Report to the Indiana General Assembly

911-Dispatch Consolidation and Funding

Fiscal Benchmarking

Managing Local Government Employee Health Care Costs

INDIANA UNIVERSITY PUBLIC POLICY INSTITUTE

SCHOOL OF PUBLIC AND ENVIRONMENTAL AFFAIRS
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Report to the General Assembly: 911 Dispatch, Fiscal Benchmarking, Managing Local Government Employee Health Care Costs

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Introduction

In the spring and fall of 2014, the Indiana Advisory Commission on Intergovernmental Relations (IACIR) conducted reviews of local government 911-dispatch consolidation and funding. More specifically, the commission reviewed the structure and funding of 911-dispatch or public safety answering points (PSAPs) in light of both the 2014 deadline for consolidation of PSAPs and the 2015 sunset of the current funding structure. Also in the fall of 2014, the commission received information on a recently released compendium of local government fiscal benchmarks and reviewed the strategies local governments are using to manage rising employee health care costs.

911-Dispatch Consolidation and Funding

Background

The Indiana Advisory Commission on Intergovernmental Relations (IACIR) has had an ongoing interest in the structure and funding of Public Safety Answering Points (PSAPs) over the last several years. In fall 2011, the commission considered the cost of PSAPs, the ideal method for collecting and distributing 911 surcharges, the distribution of PSAPs within and across Indiana counties, and progress toward the consolidation required by PL 137-2008 (2008 HEA 1204). In 2012, the Indiana General Assembly adopted a new methodology for funding PSAPs and assigned the IACIR to "*study the appropriate roles and responsibilities of the state, counties, municipalities, townships, and other political subdivisions in providing 911 and enhanced 911 services in Indiana*" (PL 132-2012 or 2012 SEA 345).

In 2014, the commission reviewed the structure and funding of PSAPs again in light of both the December 31, 2014, deadline set in PL 137-2008 for consolidation of PSAPs and the July 1, 2015, sunset of the funding structure established in PL 132-2012. The text below describes the activities and recommendations associated with the 2014 effort.

Policy Recommendations

A number of specific recommendations emerged from the 2014 discussions devoted to structure and funding of PSAPs.

Commission Recommendations

The overarching objective of our work on this issue has been to "ensure a system of funding for 911 services that it is robust, stable, and equitable, and supports high quality local 911, E911, and related public safety dispatch services. The system also must support the implementation of new technologies, and increased efficiencies, both intra-county and inter-county, over time.

To accomplish this goal, the IACIR makes the following recommendations:

1. *Encourage increased 911 system efficiencies through enhanced technologies and the adoption of best practices within and across counties.*

2. *Approach the Budget Committee to allow an appropriate increase on Statewide 911 Fees for landlines, contract mobile phones, and VOIP.*

3. *Treat 911 fees equally on all communications service as defined by IC 36-8-16.7-7, including prepaid wireless telecommunications service as defined in IC 36-8-16.6-7.*

4. *Provide additional local funding options to supplement current statewide 911 fees, including removing the link between having a public safety local option income tax and a local option income tax providing for property tax relief.*

5. *Enable local governments within counties to transfer levy capacity to county government to allow counties to fund 911, E911, and related public safety dispatch more fully and equitably with property taxes.*

6. *Establish authority for the Statewide 911 Board to audit telecommunications providers to ensure that all statewide 911 fees are being remitted.*

7. *Encourage the Statewide 911 Board to reset the minimum funding level for each county at the FY14 funding level. Establish that revenue received, in excess of the distribution amount and the network and administrative costs of the Statewide 911 Board, is distributed based on relative population. This method will direct additional revenue to counties with higher population which directly relates to additional call load.*

8. *Require the Statewide 911 Board to monitor 911-dispatch costs and funding by source and to report the results to the General Assembly every two years during each long (budget) session.*

Testimony and Research

In 2014, the IACIR took testimony and conducted its deliberations on PSAPs at meetings held on April 28, 2014, August 29, 2014, September 26, 2014, and December 5, 2014. The following individuals provided presentations or testimony to the commission during this process:

- Barry Ritter, Executive Director, Statewide 911 Board
- Association of Indiana Counties
    - David Bottorff, Executive Director
    - Andrew Berger, Director of Government Affairs and General Counsel
- Stephanie Yager, Executive Director, Indiana Association of County Commissioners
- David Vice, Executive Director, Integrated Public Safety Commission
- Terry Burnworth, President, Pyramid Consulting
- John Mallers, Principal Consultant, Financial Services Division, Maximus
- Allen County
    - Therese Brown, Allen County Commissioner
- Howard County
    - Nick Capozzoli, Communications Director, Howard County 911 Communications
    - Lawrence McCormack, Corporate Council, City of Kokomo
    - Paul Wyman, Howard County Commissioner
- Lake County
    - Brian Hitchcock, Director, Lake County 911

The minutes of the individual meetings and copies of any formal materials presented to the commission are available on the IACIR website (www.iacir.spea.iupui.edu).

Findings

The findings below summarize information received by the commission in 2014.

90 of 92 counties expected to meet the 2014 PSAP consolidation deadline
In 2008, the Indiana General Assembly passed PL 137-2008 (2008 HEA 1204) requiring the consolidation of PSAPs within counties. Those requirements were re-codified in PL 132-2012 (2012 SEA 345). Specifically, the statute requires that counties consolidate to no more than two PSAPs. Additional PSAPs may be operated within a county by public universities, excluded cities in Indianapolis-Marion County (a consolidated city), and the Indianapolis Airport Authority (an airport authority serving a consolidated city). Counties with only one PSAP on March 15, 2008, are prohibited from establishing an additional PSAP unless the new service is operated by a public university, the Indianapolis Airport Authority (an airport authority serving a consolidated city), or the largest municipality in the county. The statute allows consolidation within counties and across counties.

As of August 2014, there were four counties that had not yet met the consolidation requirements: Clark County (5 PSAPS), Lake County (17 PSAPs), Morgan County (3 PSAPs), and St. Joseph County (4 PSAPs). All except Lake and Morgan counties are expected to meet the statutory deadline. Lake County has established an interlocal agreement among 14 of their PSAPs to consolidate in early 2015. Morgan County is expected to complete the required consolidation in March 2015 (B. Ritter, testimony, August 29, 2014). To date, no structural PSAP consolidations have involved multiple counties. A consortium of local governments in northeast Indiana, including Allen County, began discussions about a potential joint dispatch center prior to 2014. These discussions have been interrupted, in part, due to a personnel change in Allen County (T. Brown, testimony, August 29, 2014).

Technology purchases offer an additional opportunity for consolidation and collaboration. More specifically, the transition from legacy phone systems to IP phone systems has allowed multiple counties to share network elements at a savings to each county. In the legacy environment, PSAPs each had their own equipment. Wayne and Allen counties have led multi-county transitions to IP networks. Marion and surrounding counties also have been successful at transitioning, with their 911 vendor, to a shared network (B. Ritter and T. Brown, testimony, August 29, 2014).

Distributions from Statewide 911 Fund were stable for FY 2013 and FY 2014
PL 132-2012 (2012 SEA 345), effective on July 1, 2012, created the Statewide 911 Fund and the Statewide 911 Fee at an initial rate at $.90 per month for landline phones, contract mobile phones, and VOIP phone service. It also required the Statewide 911 Board to raise the rate on prepaid wireless service to $.50 per transaction at the point of sale. Fees for prepaid wireless telecommunications service, as defined in IC 36-8-16.6-7, also are deposited in the Statewide 911 Fund.

Each year, counties get a guaranteed ("hold harmless") distribution. In FY 2013, the Statewide 911 Fund received enough additional revenues that there was a year-end supplemental distribution of these funds (10% equal share formula, and 90 percent using relative population). For FY 2014, counties got a 1.4 percent increase in their guaranteed distributions. There was no supplemental distribution.

Table 1 shows the annual distributions from the Statewide 911 Fund to counties. Distributions, across counties, were less in FY 2014 than FY 2013. Annual distributions by counties for FY 13 and FY 14have ranged from $86,286 and $76,968 in Benton County to $6,290,881 and $5,811,793 in Marion County. The average annual distributions to counties were $699,587 and $660,631, respectively.

Table 1. Statewide 911 Fund annual distributions to counties

	FY 2013 Distributions	FY 2014 Distributions		FY 2013 Distributions	FY 2014 Distributions
Summary			**Counties (continued)**		
All counties (Sum)	$64,362,070	$60,778,134	LaGrange	$438,636	$416,894
Minimum	$86,286	$76,968	Lake	$2,911,065	$2,638,152
Maximum	$6,290,881	$5,811,793	LaPorte	$1,645,975	$1,594,716
Median	$446,790	$426,143	Lawrence	$510,240	$483,849
Mean	$699,587	$660,631	Madison	$768,700	$692,646
Counties			Marion	$6,290,881	$5,811,793
Adams	$454,943	$435,044	Marshall	$534,235	$507,373
Allen	$2,593,186	$2,403,415	Martin	$165,233	$156,213
Bartholomew	$1,013,992	$975,682	Miami	$482,505	$461,377
Benton	$86,286	$76,968	Monroe	$779,115	$699,170
Blackford	$204,971	$194,893	Montgomery	$461,578	$439,350
Boone	$753,433	$723,989	Morgan	$615,684	$576,642
Brown	$280,674	$270,040	Newton	$225,077	$214,473
Carroll	$283,238	$269,815	Noble	$576,726	$550,459
Cass	$807,127	$789,333	Ohio	$105,542	$98,109
Clark	$1,144,829	$1,087,361	Orange	$331,237	$318,486
Clay	$431,757	$416,377	Owen	$302,059	$288,093
Clinton	$468,922	$450,025	Parke	$213,765	$200,984
Crawford	$161,829	$152,358	Perry	$296,614	$283,782
Daviess	$369,642	$350,164	Pike	$158,085	$147,350
Dearborn	$731,363	$705,646	Porter	$1,854,695	$1,773,662
Decatur	$347,359	$331,201	Posey	$386,422	$370,811
DeKalb	$553,112	$529,743	Pulaski	$208,563	$198,132
Delaware	$746,334	$678,847	Putnam	$601,620	$581,353
Dubois	$597,039	$574,285	Randolph	$356,571	$340,542
Elkhart	$1,232,586	$1,121,854	Ripley	$381,806	$364,516
Fayette	$302,068	$286,486	Rush	$315,797	$304,444
Floyd	$536,675	$492,893	St. Joseph	$1,890,109	$1,745,391
Fountain	$245,734	$233,400	Scott	$386,093	$371,688
Franklin	$363,941	$349,630	Shelby	$599,531	$575,198
Fulton	$285,031	$271,230	Spencer	$361,354	$348,621
Gibson	$344,128	$323,081	Starke	$389,548	$375,596
Grant	$472,952	$431,104	Steuben	$590,467	$572,465
Greene	$414,948	$395,296	Sullivan	$313,416	$299,609
Hamilton	$3,780,891	$3,658,205	Switzerland	$162,791	$153,737
Hancock	$1,165,437	$1,133,284	Tippecanoe	$1,555,328	$1,464,857
Harrison	$293,853	$268,470	Tipton	$242,191	$230,615
Hendricks	$1,773,855	$1,703,396	Union	$115,331	$107,226
Henry	$499,484	$470,924	Vanderburgh	$1,610,730	$1,516,594
Howard	$701,427	$654,704	Vermillion	$220,560	$208,681
Huntington	$414,770	$392,694	Vigo	$684,531	$622,233
Jackson	$596,147	$573,380	Wabash	$499,106	$480,632
Jasper	$464,660	$445,300	Warren	$126,815	$118,468
Jay	$271,992	$257,605	Warrick	$720,886	$688,967
Jefferson	$337,705	$317,375	Washington	$311,468	$293,193
Jennings	$360,342	$342,751	Wayne	$698,486	$660,603
Johnson	$1,722,114	$1,654,564	Wells	$405,790	$389,239
Knox	$455,868	$433,560	White	$435,301	$421,181
Kosciusko	$666,519	$622,941	Whitley	$390,651	$370,659

Source: Statewide 911 Board

The enabling statute allows the Statewide 911 Board to request increases in the Statewide 911 Fee. On October 12, 2013 the Statewide 911 Board passed a motion to seek State Budget Committee review for a $ .10 increase on the fee. The State Budget Committee has not yet acted on the request for review and has asked for 2 years revenue history (FY 13 and FY14) before considering a rate increase.

Statewide 911 Fees cover 43 percent of total 911 costs across six counties in recent study

In 2014, a consortium of organizations — the Indiana Statewide 911 Board, the Indiana Association of County Commissioners, and the Association of Indiana Counties — commissioned a study of E-911 costs in six counties: Hendricks, Howard, Montgomery, Tippecanoe, Wayne, and White. The study is intended to provide supplemental information about the cost of administering PSAPs and their associated dispatch centers and the sources of funding used by counties, including the Statewide 911 Fee distributions. Specifically, the study collected information about costs, revenues, population, and call volumes in 2013.[1]

In the six counties, population ranges from 24,643 in White County to 172,780 in Tippecanoe County. Annual call volume (emergency and non-emergency) is very similar for Hendricks, Howard, Tippecanoe, and Wayne counties (152,364 -167,072). White and Montgomery counties have a much smaller call volume. The proportion of total calls that are emergency calls ranges from 22 percent in Montgomery County to 57 percent in Tippecanoe and Wayne counties, with 41.7 percent across the six counties (Table 2). [2]

Table 2. PSAP population and calls

County	Population	All calls	Emergency calls	Emergency calls/total calls
Hendricks County	145,448	167,072	52,609	31.5%
Howard County	82,752	162,397	60,513	37.3%
Montgomery County	38,124	93,870	20,234	21.6%
Tippecanoe County	172,780	154,760	88,076	56.9%
Wayne County	68,917	152,364	86,774	57.0%
White County	24,643	35,088	11,120	31.7%
Total	532,664	765,551	319,326	41.7%

Source: Maximus, 2014.

The study captured the costs of each PSAP or combination of PSAPs. Generally, costs included salaries and benefits, training and travel, supplies, building rent or purchase, building and vehicle maintenance, capital costs for technology, technology contracts and maintenance, and indirect costs. The exact expense line items vary by PSAP and reflect the specific structure and service arrangements chosen by each. The cost per call ranges from $8.57 and $8.63 in Howard and Montgomery counties to $26.66 in Hendricks County, with $24.31 cost per call across the six counties. Cost per call can be affected significantly by the timing and method of financing equipment purchases. In all of the counties that have a cost per call greater than $25.00, each made a significant investment in technology in 2013. Tippecanoe and White counties made one-time technology purchases that will not recur in subsequent years. Hendricks County's cost is an ongoing lease for both telephone equipment and radios (Table 3).

[1] Maximus. *2014. E-911 Cost Study for [ ] County, Indiana*. Indianapolis. A separate report was completed for Hendricks, Howard, Montgomery, Tippecanoe, Wayne, and White counties.

[2] The IACIR's *2012 PSAP Operations Survey Results* provides similar data for 2009-2012 (January – June) prior to the adoption of the Statewide 911 Fee. The survey collected the following for each respondent PSAP: basic identifying information, management and decisionmaking structure, agencies served and services provided, annual computer-aided dispatch (CAD) events, annual call volume by type and source, operation expenses by category, and operations revenue by source. The report and associated data can be found at: http://www.iacir.spea.iupui.edu/documents/2012PSAPOperationsSurveyResults.pdf

Table 3. PSAP costs and cost per call

County	Total cost	Cost per call
Hendricks County	$4,454,408.27	$26.66
Howard County	$1,391,102.99	$8.57
Montgomery County	$810,322.29	$8.63
Tippecanoe County	$3,972,392.47	$25.67
Wayne County	$1,417,743.94	$9.30
White County	$905,197.14	$25.80
Total	$12,951,167.10	$24.31

Source: Maximus, 2014.

Across the six counties, PSAPs are funded with a combination of: Statewide 911 Fees; general revenues (property taxes, county option income taxes, etc.) assigned to the county general fund, cumulative capital development fund, or another locally designed fund; and contributions from participating local government. Table 4 shows the distributions of Statewide 911 Fees that each county received. Those fees cover from 36.9 percent of total costs in Tippecanoe County to 57.7 percent in Montgomery County. Across the six counties, Statewide 911 Fees cover 43.1 percent of total costs. When considering only eligible expenses allowed under IC 36-8-16.7-38, Statewide 911 Fees cover from 36.9 percent in Tippecanoe County to 58.2 percent in Montgomery County. Across the six counties, Statewide 911 Fees cover 44.5 percent of eligible costs, and only 3 percent of expenses reported were "ineligible" under IC 36-8-16.7-38 (Table 4).

Table 4. PSAP Statewide 911 Fee revenue and costs

County	Statewide 911 Fees	Statewide 911 Fees/total cost	Eligible costs	Statewide 911 Fees/eligible costs
Hendricks County	$1,796,253.03	40.3%	$4,077,198.84	44.1%
Howard County	$710,033.60	51.0%	$1,391,109.09	51.0%
Montgomery County	$467,354.26	57.7%	$802,784.79	58.2%
Tippecanoe County	$1,463,892.00	36.9%	$3,972,392.47	36.9%
Wayne County	$707,325.71	49.9%	$1,417,743.94	49.9%
White County	$440,838.63	48.7%	$899,514.04	49.0%
Total	$5,585,697.23	43.1%	$12,560,743.17	44.5%

Source: Maximus, 2014.

The statewide 800 MHz communications system P25 upgrade requires local governments to upgrade radios
SAFE-T is a "statewide, interoperable, wireless public safety communications system for Indiana local, state, and federal first responders/public safety officials." The system was built originally "to replace inadequate, obsolete and incompatible communications systems and allow interagency coordination and response to routine, emergency and catastrophic events." The current system was completed in 2007.

The current system is nearing capacity with little room for additional users. The equipment used in the system is no longer manufactured. By 2017, the system will no longer be repairable or upgradeable.
In light of these realities and improving technology, the Indiana Public Safety Commission (IPSC) "will upgrade the existing statewide voice communication system to P25 standards." The new P25 technology provides many benefits over the current system, including allowing integration with neighboring states (Michigan, Ohio, and Illinois), doubling existing user capacity, providing the ability to improve coverage with additional tower sites, providing more cost competitiveness and choices for radio purchases by allowing purchase from multiple manufacturers, and allowing convergence with the National Public Safety Broadband Network (FirstNet) in the future. The system will be migrated to P25 technology in phases by Indiana State Police Dispatch Region over the next two years.

As part of this transition, local governments must upgrade and re-program all radios to work on the new system. These changes must be accomplished prior to each of the phased migrations.

While there is no cost to use the P25 system, local governments are responsible for the purchase of any new radios and computer upgrades and reprogramming and template[3] fees for existing ones. Agencies face varied costs per radio depending on how recently their current radios were purchased. Some radios being used today are analog only and cannot be upgraded. These radios will have to be replaced. New radios can cost $2,000-$3,000 each to purchase. Since 2010, the Indiana Public Safety Commission has required that any new radios purchased be P25-ready. Agencies with these radios will have to pay to install the new template on each radio. Older radios may be P25-capable, but require a computer upgrade and installation of the new template. Motorola, a provided of the current system, will be providing flash kits (computer upgrade) at no cost to local agencies. EF Johnson, the second radio provider under the current system, will provide flash kits for $160. In both cases, agencies must pay the labor to install the flash kit and to install the new template. In some cases, these older radios may no longer be manufactured ("end of life"), limiting the ability to buy replacement parts for repair. Agencies will have to consider whether it is more cost effective to upgrade these old radios or to purchase new ones. (D. Vice, testimony, August 29, 2014)

In some cases, the cost to upgrade or purchase radios can be significant. For smaller local governments such as rural fire departments, purchasing or upgrading just a few radios can be a challenge.

Local governments can purchase or lease equipment through a bidding process or Request for Proposals (RFP). The IPSC also has developed a state Quantity Purchasing Agreement (QPA) that agencies can participate in without doing their own RFPs.

Local governments may fund these purchases using general or special funds. In some cases, local governments are using bonding authority to purchase new equipment. IPSC, the Department of Homeland Security (IDHS), and other agencies are working to identify grant funding to help agencies to pay for upgrades. (D. Vice and T. Burnworth, testimony, August 29, 2014)

Fiscal Benchmarking for Local Governments

Background

Over the last two years, the Indiana University Public Policy Institute (staff to the IACIR) and the Indiana University School of Public and Environmental Affairs have undertaken a project, *Fiscal Benchmarking for Indiana's Local Governments*. In September 2014, the fiscal benchmarking team released its first comprehensive report containing data and analysis on 36 fiscal indicators for all counties, townships and cities and towns. The report is available at www.policyinstitute.iu.edu/fiscalbenchmarking.

Testimony, Research and Deliberations

On September 24, 2014, the following experts provided a presentation to the commission on the recent report:

- Jamie Palmer, IU Public Policy Institute
- T. Luke Spreen, IU School of Public and Environmental Affairs

[3] The new system requires a new baseline template that ensures that a core group of talk groups and conventional channels are programmed into every radio to enhance regional and statewide interoperability.

The commission provided suggestions for additional presentations to policymakers and changes and refinements for subsequent comprehensive reports.

Managing Local Government Employee Health Care Costs

Background

Many local governments have faced rising costs for employee health insurance. In fall 2012, the IACIR took testimony on strategies local governments were employing to manage these rising costs. The commission decided to revisit the issue in 2014. The text below is a summary of the information provided in 2014.

Testimony and Research

In 2014, the IACIR took testimony on strategies for managing employee health care insurance at its October 24, 2014 meeting. The following experts provided presentations or testimony to the commission during this process:

- Christine Zoccola, Of Counsel, Bose McKinney & Evans LLP
- Eric Dreyfus, Senior Advisor, Apex Benefits Group, Inc.
- Richard Sutton, Owner, RE Sutton & Associates
- Anne Cottongim, Deputy Director & CFO, Indiana Association of Cities and Towns
- Deborah Driskell, Executive Director, Indiana Township Association
- Andrew Berger, Government Relations Director, Association of Indiana Counties
- Jeff Fox, Employee Benefit Consultant, H.J. Spier Co.

In addition to this expert testimony, the commission staff presented preliminary survey results on the provision of local government employee health care from the *2014 Survey of Local Elected Officials* and results from previous surveys.

The meeting minutes and copies of any formal materials presented to the commission are available on the IACIR website (www.iacir.spea.iupui.edu).

Findings

The findings below summarize information received by the commission.

Among types of local government, counties and cities most often provide health insurance benefits to elected officials; overall, only a small proportion of local governments provide benefits to part-time employees.
Results from the IACIR's 2008-2014 *Surveys of Local Government Officials*[4] show that the proportion of officials who indicate providing health insurance to elected officials and full-time and part-time employees varies by type of beneficiary and type of local government. Over time, county and city officials reported providing health insurance to their elected officials more than town, township, and school officials. Since 2008, more than 80 percent of county and city officials reported providing health insurance to their elected officials. Over that same period, roughly half of school officials consistently reported providing health insurance to elected officials. The proportion of township

[4] Data tables are available in Appendix A.

officials reporting providing health insurance to elected officials has declined from 35 percent in 2008 and 2010 to less than 20 percent in 2012 and 2014. Since 2008, less than 20 percent of town officials report providing health insurance for elected officials.

Since 2008, 90 percent or more of county, city, and school officials reported providing health insurance to full-time employees Between 64 and 79 percent of town officials reported providing health insurance to their full-time employees. In 2014, 67 percent indicated providing these benefits to all or some of their full-time employees. Township officials' responses were similar to those provided for elected officials. In 2008 and 2010, 44 and 37 percent, respectively, of township officials reported providing health insurance to full-time employees. A much smaller proportion indicated providing benefits to this group in 2012 and 2014 (26 and 21 percent, respectively).

Overall, about ten percent of officials reported that their local governments provide health care benefits to part-time employees. The proportion indicated by each type of officeholder varies across reporting years. An increased number of school board members indicate providing part-time employees with benefits during the time period. In 2008 and 2010, 18 percent reported providing these benefits. In 2012 and 2014, they reported 39 and 47 percent, respectively.

Local government officials have consistently reported rising employee health care costs since 2008.
Results from the IACIR's 2008-2014 *Surveys of Local Government Officials* indicate that large majorities of elected officials overall and by type of local government have reported rising health care costs over the two previous years for the 2014 and 2012 surveys and over the three previous years for the 2010 and 2008 surveys. Township trustees reported least often experiencing these increases. In 2008, only 47 percent indicated experiencing increases. In 2010, 70 percent of trustees reported experiencing increases.

Local governments are subject to initial provisions of the ACA.
As employers, local governments are subject to the Affordable Care Act (ACA). Several provisions that became effective in 2010 had the potential to raise the cost of providing health insurance to local government employees. These provisions include but are not limited to: eliminating lifetime dollar limits on essential benefits, restricting annual dollar limits on insurance coverage (banned starting in 2014), prohibiting a denial of children (under 19 years) based on pre-existing conditions, including preventative services in health plans without charging participants, and extending the ability of young adults (under 26 years) to remain on parent health plans. A prohibition against denial of coverage for adults based on pre-existing conditions became effective in 2014. Conversely, other provisions had the potential to reduce or slow the increase of these costs for local governments, such as the requirement that 80 cents of every premium dollar go to care and the requirement that insurance companies justify increases of 10 percent or more.[5]

Local governments are subject to the ACA's "play or pay" provisions.
Local governments are subject to the complex set of provisions and the implementation timing of the Affordable Care Act (ACA) "play or pay" provisions depending on their size. The basic premise of this part of the law is "an applicable large employer that fails to offer its full-time employees (and their dependents) health coverage that is affordable and provides minimum value may be subject to a penalty if a full-time employee receives a premium tax credit for purchasing individual coverage on the Health Insurance Marketplace." The ACA imposes two types of employer penalties on applicable large employers. Penalty "A" can be assessed for failure to offer coverage to substantially all of the full-time employees (the Sledgehammer). Penalty "B" can be assessed for providing coverage that is either deemed to be unaffordable or does not meet minimum value requirements (the Mallet). Penalties for "failure to offer" are generally more severe than for "unaffordability."

For the purpose of the ACA, a full-time employee is an employee who provides an average of 30 hours of service per week or more. Small employers employing fewer than 50 full-time equivalent employees are exempt from the

[5] U.S. Dept. of Health and Human Services. (n.d.) Key features of the Affordable Care Act by year. Washington D.C. Downloaded from http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html on December 2, 2014.

employer penalties. . Large employers employ 50-99 full-time employees or full-time equivalents, and very large employers employ 100 or more full-time employees or full-time equivalents. Local governments that qualify as large employers must do the required reporting for 2015, but will not be subject to employer penalties for 2015. Local governments that qualify as very large employers must file the required reporting for 2015 and will be subject to employer penalties.

In addition to meeting the coverage requirements, local governments must prepare for the IRS filings that are required for the 2015 benefit year. These filings require some records that typically have not been kept by employers, such as social security numbers for spouses and dependents. Employer health plans may also be required to obtain a health plan identifier number (HPID), but this requirement has been postponed (C. Zoccola, testimony, October 23, 2014).

In limited cases, local governments may be subject to penalties for failure to provide coverage to elected officials

Indiana law allows local governments to provide programs of group insurance to part-time and full-time employees, retired employees, and elected or appointed officers and officials (IC 5-10-8-2.2 and IC 5-10-8.2-2.6(b)). Accordingly, local governments may, but are not required to, offer coverage to elected officials under Indiana law. For the purpose of ACA, elected officials who work 30 hours or more per week count as employees. Local governments should establish a system for documenting which elected officials work 30 hours or more. As explained above, local governments that have at least 50 full-time equivalent employees (or 100 full-time equivalent employees in 2015 only may be subject to penalties for failing to offer employees affordable, minimum value health insurance coverage. (C. Zoccola, testimony, October 23, 2014).

A state health insurance pool is no longer available to local governments (except school corporations and charter schools).

In 2001, the General Assembly directed the state personnel department to develop a health insurance pool for local governments (IC 5-10-8-6.6). Unfortunately, the enabling legislation for the local unit pool yielded unreasonable premiums and very limited participation. In 2013, only nine local government units participated in the program; four of those units were townships. Given these realities and the expected complexities of the Affordable Care Act, the state personnel department discontinued the local government pool for benefit year 2014. In the 2014 General Assembly, the statute enabling the local government pool was set to expire on July 1, 2014 (PL 91 2014; 2014 SEA 225) (Christy Tittle, State Personnel Department, personal communication, on October 9, 2014 and December 1, 2014).

In 2009, the General Assembly passed a special provision allowing school corporations and charter schools "to provide health care services for active and retired employees…under any state employee health plan" (IC 5-10-8-6.7). The ability of school corporations and charter schools to participate in state employee health plans remains in effect.

Local governments use many tools to manage employee health insurance costs.

Increasing health insurance contributions by elected officials and employees

Preliminary results from the IACIR's 2014 *Survey of Local Government Officials* show that three-fifths of officials reported increasing health insurance contributions as a way to address the increasing cost of health care for the 2012-2013 benefit years. Counties, cities, and school districts reported using this strategy most often.

Self-insurance (Single government or multiple governments)

Under a self-insurance arrangement, a local government or group of local governments provides health benefits to employees and their dependents using the participating units' own funds. The local government(s) "directly funds the

health benefits of its covered enrollees" and assumes the risk for the payment of those benefits (p. 4).[6] Plans "can be funded on a pay-as-you-go basis" or through the creation of a trust fund. Local governments can choose to administer these plans directly or to retain an outside professional or firm to provide administration. "Administration of a health plan includes playing claims, resolving disputes, negotiating payment rates, and performing other administrative duties. Payment rates negotiations often involve joining an established network of providers" but in some cases involves using a health insurance broker (Brien & Panis, p. 4). Local governments "may choose to purchase stop-loss insurance coverage that insures [the local government(s)] against unexpectedly large claims…or a 'minimum premium' plan in which the [local government(s)] self-insures a fixed percentage of the estimated monthly claims and an insurance company insures the excess claims" (Brien & Panis, p. 4). Choosing a self-insurance arrangement allows local governments to achieve cost savings in many cases, through flexibility and control in establishing plan designs and other plan details. In Indiana, these plans are regulated by the Indiana Department of Insurance.

Overall, more than 25 percent of respondents to the IACIR 2014 *Survey of Local Elected Officials* indicated having adopted a self-insurance arrangement in 2012-2013 and prior to 2012. Counties and schools reported using this tool most often.

The IACT Medical Trust is a self-insurance program with multiple "cities and towns participating as one large insured group." The participating cities and towns pay a monthly premium which includes the cost of underwriting the maximum claim liability and operating costs. "The trust pays medical claims and operating costs (provider fees, legal fees, benefit consultant/broker fees, general administrative costs, and stop-loss and actuary fees)." Plan participants have access to a particular provider network (A. Cottongim, testimony, October 23, 2014).

Self-insured local governments have a number of additional tools available to manage costs. In some cases, these tools also can be used with traditional insurance options.

Risk pool management

Risk pool management is a process in which an employer, using an employee benefits broker/consultant, can create a "cost neutral" environment for both themselves as well as the employees on their health care program. "Cost neutral" for an employer means regardless of what plan design option (i.e., PPO, HSA, HDHP) or coverage tier (i.e., Employee only, Employee + Spouse, Family) a participant chooses at open enrollment, their selection will be the same expense to the employer's "bottom line." Through sophisticated data analytics and pricing tools/resources connected with the claims data, local governments are able to identify the appropriate relativities between plan options and coverage tiers in order to offer this "cost neutral" environment in their health care program (E. Dreyfus, testimony, October 23, 2014).

Consumer-driven health plans

School districts and some other local governments have maintained relatively rich health plans at a time when the private sector has moved to consumer-driven health plans. Increasingly, local governments are adopting consumer driven arrangements as strategies to manage costs. Consumer-driven health care typically refers to the combination of a high deductible health plan (HDHP) and a health savings account (pretax payment account). HDHPs are "health plans with higher annual deductible…and higher annual out-of-pocket maximum that the typical traditional health plan." These plans often are considered catastrophic coverage plans that hard against major medical cost. Health savings account hold pretax dollars, contributed by the employer, the employee, or a combination of both (J. Fox, testimony, October 23, 2014).[7]

[6] Brien, Michael J, and Panis, Constantijn. (2011). Self-insured health benefit plans. U.S. Department of Labor: Washington DC. Downloaded from http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport032811.pdf on December 1, 2014.

[7] U.S Dept. of Labor Statistics. (2010). Consumer-driven health care: what is it, and what does it mean for employees and employers. Downloaded from http://www.bls.gov/opub/mlr/cwc/consumer-driven-health-care-what-is-it-and-what-does-it-mean-for-employees-and-employers.pdf on December 1, 2014.

Contracts with exclusive provider organizations (EPO)
Local governments, as self-funding insurers, can enter into agreements with an exclusive provider organization (EPO). An EPO is a network on individual medical care providers or groups of medical care providers who have entered into written agreements with an insurer to provide health insurance to [participants]. Participants are reimbursed only for services provided "in network." There is no reimbursement of "out of network" services, except, in some cases, for emergency situations. The EPO provides medical services at significantly lower rates than it would under normal circumstances, in exchange for the steady stream of business (J. Fox, testimony, October 23, 2014).[8]

Pharmacy contracts or prescription benefit manager (PBM)
Pharmacy contracts have traditionally been paired with health care coverage contracts. In a self-insurance environment, pharmacy contracts can be decoupled from health coverage and bid through a request for proposal process. This allows multiple companies to prepare responses based on the local government's specifications. This tool is most effective for larger local governments (E. Dreyfus, testimony, October 23, 2014).

Reference-based pricing
Reference-based pricing plans, also called Cost Plus or Medicare Plus plans, typically set reimbursement rates for health care facility charges at cost or the Medicare reimbursement rate plus a markup rate (for example, 25 percent). The plan provides a cadre of co-fiduciary attorneys to whom consumers can refer their billing issues when health care providers balk at the lower reimbursement rate. In some cases, these plans may negotiate direct contracts with providers using similar reimbursement limits (E. Dreyfus and J. Fox, testimony, October 23, 2014).

Medical and prescription drug claims data analytics
Local governments are able to retrieve raw claims (medical/prescription drug) and eligibility file information from their health insurer or third-party administrator (TPA) in order to evaluate various cost and utilization metrics for their population. This information allows employers to determine where their budgetary dollars need to be spent to provide "the best bang for the buck" by minimizing cost/utilization and by reducing the overall health care risk (E. Dreyfus, testimony, October 23, 2014).

On-site medical clinics
An increasing number of local governments are implementing on-site medical clinics. Five hundred employees is the minimum number necessary to make a clinic cost effective. In some communities, small local governments are sharing clinics.

While not an inexpensive option, clinics often show a positive return on investment by reducing the cost of medical claims and employee "down time." Clinics are in or near government facilities, reducing the time away from work. They can access the clinic and easily return to work. Clinics typically provide longer appointments than providers in a traditional doctor's office. This model allows the clinic staff to focus on employee wellness in addition to treating acute conditions.

Clinic administrators can be either hospital-based or independent. Partnering with a local hospital has benefits, including that it is easier to provide clinic staffing. Hospitals, however, typically want to refer patients to hospital resources for additional care.

For schools and local governments that have had relatively rich health plans, clinics help to make the transition to high deductible health plans (HDHP) and health savings accounts more palatable (R. Sutton, testimony, October 23, 2014).

Preliminary results from the IACIR's 2014 *Survey of Local Government Officials* indicate that the use of on-site medical clinics is increasing. Overall, the proportion of official who reported implementing a clinic increased in 2012-

[8] HealthInsurance.info. Downloaded on December 2, 2014.

2013 from prior years. Counties, cities, and school districts report using this tool more often than towns and townships.

Health interventions and member engagement

Using data analytics, local governments are able to develop various health intervention programs tailored to the specific health issues and characteristics of their participants. As an example for high cost/high risk participants, local governments can provide case/disease management support to help these individuals better navigate through the health care system and properly manage their specific health issues. In situations where individuals are determined currently to be high risk but low cost from a health expenditure standpoint, local governments will be able to provide them with guidance through disease management and monitoring to close potential gaps in their own personal care. For participants who are currently both low cost and low risk, local governments will want to focus on making sure these individuals remain on the right course through the various wellness initiatives and programs.

Increasingly over the past couple of years, mobile technology tools have become available for local governments to use in providing direct outreach to health plan participants. Utilizing the data analytics described above, these tools can be used to provide targeted health communications about health plans, health interventions and incentives based on participants' personal health needs/concerns (E. Dreyfus, testimony, October 23, 2014).

Consumer cost comparison tools

Costs can vary widely from provider to provider for the same medical test or procedure. The same is true for prescription drugs across pharmacies. Several tools are now available that allow consumers to comparison shop for medical procedures and prescription medications. These tools allow the consumer to choose a good quality, lower cost option when available. Examples of the services currently available include but are not limited to: Castlight Health, myHealthcare Cost Estimator (United Healthcare), Health Care Cost Estimator (Anthem), and Good R_x (E. Dreyfus, testimony, October 23, 2014).

Health incentives

Local governments may provide incentives for particular healthy behaviors (or avoiding unhealthy behaviors). These incentives can be structured as "carrots" by which participants get something for a voluntary positive behavior, such as a deposit in a Health Savings Account (HSA) for completing a basic biometric screening or regular diabetes screening. These "incentives" also can be structured as "sticks" such as more expensive health insurance premiums for smokers. Some of the expert testimony and commission discussion suggests that some local governments are moving to the "stick" approach. Participants in good health tend to utilize voluntary positive incentives ("carrots"). The "stick" approach, such as charging higher insurance rates for failure to manage health issues, seems to gain more participation by higher cost participants (E. Dreyfus, J. Fox, and R. Sutton, testimony, October 23, 2014).

Appendix A: Selected data from the 2008-2014 *IACIR Surveys of Local Government Officials*

Table A1. Provision of health care to elected officials and employees*

	2014**								
	Elected officials			Full-time employees			Part-time employees		
Office	n	Yes-All	Yes-Some	n	Yes-All	Yes-Some	n	Yes-All	Yes-Some
County council member	48	63%	29%	48	90%	6%	43	2%	19%
County commissioner	35	80%	20%	35	97%	3%	33	3%	15%
Mayor	35	49%	34%	35	86%	6%	34	3%	6%
City council member***	21	24%	38%	22	86%	0%	19	0%	5%
Town council member	121	2%	13%	128	55%	11%	117	3%	8%
Township trustee	138	12%	7%	133	17%	8%	127	1%	3%
School board member	97	32%	18%	99	78%	19%	86	14%	33%
Total	495	26%	17%	500	59%	10%	459	4%	12%

*These data reflect survey results as of December 1, 2014.
**In 2014, officials were given the option to indicate whether all or part of each group received health care benefits.
***City council members were added to the survey in 2014.

Table A2. Provision of health care to elected officials and employees

	2012					
	Elected officials		Full-time employees		Part-time employees	
Office	n	Yes	n	Yes	n	Yes
County council member	30	93%	30	100%	26	8%
County commissioner	24	88%	25	100%	25	0%
Mayor	59	83%	58	98%	56	4%
Town council member	118	15%	118	64%	112	7%
Township trustee	75	19%	74	26%	71	1%
School board member	62	52%	65	98%	59	39%
Total	368	44%	370	73%	349	10%
	2010					
	Elected officials		Full-time employees		Part-time employees	
Office	n	Yes	n	Yes	n	Yes
County council member	32	81%	33	91%	29	14%
County commissioner	28	93%	28	100%	18	17%
County auditor*	38	89%	38	92%	24	8%
Mayor	58	72%	58	91%	48	10%
Town council member	71	15%	77	79%	71	8%
Township trustee	91	35%	82	37%	78	9%
School board member	54	48%	54	96%	49	18%
Total	372	53%	370	78%	317	11%

Table A2. Provision of health care to elected officials and employees (continued)

	2008					
	Elected officials		Full-time employees		Part-time employees	
Office	n	Yes	n	Yes	n	Yes
County council member	37	89%	37	92%	34	12%
County commissioner	31	87%	31	100%	28	25%
Mayor	41	93%	44	98%	40	5%
Town council member	88	19%	94	66%	87	7%
Township trustee	455	35%	442	44%	427	6%
School board member	77	53%	76	95%	73	18%
Total	729	43%	724	60%	689	9%

*County auditors were surveyed in 2010 only.

Table A3. Local government health insurance costs have increased over the last two years*

	2014**		2012		2010		2008	
Office	n	Yes	n	Yes	n	Yes	n	Yes
County council member	48	85%	29	83%	36	100%	37	86%
County commissioner	35	80%	25	80%	27	93%	29	86%
County auditor***			-	-	35	100%	-	-
Mayor	28	89%	55	95%	54	94%	44	93%
City council member***	19	79%						
Town council member	82	80%	86	80%	70	87%	94	71%
Township trustee	50	62%	30	70%	64	50%	405	47%
School board member	98	90%	68	93%	59	95%	84	99%
Total	360	82%	293	85%	345	86%	693	63%

*In 2014, the option to indicate that a local government does not provide health insurance was added. These data are not reported in this table. In 2012, the question was adjusted to address only the last two years, rather than the last three years in previous surveys.
** The 2014 data reflect survey results as of December 1, 2014.
***City council members were added to the survey in 2014. County auditors were surveyed in 2010 only

Table A4. Steps local governments have taken to combat the rising cost of providing health insurance to elected officials and employees by office*

Increased elected official and employee health insurance contributions				
	Benefit years 2012-2013		Benefit years prior to 2012	
Office	n	Yes	n	Yes
County council member	39	64%	38	61%
County commissioner	29	69%	29	66%
Mayor	26	54%	26	65%
City council member	15	80%	16	63%
Town council member	70	41%	73	26%
Township trustee	30	47%	34	38%
School board member	79	76%	79	70%
Total	288	60%	295	53%

Table A4. Steps local governments have taken to combat the rising cost of providing health insurance to elected officials and employees by office (continued)

Reduced health insurance coverage

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	38	34%	36	28%
County commissioner	29	21%	26	15%
Mayor	26	42%	26	31%
City council member	13	54%	15	53%
Town council member	71	20%	74	9%
Township trustee	30	23%	33	18%
School board member	76	54%	75	48%
Total	283	35%	285	28%

Reduced health insurance eligibility for officials and employees

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	27	11%	34	18%
County commissioner	16	31%	27	15%
Mayor	9	11%	26	8%
City council member	6	17%	16	25%
Town council member	23	9%	73	4%
Township trustee	16	13%	31	9%
School board member	21	24%	73	36%
Total	118	16%	281	17%

Reduced health insurance costs through a cooperative purchasing arrangement with the state of Indiana or another local government

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	36	3%	35	3%
County commissioner	28	11%	28	11%
Mayor	26	23%	26	12%
City council member	13	38%	16	19%
Town council member	71	13%	70	7%
Township trustee	29	7%	32	9%
School board member	71	37%	71	41%
Total	274	19%	278	17%

Table A4. Steps local governments have taken to combat the rising cost of providing health insurance to elected officials and employees by office (continued)

Reduced health insurance costs by changing vendors

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	36	47%	36	36%
County commissioner	29	34%	28	46%
Mayor	27	41%	25	32%
City council member	13	54%	14	36%
Town council member	71	31%	71	34%
Township trustee	29	24%	32	31%
School board member	73	33%	72	42%
Total	278	35%	278	37%

Adopted a self-insurance arrangement

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	38	37%	36	39%
County commissioner	28	61%	28	71%
Mayor	26	15%	26	27%
City council member	12	25%	16	19%
Town council member	71	8%	71	6%
Township trustee	28	11%	30	7%
School board member	70	34%	73	44%
Total	273	26%	280	29%

Operated a health clinic for employees

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	37	38%	33	15%
County commissioner	29	48%	28	25%
Mayor	26	27%	26	23%
City council member	13	38%	16	13%
Town council member	71	3%	72	6%
Township trustee	29	17%	32	9%
School board member	73	49%	75	39%
Total	278	30%	282	20%

Table A4. Steps local governments have taken to combat the rising cost of providing health insurance to elected officials and employees by office (continued)

Reduced non-insurance expenditures

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	36	44%	35	46%
County commissioner	29	45%	27	30%
Mayor	24	50%	24	46%
City council member	13	38%	16	38%
Town council member	70	14%	71	13%
Township trustee	25	20%	29	17%
School board member	67	54%	69	54%
Total	264	37%	271	34%

No action taken

	Benefit years 2012-2013		Benefit years prior to 2012	
Office	**n**	**Yes**	**n**	**Yes**
County council member	10	20%	9	22%
County commissioner	6	17%	6	33%
Mayor	4	0%	4	0%
City council member	4	0%	5	0%
Town council member	36	17%	36	22%
Township trustee	15	20%	16	13%
School board member	21	10%	21	5%
Total	96	15%	97	15%

*These data reflect survey results as of December 1, 2014.