

## **SEHCB BEST PRACTICES FOR OHIO'S PUBLIC SCHOOL DISTRICTS (2010-2012)**

### **SEHCB FIRST SET OF BEST PRACTICES**

In 2008 the Board adopted its first set of best practices, which are listed below. These best practices went into effect January 2009, but due to the provisions in ORC 9.901 districts did not have to implement them until after January 1, 2010.

The initial set of SEHCB best practices is as follows:

- 1) **All health plans subject to O.R.C. § 9.901 shall include a wellness or healthy lifestyle program.** According to **O.A.C. § 3306-2-1**, a “wellness or healthy lifestyle program” means a program that consists of a combination of activities designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, encourage modifications of his or her health status, and enhance his or her personal well-being and productivity, with a goal of preventing illness and injury.
- 2) **All health plans subject to O.R.C. § 9.901 shall include a disease state management program.** According to **O.A.C. § 3306-2-02**, “disease management” means a program that includes both education and support activities designed to increase individuals’ awareness and understanding of their disease(s), promote voluntary behavior change, improve self-care, with the goal of preventing or managing complications associated with targeted chronic diseases.
- 3) **All health plans subject to O.R.C. § 9.901 shall include access to institutions and providers offering demonstrated clinically superior health care for complex medical conditions.** According to **O.A.C. § 3306-2-02(D)**, “clinically superior healthcare” means a medically necessary procedure, process, activity or treatment plan that has demonstrated greater effectiveness than competing procedures or treatment plans in producing positive clinical outcomes and financial results.
- 4) **All health plans subject to O.R.C. § 9.901 shall undertake periodic dependent eligibility audits.** According to **O.A.C. § 3306-2-04(E)**, a “dependent eligibility audit” means a process which reviews the eligibility requirements of a health care plan and verifies the eligibility of all dependents currently receiving benefits under the health care plan.

**SEHCB SECOND SET OF BEST PRACTICES ADOPTED JUNE 2010 AND APPROVED BY JCARR  
MARCH 2011**

**I. Transparency Best Practice. O.A.C. §3306-2-03**

**A. Public Disclosure of All Insurance Procurement Costs**

All health care plans offered to health plan sponsors shall be evaluated, negotiated, procured, and administered in a transparent manner. Transparency requires public disclosure of all costs a health care plan or a health plan sponsor pays to or receives from any person or entity related to the designing, procuring, administering, and evaluating a public school district's health care plan.

**B. Rules for Joint Purchasing Arrangements**

Any school district that is a member of a joint-purchasing arrangement shall:

- (1) only participate in a joint purchasing arrangement that is audited at least biannually in accordance with the Generally Accepted Government Auditing Standards (GAGAS) in the United States and submits such information to the Board; and
- (2) only enter into an agreement with any joint purchasing arrangement that holds cash and cash equivalents in a separate interest-bearing account in a financial institution authorized to do business in the State of Ohio; and
- (3) only participate in a joint purchasing arrangement that invests its funds in accordance with the requirements of Chapter 135 of the Revised Code; and
- (4) only participate in a joint purchasing arrangement that requires plan fiduciaries to be trained as such at least triennially.

**II. Cost Containment Best Practices. O.A.C. § 3306-2-04**

**A. Competitive Bidding for Procuring Health Insurance**

Each school district or educational service center that procures its health care plans independently or each joint purchasing arrangement that procures health care plans on behalf of school districts or ESC's shall participate in a formal, competitive procurement process for health insurance coverage and, if appropriate, health consulting services no less than every 3 years (except in cases of financial exigency) and no more than every 5 years.

This best practice forces districts/Health Plan Sponsors to do everything they can to get the best deal possible when purchasing health care benefits. Such a provision is not required by the state of Ohio today, but will be once JCARR makes a rule and places it in the OAC.

**B. Prescription Drug Purchasing**

Each health plan sponsor shall:

- (1) employ a tiered pharmacy plan incorporating a drug formulary;
- (2) include in their health care plans that generic drugs must be dispensed where applicable in order for the health care plan provisions to apply, unless:

- (a) a less expensive option is available; or
- (b) a physician has indicated that the prescription is to be dispensed as written and that drug is a covered drug under the benefit plan.

**C. Labor-Management Health Benefits Committee**

Each health plan sponsor shall establish or maintain a labor-management health benefits committee. The committee will have the responsibility of reviewing all health benefits related issues including but not limited to benefits design, costs, and communications to district personnel. The Committee will make recommendations to the superintendent, all school employees and school employee organizations regarding health benefits and costs. The Committee will consist of certified, classified and administrative personnel. The Committee shall receive labor-management health benefits committee training triennially by the School Employees Health Care Board (SEHCB) or an SEHCB-approved training organization.

**D. Reserve Funding for Self-Funded Plans**

All health plan sponsors that maintain a self-insured health care plan shall reserve funds as advised in an actuarial report to the health plan sponsor by an actuary who has achieved the designation of Member of the of the Academy of Actuaries. The reserve amounts will include IBNR (Incurred But Not Reported) claims plus no more than 30% of expected annual claims. Amounts over the aforementioned reserve levels shall be returned to the member districts in accordance with the governing documents for the health care plan. Amounts under the aforementioned reserve levels shall be billed to the member districts in accordance with the governing documents for the health care plan. The specific methodology for setting reserve levels must be disclosed to the board under Ohio Administrative Code § 3306-3-02.

**III. Certification of Compliance. O.A.C. § 3306-3-01**

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