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# Analysis of Pooling Opportunities for Northeast Ohio Colleges

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# Introduction and Background

In 2006, legislation (HB 66 sec. 9.901 of the ORC) was adopted in Ohio calling for the assessment of the feasibility of pooling the risk of health care benefits in Ohio schools, public colleges and universities. The genesis of this legislation was rooted in the belief that economies of scale could be generated in the provision and procurement of health benefits on a pooled basis. With budgetary pressures upon Ohio's public institutions, potential savings attributable to cooperative efforts were felt to be worthy of exploration by the State. In August of 2006, the School Employee Health Care Board retained Mercer to assist in reviewing pooling approaches for Ohio K-12 schools and in December, 2006, Mercer prepared a report with recommendations to the Governor for the development of regional pooling approaches for the K-12 school districts in Ohio.

In addition, Mercer was subsequently asked to prepare an analysis of the feasibility of pooling the benefits of the public institutions of higher education. In Mercer's report to the Ohio Department of Administrative Services, it was observed that a statewide, single pooling approach for all State colleges was not the most efficient model for generating savings. Instead, it was recommended that regional partnerships of 2-year and 4-year colleges/universities be created to best capture local efficiencies in the provision of healthcare benefits.

In this study, Mercer has analyzed and summarized potential savings associated with pooling medical plan benefits of Ohio Public institutions of higher education which could be achieved in the following areas:

- Removal of indemnity plans (or replacement into managed network plans)
- Best network practices
- Fully insured risk charges
- Premium taxes
- Eliminating broker commissions
- Improved administrative arrangements
- Other areas of savings, including ancillary benefits

Subsequently, Mercer was retained by a group of Northeast Ohio 4-year and 2-year colleges and universities to assess the opportunities for achieving cost savings through pooling of the employee benefit plans offered by those schools. In addition, the scope of the project was expanded to include a discussion of potential savings from additional benefits (such as life, disability, dental and vision insurance) as well as the impact of common plan design approaches.

A group of nine colleges participated in the study, including:

- University of Akron
- Cleveland State
- Cuyahoga Community College

- Kent State
- Lakeland Community College
- Lorain County Community College
- Northeastern Ohio Universities Colleges of Medicine and Pharmacy
- Stark State College
- Youngstown State

The following report discusses the approach to gathering data, analyzes the information provided by the schools and other sources, discusses pooling strategies and alternatives, and provides recommendations and estimates of savings that can be achieved. The report is organized as follows:

- Methodology of Review
- Data Analysis
- Recommendations and Considerations

In the interest of efficiency, Mercer was asked to leverage previous work performed for the State of Ohio and has made efforts to reference this previous work where appropriate within public record guidelines.

Mercer appreciates the opportunity to work with the Northeast Ohio colleges and universities on this important project.

# Methodology of Review

This analysis is based upon data provided directly by the colleges and universities. In order to efficiently analyze the current benefits offered by these institutions Mercer used data from the 2006 Mercer Survey of Employer Sponsored Health Plans and leveraged previous research conducted on behalf of the Ohio School employees to provide a framework for discussing the assumptions and cost/savings analysis.

**Data Collection**
Mercer was provided with a list of names and email addresses for HR representatives from nine Northeast Ohio Schools listed below. The data requested in the questionnaire included the following:

- Demographics
- Type of plan offered and employee enrollment by plan type
- Health plan costs for 2005 and 2006
- Plan design (contributions, deductibles, co-pays, coinsurance, out-of-pocket maximums, etc.)
- Rx, Dental, STD, LTD, and Life coverage information
- Type of funding
- Current vendors

**List of Institutions**
The following is a list of the 9 institutions from which Mercer requested data.

1. Northeastern Ohio Universities Colleges of Medicine & Pharmacy
2. The University of Akron
3. Kent State University
4. Cleveland State University
5. Cuyahoga Community College
6. Youngstown State University
7. Lakeland Community College
8. Stark State College
9. Lorain County Community College

**Financial Analysis**

Mercer reviewed the data provided for financial accuracy and consistency and, where necessary, followed up with the schools to confirm any outstanding data elements. Due to stringent time constraints associated with the deliverable target dates, Mercer's data request was streamlined to ease the data collection process to the schools. It should be noted that the schools were extremely cooperative and thorough (within the time constraints given) and the cooperation of the schools is greatly appreciated.

Mercer relied upon the data as provided by the various responding organizations. Mercer did not perform an audit of the data and cannot opine as to the quality of the data. All data-capture processes involve some level of human error and inconsistency. Given the limited number of data points for some of the reviewed benefits (e.g. short term disability) Mercer's actuaries applied reasonability tests to the data and supplemented gaps with additional survey information and/or professional judgment where necessary. These items are noted where appropriate.

All cost estimates are based on the assumptions and information available at the time of analysis, and are subject to unforeseen, random events. Therefore, any projections must be interpreted as having a likely range of variability from the original analysis. The HR representatives from each school were contacted and sent an email with a detailed explanation of the study, the data collection process and a customized/automated questionnaire.

For the purpose of the overall cost estimate and relative savings projections, it is believed that the data shown in this report provides a fair assessment of the cost saving opportunities. The estimated cost savings accruing to any school is a function of underwriting variables including current demographics, plan design, vendors, and provider mix and may vary school by school.

# Data Analysis

Mercer analyzed cost and benefits data reflecting the 9 institutions and has provided an executive summary of these results. In addition, Profile Reports comparing the individual college data institution by institution is provided in the Appendix.

## Executive Summary

### General Information – Health Benefits

- Total health benefit cost per active employee* among the 9 participating schools averaged $8,544 in 2006.
- Costs for the 9 institutions ranged from a low of $5,543 to a high of $11,628 per employee.
- All nine of the participating schools offer employees a PPO (Preferred Provider Organization) plan.
- None of the schools offer a consumer driven health plan (CDHP).
- The majority of employees (69.8%) are enrolled in the PPO plan. 24% of employees are enrolled in the HMO plan.
- Because only one school offered a POS (Point of Service) plan, detailed information and plan comparison for the POS plan is not included in this report.
- All of the 9 schools use Medical Mutual of Ohio for administration of their respective PPO plans.
- The total number of employees covered by the 9 schools is 10,370 (average of 1,152 employees each).
- The number of covered employees ranges from 237 employees at NE Ohio Universities College of Medicine to 2,145 at U. of Akron.
  (*Total health benefit cost per employee is the total gross cost for all medical, dental, prescription drug, MH/SA, vision and hearing benefits for all active employees and their covered dependents, divided by the total number of covered employees only.)

### Plan Design

- 19 different plans were recognized during the data collection process (average of 2.1 per institution).
- Of the 19 plans, the majority (79%) are self-funded.
- Some schools omitted pieces of data or provided portions of data that could not be confirmed; therefore certain information provided by individual schools was excluded in order to ensure more accurate calculations.
- Of the 9 schools reporting having a PPO plan, only 8 reported that contributions were required.
- Employee contributions are required by all schools for HMO coverage.

### Other Coverage (STD, LTD, Life, Rx, and Dental)

- 3 schools reported that an STD plan was offered.
- 8 schools reported offering an LTD plan.
- All schools offer some form of a Basic Life plan.
- All schools offer a dental benefit.
- While one school did not confirm offering an Rx benefit, the other 8 schools did report offering an Rx benefit.

- Considerable variance in design and costs exists between colleges, for all coverages.

## General Information

| **Total Health Benefit Cost Per Active EE*:** |
|---|
| Range (2006) = $5,543 - $11,628<br>Average (2006)= $7,994 |

| **Summary for types of plans offered:** |
|---|
| # of schools offering:<br><br>Indemnity plan = 3<br>PPO plan = All<br>POS plan** = 1<br>HMO plan = 6<br>CDHP = 0 |

| **Total # of employees enrolled in all plans** = 10,370<br>**Employee Enrollment (all 9 schools):** |
|---|
| % enrolled in:<br><br>Indemnity plan = 1.3%<br>PPO plan = 69.8%<br>POS plan = 4.8%<br>HMO plan = 24%<br>CDHP = 0% |

* Total health benefit cost per employee is the total gross cost for all medical, dental, prescription drug, MH/SA, vision and hearing benefits for all active employees and their covered dependents, divided by the total number of covered employees only.

** Youngstown was the only school offering a POS plan.

- **Health costs vary significantly among the 9 schools.**
- **Most employees participate in a PPO plan.**
- **All 9 of the schools offer a PPO plan.**

## Plan Design
## STD, LTD, and Life

**Copays and Co-Insurance:**

PPO In Network Copay: 7 schools require copay
Range = $10-$15

PPO Out of Network Coinsurance: 8 schools require *coinsurance*
Range = 20% - 30%

HMO In Network Copay: 6 of 6 schools require copay
Range = $5 - $15

**Deductibles (PPO)*:**

Individual In-Network - Range = $0 - $354
Individual In-Network - Avg = $242

Individual Out-of-Network - Range = $75 - $708
Individual Out-of-Network - Avg = $343

Family In-Network - Range = $0 - $750
Family In-Network - Avg = $526

Family Out-of-Network - Range = $150 - $1,500
Family Out-of-Network - Avg = $741

**Funding: (19 plans included in the data)**

Fully Insured = 21% of the plans (4)
Self-Funded = 79% of the plans (15)

- **EE contributions vary widely.**
- **Deductibles and coinsurance differ.**

**Average Cost per Active EE**:**

PPO Range (2006) = $4,924 - $9,668
PPO Avg (2006) = $7,740

HMO Range (2006) = $4,480 - $11,282
HMO Avg = $7,810

**Monthly Contributions***:**

**PPO**: 8 of 9 schools require individual and family contributions
*Indvidual* -
Range = $8 -$94
Avg = $45

*Family* -
Range = $21 - $242
Avg = $125

**HMO**: 6 of 6 schools require individual and family contributions
*Individual* -
Range = $16 - $105
Avg = $51

*Family* -
Range = $42 - $256
Avg = $139

* Cuyahoga, Lakeland, and CSU have no in-network deductible.
** Univ. of Akron HMO data was excluded pending confirmation.
*** Stark did not submit contribution data.

## STD, LTD, and Life

**STD - 3 schools offer STD**

**Benefit period** ranges from 24 weeks to 6 months

**Elimination periods** range from exhaustion of sick and vacation time to 14/28 days for injury/sickness

**STD rates** range from age-based to $.20 per $100 payroll

**LTD - 8 schools offer LTD**

**Benefit percentages** range from 50% to 70% of salary

**Elimination periods** range from the exhaustion of STD to 180 days

**Volumes** range from approximately $321K to $104M

**LTD rates** range from $.00013 to $.87

*It is unknown if the .00013 rate is calculated as a percent of payroll

**Life - All schools offer Life***

**Benefit amounts** range from a flat $25K to 3x base annual salary

**Maximum amounts** range from $50K to $250K

**Volumes** range from approximately $16M to $411M with an average volume of approximately $134M

**Basic Life rates** per $1,000 range from $.11 to $.22 with an average rate of $.17

## Rx and Dental

**Dental: All 9 schools offer dental benefit****

Avg cost per active EE for combined plans:

Range (2006) = $451 - $700
Avg (2006) = $587

Individual Deductible:
# of schools requiring deductible: 8 schools
Range = $25 - $50
Avg = $41

Type of plan offered:
Dental PPO = All schools
Dental HMO = 2 schools

**RX: 8 of 9 schools offer Rx benefits*****

Generic Copay - Range = $2 - $20
Generic Copay - Avg = $10

Formulary Brand Copay - Range = $17 - $40
Formulary Brand Copay - Avg = $23

Nonformulary Brand Copay - Range = $30 - $80
Nonformulary Brand Copay - Avg = $46

* Cuyahoga's basic life rate was excluded pending confirmation.
* *Stark's active cost per EE was excluded pending confirmation.
* ** Stark did not confirm an Rx offering.

- **Dental deductibles are either $25 or $50 for individuals.**
- **Copays vary significantly for Rx.**

# Cost/Savings Analysis

The following section presents a cost/savings analysis generated based on data submitted by the two-year and four-year institutions. All costs in this section reflect medical and prescription drug expenses as reported by the responding two-year and four-year institutions. For the purpose of the overall cost estimate and relative savings projections, it is believed that the data shown in this report provides a fair assessment of the cost savings opportunities. The estimated cost savings accruing to any school is a function of underwriting variables including current demographics, plan design, vendors, and provider mix and may vary school by school.

Key Assumptions:

- All figures are on a 2006 basis per the information collected.
- For purposes of comparing medical plan designs: 1) For all plans that have an in network out of pocket maximum, we have assumed an in-network coinsurance level of 90%; 2) All plans without an in- network out of pocket maximum would have an in-network coinsurance level of 100%.
- Because of the lack of Rx cost/design information, we assumed the same Rx cost across all plans of $1,300 PEPY based on Mercer's marketplace knowledge
- Ohio premium tax is 2%.
- Broker commissions are assumed to be 1.5% on fully-insured lives based on Mercer's marketplace knowledge.
- Pharmacy costs assume $100 per employee per year.
- Administrative cost percentage based on tiers set up by group size.
- Purchasing the different lines of coverage would be done as one collective group for all of the 9 universities
- Currently the universities are using some of the better networks in the northeastern area of Ohio in terms of provider discounts and network access. We would expect very little savings from "deeper discounts" by changing vendors/networks.

Findings:

- 17% of current enrollment is in fully-insured products. These are all HMOs.
- Current plan designs offered are very rich, switching the entire enrollment to a more cost competitive plan design (e.g. the University of Akron PPO & HMO plan design) is expected to save 3.3% of medical spend while still offering a benefit competitive with other employers.
- 6 of the 9 plans currently do not offer an STD plan; creating a "standard" plan would be a cost increase.
- Savings through larger scale on administrative fees/retention for each product line is close to 2% overall
- Additional savings potential is available through combined stop loss coverage pooling.
- We expect that if the separate universities were combined together to purchase their Rx on a carve-out basis, there is substantial savings through use of either a coalition or piggy-backing on the rest of the State of Ohio employee negotiations.

## Cost Baseline

| | | **Total** |
|---|---|---|
| Total Schools | | 9 |
| Assumed Medical/Dental Covered Employees | | 10,370 |
| Assumed 2006 Cost | | $82,898,356 |
| | | |
| **Resulting Breakout of Costs:** | | |
| Medical | 74.1% | $61,448,482 |
| Rx | 16.3% | $13,481,000 |
| Admin | 9.6% | $7,968,874 |
| TOTAL | 100.0% | **$82,898,356** |
| | | |
| Dental | | $6,449,676 |
| Life & AD&D | | $2,644,607 |
| LTD | | $550,385 |
| TOTAL Ancillary | | **$9,644,667** |

## Cost Savings Estimates

| | Low Savings | Medium Savings | High Savings |
|---|---|---|---|
| **Removal of Indemnity Plans:** | | | |
| Enrollment in Product | 1.3% | 1.3% | 1.3% |
| Cost reduction due to Implementing Discounts | 35.0% | 40.0% | 45.0% |
| Overall Population Savings | $286,000 | $327,000 | $368,000 |
| **Standardizing Medical Plan Designs:** | | | |
| Offer 1 PPO & 1 HMO with market competitive designs | 3.3% | 3.3% | 3.3% |
| Overall Population Savings | $2,034,000 | $2,034,000 | $2,034,000 |
| **Best Network Practices:** | | | |
| Enrollment Advantaged by switching to "Best In Market" discounts | 0.0% | 0.0% | 0.0% |
| Cost reduction due to Implementing Discounts | 10.0% | 15.0% | 20.0% |
| Overall Population Savings | | | |
| **Fully Insured Risk Charge:** | | | |
| Fully Insured Premium | $11,315,481 | $11,315,481 | $11,315,481 |
| Insurer Profit Margin % | 1.0% | 2.0% | 3.0% |
| Overall Population Savings | $113,000 | $226,000 | $339,000 |
| **Premium Tax:** | | | |
| Fully Insured Premium | $11,315,481 | $11,315,481 | $11,315,481 |
| Premium Tax Rate | 2.0% | 2.0% | 2.0% |
| Overall Population Savings | $226,000 | $226,000 | $226,000 |
| **Eliminate Broker Commissions:** | | | |
| Assumed Current Commissions (% of Premium) | 1.5% | 1.5% | 1.5% |
| Fully Insured Premium | $11,315,481 | $11,315,481 | $11,315,481 |
| Overall Population Savings | $170,000 | $170,000 | $170,000 |

| | Low Savings | Medium Savings | High Savings |
|---|---|---|---|
| **Improved Medical ASO Arrangements:** | | | |
| Current ASO Expense (% of Premium) | 9.6% | 9.6% | 9.6% |
| Assumed ASO Expense (% of Premium) | 8.0% | 8.0% | 8.0% |
| Overall Population Savings | $1,337,000 | $1,337,000 | $1,337,000 |
| **Improved Dental Retention:** | | | |
| Current Retention (% of Premium) | 12.6% | 12.6% | 12.6% |
| Assumed Retention (% of Premium) | 10.8% | 10.8% | 10.8% |
| Overall Population Savings | $117,000 | $117,000 | $117,000 |
| **Improved Life/AD&D Retention:** | | | |
| Current Retention (% of Premium) | 13.9% | 13.9% | 13.9% |
| Assumed Retention (% of Premium) | 8.7% | 8.7% | 8.7% |
| Overall Population Savings | $138,000 | $138,000 | $138,000 |
| **Improved LTD Retention:** | | | |
| Current Retention (% of Premium) | 32.0% | 32.0% | 32.0% |
| Assumed Retention (% of Premium) | 28.6% | 28.6% | 28.6% |
| Overall Population Savings | $18,000 | $18,000 | $18,000 |
| **Improved Rx Contracts:** | | | |
| Improved Negotiations | 5.0% | 7.0% | 9.0% |
| Overall Population Savings | $674,000 | $944,000 | $1,213,000 |
| **Overall Savings:** | **$5,113,000** | **$5,537,000** | **$5,960,000** |
| **% of Total Cost** | **5.5%** | **6.0%** | **6.4%** |

# Considerations

Size matters in the procurement of health care benefits. Generally the larger the risk pool, the lower the cost of plan sponsorship due to lower risk management costs, lower administrative costs (including vendor cost, internal sponsor costs, and communications cost), more sophisticated cost containment/cost management solutions, and more professional program management. These advantages are largely scale based. For example, many major corporations have uniform plan designs and plan administration across divisions and geographies to minimize costs. Plan sponsors that have more decentralized structures (for specific business reasons) generally have higher costs, all other things equal. Experience has demonstrated that benefits risk can be mitigated through the pooling of progressively larger groups, most notably by creating predictability of claims experience and economies of administration. The 2006 Mercer National Survey of Employer-Sponsored Health Plans documents this practice among colleges and other employers.

| Number of Employees | Percent of employers whose PPO is self funded |
|---|---|
| 500 - 999 | 55% |
| 1,000 - 4,999 | 71% |
| 5,000 - 9,999 | 87% |
| 10,000 - 19,999 | 92% |
| 20,000 or more | 95% |

*Includes employers with and without stop-loss.

Aggregating college employees could theoretically create a risk pool sufficiently large to generate administrative cost savings, economies of scale in purchasing, and predictability of expenses. As identified in Mercer's April 2007 analysis,"the incremental savings accruing to already large risk pools (as is found among some of the largest Ohio universities) may not be of significant size to merit a single (State-wide) approach." However it was identified that the smaller colleges could partner with larger institutions in local (regional) pooling networks to achieve additional savings.

Simply combining disparate organizations, however, comes with its own complexity and challenges. Desire for local control and autonomy, large and diverse collective bargaining populations, competing market forces, legal restrictions on multiple employer welfare associations, infrastructure costs and time associated with collaborative efforts, and status quo are significant points of resistance.

## Approaches

Balancing the cost advantages with the issues noted here creates a spectrum of "pooling" approaches for consideration. Pooling discussions typically encompass a broad set of definitions and approaches. These approaches can include:

**Approach 1:**
**Information sharing** – Colleges may find it advantageous to be aware of the costs and benefits assumed by its comparator colleges. With this information, internal purchasing decisions and vendor negotiations may be enhanced. In this approach, the colleges may wish to share specific data related to vendor relationships for each of its benefits coverages, allowing for autonomy of decision making while potentially leveraging the data with its vendors and employees.

**Approach 2:**
**Best Practices** - As was discussed in previous analyses for the State, development and adoption of best practice standards for plan administration, design and management can be encouraged and may created savings. Savings will accrue from the depth of implementation and the breadth of acceptance by the colleges and vendors. These best practices could include:

- Funding and Stop Loss Insurance
- Commissions
- Networks
- Eligibility
- Governance and Structure
- Funding and Reserve Requirements
- Claims Administration Requirements
- Claim Processing
- Customer Service
- Web Technology Capabilities Quality Improvement
- Appeals Administration
- Client Relationships
- Vendor Management
- Reporting Requirements
- Plan Design
  - Medical & Prescription Drug
  - Pharmacy – Collective Purchasing Recommendation
  - Health Management, Care Management/Disease Management, Wellness
  - Additional Coverages
- Communication

- Education

**Approach 3:**
**Common procurement** - The colleges can benefit from combining the scale of the various colleges to solicit coverages and contracts with vendors. This approach has been used by the Ohio Inter-University Council and other school consortia that contract with vendors as a single entity. This approach reduces the cost and time associated with procurement as this expense is shared. However, autonomy of decision making is reduced at the college level and requires creating shared objectives and criteria for selecting vendors. The pool would commonly procure services for network administration, claims administration, risk pooling, and support services, while leaving plan design to the discretion of each local institution. This approach permits the leveraging of the enhanced scale of the combined entities while recognizing the unique demographic, cultural, and labor market situations of the different colleges. The common procurement approach does not necessarily require that all colleges adopt the same plan design or features.

**Approach 4:**
**Common design, procurement and management** – In addition to shared procurement of vendor relationships, the colleges may find it advantageous to move to common benefit plan designs to improve employee communications and reduce administrative and vendor costs. The colleges may agree to centrally manage the procurement and design processes or even contract for these services. A potential disadvantage to consider is the inability to use benefits as a competitive advantage against other schools. Conversely, this may be desired to foster cooperation between the entities and ease transfers and job changes. As an example, the State Teachers Retirement benefits do not vary by school; other employee benefits can be structured in a similar, common manner. Finally, plan design and employee contributions may be subject to collective bargaining and may inhibit efficiencies gained from a common design.

**Approach 5:**
**Combined risk sharing** - The final step toward pooling, and the approach most think of in discussing the topic, entails combining the financial risk associated with the benefit plans. This can take many forms, but on a generic level it refers to an approach that shares the claims experience, administrative, and management costs among the colleges. In the case of the medical plans, this could be through a single self-funded pool in which claim costs are charged back to the colleges on some shared basis. This can include the use of a common insured stop loss contract to mitigate the risk of large claims to any one college. The advantage in this scenario is the reduction in monthly claims variability to any one participating group. A disadvantage is that by its nature, some groups with good experience subsidize the bad experience of other groups. In addition, current multiple employer welfare association (MEWA) laws create issues that would need to be addressed or explored.

The larger the risk pool, the more predictable the claims experience. Therefore, as risk pools increase in size, the cost of risk management decreases since insured margins, stop loss premiums and other risk management expenses are mitigated and/or

eliminated. Aggregating all Northeast Ohio colleges studied here would create a risk pool estimated to be approximately 10,000 employees. Total benefits expenditures are estimated to be approximately $100 million. Savings were estimated assuming successfully addressing the following issues:

- Removal of indemnity plans
- Eliminating fully insured risk charges
- Eliminating premium taxes
- Eliminating broker commissions on insured coverages
- Improved administrative (ASA) arrangements
- Migration to market based plan design
- Common procurement of insured ancillary benefits (LTD, STD, Life, Pharmacy, etc.)
- Considerations for maximizing funding opportunities
- Adoption of Best Practices

Each of these strategies is explored further on the next pages and assumes pooling approaches that assure maximal success in driving these savings.

# Cost Reduction Strategies

**Removal of Indemnity Plan**

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

A common challenge, as referenced above, is the ability to offer plan discounts out of the local market area. Frequently the most cost effective network option for the local employees is not the most cost effective option outside of the local market, leaving the out-of-area employees with limited access to network providers, if any. As recommended in the original college pooling analysis, it may be advantageous to create a non-Ohio network option to be available to all the schools.

**Best Network Practices**

Different insurance companies and managed care networks have strengths in different Ohio markets. There is no single network offering the deepest discounts in all areas of the state. However on a regional level specific networks have been observed to offer deeper discounts and greater network access. In Northern Ohio, Medical Mutual of Ohio (MMO) enjoys this market advantage. This is supported by the fact that all the colleges in the study currently work with MMO. Unlike the statewide analysis, it was not observed that significant savings would be achieved by contracting with a different managed care network as the colleges already enjoy this market advantage on their own.

In the network management category however, network access should also be considered from a best practice and efficiency perspective. Contracting networks should be held to procurement standards stipulating the number of primary care, specialists, and hospitals to be accessible to employees residing within the geographic region and throughout the state. Access to trauma facilities, transplants, and other tertiary care services must be assured and should reflect best practice measures developed by organizations such as NCQA. The combined group of colleges may be in a position to better negotiate with MMO to build network standards that meet these enhanced criteria. Furthermore, the scale of the combined group may alter the partnership model between the Northeastern Ohio Universities College of Medicine and MMO perhaps resulting in more favorable market share to NEUCOM. On a related path, the colleges may explore identification of high performing provider networks. This approach includes identification of the cost effective and higher “quality” providers, with plan steerage to those providers. Cost savings associated with this strategy were

not explored in this study but could be explored further.

**Fully Insured Risk Charge**

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

**Reduce/Eliminate Premium Tax**

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

**Eliminate Broker Commissions**

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

Under the proposed approach, commissions, overrides, contingent commissions and other payments, trips, and awards from insurance carriers related to the benefits offered through the colleges will be eliminated. This does not preclude colleges from entering into direct contractual fee arrangements for services with brokers, consultants, or advisors for local level advice. Smaller colleges may again see the greater benefit of this strategy.

**Improved Administrative (ASO) Arrangements**

Streamlining plan administration may offer additional savings opportunities. Because of the wide difference in covered populations between schools, process improvements can be offered to effectively administer eligibility of employees and dependents. It has been observed that colleges are frequently the largest employer in a given community and as such, often offer more generous benefit plans than smaller local employers. Consequently, colleges may be covering individuals who may have access to other coverage. Strategies for steering dependents off of the college's plan include the use of spousal surcharges or carveouts and dependent

eligibility audits. An ancillary benefit of improved eligibility monitoring is the impact upon tuition reimbursement plans for staff and their dependents. As dependents (or staff) are identified who may not meet dependent eligibility requirements in the health plan, their eligibility for participation in tuition reimbursement plans should also be questioned.

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

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

Claim administration requirements are not limited to how a claim is processed. Claim administration covers a number of functions that must all be working in concert to enable the administrator to deliver efficiently and effectively on service commitments. Standards should be developed on best practices dimensions and performance monitoring metrics that we have observed in the administrative environment in claims appeals, customer services, processing, and client relationships. Given the existing relationship with MMO, the colleges can benefit from a combined audit and service guarantee approach that reduces the cost to each college.

Further reductions in the administrative costs charged by the vendors may be possible through combined procurement, and enhanced through common plan design strategies. Our savings estimates assume only estimated savings associated with combined procurement.

## Migration to Market-Based Plan Design

### Medical

There is a wide variance between colleges in the costs and plan designs. Plan designs currently in place offer a wide range of employee choices, including differing network models (HMOs, PPOs) and plan features (deductibles, copays, coinsurance). The differing plan designs and plan features actuarially create different levels of employee cost sharing – the higher the deductibles or copayments, the lower the overall cost to the employer. However there is no known correlation between the value of the benefits offered and the cost per employee.

It is feasible that the colleges could migrate to a common plan design, or a limited choice of options. Migrating to a market average plan will not generate cost savings, other than modest reductions in the plan design changes and claims administrative expenses.

However, plan designs can be set at a level that remains competitive to the broader employer market place, yet shifts costs to employees. This strategy presents cost savings to the degree colleges can change their existing plan designs and employee contributions to match the market based design. Some important points for consideration relative to this approach include:

- Any new plan designs will require significant change to existing collective bargaining agreements. Transitioning from the current plans to new options would need to be staged or legislation enacted to override current contracts.
- Eliminating plan designs creates winners and losers. Creating a model plan that has a relative cost value equivalent to the plans currently offered will, by definition, not generate any cost savings. Cost savings will only accrue to the degree plans are implemented that have a lower overall value to the plan participant, shifts costs to the individual or better manages employee health. Communications to employees become critical to manage the messages and perceptions of employees.
- Cost savings can be achieved through the implementation of best practice plan management, as discussed in later sections and including maintenance of eligibility, underwriting, reserve setting, selection of managed care networks, claim administrators, and health management vendors

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

Colleges may benefit from consistent guidance on the design and pricing of these models as a plan option available to employees. Adding a high deductible plan option to the plan design choices, if designed in keeping with HSA requirements and no employer account contribution, would generate further savings for the colleges. This presumes employee contributions for all plans accurately reflect the relative value of the plans

**Dental**

As with medical coverage, the colleges may elect to combine procurement of this coverage and develop preferred plan design models. Estimated savings shown assume reduced insurer retention levels due to the economies generated by the combined group of 10,000 employees.

### Life/AD&AD

Life insurance, accidental death and dismemberment coverage, personal accident insurance, and business travel accident insurance are optimal benefits for pooling and rationalization of plan design. From a benefit level perspective, life insurance benefits vary by college, though plan choice does not significantly drive administrative costs and retention levels in life insurance premiums. The colleges may wish to offer a limited choice of plans purchased through a single vendor to drive down retention costs and administrative complexity. Scale of total life coverage and premium is a significant driver of potential cost savings, yielding an approximate reduction of costs by 5%. Further savings can be generated to employees through the common procurement of employee paid coverages such as voluntary life insurance, dependent life insurance, or personal accident insurance. It may be cost effective to approach the vendor markets for the life coverages on a combined basis to maximize the insured volume and lower overall premium rates.

### Disability Benefits

As with other ancillary benefits, economies are generated from the enhanced scale of the pool and leverage created by joint purchasing. However, based upon the data provided, very few colleges offer short term disability coverage. While long term disability coverage is provided, the reported premiums were of a low amount generating relatively little actual dollar savings. However, relatively little effort would be required to generate this modest savings.

### Pharmacy Benefits

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

As explored in the prior study a single pharmacy benefit procurement approach can generate cost savings to the colleges if this strategy is mandatory for the colleges. This approach combined with a Pharmacy Director to provide oversight and monitoring of the PBM program will be necessary.

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

Mercer estimates that a voluntary prescription drug collective could save new participating schools from 1% to 3% of their current prescription drug spend equating to an additional $130,000 to $390,000.

### Implementing Optimal Health Management/Wellness

A more active health, disease and care management program could be developed for the colleges and universities. In the surveys of higher education, participation in wellness programs was relatively low among the 2 year colleges (only 4 of the 23 colleges reported having a wellness program). These programs have grown dramatically over the past three years and are now mainstream cost containment strategies at the majority of larger plan sponsors. It is recommended that a consistent approach to gathering health information through the use of health risk assessments be initially considered. The effectiveness of the use of these tools can be further enhanced through leveraging biometric screening techniques, health coaching, and analysis of the data generating from these tools

Beyond the question of immediate cost savings, progressive health management programs targeted at the needs of the employee population are recommended. Disease management programs focused on managing chronic conditions such as diabetes, asthma, and heart disease are commonly offered by managed care organizations and specialty vendors. Care management strategies focusing on the acute catastrophic cases offer potential savings if combined with steerage to centers of excellence specialized in the management of those cases. The implementation of a common health risk assessment tool and strategy can reduce the per person administrative costs while developing a common data source and vehicle to manage the identified health conditions across all of the colleges.

Ohio universities offer medical schools and hospitals with nationally recognized expertise in managing a broad variety of conditions. It was also noted by some universities that there is potential for leveraging the resources of existing in-house university health, wellness, and disease management programs. Opportunities with NEUCOM should be explored and were outside the scope of this analysis.

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

### Common Procurement of Insured Ancillary Benefits

Unlike healthcare benefits that are delivered locally, ancillary benefits such as life insurance, accidental death, dental, personal accident, vision insurance, flexible spending account administration, and disability insurance can be jointly purchased to deliver lower

costs to the colleges and employees. As with the pharmacy benefits, a single joint procurement of these benefits will create purchasing mass and savings to the colleges. Quantification of these savings is outside of the scope of this report, though 5%-10% savings have been seen to be achievable in other joint purchased efforts by other colleges.

**Considerations for Maximizing Funding Opportunities**

Medical plan sponsors manage risk through a combination of techniques. For plan sponsors with only a few hundred employees, the medical plan is often fully insured. Larger plan sponsors use a self-insured approach with low levels of ISL (individual stop loss) insurance as well as ASL (aggregate stop loss) coverage in some cases. These plan sponsors take on more risk and experience more volatility year to year in exchange for what are, on average, lower overall costs. As the group size increases, self-insurance becomes more prevalent. For the largest size groups, the prevalence and/or level of stop loss coverage (ISL and ASL) diminishes. The implementation of a self-funded pooled option for colleges currently fully insured can produce savings in the reduction of administrative costs through economies of purchasing, elimination of premium taxes, and lower risk charges. Since the fully insured schools tend to be smaller, the percentage savings is greater to these institutions.

However, this presumes that self-funding of the colleges on a stand-alone basis is an optimal approach – it is not necessarily so and is contingent upon the institution's ability to manage the variable cash flow in a self-funded environment. In order for the smaller schools to benefit from the savings projections while mitigating the greater cyclicality of claims expenses, these institutions would need to participate in a common risk pool with other schools. This pooling could take different forms, but at a minimum should optimally include a total risk pool of 10,000 covered employees as is present with the Northeast colleges. At this level, the need for stop loss coverage diminishes and internal risk charges can be fairly calculated and allocated. A single state-wide risk pool could achieve this scale.

In addition, minimum reserve requirements are recommended that would fund a minimum of 2.5 months of expected claims. A customized transition plan to fund this level will be required to recognize existing funding status of self-funded plans and the migration of fully-insured plans to a self-funded pool.

## Adoption of Best Practices

The term “best practices” is used to identify the optimal standards to be achieved across a broad spectrum of criteria. The intent of the pooled approach is to assure that school districts and their employees benefit from efficient delivery and design of employee benefits. The Board will maintain responsibility for determining the best practice criteria, measures and results. It is recommended that the criteria and measures be reflective of documented standards developed by broadly accepted organizations or published journals. This can include reference to criteria developed by such organizations as NCQA, CMS, consulting firm benchmarks, medical and industry journals. Criteria are recommended around structural, process and health outcome measures as suggested in the following section. It is anticipated in early years that the orientation will be toward structural and process measures with continuous improvement on health outcomes as a longer-term goal.

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

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