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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Disclaimer

KSU, through its Center for Public Policy and Health (CPPH), and the ODAS have put in substantial efforts to ensure that this document contains helpful information about current health insurance purchasing practices of public entities in Ohio. This report also provides an initial look at some of the advantages and disadvantages of different health insurance purchasing arrangements. However, this document is not meant to be used as a guide for purchasing health insurance. KSU and ODAS have developed a Resource Guide to help local entities think through the process of health insurance purchasing decisions. Interested officials can find the Resource Guide on the KSU-CPPH and the ODAS websites. 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 you use of the information provided in this report.

Note to 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health insurance in Ohio are in the process of undergoing significant change, so information provided here may become outdated.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 report, readers are encouraged to supplement the information in this report with current or more recent information whenever possible.

Report Highlights

This report provides an integrated description of the use of health benefit consortia by public entities in Ohio. It also offers information on the costs and benefits associated with the use of these consortia by public entities in Ohio, as well as their advantages and disadvantages. The report's findings are based on data obtained from the State Employment Relations Board (SERB) of Ohio, and a review of literature on health benefit consortia and recent changes in American health insurance markets. Key findings in the report are summarized below.

Use of Health Benefit Consortia in Ohio

- There appear to be at least 53 health benefit consortia (or similar joint purchasing arrangements) serving public entities in Ohio.
- The average reported length of public entity participation in health benefit consortia is 15 years.
    - School districts reported longer periods of participation than other kinds of Ohio public entities.
- SERB survey data from 2014 indicate that 59% of health plans purchased by public entities responding to the survey were purchased through health benefit consortia. However, school districts appear more likely to purchase pooled health benefits than other kinds of public entities.
    - 79% of school district health plans were purchased through health benefit consortia.
    - 30% of health benefit plans purchased by other public entities were purchased through health benefit consortia.
- Saving money was the most frequently mentioned motivating factor for joining a consortium (84%), although the ease of purchasing health benefits through a consortium (44%) and more extensive benefits (36%) were also mentioned frequently (SERB, 2015A).
- The majority (74%) of health plans purchased through a consortium are self-funded plans, while the majority (73%) of individually purchased plans were fully-insured plans (SERB, 2014A).
- About half (51%) of public entity plans purchased by organizations with more than 100 employees are purchased through consortia, while almost two-thirds (63-64%) of health plans purchased by public entities with 100 or fewer employees are purchased through consortia.

Health Benefit Plans: Costs and Benefits

- Public entities participating in health benefit consortia reported lower costs for monthly premium contributions for both individuals and families.
- Employees of organizations participating in health benefit consortia appear to pay lower network deductibles for both single and family coverage and to have lower out of pocket maximum payments than do employees who participate in individual insurance plans.

While these findings point toward potential cost and health benefit advantages of health benefit consortia for Ohio public entities, officials from these entities should recognize that these findings are preliminary and based on a limited number of bi-variate associations. Public officials should therefore

evaluate the appropriateness of specific consortium and other health benefit opportunities based on their entities' circumstances when deciding how best to provide health benefits to their employees. To assist with this kind of effort, the Ohio Department of Administrative Services (ODAS) and the Kent State University Center for Public Policy and Health (KSU-CPPH) have released a Resource Guide simultaneously with this report (KSU-CPPH, 2016). Public entity officials may benefit by consulting that guide as they review their own particular circumstances.

Potential Advantages and Disadvantages of Joining Health Benefit Consortia

While experiences with consortium purchased health benefit plans are likely to vary, the literature reviewed for this project suggests that health benefit consortia hold the potential for a number of advantages and disadvantages. Some of these are reported below.

- Entities participating in health benefit consortia may experience the following potential **advantages**:
    - leveraged purchasing power that can reduce premium rates;
    - premiums based on experience ratings rather than community rating;
    - an array of plans for employees to choose from;
    - shared administrative costs, and;
    - added capability to self-fund health benefits.[1]

- Entities participating in health benefit consortia may experience the following potential **disadvantages**:
    - difficulties coordinating with other entities;
    - costs related to the use of health benefit consortia (e.g., terminal liability, legacy costs);
    - inability to join health benefit consortia due to past claims history (e.g. adverse selection);
    - difficulty in leaving a health benefit consortium if/when desired, and;
    - joining a health benefit consortium that could potentially fail.

Overall, health benefit consortia appear to be a commonly used means by which public entities in Ohio purchase health benefits for their employees. The use of these consortia may result in cost and benefit advantages, as well as potential disadvantages that may need to be addressed by the entities using them. Due to incentives developing in the health insurance market, it appears likely that public entities will continue to use consortia to purchase health benefits for their employees and may make more frequent use of them in the future.

Note. Due to state requirements relating to SERB's sampling of public entities for its survey, the SERB data used in this report appear to disproportionately reflect the practices of school districts and larger public entities.

[1] While public entities are able to self-fund without joining a consortium, collaboratively purchasing health insurance may allow smaller entities that would be too small to self-fund their employee health insurance to take advantage of the practice by joining consortium-based purchasing arrangements.

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Introduction

Public entities in Ohio are being subjected to the same shifts in the health insurance landscape as private businesses and individuals. Health benefits are an important issue for public entities because they represent a form of compensation for public employees and a significant source of expenditures for the entity as a whole.

This report seeks to create an integrated description of the use of health benefit consortia by public entities in Ohio, including school districts, counties, cities, townships, institutions of higher education and others. It also provides basic information on some of the reported costs and benefits of health benefit consortia for public entities, and the potential advantages and disadvantages of their use. To accomplish these purposes, the following topics relating to health insurance are discussed.

- **The Changing Health Insurance Landscape**: Since passage of the Affordable Care Act (ACA)[2] in 2010, employers, individuals, and healthcare providers have seen significant changes in health insurance arrangements in Ohio and elsewhere. For employers, the passage of the ACA has led to changes in requirements and fees associated with employer provided health benefits. These changes are affecting both private sector employers and public entities.

- **Intergovernmental Collaboration to Reduce Costs**: For some time now, public entities have faced budgetary stresses associated with rising health care costs. As a result of these cost increases, local governments and other public bodies have seen an increase in expenditures associated with providing health benefits to their employees and have explored and implemented options for reducing costs. One option has been participation in health benefit consortia, where multiple public entities come together to purchase health benefits for their employees.

- **Current Use of Health Benefit Consortia in Ohio**: Data from the 2014 and the 2015 State Employment Relations Board (SERB) annual surveys of public entities regarding their health insurance purchasing practices are used to assess the current use of health benefit consortia by public entities in Ohio. More specifically, information on the overall use of health benefit consortia by public entities in Ohio is broken down among various types of public entities (e.g., cities, townships, counties, school districts, institutions of higher education). Information is also presented on the role that the type of insurance (i.e., fully-insured vs. self-funded) and the entity's size may play in influencing judgments regarding whether or not to join or participate in a health benefit consortium. Finally, some basic information is presented on the mean costs and benefits paid by employers and employees, based on whether or not they participate in a health benefit consortium.

[2] 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.

- **Advantages and Disadvantages of Health Benefit Consortia**:
  Potential advantages for public entities that join a health benefit consortium include allowing government entities to increase the number of individuals or entities in their health benefit risk pool. This may enable cost savings for the participating entities and/or the continuation or improvement of health benefits as health care costs continue to rise and changes are made in the health insurance marketplace. However, there are also potential disadvantages to participating in a health benefit consortia, such as coordination difficulties and limitations on the extent to which different public entities may join or leave a health benefit consortium.

Additional information on each of these topics is presented on the pages that follow.

Fully-Insured vs. Self-Funded Health Plans

Under ***fully-insured health plans***, the fully-insured premium rate is paid every month, which does not vary, except for headcounts (new additions or terminations to the plan). At the end of the plan year, a fully-insured employer will have paid premiums every month regardless of whether or not they had any claims.

In a ***self-funded health plan***, an employer directly funds all of its claims. On the self-funded basis the employer would have paid the administrative and stop loss fees, plus payments for actual claims incurred. The employer's fund gets to keep all the money that is not paid out; however, if liabilities exceed the self-funded entities' reserves, then that entity will have to pay the difference (Brown 2015).

Contextual Background

There are at least two major contextual trends that appear likely to affect the use of health benefit consortia by public entities in Ohio. The first is the changing landscape of health insurance coverage associated with rising health care costs and the implementation of the ACA, which may affect incentives for public entities to participate in health benefit consortia. The second trend is the increased frequency with which local government entities collaborate with one another, such as participating in health benefit consortia, to accomplish mutually beneficial ends. Both of these trends may make health benefit consortia more attractive for public entities and are discussed below.

First Trend: A Changing Health Insurance Landscape

Health care costs have been on the rise. At the state and local level, health care spending rose from $45.3 billion in 2003 to $64.9 billion in 2013, a 19.6 billion dollar increase over the past decade (Kaiser Family Foundation, 2015b). Furthermore, for the State of Ohio, the average annual growth percentage in health

care expenditures per capita from 1991-2009 is 5.5% (Kaiser Family Foundation, 2015A).

With the passage of the ACA, there have been significant changes in the health care arena which may impact public officials' decisions related to participating in health benefit consortia. Certain requirements and fees, which have been rolled out in a staggered fashion, apply only to certain sized employers and certain types of health plans (i.e. fully-insured plans and self-funded plans). As a result, these requirements and fee structures may incentivize some forms of health benefit arrangements over others. Public officials, along with their private and non-profit counterparts, are now beginning to sort through the details surrounding these new requirements and fees in order to make good decisions about how and where they purchase health insurance for their employees.

ACA requirements and fees based on entity size. Under the ACA, new requirements and fees have been imposed based on entity size. Below are some examples[3]:

- **Employer Shared Responsibility Provisions.** Under the ACA, only large employers may be penalized for non-compliance with this provision (Brown, 2013). Large employers are defined as employers with 50 or more full-time-equivalent employees (30 hours a week on average or the monthly equivalent of 130 hours a month; Brown, 2013). By 2016, all applicable large employers must report whether they offer coverage to full-time employees that meets minimum value requirements (pays at least 60 percent of all costs and benefits under the plan) and whether the coverage is affordable (employee's share of the premium does not cost the employee more than 9.5% of their annual household income; Internal Revenue Services, 2015).

- **Modified (adjusted) Community Rating Rules**. Prior to the ACA, health insurers in most states could use factors such as medical history and use of health services in determining premium costs; however, as of 2014, health insurers in the small and individual markets are only allowed to adjust premiums based on individual/family enrollment, geographic area, age, and tobacco use (Centers for Medicare and Medicaid Services [CMS], 2013). While the recent Protecting Affordable Coverage for Employees Act (PACE, 2015) has prohibited the federal government from increasing the size threshold for experience rating from 50 to 100 employees (as was intended prior to passage of this 2015 law), states may still have the authority to do so. To the extent states use this kind of authority, they may affect the costs of public entity health benefit plans in ways which make health benefit consortia worth considering.

[3] For more information on the ACA and requirements and fees that apply to public entities based on size and apply to both fully-insured and self-funded plans, please see *Resource Guide: Health Insurance Choices for Ohio Public Entities* which the KSU-CPPH has developed in partnership with Ohio Department of Administrative Services. The document was released in 2016 concurrently with this Report. Further information can also be found by reviewing the cited references.

According to at least some observers, a switch to community ratings would lead to higher premiums for many small businesses, particularly those with a younger and healthier staff that had lower premiums pre-ACA (Hamilton, 2013). Self-funded plans and grandfathered[4] plans are not subject to the new adjusted-community rating requirement (Corlette, 2015). Small organizations may avoid premium hikes associated with a move to community rating by dropping coverage or switching to a self-funded plan (Hamilton, 2013). For small public entities, joining a health benefit consortium of public entities may be the best or only way to take advantage of the benefits of self-funded status.

ACA requirements and fees based on type of health plan. A number of the ACA's fees are applied only to fully-insured plans and not self-funded plans. As a result, it is reasonable to anticipate a move toward greater use of self-funded plans, as employers seek to minimize costs associated with ACA compliance and fees. For smaller public entities, an effective way to take advantage of the benefits of self-funded mechanisms may be to join a health benefit consortium. Below are some fees that are only applicable to fully-insured plans.

- **Market Share Fee**. This permanent fee is only applicable to fully-insured plans (Florida Blue, 2015). The fee started in 2014, with an additional fee scheduled to be imposed in 2018 with premium increases (Florida Blue, 2015). The fee funds the premium tax subsidies for low-income individuals and families that purchase insurance from the public exchanges (Medical Mutual, 2015).

- **Risk Adjustment Fee**. This permanent fee is only applicable to fully-insured plans in individual and small group markets and non-grandfathered platinum, silver, gold and bronze health plans that are purchased both inside and outside of the exchange (Williamson, 2013). The fee started in 2014, with charges scheduled to begin in 2015 (Williamson, 2013). This fee funds government cost to administer the Risk Adjustment Program.

Experience Rating vs. Community Rating

Insurance providers may use experience ratings or community ratings to establish health insurance costs.

In an ***experience rated plan***, premiums are based on the actual health care claims incurred by the participants in the plan, rather than by demographic information that may be used through community rating processes; however, only plans sold to larger employers or self-funded plans are eligible to use experience ratings (National Association of Health Underwriters (NAHU), 2015). For experience-based cost calculations, annual premium changes are based on claim experiences of prior years and any increase in costs of providing health insurance (NAHU, 2015).

In a ***community rated plan***, premiums are based on the pooled factors of the community within which the participants reside (CMS, 2015). The premiums are often higher with a community rated plan, compared to an experience rated plan, since the claims experiences are not well known and premiums need to cover any unexpected costs (NYSBA, 2009).

[4] "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).

- **Exchange User Fee**. This permanent fee is applicable to fully-insured and non-grandfathered plans. The fee started in 2014 with the health insurance carriers being charged 3.5% of their premium for all business on a federal facilitated exchange (Williamson, 2013). This fee helps fund and support the federal exchanges (Medical Mutual, 2015).

In addition to avoiding the three fees highlighted above, self-funded plans are not subject to some of the ACA's plan requirements, such as the Modified Community Rating Requirements for small employers discussed above (see Kent State University [KSU] Center for Public Policy and Health [CPPH], 2016 for more details).

Second Trend: Collaboration Among Local Government Entities in Ohio

Ohio is home to more than 3,500 local government entities, and these entities have been challenged to maintain service levels while finding ways to reduce costs (Hoornbeek et al., 2009). As a result, local government entities in Ohio appear to be paying increasing attention to the subject of inter-governmental collaboration. Inter-governmental collaboration takes many forms, but often the goals of the collaboration are to reduce costs and enhance public services through cost sharing arrangements, joint use of staff and resources, and/or merging services completely (Center for Public Administration and Public Policy, 2011). Such collaborative activities have been pursued by general purpose local government entities, such as cities and counties, school districts, local health districts, and special purpose governments such as park districts, sewer districts, etc.

The recent recession and the resulting loss of revenues for government entities has led to increased attention on creative local government partnerships. A small sample of such collaborative actions identified by KSU-CPPH (Center for Public Administration and Public Policy, 2011) include:

- Joint economic development districts/zones
- Joint equipment and supply purchasing
- Public health department/district consolidation
- Collaborative storm water management
- Anti-poaching agreements (economic development)
- Joint vehicle maintenance agreements

In the realm of health insurance purchasing, Ohio's SERB has documented widespread participation in health benefit consortia by local government entities (SERB, 2014B). This trend is another example of how local governments in Ohio are looking for creative ways to reduce costs while maintaining their current level of service operation. We provide a more detailed discussion of the current use of health benefit consortia – based on survey data provided by SERB – in a later section of this report.

Methods

While our work on this project included a wide range of research and investigation efforts[5], this report relies heavily on surveys conducted by the SERB of Ohio. [6] A review of relevant literature was conducted, and this enabled the identification of a number of potential advantages and disadvantages associated with health benefit consortia.

SERB's Annual Cost of Health Insurance in Ohio's Public Sector (Survey)

Each year, SERB conducts a survey of public entities in Ohio. The annual survey is completed by the vast majority of eligible public entities in Ohio, with very high response rates (92.8% in 2014 and 95.8% in 2015; SERB 2014B; SERB 2015B). The purpose of the survey is to "provide data on various aspects of health insurance, plan design, and cost for government entities" (SERB, 2014B).

This report analyzes data from the surveys conducted in 2014 and 2015, but the majority of the data referenced here are from the 2014 survey. The 2014 survey and a dataset of responses to it were provided by SERB in early 2015. SERB also included several targeted questions on health benefit consortia in its 2015 SERB survey, and provided responses to these questions to us in April 2015, immediately after the data were collected and compiled. A complete dataset from the 2015 survey was made available by SERB in August of 2015. However, this document reports on responses to the targeted questions on consortia received in April 2015, but not on other questions in the 2015 SERB survey which became available in August 2015.

Survey participants. Below is a description of the entities that participated in the 2014 and 2015 SERB survey.

***2014 SERB survey*.** In January 2014, SERB sent the 2014 survey 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 survey in total represented 392,304 public employees in the State of Ohio – including state employees (SERB, 2014B).

2015 SERB survey. In January 2015, SERB sent the 2015 survey to 1,322 public entities, and 1,266 of them were completed by administrators from the jurisdictions involved—a response rate of 95.8% (SERB, 2015B). The survey in total represented 383,638 public employees in the State of Ohio—including state employees (SERB, 2015B).

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[5] In carrying out this project, data provided by SERB were analyzed, a substantial literature review was conducted, a sample of public sector collective bargaining agreements was reviewed and analyzed, interviews and surveys were conducted with representatives of public sector health benefit consortia, and discussions with representatives of smaller public entities were undertaken. More information on these efforts can be obtained by contacting the KSU-CPPH.

[6] We thank Justin Brown and his colleagues at SERB for their valuable assistance.

2014 and 2015 SERB survey response rates. Table 1 provides a breakdown of SERB's sampling framework for the survey as presented in its 2014 and 2015 reports (SERB 2014B and 2015B). Villages and smaller townships were not included in the survey (SERB, 2014B). This is because, according to the Ohio Revised Code, Chapter 3314, to be considered a "public employer" for the purpose of the SERB survey, a municipal corporation must serve at least 5,000. As a result, the survey – and analyses based upon it – is biased away from very small public entities. In addition, more than one-half of both the sampling frame and the survey responses represented school districts, so school districts are over-represented relative to other kinds of public entities in the aggregate results. Readers should be aware of these biases as they interpret the results presented below.

Table 1: 2014 & 2015 SERB Survey Sampling Framework & Response Rates

Entity Type	2014 Surveys Completed/ Number Sampled (Response Rate)	2015 Surveys Completed/ Number Sampled (Response Rate)
School Districts	696/720 (97%)	695/712 (98%)
Cities	226/251 (90%)	241/251 (96%)
Townships	122/152 (80%)	140/154 (91%)
Counties	81/88 (92%)	84/88 (95%)
Metropolitan Housing Authority	38/40 (95%)	36/40 (90%)
Colleges and Universities	34/37 (91%)	33/37 (89%)
Fire Districts	17/18 (95%)	20/20 (100%)
Regional Transit Authorities	13/15 (87%)	13/14 (93%)
Port Authorities	3/5 (60%)	3/5 (60%)
State of Ohio	1/1 (100%)	1/1 (100%)
Total	1,231/1,327 (92.8%)	1,266/1,322 (95.8%)

Analyzing SERB survey data. After receiving the 2014 dataset from SERB, we reviewed the contents of the dataset, including the variable list and codebook that were provided with it. The data were transferred from Microsoft Excel to IBM SPSS Statistics to enable more extensive analyses. Our analysis of the SERB data sought to build from the useful descriptive analyses produced by SERB staff and presented in their 2014 annual report (SERB, 2014). Our analytical approach used the following steps:

- Review the contents of the dataset
- Perform descriptive analyses of:
    - Use of health benefit consortia among different kinds of public entities (e.g., schools, cities, counties, etc.)
    - Use of health benefit consortia and use of fully-insured versus self-funded mechanisms
    - Use of health benefit consortia and public entity size
- Perform bivariate analyses to understand relationships between the use of health benefit consortia and health plan costs and benefit levels
    - Cross-tabulations and t-tests of public entity costs and benefits data were used to test the relationship between the costs and benefits associated with health benefit plans purchased through health benefit consortia compared to health benefit plans purchased by individual public entities[7], as well as differences between fully-insured and self-funded health plans.
- Investigated health benefit consortium contacts provided by survey respondents and we interviewed and surveyed them wherever possible to develop an un-duplicated list of health benefit consortia serving public sector entities in Ohio.

While our analytical methods are appropriate for their purposes given the time and data available, they do carry limitations – above and beyond the survey biases identified above. Our cross-tabulations and t-tests reflect bivariate relationships, and do not control for other possible determinants of health plan costs and benefits. As a result, our data suggest measures of association only, and do not necessarily reflect true and complete measures of the costs and benefits that would be experienced by Ohio public entities purchasing health benefits individually and through consortia, respectively. They do not test for, or necessarily suggest, causal relationships. In addition, in spite of the very high response rates to the SERB survey, we cannot be certain that our inventory of health benefit consortia serving Ohio public entities is comprehensive.

Despite these limitations, our analyses are based on survey data that include responses from a large proportion of public entities in Ohio serving populations of 5,000 or more, and they suggest bi-variate correlations between the use of health benefit consortia and self-funded health plans and measures of health plan cost and benefit generosity. In addition, our inventory of health benefit consortia serving public entities in Ohio is the largest and most comprehensive one that we know to be available to date.

[7] In this context, we are defining "individual insurance plans" and "individual insurance" to mean either fully-insured or self-funded plans *purchased/funded by a single entity,* rather than *by a consortium of entities* (ie. purchased through collaborative means).

Review of Literature

Members of our team also reviewed scholarly and professional literature related to health benefit consortia. Particularly, we focused our review in the following areas:

- The logic of health benefit consortia
- The potential advantages of health benefit consortia
- The potential disadvantages of health benefit consortia
- The relationship between health benefit consortia and changes in the health insurance marketplace

Based on this review of literature, potential advantages and disadvantages associated with participation in health benefit consortia are listed later in this report.

Current Use of Health Benefit Consortia in Ohio

There are dozens of health benefit consortia currently operating in Ohio. Using the results of SERB's annual surveys of local government officials regarding their insurance purchasing practices, we have been able to document the existence of 53[8] health benefit consortia that appear to be operating and providing services for public entities in Ohio. While this list is not comprehensive – as there may be other health benefit consortia operating in Ohio that were not reported in the survey results, the data provide a helpful snapshot of the types of health benefit consortia that are currently active in Ohio. The full list of known public entity health benefit consortia in Ohio can be found in the Appendix to this report. Perhaps not surprisingly, of the health benefit consortia reported, many appear to be dedicated exclusively to school districts. These types of health benefit consortia make up a substantial portion of the overall list, and their development may have been aided by Educational Service Centers that were established to assist school districts with their collaborative efforts.

How Common is Purchasing Health Benefits Through Consortia Among Ohio's Local Governments?

Overall, 59% of *health plans* reported to have been purchased by Ohio public entities in the 2014 SERB survey were purchased through health benefit consortia. Table 2 displays information on the number and percentage of health benefit plans offered by responding public entities that are provided through health benefit consortia and health benefits purchased by individual public entities.

[8] To create the final list of health benefit consortia, we removed known duplicate entries, and conducted multiple telephone follow up contacts to verify that the consortia named by SERB survey respondents were in fact separate and distinct consortia providing services to public entities in Ohio. In addition to the 53 health benefit consortia, the Jefferson Health Plan has 8 affiliated health benefit consortia pools, and the Lawrence County Schools Council of Governments has 1 affiliated health benefit consortia pool. More complete information on many of these consortia is included in the Resource Guide mentioned earlier in this report.

Table 2: Health Benefit Purchasing by Health Benefit Consortia Individual Public Entities

Government Entity Type	Purchased through Health Benefit Consortia (fully insured/self-insured plans purchased/funded collaboratively) [# (%) of Health Plans]	Purchased by Individual Public Entities (fully insured/self-funded plans purchased/funded by a single entity) [# (%) of Health Plans]	Total Number of Health Plans
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
Total	1075 (59%)	762 (41%)	1837[9]

Source: 2014 SERB Survey Dataset

As shown in Table 2, the majority of respondents were school districts (1082/1837 = 59%), followed by cities (329/1837 = 18%), counties (142/1837 = 8%), townships (132/1837 = 7%), special districts—fire districts, metropolitan housing authority, port authorities (4%), and colleges/universities (4%). Among the different entity types, school districts have the highest level of participation in health benefit consortia, with 79% of school health plans purchased through health benefit consortia. Of the remaining sampled entities, 26% of cities, 39% of counties, 39% of townships, 20% of special districts, and 21% of colleges/universities' health plans were purchased through health benefit consortia. Overall, about 30% of health benefit plans purchased by public entities other than school districts were purchased through health benefit consortia.

In addition, the initial 2015 SERB data indicate that utilization of health benefit consortia may not be a new phenomenon for many public entities in Ohio. According to the 2015 survey results, the average number of years public entities have participated in the health benefit consortium that they are

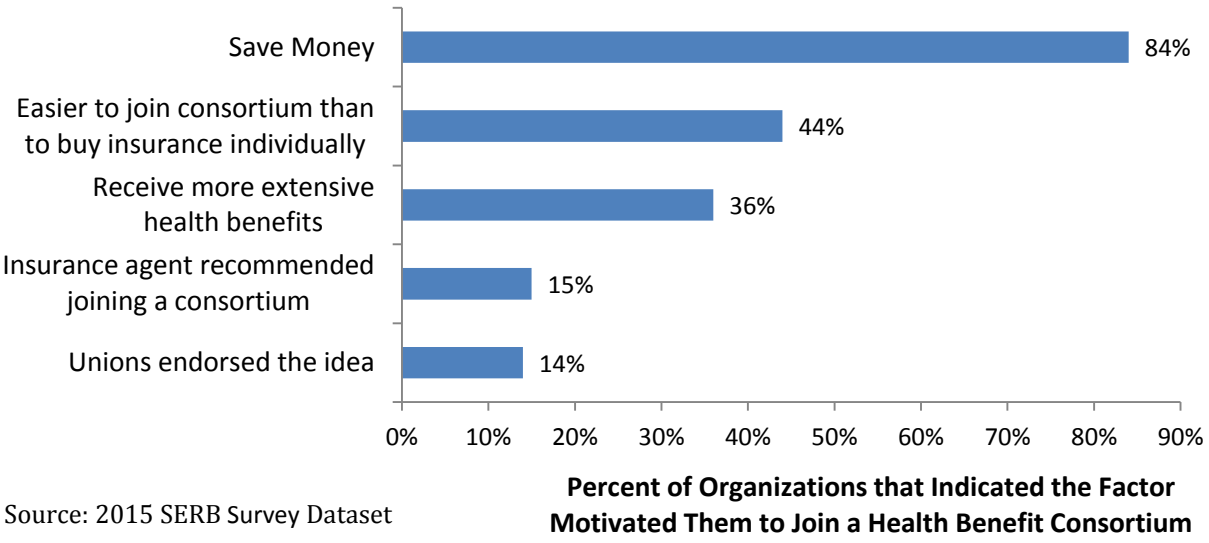
[9] In this table, and throughout the document, plan and entity totals may vary due to missing data associated with the specific variable(s) being analyzed.

currently enrolled in is 15 years. The range of the responses went from 0 to 50 years. However, a review of the data shows that school districts have typically engaged in health benefit consortia longer than other public entities. For example, school districts reported having participated in health benefit consortia an average of 18 years (standard deviation[10] = 10.44) with a range of 0 to 50 years, while other public entities reported participating in health benefit consortia an average of a little over 7 years (standard deviation = 7.64) with a range of 0 to 30 years. Consequently, it appears that certain public entities, such as school districts, have had a head start on purchasing through health benefit consortia compared to other kinds of public organizations in Ohio.[11] This "head start" may explain the more frequent use of consortia by school districts as compared to other kinds of Ohio public entities.

Motivation for Joining Health Benefit Consortia

Data from the 2015 SERB survey of public entities also shed light on the factors motivating public officials to purchase health insurance through health benefit consortia. Figure 1 highlights initial results relating to factors motivating the utilization of health benefit consortia by Ohio public entities. Saving money, ease of purchasing through health benefit consortia, and receiving more extensive health benefits were factors that many responding public entity officials cited as reasons their organizations chose to join a health benefit consortium. Saving money was the factor most often cited, with 84% of responding organizations indicating it motivated them to join a health benefit consortium.

Figure 1. Motivating Factors for Joining a Health Benefit Consortium



Source: 2015 SERB Survey Dataset

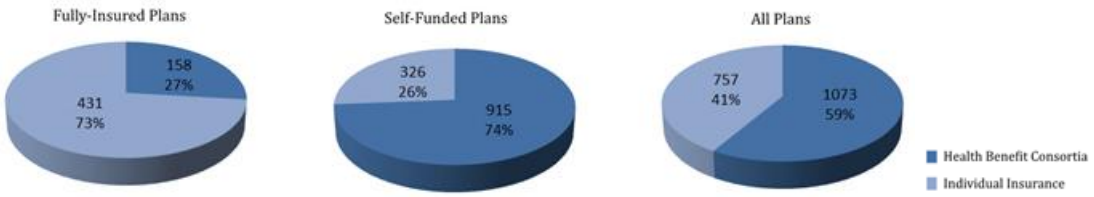
[10] Standard deviation is an indicator of how widely numbers are spread out or dispersed around the mean (MathIsFun, 2014). Larger standard deviations indicate a greater dispersion than smaller standard deviations.

[11] One possible explanation for this difference lies in the existence of Educational Services Centers, which have, for many years, worked with school districts to achieve cost savings and service expansions in Ohio. There is no similar institutional arrangement for most other Ohio public entities, and these public entities may have been slower in developing collaborative arrangements as a result.

Insurance Type and Health Benefit Consortia Purchasing

One potential underlying reason why public entities may join health benefit consortia is to enable them to expand the numbers of insured persons to a point where the entities can take advantage of self-funded health benefit arrangements. For this reason, we investigated the extent to which entities participating in health benefit consortia were using self-funded health benefit plan arrangements, as opposed to purchasing fully-insured policies from insurance companies. Among the 1,073 health plans that were reported to purchase health benefits through health benefit consortia, 915 (85%) were reported to be self-funded. It thus appears clear that health plans purchased through consortia are more likely to be self-funded than fully-insured. Viewed from another perspective, we also found that of those entities that reported purchasing self-funded health benefit plans, 74% of their health plans were purchased through a health benefit consortium. By contrast, 26% were individually purchased plans. Of the fully-insured health plans, only 27% were reportedly purchased by health benefit consortia. Figure 2 highlights these figures.

Figure 2. Health Benefit Consortia Participation Compared by Type of Health Insurance

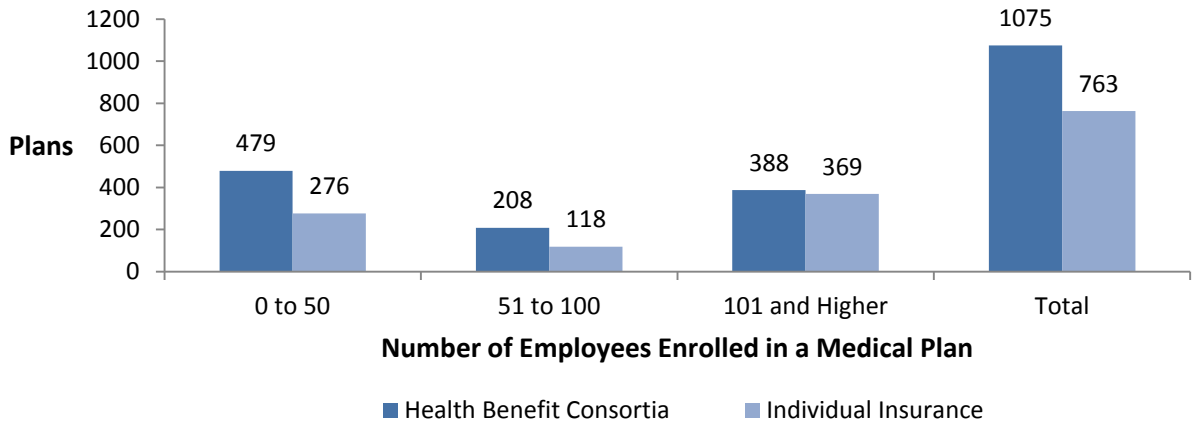


Fully-Insured Plans n=589, Self-Funded Plans n=1241, All Plans n=1830
Source: 2014 SERB Survey Dataset

Participation in Health Benefit Consortia Among Public Entities of Different Sizes

Figure 3 highlights participation in health benefit consortia among insurance plans serving entities with varying numbers of employees enrolled in medical plans. In the figure, we categorize the 1,838 insurance plans in SERB's sample by number of employees enrolled in the plan. For large plans (101 employees enrolled and higher), about half of the plans (51%) in the SERB dataset were purchased through health benefit consortia and the other half (49%) were purchased individually. For plans enrolling 51 to 100 employees, about 64% were purchased through health benefit consortia and 36% individually. Finally, of small plans with 0-50 employees enrolled, 63% were purchased through health benefit consortia and 37% individually. In short, medical plans were more likely to be purchased through health benefit consortia when the number of employees enrolled in a medical plan was 100 or fewer.

Figure 3. Insurance Plan Size by Health Benefit Consortia Participation



Source: 2014 SERB Survey

Overall, the findings reported above suggest that health benefit consortia are already a common mechanism by which public entities in Ohio purchase health benefits for their employees – particularly among school districts. They also suggest that a number of health benefit consortia have been used in Ohio for quite some time. Given the changing health insurance market and apparent incentives in the ACA (discussed above), there is reason to believe that the use of health benefit consortia may very well increase further in the future – perhaps particularly among general purpose governments (cities, counties and townships) that may be seeking advantages associated with larger pools of insured employees in the current health insurance market – advantages which are already enjoyed by many school districts in the state.

Health Benefit Consortia: A Preliminary Look at Costs and Benefits

To understand whether there are consistent associations between the type of health insurance purchasing arrangement and the costs and benefits of public entity health benefit plans, we used data from the SERB (2014A) dataset to identify measures of health benefit costs to employers and employees. We also identified measures of the generosity of benefits from the SERB dataset.

We identified four measures of health insurance cost. They are as follows:
(1) monthly employer contribution for the single employee medical plan;
(2) monthly total (employer and employee) contribution for single employee medical plan;
(3) monthly employer contribution for the family medical plan, and;
(4) monthly total (employer and employee) contribution for the family medical plan.

Similarly, we identified four measures of the generosity of health benefits provided by the public entities in the SERB 2014 sample. They are as follows:
(1) amount of deductible paid by an employee for a single plan in-network;
(2) amount of deductible paid by an employee for a family plan in-network;
(3) out of pocket maximum health payments for plans covering a single individual, and ;
(4) out of pocket maximum health payments for plans covering a family.

For each of these sets of measures, t-tests were conducted to determine if health benefit costs were systematically lower for health plans offered by health benefit consortia than for individually purchased health benefit plans. T-tests were also conducted to ascertain whether health plans offered by health benefit consortia were systematically more generous in regard to the benefits provided to employees.

Table 3 provides the results of these bi-variate statistical (t-test) analyses. They show that public entities participating in health benefit consortia reported lower costs across the board, in terms of premium contributions for both individuals and families. These reduced costs appear to accrue to the public entities themselves, as employer costs were lower for participants in health benefit consortia. Some of these savings may also extend to employees as well, as the total contributions (employer and employee) were also consistently lower for participants in health benefit consortia than participants in individually purchased insurance plans.

A similar pattern was found for the benefits variables. Employees working at organizations participating in a health benefit consortia appear to pay a lower network deductible for both single and family coverage than do employees who participate in benefit plans purchased by individual public entities. They were also more likely to have lower out of pocket maximum payments. Both of these sets of results were also statistically significant, and were therefore not likely to be attributable to chance. While these results suggest that public entities purchasing health benefit plans through consortia may get "more for their money," it is important to remember that these analyses do not control for other factors which may affect health benefit plan cost or benefits, and they measure only a handful of indicators that may be of importance to employers and the employees whom they insure. Even so, they do suggest that there may be cost and benefit advantages to purchasing health benefits through consortia that officials representing public entities should consider. [12]

[12] Some of the cost savings and enhanced benefits associated with participation in a consortium may be traceable to the consortium's ability to take advantage of larger numbers of insured persons to self-fund their health insurance plans. Analysis of variance (ANOVA) tests were conducted on the health insurance costs and benefits variables in Table 3 to assess whether health benefit consortia participation (i.e., health benefit consortia vs. health benefits purchased by individual public entities) and type of insurance (i.e., fully-insured vs. self-funded) influence health benefit costs and benefits. The results suggest that cost savings and greater benefits may be due to participating in a health benefit consortium, self-funding, and/or an interaction between health benefit consortia and self-funding. Therefore, some of the cost savings and enhanced benefits shown in Table 3 may result from entities being able to self-fund their health benefits and not just from joining a consortium.

Table 3: The Costs and Benefits of Purchasing Arrangement Types

Independent Group T-Test Between Health Benefit Consortia Participation and the Health Insurance Costs and Benefits Variables

	Purchased by Health Benefit Consortia			Purchased by Individual Public Entities			
	*N**	*M**	*SD**	*N*	*M*	*SD*	*t-test*
Costs (in dollars)							
Single: Employer Monthly Contribution	1066	469.83	107.45	735	493.95	161.30	3.55****
Single: Total Monthly Contribution	1068	533.67	115.22	737	558.93	171.75	3.49***
Family: Employer Monthly Contribution	1059	1187.48	230.2	736	1298.26	347.15	7.58****
Family: Total Monthly Contribution	1060	1368.79	270.32	738	1475.74	376.30	6.62****
Benefits (in dollars)							
Single: Employee deductible in network	1074	807.37	1065.98	758	1019.73	1191.24	3.92****
Family: Employee deductible in network	1074	1666.05	2230.8	757	2075.16	2441.49	3.66****
Single: Out-of-Pocket Maximum Including Deductible	1074	1758.08	1428.61	760	2024.27	1571.24	3.71****
Family: Out-of-Pocket Maximum Including Deductible	1073	3596.86	2954.12	759	4131.25	3230.42	3.61****

*N = Sample Size (# of health benefit plans); M=Mean ($'s), SD=Standard deviation ($'s): ***p=.001; ****p=.0001.

Source: 2014 SERB survey dataset

Health Insurance Costs and Benefits: A Brief Summary

The results presented here suggest that public entities that are involved in health benefit consortia tend to have lower monthly premium contributions for health benefits than public entities that purchase their health insurance individually. These results are consistent across both single and family medical insurance plans.

The results also suggest that plans offered by health benefit consortia have more generous benefits than health plans purchased by an individual public entity (either fully-insured or self-funded plans purchased by a single entity), as measured by comparisons of deductibles and out of pocket maximums across these two kinds of plans. These results are also consistent across both single and family medical insurance plans. However, it is important to note that these suggestions are based on a limited number of health benefit cost and benefit measures, and that further investigations could yield differing conclusions. In addition, initial data from the 2015 SERB survey indicate that public officials do not

appear to be rushing to opt out of their current heath benefit consortia. Out of 719 responses, 687 (95.5%) indicated that they plan to participate in the same health benefit consortium next year.

Potential Advantages and Disadvantages of Joining Health Benefit Consortia

While our primary purpose in this document has been to report on the use of health benefit consortia by public entities in Ohio, we have also been able to supplement this information with some preliminary analyses of costs and benefits associated with the use of these consortia. When this information is combined with information compiled through other activities associated with our recent investigations in this area, it enables us to better understand some of the key advantages and disadvantages of health benefit consortia for public entities in Ohio.

Is it beneficial for government entities in Ohio to join health benefit consortia? Are there barriers and disadvantages to relying on a health benefit consortium health plan? Based on a literature review conducted as a part of this project, analyses of information collected by SERB, and communications with multiple health insurance professionals, we offer the following advantages and disadvantages of health benefit consortia for consideration by Ohio public entities.

Potential Advantages

1. **Economies of Scale and Leveraged Purchasing Power**
   One way cost savings are attained using health benefit consortia is by achieving economies of scale, particularly for small employers who may pay higher premiums than larger employers (Wicks, 2002). Health benefit consortia may help small public employers purchase affordable insurance with the same premium rates that may benefit larger employers in the private sector (Bender & Fritchen, 2008). While simply forming voluntary pools or exchanges will not automatically guarantee cost reductions, those groups that are cohesive can act as an "active purchaser" to seek out plans that have a better value (Curtis & Neuschler, 2009).

2. **Experience Rated**
   Health benefit consortia can also keep costs down because they enable members to participate in larger plans that can be experience rated rather than community rated, as required by federal law for smaller plans. Health benefit consortia may therefore save money by taking advantage of positive experience-ratings that are not tied to risks in the community at large (New York State School Boards Association [NYSBA], 2009). Since health benefit consortia can qualify for premiums based on claims experience, they may also have the ability to design health plans that best match the needs of their members — something an individual community-rated plan may lack (NYSBA, 2009).[13]

[13] Health benefit consortia may also have flexibility to tailor plans to meet the specific needs of their members that may not be present with some fully insured health plans.

3. **Choice of Plan**
   Purchasing health benefits through a health benefit consortium may allow entities the opportunity to offer their employees an array of health insurance plan options; therefore, employees can select the plan that best fits their needs (Wicks, 2002). Typically, due to the administrative burdens of having multiple health insurance contracts, small employers often are only able to offer one health insurance plan unless they join a health benefit consortium (Wicks, 2002).

4. **Shared Administrative Costs**
   Through a health benefit consortium agreement, organizations may share administrative costs such as the costs of processing insurance-related paperwork (Wicks, 2002). Small public entities may also benefit from targeted cost containment efforts by pooling their resources to add health insurance expertise and/or add to their size (National Conference of State Legislatures, 2012).

5. **Self-Funding**
   Another potential advantage to joining a health benefit consortium is that it may allow smaller public entities to enjoy benefits flowing from self-funding mechanisms that they would not otherwise have the size to utilize. There is a potential to save money through only paying for claims incurred (instead of a premium [fully-insured]). In addition, a self-funded plan does not have to meet all of the insurance laws and requirements imposed by a state and it may not be subject to all of the fees implemented by the ACA that are applicable to fully-insured plans (NAHU, 2015)[14].

Potential Disadvantages

1. **Coordination Difficulties**
   Barriers to participating in a health benefit consortium purchasing arrangement include the tendency of public entities to operate in silos and suffer from coordination difficulties associated with differences in mission, values, program priorities, population health needs, and governing laws (Bailit & Burns, 2013).

2. **Terminal Liability and Legacy Costs**
   Terminal liability describes funds owed by the health benefit consortium after it dissolves (NYSBA, 2015). Legacy costs are costs incurred by the health benefit consortium prior to an

[14] Plans that are self-funded may purchase "stop-loss" insurance, which limits the amount of claims an entity is responsible for paying and may guard against losses associated with claims that exceed collected premiums (NYSBA, 2015). The stop-loss insurance is paid on top of the medical administration fees and claims, and rates may be determined by prior years plan experience.

entity joining the group. Public entities may be responsible to assist in paying these costs after joining the health benefit consortium (NYSBA, 2015).

3. **Adverse Selection**
   Entities with an older population, which typically have more health care needs, or groups with costly claims histories may not be good candidates for joining a health benefit consortium (NYBSA, 2015), and may therefore have difficulty finding a health benefit consortium that wants to include them in the health benefit consortium risk pool.

4. **Policies and Procedures to Leave a Health Benefit Consortium**
   In 2015, staff from the KSU-CPPH interviewed a sample of health benefit consortia operating in Ohio. The majority of health benefit consortia (71%) indicated that entities were not able to leave the health benefit consortium at any time without a penalty. In addition, it was found that most of these entities were required to participate in the health benefit consortium for at least 24 months before they were eligible to leave the health benefit consortium.

5. **Potential to Fail**
   Not all health benefit consortia last. Even health benefit consortia that initially were successful have failed (Wicks, 2002).

Conclusion

Our findings above suggest that the use of health benefit consortia is prevalent in Ohio, especially among Ohio school districts. By comparison, general purpose governments, such as counties and cities, appear to make relatively less use of health benefit consortia (SERB, 2014B). However, changes in market structure associated with the implementation of the ACA, along with the responses of employers to the changing requirements and fee structures of the ACA, may contribute to further growth in the use of health benefit consortia by Ohio's public entities. Our initial analysis of benefit plan costs and the generosity of benefits indicates that there may be financial benefits to jointly purchasing health benefits – perhaps as a means to utilize self-funding mechanisms. At the same time, however, while our investigations of health benefit consortia found clear advantages to this kind of health benefit purchasing arrangement for public entities in Ohio, we also uncovered potential disadvantages that should be considered and evaluated by public entities that are making health benefit plan decisions for their employees. Public entities may benefit from educational efforts that enable them to improve their health benefit purchasing practices during a time of substantial change in the health insurance market. Our hope is that the information presented in this report is helpful in this regard.

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Appendix: Listing of Consortia Reported to be Operating in Ohio

Data were obtained from the 2014 and 2015 SERB surveys and may not to be fully exhaustive. Additional information on a number of these consortia may be found in the Resource Guide that accompanies this report (KSU-CPPH, 2016).

Joint Health Purchasing Arrangements Reported as Providing Services to Public Entities in Ohio	
1. Allen County Schools Health Plan	19. Mahoning County School Employees Insurance Consortium (MCSEIC)
2. Ashtabula County Schools Council of Governments	20. Mercer Auglaize Benefit Trust
3. Brown County Schools Insurance Consortium	21. Metropolitan Education Council
4. Buckeye Ohio Risk Management Association	22. Midwest Employee Benefit Consortium (MEBC)
5. Central Ohio Health Insurance Consortium	23. North Central Ohio Trust
6. Clermont County Insurance Consortium	24. Ohio Public Entity Consortium (OPEC)
7. County Employees Benefit Consortium	25. Ohio Public Healthcare Risk Pool (previously Ohio Housing Authority Commission)
8. County of Lorain Health Plan	26. Ohio School Benefit Cooperative (OSBC)
9. Cuyahoga County	27. Ohio School Employee Insurance Consortium (OSEIC)
10. Employers Health Purchasing Corp.	28. Optimal Health Initiatives (OHI)
11. Franklin County Consortium	29. Paulding County School Consortium
12. Great Lakes Regional Council of Governments	30. Pickaway County Public Employees Benefit Consortium
13. Greater Cincinnati Insurance Consortium	31. Portage Area School Consortium
14. Hancock County School Consortium	32. Preble County Schools Regional Council of Governments
15. Harding County Schools Consortium	33. Putnam County School Consortium
16. Health Action Council	34. Ross County School Employees Insurance Consortium
17. Health Transit Pool of Ohio	35. Shelby County Schools Health Insurance Consortium
18. Huron-Erie School Employee Association	36. Southwestern Educational Purchasing Council

37. Inter University Council Purchasing 38. Jefferson Health Plan *Center for Local Government (CLG) *Erie Shore Pool *Health Benefit pool * Ohio Benefits Cooperative (OBC) *Ohio Public Employer Cooperative *Ohio Valley Pool *Sandusky-Ottawa County Pool (San-Ott) *South Central Ohio Insurance Consortium (SCOIC) 39. Lake Co. Board of Commissioners 40. Lake Co. Schools Health Care Benefits Program 41. Lake Erie Regional Council of Governments 42. Lawrence County Schools Council of Governments *Rock Hill LSD 43. Logan County School Employee Consortium	44. Southwestern Ohio Organization of School Health (SWOOSH) 45. Stark County Schools Council of Governments 46. Suburban Health Consortium 47. Summit County Health Connection 48. Teamsters Local #377 Health and Welfare Fund 49. Trumbull County Schools Insurance Consortium 50. Van Wert Area Schools Insurance Group (VWAISG) 51. Wayne County Commissioners 52. Wood County School Consortium 53. Wyandot Crawford Health Benefit