions

- Of the 285 CBA's reviewed, only 47 (16%) appeared to give public sector managers complete control regarding decisions to make changes in employee health benefit plans.

Officials should consider the items assessed in the bullets above as they assess their needs, and then consider drafting specifications for what they want their health package to include. These specifications could then be used to solicit proposals from insurance providers and/or third party administrators, as appropriate.

Step 2: Identify Professionals and Resources that can Help Officials Understand Their Organization's Needs and Assist Them in Evaluating Options

Public entities in Ohio have varying capacities internal to their organizations to handle identifying, evaluating, deciding upon, and administering health benefit plans for their employees. It is important for officials to understand what expertise they have in-house and what external expertise may be needed to help them make the proper decisions for their organization. In this regard, public entity officials should consider:

- Whether or not they have their own Human Resources Department which has the expertise needed to support their decision-making and administration of health benefits.

- Whether or not they should consult with licensed industry professionals for assistance.

The Ohio Department of Insurance (ODI) licenses professionals in the insurance industry, and individuals and organizations providing insurance related services must be licensed to do business in Ohio (ORC, 3905; ORC, 3959). Licensed industry representatives are available to help officials with identifying and comparing different insurance products. There are three main types of health insurance licenses provided by ODI under its "accident and health" category (ODI, 2015).

- Insurance Agent - A person who sells, solicits, or negotiates insurance arrangements, as per the Ohio Revised Code (ORC 3905.01).

- Business Entity - A corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity (that sells/solicits/negotiates insurance; ORC 3905.01).

- Third Party Administrator - Is any person or organization that adjusts or settles claims in connection with life, dental, vision, health or disability insurance plans, self-insurance programs or other benefit plans for a sponsor of a plan if either the sponsor or the plan is domiciled in this state or has its principal headquarters or principal administrative offices in this state (ODI, 2015).

The ODI hosts a number of consumer tools online that may be useful to officials from public entities who are working with insurance professionals:

- An agent locator that can be used to identify individual agents, insurance business entities, and TPAs.[9]

- Public entities' officials can obtain complaint histories of agents/brokers/ health insurance corporations through the ODI website. The public entity official can enter the name of the agent, for instance, through a search engine located under the "administrative actions" link on the ODI homepage, to pull up records ("journals") on administrative actions taken by the agency. These records ("journals") contain only complaints that the ODI found reason to address with administrative action(s).[10]

- Services and resources are provided for public entity officials to use on the ODI website for help with filing complaints. The website has a complaint form with a PDF document that explains the complaint filing process on its website, along with an accompanying easy to follow flow-chart.[11]

The appendices to this guide include a number of potentially helpful resources, including:

- A listing of health benefit consortia known or thought to be providing services to public entities in Ohio and some basic information on their operations.[12] (Appendix A)

- A glossary of terms used in the health insurance industry. (Appendix B)

- A list of supplemental readings relevant to health benefit purchasing for public entities. (Appendix D)

- A decision-making tool that can be used by officials to assist them in evaluating specific health benefit plan options and making decisions that meet their needs. (Appendix E)

[9] https://gateway.insurance.ohio.gov/UI/ODI.Agent.Public.UI/AgentSearch.mvc/DisplaySearch
[10] https://legacy.insurance.ohio.gov/journalsearch/journalsearch.aspx
[11] https://www.insurance.ohio.gov/Consumer/OCS/Documents/HowtoComplain.pdf
[12] The list of consortia in Appendix A to this document includes 34 (of 53) health benefit consortia that were verified by the project team to be providing services to public entities in summer of 2015, and which provided permission to be listed in this Guide. Information about these consortia and means by which they can be contacted are also provided. Appendix A also lists the names of additional consortia reported to SERB (2014) to be operating in Ohio at that time, but which did not respond to the project team's inquiries during the summer of 2015.

While none of these tools are likely to address all aspects of the information needed to make appropriate health benefit plan choices, we hope and expect that the tools provided will be useful and will make the job of making health benefit plan decisions easier than it otherwise might have been.

And finally, public entity officials should consider engaging with their peers to learn from their experiences and apply those lessons to their own decision-making processes as they deem appropriate.

Step 3: Identify Options

By using the resources identified above and investigating information on the past performance of various insurance professionals, public entities should be able to generate a list of potential health benefit options to consider. The organizations listed in the Appendix A to this Resource Guide would be ones to consider for those public entities interested in exploring health benefit consortium options.

Once a handful of health benefit provider prospects are identified, the public entity should consider soliciting proposals from three or more providers. Health benefit plan specifications should be drafted first, so that all of the parties are quoting the same level of health benefits (see Step 1). These specifications could overview the plan details and costs that an entity would like in a health plan – much like is done for purchasing equipment or vehicles for public entities. However, the purchase of a health benefit plan is not a lowest bid procedure, but a negotiated service contract.[13] A public entity can solicit proposals on its own, or through a licensed insurance broker or consultant.

There are numerous types of health benefit plans, numerous coverages, and resulting cost rates. Officials should work to ensure that the proposals received meet or exceed the minimum coverages outlined in their specifications. Once an official has received the written proposals and it has been determined that it meets her/his minimum specifications, the next step is to compare the options.

Step 4: Compare Options

When comparing plan options, the following questions are important for a proper evaluation:

1. What are the price comparisons among the proposals? Cost is an important factor.

[13] When looking at alternative insurance programs or consortia, public officials may be asked to provide a claims history. They should obtain and/or request this information so they have it available for prospective health benefit service providers. In many cases, existing health benefit providers should make available the annual claims history for their covered organizations. This information can be utilized by prospective insurers to measure risk factors and provide realistic ratings for entities. Some consortia may utilize these reports to ascertain if a public entity would be a worthy member of their consortium.

a. Co-payments?
b. Deductibles?
c. Co-insurance percent?
d. Out-of-pocket maximums?
e. Yearly premium contributions?

2. What preferred provider network does a plan use? Will your employees be forced to switch doctors because of the change in carrier?

3. What hospitals are on the proposed health benefit plan?

4. What does each proposal contain that goes beyond the minimum specifications?

5. Are there other non-quantifiable considerations that are important to an organization that should be folded into the comparison?

The comparison of fully-insured products and self-funded products presents challenges. While both kinds of products provide health benefits for the entity's employees, the administration and provision of services across these types of benefit plans are different. For example, a self-funded product may be administered by a licensed TPA (third party administrator) that is hired to process and pay claims, while a fully-insured plan might provide a different range of services. Differences in administrative procedures and their potential costs should be considered. The decision making tool in Appendix E may help officials with organizing and completing assessments of the alternative proposals they receive.

Step 5: Make Decision Based on the Organization's Needs

Understanding the human health and fiscal needs of the organization, acquiring the necessary expertise to support the decision making process, establishing minimum specifications, and identifying and comparing alternatives will lead officials to a final decision on what type of health benefit plan they need and what method to use when purchasing it. In general, this decision should be assessed and evaluated with sufficient time and care, and in consultation with the organization's key stakeholders, as appropriate.

When making decisions regarding a health benefit plan to choose, it is necessary and appropriate to recognize that adjustments in health benefit plans may need to be made over time.

Step 6: Assess, Evaluate, and Adjust over time

It is important for officials to continually assess, evaluate, and make adjustments in their health benefit plan(s) as they obtain new information on its (their) impacts on their employees, stakeholders, and financial situation. An insurance company or consortium may be able to offer a better deal for a community that they were not able to provide previously. It may thus be a good idea for officials to consider soliciting proposals for new health benefit plans over time, even if they are comfortable with their current plan. There may in fact be better value in the market.

Also, things change within an organization. New employees come on board, other employees leave. Budgets go up and down, and insurance markets continue to change. These changes need to be accounted for as public entities assess, evaluate, and make adjustments in their health benefit plans over time.

Special Considerations Related to Health Benefit Consortia

While the decision making process described above can be applied to both individually purchased and jointly purchased insurance plans (eg. health benefit consortia), exploring health benefit consortia as a potential option appears to make sense in the changing health insurance environment prevailing in Ohio today. It also comes with some special considerations. The decision tool in the Appendix E includes a framework for considering the questions described below:

1. *How are costs allocated across the members of the consortium?*

   As noted above, in some cases, the costs of participating in a health benefit consortium are allocated similarly across all members of the consortium equally. In other cases, costs are allocated based on the claims experience(s) of particular members. While both of these approaches may have their benefits for individual consortium members, these benefits may not be the same for any particular entity.

Health Benefit Consortium Official Survey Results:
How are Member Contributions Established?

- 41% (7/17) of the consortium officials surveyed reported that costs are allocated equally across all of their consortium members.
- By contrast, 47% (8/17) reported that their consortium allocated costs based on past claims experience within member organizations. As a result, in these Health Benefit Consortia, members pay different costs.

* "Other" was selected by 2/17 consortium officials.

Public entities with particularly strong claims histories (e.g., relatively low levels of paid out benefits) may fare better with an allocated balance consortium because their actual costs may be lower than the costs of other consortium members. On the other hand, public entities with relatively weak claims histories may benefit from more classically organized "pooled" consortia for the opposite reason.

One thing to remember, however, is that claims histories may change over time, and your organization's recent claims history may not reflect future claims, so your entity's specific financial interests may change over time.

2. *Can organizations bring their existing plan to the consortium?*

   a. Can an organization bring their existing plan to the consortium, thereby insuring its employees that there will be no change in coverage levels?

Health Benefit Consortium Officials Survey Results:
Are Health Benefit Consortia open to new plans?

- About half (8/17) of the consortium officials indicated that their consortium was open to establishing new plans requested by members.
- The other half (8/17) of surveyed consortia only offered a standard plan or set of plans to members.

* "Other" was selected by 1/17 consortium officials.

   b. Are organizations required to select an existing plan offered by the consortium?
      1. How many plans are available?
      2. Are any plans identical or very similar to an organization's existing plan?

   Public entities may want to insure that their savings are the result of administrative savings and/or fee savings and not the purchase of less coverage for their employees and their families.

Health Benefit Consortium Officials Survey Results:
How Many Plans do Consortia typically have available to members?

- The majority of responding consortium officials surveyed (10/15) indicated that their consortium offered between one and three medical plans with the most common number of medical plans offered being one (5/15).
- The other consortia officials (5/15) reported the number of plans offered to members was from 6 to 7 medical plans all the way to an unlimited number of plans.

3. *What are the rules for joining a consortium?*
    a. Are there fees to join the consortium?
    b. Are there continual fees that would need to be paid regularly over time?
    c. What is the length of the agreement?

    The answer to these and other questions should be included in the consortium's bylaws and/or governing documents.

Health Benefit Consortium Officials Survey Results:
Rules for Joining a Consortium

- 63% of the consortia interviewed/surveyed had restrictions based on the type of public entities allowed into the consortium (n=35).
- 31% of consortia interviewed/surveyed had restrictions based on geographic location of member entities (n=35).
- Of those consortia that responded, 58% had restrictions that were based on "acceptable" claims histories for prospective members (n=17).
- Minimum size (18%) and maximum entity size (12%) were also restrictions noted by some of those surveyed (n=17).

4. *What are the rules for leaving health benefit consortia?*

    Once again, it is appropriate to ask a number of questions.
    a. Must written notice be provided to leave?
    b. How long in advance must notice be provided? Are there specific time periods for notifying the consortium of a member's desire to leave?
    c. Does the consortium provide a claims history regularly so that an organization can utilize this history to get quotes from other insurance organizations in the future?

d. How is the "run out" of claims addressed? If there are claims that have been incurred by a consortium member's employees but not yet submitted or paid, will they be paid after it has exited the consortium since they were incurred while the entity was a member?
e. Upon departure, would an entity receive its portion of any cash reserves that it has paid and have accumulated during its membership period?

Health Benefit Consortium Officials Survey Results:
Rules for Leaving a Consortium

- 71% (11/17) of the officials surveyed indicated that their consortium did not allow their members leave at any time without penalty.
- Among responding consortia, the average required duration for membership is about two years (n=10).

5. *How stable is the consortium?*

a. How long has the consortium been in existence?
b. What are the levels of its cash reserves?
c. What are the recent trends with its cash reserves? Have they been increasing or decreasing?
d. What is the number of members?
e. What is the number of lives covered?
f. What is the recent history of entering and exiting members?

Health Benefit Consortium Officials Survey Results:
Stability of Consortia

- Jointly purchasing health insurance is not a new idea. A majority of the health benefit consortia responding to our survey had existed for more than 20 years, and many of these long-lasting consortia served school districts (n=17).

- About 64% of the consortium officials surveyed who were affiliated with organizations that have existed for at least 5 years indicated that their consortium showed growth over the past five years, while 14% showed decreasing membership and 21% stayed the same (n=14).

6. *Is the consortium located in close physical proximity to the public entity?*

   Some organizations are simply more comfortable knowing that the consortium is located in their area. With modern communication, other entities may be indifferent to this issue.

7. *What are the present cost rates? How have they been changing in recent years?*

   For public entities, it is often helpful to have stable and relatively predictable health benefit costs, as this may improve the entity's ability to plan and budget for the future.

8. *Do labor unions have a role in this decision?*

   a. Organizations need to know if their union contracts require union approval of changes in health benefit plans, and/or changes from individual purchased plans to consortium based plans?
   b. Do collective bargaining agreements require a renegotiation for changes in health benefit plans and/or movement to consortium based arrangements?

Labor Unions Often Play a Role in Making Health Benefit Purchasing Decisions

- Our project team reviewed 285 Collective Bargaining Agreements (CBAs) in SERB's online database and found that:
  - Unions had influence in the health benefit decision-making process in about 58% (166/285) of the CBAs reviewed.
    - Unions had effective approval/veto power specified in 36% (102/285) of the agreements.
  - Managers had significant latitude in the health benefit decision making process in about 42% of the CBAs reviewed.
    - In 26% (119/285) of the CBA's reviewed, public managers had constraints on the health benefit decisions they could make clearly articulated in the CBA.
    - Managers had complete control of the process in only 16% (47/285) of the CBAs reviewed.

Using the decision-making processes identified above and devoting attention to the considerations described in this section, public entity officials should be able to create a sensible framework for making health benefit purchasing decisions which benefit their employees and their families, their organization, and the constituent they serve.

Conclusion

Budgetary challenges facing public entities in Ohio and changes in the health insurance market and its regulatory requirements are forcing public officials to revisit how and where they are purchasing health benefits for their employees and their families. There are many different forms of health benefit packages, including self-funded plans and fully-insured plans. Health benefits can also be purchased individually by an organization or through a health benefit consortium. Many public entities in Ohio, especially school districts, are purchasing their health benefits through consortia.

While consortia have been utilized by public entities in this state for many years, each entity's situation is different and, as a result, public officials need to conduct their own decision-making processes that take into consideration their organization's own unique situation and needs. This Resource Guide has suggested many factors that can be taken into consideration, and it poses a number of questions that public entity officials may ask of various health benefit providers. The Guide also offers a decision making tool in Appendix E that may be helpful for officials to use in comparing different plans, and in exploring consortia as an option for purchasing health benefits. There may very well be other tools and resources that exist for use by these entities, and officials should find what works best for their own situations.

The changing health benefit landscape in this country presents a challenge for public managers. Engaging in a stepwise process to identify, compare, and select what type of health benefit product works best for an individual organization will help public officials to make decisions that have a positive impact on their employees, their employees' families, their constituents and stakeholders, and the public entity as a whole.

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Appendix A: Health Benefit Consortia in Ohio

Health Benefit Consortia Confirmed to be in Operation, Summer 2015

Consortia Name	Contact	Address	Phone	Email	Website	Types of Public Entity Served	Geographic Restriction
Ashtabula County Schools Council of Governments	Jerome Brockway PhD	1565 State Route 167. Jefferson, Ohio. 44047	440-576-6015	jerome.brockway@atech.edu	———	School Districts Only	Ashtabula County ONLY
Brown County Schools Insurance Consortium	James Frazier	9231 B Hamer Road, Georgetown, OH 45121	937-378-6118	james.frazier@Brown.k-12.oh.us	———	Educational entities	Educational entities residing in rural Southern Ohio
Central Ohio Health Care Consortium	Matt Peoples	36 High Street Canal Winchester, Ohio	614-834-5111	mpeoples@canalwinchesterohio.gov	———	Organizations that are defined as a public entity by the ORC (municipalities and special districts, etc.)	No Restrictions
Clermont County Insurance Consortium	Jeff Weir	2400 Clermont Center Drive, Suite 100, Batavia, OH 45103	513-735-8300	weir_j@ccesc.org	———	No Restrictions	Would consider including school districts in other counties

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
County Employee Benefits Consortium of Ohio (CEBCO)	Doug Foust	209 East State St. Columbus Ohio 43215	614-220-7984	dfoust@ccao.org	www.cebco.org	Counties only	No Restrictions
Employers Health Purchasing Corporation	Mike Stull (Chief Marketing Officer)	5775 Perimeter Dr. Dublin, OH 43017	614-763-0007	mstull@employershealthco.com	http://www.employershealthco.com/	All Entities	No Restrictions
Franklin County Cooperative Health Benefits Program	Margaret Snow	373 S. High St., 25th Floor, Columbus, OH 43215	614-525-5539	mksnow@franklincountyohio.gov	http://bewell.franklincountyohio.gov/	Local government and other special districts	No Restrictions
Great Lakes Regional Council of Government	Amy Hendricks	21620 Mastick Road, Fairview Park, OH 44126	440-331-5500 X 1119	ahendricks@fairview.k12.oh.us	www.fairviewparkschools.org	All entities	No Restrictions
Hardin County Schools Consortium	Rick Combs	P.O. Box 98 Dola 45835	419-759-2100	hccombs@wcoil.com	———————	Public Schools only	No Restrictions

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
Health Action Council	Patty Star	6133 Rockside Rd Suite 210 Cleveland, Ohio 44131	216-236-0362	pstarr@haco.org	www.healthactioncouncil.org	All entities	No Restrictions
Health Transit Pool of Ohio	Barbara Rhoades	1 Park Center Drive #330 Wadsworth, Ohio 44281	330-334-6877	BarbaraR@healthtp.org	www.healthtp.org	Must be an Ohio public transit formed under Ohio statute, RTA, CTB, or an individualized department of a county	No Restrictions
Huron-Erie School Employee Association	Sharon Mastrioni	316 W Mason Road Milan, OH 44846	419-499-4663	smastroi@ehove.net	_____	Public School Districts	No Restrictions
Inter-University Council Purchasing Group	Cindy McQuade	10 West Broad Street, Suite 450 Columbus, Ohio 43215	614-464-1266	Mcquade.2@osu.edu	_____	Serve public four-year universities and 2-year colleges	No Restrictions

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
Jefferson Health Plan/Umbrella Plan **Separate Health Benefit Pools under Jefferson Health Plan:** Center for Local Government (CLG) Health Benefit pool Ohio Public Employer Cooperative Sandusky-Ottawa County Pool (San-Ott) Ohio Benefits Cooperative Ohio Valley Pool South Central Ohio Insurance Consortium (SCOIC) Erie Shore Pool	David Manning	1755 Indian wood Circle, Suite 100, Maumee, OH 43537	419-794-7330	dmanning@burnsconsulting.com	www.jeffersonhealthplan.org	All entities	No Restrictions

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
Lake County Board of Commissioners	Joel Dimare	_____	(440)-350-2366	Joel.Dimare@lakecountyohio.gov	_____	Only County departments, county boards, townships and municipalities in Lake County	Lake County (would consider political subdivisions from other Counties)
Lake County School Health Care Benefits Program	Michael Vaccariello	_____	440-428-9328	michael.vaccariello@madisonschools.net	_____	School districts and educational entities	No Restrictions
Lawrence County Schools Council of Government	James Payne	111 S 4th Street 3rd Floor Court House Ironton, OH 45638	419-436-4085	james.payne@lc.k12.oh.us	_____	Serve a group of educational entities – Local School Districts, ESC	No Restrictions
Logan County School Employee Consortium	Robert Kuehnle	4740 County Road 26 Bellfontaine, OH 43311	937-593-9211	kuehnler@benjaminlogan.org	_____	School Districts	No Restrictions

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
Mahoning County Employees Insurance Consortium	Dr. Ronald J. Iarussi	100 Debarpolo Place Youngstown, OH 44512	330-965-7828	r.iarussi@mahoningesc.org	http://www.mahoningesc.org/	School Districts Only	No Restrictions
Mercer Auglaize Benefit Trust	Steve Dandurand	PO Box 906 Fostoria, OH 44830	419-436-4085	sdandurand@corporateonebenefits.com	_____	Local School Districts Only	Mercer and Auglaize Counties
Metropolitan Education Council	Suzie Strait	_____	614-336-8030	sstrait@andrewins.com	_____	All entities but serves schools districts	No Restrictions, but primarily in central Ohio
Midwest Employee Benefit Consortium	Erica Preston Alt. Contact: John Bergman	2095 Blackhoof Street, Wapakoneta, OH	419-739-6710	epreston@auglaizecounty.org	_____	County and Health Districts	Mercer , Auglaize and Hancock Counties
North Central Ohio Trust	Dr. Larry Cook	928 West Market Street, Suite A, Tiffin, Ohio 44883	419-447-2927	lcook@ncoesc.org	www.ncoesc.org	School Districts Only	Seneca County Only

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
Ohio Public Entity Consortium	Erin Patton, CFO	P.O. Box 1135 Dublin Ohio 43017	614-873-6000	epatton@ohiopublicentity.com	www.ohiopublicentityconsortium.org	All Entities	No Restrictions
Ohio Public Healthcare Risk Pool	Steve Hopp	Two Summit Park Drive, Suite 235, Independence OH, 44131	234-380-4466	steve_hopp@ajg.com	_____	To participate, the public entity must be a Housing Authority in Ohio	No Restrictions
Ohio School Benefits Cooperative	Christine Wagner	205 N 7th St. Zanesville OH 43701	740-452-4518	Christine.wagner@mvesc.org	www.mvesc.org	Only School Districts	No Restrictions
Southwest Ohio Organization of School Health	Valerie Bogdon-Powers	4990 East Galbraith Road Cincinnati, Ohio 45236	513-745-0707	valerieb@horanassoc.com	http://myswoosh.org/	All public entities	No Restrictions
Southwestern Ohio Educational Purchasing Council	Doug Merkle	303 Corporate Center Dr. Suite 208, Vandalia, OH 45377	937-890-3725	doug.merkle@epcschools.org	epcschools.org	Public School Districts and County Boards of Developmental Disabilities	No Restrictions

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
Stark County Schools Council	Joe Chaddock	2100 38th NW, Canton, OH 44709	330-492-8136	joe.chaddock@email.sparcc.org	http://www.starkcouncilofgov.org/ index.php?page=insurance	All public entities	No Restrictions
Suburban Health Consortia	Glen Szana	Group Health Care Consulting 1616 E Wooster Suite 20 Bowling Green, OH 43402	419-354-7500	gszana@ghconsulting.com	_____	Currently only Local School Districts	No Restrictions
Summit County Health Connection	Wendy Weaver	175 S Main St Akron, OH 44308	330-643-2783	wweaver@summitoh.net	www.co.summitoh.net	Political subdivisions only: Cities, Villages, Townships, County	Only Summit County
Teamsters Local 377 Health and Welfare Fund	Rita Banks	1223 Teamster Drive Downstairs Office Youngstown Ohio	330-744-3148	rbanks@neo.rr.com	_____	Members of Teamsters union and belong to local 377	Employees have to be members of Teamsters Local 377 (Youngstown area)

Consortium Name	Contact	Address	Phone	Email	Website	Types of Public Entities Served	Geographic Restriction
Trumbull County Schools Insurance Consortium	Lori Simione	6000 Youngstown Warren Rd. Niles Ohio 44446	330-505-2800	Lori.Simione@neomin.org	_____	All entities	No Restrictions
Wayne County Employee Benefit Plan	Patrick Herron	428 West Liberty Street Wooster, Ohio 44691	330-287-5400	pcherron@wayneoho.org	http://www.wayneohio.org	Serves entities defined as political subdivisions by the ORC	Only Wayne County

Note: The listing above includes known health benefit consortia providing services to public entities in Ohio. The consortia listed were confirmed as being in operation in the Summer of 2015. Nineteen additional health benefit consortia, which were reported by third parties as providing services to public entities in Ohio, are listed below. The project team tried, but was not able, to reach these 19 additional consortia during the Summer of 2015 to verify their continuing services and to collect the kind of information that is presented above. In addition, an Appendix to the document, "Adapting to the Changing Health Insurance Landscape: A Look at the Use and Effects of Health Benefit Consortia by Public Entities in Ohio", which was released by the KSU-CPPH and the Ohio Department of Administrative Services in the Summer of 2016, includes a full listing of consortium names from the tables above and below.

Other Health Benefit Consortia Reported to be Operating in Ohio

This list of consortia was obtained from the 2014 and 2015 State Employment Relations Board (SERB) Insurance Surveys, and is included to provide a more extensive list of Ohio health benefit consortia. The project team was unable to confirm contact information with officials with the consortia included on this list, and therefore, do not present that information here.

Consortia Name	Address	Website
Allen County Schools Health Plan	9105 Harding Hwy. Harrod, OH 45850	https://pcms.plansource.com/entities/31046/pub_nodes/1019
Buckeye Ohio Risk Management Association	255 W. Riverview Napoleon, Ohio 43546	———
County of Lorain Health Plan	6155 Park Sqre. Dr., Ste. 7 Lorain, OH 44053	http://www.loraincounty.us/commissioners-departments/personnel
Cuyahoga County Healthcare Regionalization Program	2079 E. 9th St., Cleveland OH 44115	http://regionalcollaboration.cuyahogacounty.us/en-US/Healthcare_Regionalization.aspx
Greater Cincinnati Insurance Consortium	4977 Delhi Ave, Cincinnati, OH 45238	http://www.gc-insurance.com/contact.aspx
Hancock County School Consortium	7746 County Road 140 Findlay, Ohio 45840	———
Lake Erie Regional Council of Governments	1885 Lake Avenue Elyria, Ohio 44035	———
Ohio School Employee Insurance Consortium (OSEIC)	6075 Manchester Rd. Akron, Oh 44319	———
Optimal Health Initiatives (OHI)	P.O.Box 194 345 N. Chillicothe Street Plain City, OH 43064	http://www.ohi-online.org/
Paulding County School Consortium	405 North Water Street Paulding, Ohio 45879-1251	———
Pickaway County Public Employees Benefit Consortium	9579 Tarlton Road Circleville, Ohio 43113	———
Portage Area School Consortium	Portage County, Ohio	———

Consortia Name	Address	Website
Preble County Schools Regional Council of Governments	597 Hillcrest Dr. Eaton, OHIO 45320-1793	_____
Putnam County School Consortium	124 Putnam Parkway Ottawa, OH 45875	http://putnam.noacsc.org/
Ross County School Employees Insurance Consortium	475 Western Avenue, Suite E, Chillicothe, Ohio 45601	http://www.rpesd.org/
Shelby County Schools Health Insurance	Shelby County, Ohio	_____
Van Wert Area Schools Insurance Group (VWAISG)	205 West Crawford Street Van Wert, Ohio 45891	_____
Wood County School Consortium	Wood County, Ohio	_____
Wyandot Crawford Health Benefit	Wyandot County, Ohio	_____

Source: 2014 and 2015 SERB Insurance Survey datasets. Address and website information was retrieved from the 2014/2015 SERB Insurance Survey datasets, consortium websites, and from independent audits of the consortia conducted by the Ohio Auditor of State.

Appendix B: Glossary of Key Terms and Concepts

This Glossary of key terms and concepts is intended to assist users of this document in understanding the terms used and concepts conveyed in this document. It is not intended to represent a comprehensive listing of terms used in the insurance industry or in the ACA legislation. Readers looking for further information may want to consult the reference sources listed at the end of this Glossary.

A

Actual Charge:

"The dollar amount a health care provider bills for a particular medical service or procedure" (ODI: Healthcare Reform Website Glossary, 2015).

Administrative Costs:

"Costs related to activities such as utilization review, marketing, medical underwriting and claims processing" (ODI: Healthcare Reform Website Glossary, 2015).

Adverse Selection:

"Among applicants for a given group or individual health insurance program, the tendency for those with an impaired health status or those prone to higher-than-average benefits usage, to be enrolled in disproportionate numbers in lower deductible plans" (ODI: Healthcare Reform Website Glossary, 2015).

Affordable Care Act (ACA):

The ACA is a shorthand term for the "Patient Protection and Affordable Care Act (PPACA)", a piece of legislation signed into law on March 23, 2010 by President Barak Obama. This legislation outlines adjustments and enhancements to health plan structures, including but not limited to defining comprehensive coverage guidelines, expanding coverage for individuals and is intended to reduce health care spending in the US. (HealthCare.gov: Glossary, 2015) [in this Resource Guide, we also use this term as an umbrella term covering not only the PPACA, but also the "Health Care and Educational Reconciliation Act of 2010" which passed and signed shortly after the PPACA.]

"Affordable Coverage":

"Employer coverage is considered affordable - as it relates to the premium tax credit - if the employee's share of the annual premium for the lowest priced self-only plan is no greater than 9.56% of that single individual's annual household income. People offered employer-sponsored coverage that's affordable and provides minimum value, are not eligible for a premium tax credit" (HealthCare.gov: Glossary, 2015).

Agent:

A "licensed salesperson that represents one or more health insurance companies and presents their products to consumers" (ODI: Healthcare Reform Website Guide, 2015).

Allowable Costs:

"Charges for services rendered or supplies furnished by a health provider which qualifies as covered expenses for insurance purposes" (ODI: Healthcare Reform Website Glossary, 2015).

Annual Limits

"The PPACA bans annual dollar limits that job related plans and individual health insurance plans can put on most covered health benefits. Before the health care law, many health plans set an annual limit – a dollar limit on their yearly spending for covered benefits. One was required to pay the cost of all care exceeding those limits". Two exceptions to annual limits are that plans can put an annual dollar limit and a lifetime dollar limit on spending for health care services that are not considered essential health benefits. Secondly, grandfathered individual health insurance policies are not required to follow the rules on annual limits. (DHHS, 2015)

Attachment Point:

This number represents the overall limit of claim liability for the group (employer). Beyond this point the stop loss policy compensates the group at the end of the contract period (Wans, 1991).

B

Beneficiary:

“This is a person who receives benefits of any insurance plan or policy” (ODI: Healthcare Reform Website Guide, 2015).

Benefit:

”The amount payable by the insurance company to a claimant, assignees or beneficiary when the insured suffers a loss” (ODI: Healthcare Reform Website Guide, 2015).

Benefit Maximum:

“The most a health insurance policy will pay for a specified loss or covered service. Benefits may be paid to the policy holder or a third party” (ODI: Healthcare Reform Website Guide, 2015).

Benefit Period:

“The period when services are covered under your plan and also when benefit payments from an insurance policy are available such as: maximums, deductibles and coinsurance limits accumulate” (ODI: Healthcare Reform Website Guide, 2015).

Broker:

See “Agent.”

C

Cadillac Tax:

A 40% excise tax assessed on high premium health plans that offer rich benefits exceeding more than $10,200 (single) or $27,500 (family) annually). This penalty is not in effect until 2020 and is subject to change and is only accurate as far as the date of this document production (Blue Cross Blue Shield: New Health Care Reform Fees , 2015).

Carrier:

"The insurance company or Health Maintenance Organization (HMO) offering a health plan" (ODI: Healthcare Reform Website Guide, 2015).

Cash Reserve:

A portion of the premium retained to pay future claims (NAIC): Glossary of Insurance Terminology, 2015).

Claims:

"A request for payment for services provided by a health care professional" (ODI: Healthcare Reform Website Guide, 2015).

Co-insurance:

"Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount" (HealthCare.gov: Glossary, 2015)

Community rating:

This is a way of pricing insurance, where every policyholder pays the same premium, regardless of health status, age or other factors (ODI: Healthcare Reform Website Guide, 2015).

Co-payment (co-insurance):

"A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service". (HealthCare.gov: Glossary, 2015)

Coverage:

"All or part of an individual's health care costs, paid either by insurance or by the government" (ODI: Healthcare Reform Website Guide, 2015).

Covered Services:

"These are services for which an insurance policy will pay" (ODI: Healthcare Reform Website Guide, 2015).

D

Deductible:

The amount an individual must pay for health care expenses before insurance (or self-insured health plan) covers the cost (ODI). For instance, a plan deductible of $1,500 means that the enrollee will pay 100% of any medical or pharmaceutical expenses until the costs have exceeded the $1,500(deductible) at which you will share the costs with your plan through co-insurance or co-pays (ODI: Healthcare Reform Website Guide, 2015).

Dependents:

Spouse and/or unmarried, dependent children (whether natural, adopted or step up to age 26) of an insured (ODI: Healthcare Reform Website Guide, 2015).

Dividend:

A refund of a portion of the premium paid by the insured from insurer surplus This is a portion of the corporate earnings and may be paid a certain number of times each year (like each quarter) (NAIC: Glossary of Insurance Terminology, 2015).

E

Economies of Scale:

"The cost advantage that arises with increased output of a product. Economies of scale arise because of the inverse relationship between the quantity produced and per-unit fixed costs; i.e. the greater the quantity of a good produced, the lower the per-unit fixed cost because these costs are shared over a larger number of goods"(Investopedia: Economies of Scale Definition, 2003).

Effective Date:

"The date your insurance is to begin. You are not covered until the policy's effective date" (ODI: Healthcare Reform Website Guide, 2015).

Employer Shared Responsibility Provisions (i.e. Employer Mandate):

The Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (added to the Code by the ACA) state that in year 2015 and after, employers employing at least a certain number of employees (50 full-time employees or 50 full-time equivalent employees) will be subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code, which defines penalties for employers not providing adequate health benefits for their employees. As defined by the statute, a full-time employee is an individual employed on average at least 30 hours of service per week. As defined by the statute, a full-time employee is an individual employed on average at least 30 hours of service per week. An employer that meets the 50 full-time

employee threshold is referred to as an applicable large employer. (IRS: Shared Responsibility Provision, 2015). *For information on penalties please refer to "Pay or Play Penalties."

Employee Retirement Income Security Act (ERISA):

ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. ERISA does not cover retirement plans established or maintained by governmental entities (DOL: Health Benefits Advisor-Glossary, 2015).

Essential (Health) Benefits:

"The PPACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits" (Healthcare.gov: Essential Health Benefits, 2015).

These health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (HealthCare.gov: Glossary, 2015).

Exchange User Fee:

The federally-facilitated exchange user fee helps to fund and support federal exchanges. Health insurance carriers are charged 3.5% of their premium for all business on a federal exchange starting in 2014. This fee only impacts non-grandfathered health plans (Medical Mutual: Healthcare Reform Costs and Fees, 2015).

Experience Rating:

"A system where an insurance company evaluates the risk of an individual or group by looking at the applicant's health history "(ODI: Healthcare Reform Website Guide, 2015).

Explanation of Benefits (EOB):

"A statement from an insurance company showing which payments have been made on a claim" (ODI: Healthcare Reform Website Guide, 2015).

F

Fee for Service:

"Traditional insurance that does not place restrictions on which doctors you can use" (ODI: Healthcare Reform Website Guide, 2015).

Fully-Insured Plans:

This is a health plan where an employer group contracts with a health care carrier to provide health insurance coverage to its employees and their dependents. The carrier underwrites and administers the health plan, and also pays the covered claims (Cigna: Glossary of Health Care and Health Insurance Terms, 2015).

Full-Time Employee:

An employee who works an average of at least 30 hours per week or on average 130 hours per month (HealthCare.gov: Glossary, 2015).

Full-Time Equivalent Employee (FTE):

Full-time equivalent employees are calculated based upon a combination of full time and part time employees. Employees scheduled to work 20 hours per week are counted as 0.5 FTEs. The formula looks like this: Employee's scheduled hours divided by employer's hours for a full-time (FT) workweek. Another way of stating the formula is: hours scheduled ÷ FT hours. Using this formula, two employees who work 20 hours per week is 40 ÷ 40 = 1.0 FTE (Society for Human Resource Management [SHRM]: How Employers Calculate Full-Time Equivalent employees, 2015).

G

Grandfathered Plans:

"Grandfathered plans are those that were in existence on March 23, 2010 and have not been changed in ways that substantially cut benefits or increase costs for consumers" (HealthCare.gov: Glossary, 2015).

Group health plan:

"An employee welfare benefit plan that is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise" (ODI: Healthcare Reform Website Guide, 2015).

H

Health Insurance Consortium:

"A group of similar businesses or organizations that join together to provide insurance coverage" (Investopedia, 2015). In this document, we use the term "Health Benefit Consortium" as a synonym for this term.

Health Benefit Consortium:

See “Health Insurance Consortium”.

I

Incurred Claims:

These are paid claims plus amounts held in reserve for those that have been incurred but not yet paid (NAIC: Glossary of Insurance Terminology, 2015).

In-Network:

“This is providers or health care facilities that are a part of a health plan’s network of providers with insured individuals paying less with an in-network provider” (ODI: Healthcare Reform Website Guide, 2015).

In-Network Copayment:

“A fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments” (HealthCare.gov: Glossary, 2015).

J

Joint Insurance Purchasing Arrangement:

See “Health Insurance Consortium.”

L

Large Group Employer (for Employer Shared Responsibility Provisions):

A large group employer is defined by having 50 or more full-time employees or equivalents. (IRS: Affordable Care Act Tax Provisions for Employers, 2015).

Loss Reserve:

"The amount that insurers set aside to cover claims incurred but not yet paid" (NAIC: Glossary of Insurance Terminology, 2015).

M

Market Share Fee (also referred to as "Health Insurer Fee"):

"The market share fee, referred to as the annual fee on health insurance providers in the PPACA regulations, is based on each carrier's market share of net annual health insurance premiums collected. This permanent fee is effective beginning in 2014. The fee will fund premium tax subsidies for low income individuals and families purchasing insurance through the public exchanges. After 2018, the fee will increase in proportion to overall premium growth" (Medical Mutual: Fees and Taxes in Healthcare Reform, 2013).

Maximum Dollar Limit:

"The maximum amount of money that an insurance company (or self-funded company) will pay for claims within a set time period" (ODI: Healthcare Reform Website Guide, 2015).

Medical Loss Ratio:

"The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. For instance, a medical loss ratio of 80% indicates that the insurer is using the remaining 20% to pay overhead expenses, such as administrative costs" (ODI: Health Reform Glossary, 2015).

Medical Underwriting:

"A process used by insurance companies to try to figure out your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price, and with what exclusions or limits" (Healthcare.gov: Glossary, 2015).

Minimum Essential Coverage (MEC):

"The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act" (HealthCare.gov: Glossary, 2015).

Minimum Value:

"A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population" (HealthCare.gov: Glossary, 2015).

N

Network:

"The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services" (HealthCare.gov: Glossary, 2015).

O

Open Enrollment Period:

"This is a period in which individuals may enroll for an insurance policy" (ODI: Healthcare Reform Website Guide, 2015).

Out-of-Network Provider:

A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as a Health Maintenance Organization or Preferred Provider Organization). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher proportion of the total costs when he/she seeks care from an out-of-network provider (ODI: Healthcare Reform Website Guide, 2015).

Out-of-Pocket Maximum:

A predetermined limited amount of money that the individual must pay themselves before an insurance company or self-funded health company will pay 100% for an individual's health care expenses (ODI: Healthcare Reform Website Guide, 2015).

P

Patient Centered Outcome Research Institute (PCORI) Fee:

"This fee funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services. The research will help patients, health care professionals and policymakers make better informed decisions about treatment options" (Blue Cross Blue Shield: New Health Care Reform Fees, 2015).

The Patient Protection and Affordable Care Act (PPACA):

The Patient Protection and Affordable Care Act (PPACA) is a piece of health care legislation that was signed into law on March 23, 2010 by President Barack Obama (HealthCare.gov: Glossary, 2015). Please refer to ACA for further information.

"Pay or Play" Penalties:

"Under the "shared responsibility" provision of the Patient Protection and Affordable Care Act (PPACA), beginning in 2014 employers with 50 or more full-time employees (FTEs) working 30 or more hours per week (including the sum of hours by part-time workers that added together equal "equivalent" full-time workers) will face penalties if they do not offer FTEs "affordable" insurance.

Large employers that do not offer coverage to their full-time employees, they face a penalty of $2,000 times the total number of full time employees if at least one full time employee receives a tax credit to purchase coverage through a government-run health insurance exchange established under the PPACA. However, the $2,000-per-full time employee penalty will not apply so long as employers offer coverage to at least 95 percent of their full-time employees and their dependent children up to age 26.

Large employers that do offer coverage to their full-time employees (and dependent children up to age 26), but the coverage is "unaffordable" to certain employees or does not provide minimum value, will face a penalty of $3,000 times the number of FTEs receiving tax credits for exchange coverage (not to exceed $2,000 times the total number of FTEs)." (SHRM, 2015)

Premium:

"The amount that must be paid for your health insurance or plan; which can be paid monthly, quarterly or yearly" (HealthCare.gov: Glossary, 2015).

Public Entity:

"A public entity means the state (of Ohio) or any political subdivision of the state located entirely within the state, including, without limitation, any municipal corporation; county; township; school district; governing authority of a community school district established under Chapter 3314 of the Ohio Revised Code; college preparatory boarding school established under Chapter 3328 of the Ohio Revised Code or its operator; state institution of higher learning; public or special district; state agency, authority, commission, or board; or other branch of public employment" (ORC: Chapter 4117, 2015).

This definition is derived from language defining "public employer" as found in ORC Chapter 4117.

R

Rating:

The process of evaluating, or underwriting, a group or an individual to figure out a health insurance premium rate in relation to the risk the health insurance company takes to cover health care of the person or group. Key components of the rating formula include age, sex, location, and how many benefits the plan includes (AARP, 2015).

Reinsurance Fee:

See “Transitional Reinsurance Fee”

Risk:

“The chance, probability or amount of possible loss to the insurance company” (ODI: Healthcare Reform Website Guide, 2015).

Risk Adjustment User Fee:

“Health insurers will be assessed an annual risk adjustment user fee on all individual and small group policies that are compliant with the new ACA underwriting restrictions. The fee is to fund the government’s cost to administer the Risk Adjustment Program.” (Medical Mutual: Fees and Taxes in Healthcare Reform 2013).”The Risk Adjustment program is designed to help stabilize both the individual and small group insurance marketplaces. The program assists insurance carriers covering high-risk individual and small group members” (Medical Mutual: Federally Mandated Fees for Employers, 2015).

Risk Pooling:

See “Health Insurance Consortium.”

S

Self-Insured Plan:

“An organization (usually an employer) that pays for health care costs out of the organizations own pocket” (ODI: Healthcare Reform Website Guide, 2015).

Self-Insurance:

The method of providing employee benefits in which the group purchases no insurance at all, thereby assuming full responsibility for the claims (Wans, 1991).

Small Group Employer (for Community Rating Provisions):

The Protecting Affordable Coverage for Employees Act defines small group employers as those with 1 - 50 employees. States may define small employers as having one to 100 full-time employees (PACE, 2015).

Stop-Loss:

"The dollar amount of claims filed for eligible expenses at which you have paid 100% of your out-of-pocket expense and then the insurance company will begin to pay 100% of the costs. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance" (ODI: Healthcare Reform Website Guide, 2015).

Stop-Loss Insurance:

Stop-loss insurance (also known as excess insurance) is a product that provides protection for self-insured employers by serving as a reimbursement mechanism for catastrophic claims exceeding pre-determined levels (Self Insurance Institute of America, accessed on June 25, 2016 via http://www.siia.org/i4a/pages/Index.cfm?pageID=4549).

T

Third Party Administrator:

"A person or organization that manages the payment, processing and settlement of life, health, dental, disability and self-insurance claims for an organization" (ODI: Healthcare Reform Website Guide, 2015).

Transitional Reinsurance Fee:

The Transitional Reinsurance Fee is an annual fee on fully-insured and self-funded health plans from 2014-2016. The transitional reinsurance program will collect contributions from contributing entities to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S.

Treasury for the 2014, 2015 and 2016 benefit years (CMS: The Transitional Reinsurance Program, 2014). The amount of the fee changes per year and is charged on a Per Member Per Year (PMPY) basis. The amount due for year 2014 is $63 PMPY, the due in year 2015 is $44 PMPY, and the amount due in year 2016 is $27 PMPY (Cigna: Fees and Taxes, 2015).

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Appendix C: The Research and Information Development Approaches Used to Create This Resource Guide

Introduction

Since the beginning of 2015, the Center for Public Policy and Health at Kent State University (KSU-CPPH) has undertaken multiple activities to produce the information contained in this Resource Guide. These activities include:

- building a project team with experience and expertise in subject matters relevant to this Guide;
- consulting with key professionals in professions relevant to the subject matters in this Guide;
- searching professional and scholarly literatures associated with health benefit consortia, the changing nature of the US health insurance market, ACA implementation, and "best practices" for purchasing health benefit plans;
- obtaining and analyzing survey data on health benefit plan choices of larger public entities in Ohio obtained from surveys conducted by the State Employment Relations Board (SERB);
- conducting targeted research in key areas, including Collective Bargaining Agreements (CBA's) between unions and public sector entities in Ohio, the practices of health benefit consortia in Ohio, and the practices and views of smaller public entities in Ohio on health benefits for their employees, and;
- incorporating feedback from State of Ohio officials relevant to this guide and updating the guide to reflect federal legislative changes occurring between Fall of 2015 and Spring of 2016.

Information and insights gained through these efforts have been used to produce this Resource Guide for public entities in Ohio. In the paragraphs that follow, we summarize our approaches to carrying out these activities.

Project Team Experience and Expertise

Our project team includes individuals with experience in collaborative governance, local government administration, health insurance practices, and data analysis and research. Dr. John Hoornbeek has provided overall leadership for the project, and he brings background and expertise in health policy and management, collaborative endeavors among public entities in Ohio, and public policy research and analysis. Dr. Thomas Pascarella brings decades of local government administration experience to the project, as well as expertise in local government collaboration and local government health benefits administration. Ms. Heather Mikulski, a former Client Manager at a local Third Party Administrator and doctoral student in Public Health at KSU, brings a decade and a half of health insurance experience to the project, and – over the last several years – her work has been affected by implementation of the ACA. She has provided input and guidance on aspects of the project dealing with health insurance practices and implementation of the ACA. Her experience with the ACA has been supplemented by the experiences of Dr. Pascarella, who has been evaluating the impacts of the ACA on health benefits in the City of Tallmadge, Ohio, where he serves as Director of Administration. Mr. Matthew Stefanak, a former Health Commissioner from Mahoning County, Ohio, has brought additional experience in local government administration and health policy to the project. Dr. Kimberly

Laurene and Dr. Rebecca Fischbein have brought experience in data and statistical analysis to the project. And Mr. Joshua Filla supplements the expertise above with experience in working on issues associated with local government administration, public sector collaboration, and public health service provision in Ohio. Ms. Kathryn Bland and Ms. Marissa Bland – Masters of Public Health students at KSU -- have also applied their educational backgrounds and experiences to the development of this Resource Guide. Dr. Willie Oglesby, who has taught a graduate level seminar on ACA implementation at KSU, also reviewed and provided input on key portions of this Resource Guide.

Consultations with External Professionals

In gathering information to develop this Resource Guide, we have also contacted and benefited from ideas and guidance provided by professionals from a number of different organizations. Through contacts made available by ODAS, we contacted and sought insights from professionals with years of experience in the health insurance industry in Ohio. We have also consulted with officials associated with health benefit plan consortia in Ohio, and they have provided valuable information on the prevalence and practices of health benefit plan consortia. In addition, we have sought out and benefited from perspectives offered by public entity officials with responsibilities relating to health benefit administration, as well as officials from government agencies with expertise and/or responsibilities relating to health benefit regulation, ACA implementation, and the collection of information on health plan choices and administration in Ohio. The agencies consulted include the United States Department of Health and Human Services, the Ohio Department of Insurance Regulation, and the State Employment Relations Board of Ohio.

Searches of Relevant Literature

Members of the project team also conducted literature searches for information on a range of subject matters relevant to the information provided in this Resource Guide. In so doing, they sought out and reviewed information from both professional and scholarly sources. The literature searches focused on health benefit consortia and their use and impacts on the cost and nature of health plan benefits, health benefit planning and practices associated with public entities, the changing health insurance market and ACA implementation, the roles of labor unions in health benefit plan selection and management, and "best practices" for selection of health benefit plans. Selected materials from these reviews of literature are included in the Reference section for this document and in Appendix D.

Review and Analysis of State Employment Relations Board (SERB) Data

Each year, the State Employment Relations Board (SERB) of Ohio conducts a survey of public entities in Ohio that serve populations of more than 5,000 people. About 1800 public entities in the state are surveyed regarding their health insurance choices and benefits. While the survey includes information on many aspects of health insurance benefits provided to public employees and their families, it also includes information on the use of health benefit plan consortia.

In December 2014 and early 2015, the project team visited with the staff of the SERB and they provided a report on the findings of their 2014 SERB survey (SERB, 2015) as well as the data set underlying it. Both the report and the data set have been reviewed and analyzed in various ways, and this work with the SERB collected survey data has informed this Research Guide. The focus with

respect to this information has been on the use of health benefit consortia, and the costs and benefits associated with health benefit plans in Ohio. Results flowing from these analyses of SERB data inform this Resource Guide and the information it provides on the use of various kinds of health benefit plans by differing types of entities.

The results gleaned from the SERB data also enable a foundation for bi-variate quantitative analyses comparing the costs and benefits of public entity health plans that are purchased individually and jointly, as well as additional analyses comparing fully-insured and self-funded health plans. These analyses are presented in the companion resource document to this Resource Guide, Adapting to the Changing Health Insurance Landscape: A Look at the Use and Effects of Health Benefit Consortia by Public Entities in Ohio. This report was completed concurrently with this Resource Guide and can be accessed through the Ohio Department of Administrative Services and the KSU-CPPH.

Project team members also met with the SERB staff regarding the 2015 survey, and – as a result – the SERB staff included some additional questions on health benefit consortia in their 2015 survey. In the Spring of 2015, data on the responses to these additional questions became available, and information from those responses is also included in this Resource Guide.

Targeted Supplemental Research

The project team supplemented the information gained through the activities above with several other targeted research efforts. These research efforts are described briefly below.

Analysis of Collective Bargaining Agreements (CBAs) & their Implications for Health Benefit Plans

A key issue for a number of public entities seeking to make changes in their health benefit plans relates to the provisions of their CBA's and their impacts on the ability of public entity officials to make changes in health plans. In some cases, collective bargaining agreements may restrict the ability of public officials to make changes in the health plans serving their employees. To gain a better sense of the extent to which this is the case, members of the project team reviewed a sample of 285 collective bargaining agreements obtained through the SERB's electronic dataset of these agreements to ascertain the prescribed roles of unions, employees, and public entity managers in approving or advising on health benefits plans affecting them. This review provided insights on the constraints and opportunities associated with CBA provisions relating to the health benefit plans of public entities in Ohio. Information from these reviews has been incorporated into the Resource Guide where appropriate. Readers interested in these reviews may contact the KSU-CPPH.

Survey of Health Benefit Consortium Officials

Through the SERB dataset and other means, the project team was able to compile a list of 53 health benefit consortia providing services to public entities in Ohio. To improve our understanding of both the number and nature of health benefit plan consortia operating in Ohio, the project team developed an interview protocol and survey instrument, and sought appropriate review by the Kent State University Institutional Review Board (IRB). It then administered interviews and a follow up survey to health benefit consortia officials throughout Ohio. Through the interviews and follow up surveys, the

team consulted with officials from 36 of the 54 consortia known to be operating in the state at that time.[14]

Through these efforts, the project team identified fully operating health benefit consortia in Ohio and gained information on the types of public entities they served. Consortium officials who responded to the project team's inquiries and consented to having their names and contact information included in the Resource Guide are listed in the Appendix A-1 of this Resource Guide. Appendix A-2 includes baseline information on other health benefit consortia that were reported to SERB. However, because the project team was not successful in communicating directly with officials from this latter group of consortia during the Summer of 2015, the information provided on these consortia is limited to their reported names and whatever location information we could obtain from external sources. Information from the interviews and follow up surveys of consortia are included in the Resource Guide, and has been used as one source of information to support development of the steps and/or considerations outlined in this Resource Guide.

Interviews with Officials from Smaller Local Governments

While the SERB data sets and reports are tremendously helpful in understanding health benefit choices made by public entities in Ohio, the data contained in them are biased toward larger public entities and school districts, both of which are over-sampled in comparison to their distribution across the more than 3500 public entities in the state. For this reason, the project team conducted brief interviews with a small sample of local officials affiliated with local jurisdictions that serve less than 5,000 people within the state to learn more about their health benefits practices and interests and concerns in this area. The information gained through these interviews is used to help assure – to the extent possible, given available time and resources -- that key elements of the Resource Guide are applicable to this portion of the population of public entities in Ohio.

Updating the Guide Based on Sponsor Feedback and to Account for Recent Federal Policy Changes

After receiving useful feedback from State of Ohio officials, the project team investigated federal legislative changes relevant to the implementation of the ACA that were enacted between October of 2015 and May of 2016. Based on the feedback received and further investigations of recent federal legislative changes, the project team updated this guide. At this time, the project team also made a final review of the document to identify and make appropriate adjustments in presentation of the material offered in the guide.

[14] During the data collection phase of this project there were 54 consortia identified through the SERB dataset. However, after the data collection and analysis took place one consortium merged with another resulting in a final total of known consortia operating in Ohio of 53. However, we do report a survey universe of 54 consortia here as the merger did not occur until after data collection and analysis were complete. In addition, the Appendix A-1 compilation process used to compile the consortium information presented in Appendix A-1 relied heavily on the phone interview component of the data collection process mentioned above, and as a result, there may be ambiguities between the information presented in Appendix A-1 and the survey results. We did not attempt to address those ambiguities specifically as we analyzed the data, and treated the Appendix A-1 information collection and the survey data analyses as two separate processes.

Through the activities described above, the project team learned a great deal about the changing health insurance market, the health benefit purchasing practices of public entities, the public sector health benefit consortium business in Ohio, and opportunities for public entities to make appropriate health benefit choices in a changing health insurance market. Our learnings are documented in this Resource Guide and its companion document, Adapting to the Changing Health Insurance Landscape: A Look at the Use and Effects of Health Benefit Consortia by Public Entities in Ohio.

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Appendix E: Decision Making Tool

After your organization has requested health benefit proposals, the sample tables in this Appendix can help your organization organize and compare various health benefit proposals. Part A can be used to determine if the health benefit proposals your organization requested meet your organization's minimum specifications. Part B contains tables for evaluation of medical/prescription, dental, and vision plans. If your organization is not evaluating vision plans, for example, do not complete that specific table. The tables contain sections for three health benefit proposals, but additional proposals may be considered.

Part A: Minimum Specifications Evaluations

Overview: This table can be used to help your organization assess whether health insurance proposals meet the minimum acceptable requirements for your organization. Extra rows are provided to enable you to add criteria specific to your organization.

Step 1: In the column labeled, "Minimum Specifications," list the minimum acceptable benefits your organization will accept for each listed criterion.

Step 2: Enter the dollar amounts for each proposal. Then evaluate whether each proposal meets the minimum specifications for each criterion. Place a checkmark in the appropriate "Yes" or "No" column.

Step 3: Determine whether each health benefits proposal has met the minimum specifications. The costs of plans that have met the minimum specifications can be evaluated using the tables in Part B.

Criteria		Proposal 1			Proposal 2			Proposal 3		
	Minimum Specifications	Dollar Amount	Yes	No	Dollar Amount	Yes	No	Dollar Amount	Yes	No
Co-payment for office visit										
Co-payment for specialist										
Co-payment for emergency room visit										
Co-payment for urgent care visit										
Deductible paid by the employee: Network, Single Plan										
Deductible paid by the employee: Network, Two Person Plan										
Deductible paid by the employee: Network, Family Plan										
Deductible paid by the employee: Non-network, Single Plan										
Deductible paid by the employee: Non-network, Two Person Plan										
Deductible paid by the employee: Non-network, Family Plan										
Network co-insurance percent that the plan covers										
Non-network co-insurance percent that the plan covers										

Criteria		Proposal 1			Proposal 2			Proposal 3		
	Minimum Specifications	Dollar Amount	Yes	No	Dollar Amount	Yes	No	Dollar Amount	Yes	No
Out-of-pocket maximum including the deductible: Network, Single Plan										
Out-of-pocket maximum including the deductible: Network, Two Person Plan										
Out-of-pocket maximum including the deductible: Network, Family Plan										
Out-of-pocket maximum including the deductible: Non-network, Single Plan										
Out-of-pocket maximum including the deductible: Non-network, Two Person Plan										
Out-of-pocket maximum including the deductible: Non-network, Family Plan										
Are all the minimum specifications met? (Check "Yes" or "No.")										

Part B: Evaluation of Costs for Health Insurance Proposals

Medical and Prescription Plans

Overview: This table can be used to help your organization assess the costs of medical plans and prescription plans of health benefit proposals that meet the minimum specifications specified by your organization in Part A.

Step 1: In the column labeled, "Number of Employees," list the number of employees currently enrolled in that specific type of plan.

Step 2: Complete the "Yearly Cost" column for each health benefit proposal. Plans may have the prescription plan included in the medical plan. However, other plans may have the medical plan and prescription plan separate, in which case you need to add the medical plan and prescription plan cost together and then list the cost in "Yearly Cost."

Step 3: Calculate the "Total Yearly Cost" column for each proposal by multiplying the "Number of Employees" column by the "Yearly Cost" column for each row.

Step 4: Sum the "Total Yearly Cost" column for "Employee Total Yearly Cost" and "Employer Total Yearly Cost" to calculate the total yearly cost for employees and employers for each proposal. This will provide you with a total cost figure for employees and employer, respectively. These figures can be added together to provide a total cost.

Medical and Prescription Plan Costs		Proposal 1		Proposal 2		Proposal 3	
	Number of Employees	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost
Employee yearly premium contributions: Single Plan							
Employee yearly premium contributions: Two Person Plan							
Employee yearly premium contributions: Family Plan							
Employee Total Yearly Cost							

Medical and Prescription Plan Costs		Proposal 1		Proposal 2		Proposal 3	
	Number of Employees	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost
Employer yearly premium contributions: Single Plan							
Employer yearly premium contributions: Two Person Plan							
Employer yearly premium contributions: Family Plan							
Employer Total Yearly Cost							

Dental Plans

Overview: This table can be used to help your organization assess the costs of dental plans of health benefit proposals that meet the minimum specifications specified by your organization in Part A.

Step 1: In the column labeled, "Number of Employees," list the number of employees currently enrolled in that specific type of plan.

Step 2: Complete the "Yearly Cost" column for each health benefit proposal.

Step 3: Calculate the "Total Yearly" column for each health benefit proposal by multiplying the "Number of Employees" column by the "Yearly Cost" column for each row.

Step 4: Sum the "Total Yearly Cost" column for "Employee Total Yearly Cost" and "Employer Total Yearly Cost" to calculate the total yearly cost for employees and employers for each proposal. This will provide you with a total cost figure for employees and employer, respectively. These figures can be added together to provide a total cost.

Dental Plan Costs		Proposal 1		Proposal 2		Proposal 3	
	Number of Employees	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost
Employee yearly premium contributions: Single Plan							
Employee yearly premium contributions: Two Person Plan							
Employee yearly premium contributions: Family Plan							
Employee Total Yearly Cost							

Dental Plan Costs		Proposal 1		Proposal 2		Proposal 3	
	Number of Employees	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost
Employer yearly premium contributions: Single Plan							
Employer yearly premium contributions: Two Person Plan							
Employer yearly premium contributions: Family Plan							
Employer Total Yearly Cost							

Vision Plans

Overview: This table can be used to help your organization assess the costs of vision plans of health benefit proposals that meet the minimum specifications identified by your organization in Part A.

Step 1: In the column labeled, "Number of Employees," list the number of employees currently enrolled in that specific type of plan.

Step 2: Complete the "Yearly Cost" column for each health benefit proposal.

Step 3: Calculate the "Total Yearly" column for each health benefit proposal by multiplying the "Number of Employees" column by the "Yearly Cost" column for each row.

Step 4: Step 4: Sum the "Total Yearly Cost" column for "Employee Total Yearly Cost" and "Employer Total Yearly Cost" to calculate the total yearly cost for employees and employers for each proposal. This will provide you with a total cost figure for employees and employer, respectively. These figures can be added together to provide a total cost.

Vision Plan Costs		Proposal 1		Proposal 2		Proposal 3	
	Number of Employees	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost	Yearly Cost	Total Yearly Cost
Employee yearly premium contributions: Single Plan							
Employee yearly premium contributions: Two Person Plan							
Employee yearly premium contributions: Family Plan							
Employee Total Yearly Cost							

Vision Plan Costs		Proposal 1		Proposal 2		Proposal 3	
Employer yearly premium contributions: Single Plan							
Employer yearly premium contributions: Two Person Plan							
Employer yearly premium contributions: Family Plan							
Employer Total Yearly Cost							

Part C: Additional Considerations

Overview: This table can be used to record additional general considerations and consortium considerations (as/if applicable) that your organization may want to assess when considering health benefit proposals.

General Considerations	Proposal 1	Proposal 2	Proposal 3
Fully-insured or self-insured health plan?			
Type of approval needed to switch health insurance plans (e.g., renegotiation of contract, union approval)?			
Length of agreement?			
Employees able to use the same doctors and hospitals?			
Any special programs offered (e.g., wellness program, disease state management program)			

Other General Considerations	Proposal 1	Proposal 2	Proposal 3

Consortium Considerations	Proposal 1	Proposal 2	Proposal 3
Annual fees for participating in the consortium?			
Number of health plans offered?			
Number of members in the consortium?			
Number of members joining in last two years?			
Number of members leaving in the last two years?			
Number of lives covered?			
Location of the consortium?			
Pooled or allocated balance used?			
Level of cash reserves?			
Length of notice to leave the consortium?			
Claims history provided in a regular/timely fashion?			
Who pays run out?			
Able to bring current plan to the consortium?			

Other Consortium Considerations	Proposal 1	Proposal 2	Proposal 3