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Reem Aly
Health Policy Institute of Ohio
Vice President, Healthcare System and Innovation Policy
Vision

To influence the improvement of health and well-being for all Ohioans.

Mission

To provide the independent and nonpartisan analysis needed to create evidence-informed state health policy.
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- Cardinal Health Foundation
- United Way of Greater Cincinnati
- Mercy Health
- CareSource Foundation
- SC Ministry Foundation
- United Way of Central Ohio
Today’s webinar objectives

• Overview of HPIO’s publication **Private Health Insurance Basics 2016**

• Data and information on:
  – Private health insurance coverage landscape
  – Affordable Care Act health insurance marketplace
  – Employer-sponsored health insurance trends

• Panel discussion on current policy issues and trends impacting the private health insurance market
## Private Health Insurance Basics 2016

**Fact sheet overviews**

### Fact sheet 1
Overview of private health insurance coverage (4 pages)
- What is health insurance?
- Private health insurance coverage
- Health coverage landscape in Ohio
- What does it mean to be uninsured?
- How does health insurance work?

**What is health insurance?**
Health insurance is a contract between an individual or group and a health insurance issuer (i.e., health plan issuer), where premium payments are made to the issuer in exchange for the issuer’s payment of healthcare expenses for individuals covered by the issuer’s health plan (also referred to as covered individuals or health plan enrollees).

### Fact sheet 2
Private health insurance regulation (2 pages)
- State regulation of private health insurance
- Federal regulation of private health insurance

**State regulation of private health insurance**
Health insurance is primarily regulated at the state level. State regulations address issues including health insurance issuer licensing, business practices, market conduct, rate review, benefit mandates and consumer protections. However, the breadth and scope of health insurance regulations vary by state.

### Fact sheet 3
Summary of Affordable Care Act (ACA) reforms (4 pages)
- Overview of the ACA
- ACA reforms on obtaining/maintaining coverage
- ACA reforms on premium rate setting
- ACA reforms on covered services and cost-sharing limits
- ACA reforms on consumer protections

**Overview of the ACA**
The Patient Protection and Affordable Care Act, enacted in 2010, established a series of minimum federal standards governing the issuance of and access to private health insurance coverage, health plan benefit structures and outlining consumer protections. The majority of the ACA health insurance reforms took effect on Jan. 1, 2014.

### Fact sheet 4
Non-group (individual/family) coverage and the Affordable Care Act health insurance marketplace (8 pages)
- Non-group (individual/family) coverage
- Individual mandate (individual shared responsibility provision)
- ACA health insurance marketplace

**Non-group (individual/family) coverage**
Individuals and families can purchase non-group health insurance coverage from:
- A private health insurance issuer
- An insurance agent, broker or online
- A private exchange
- The federally mandated ACA health insurance marketplace (exchange)
Private health insurance basics 2016

Overview of private health insurance coverage

What’s inside?
Purpose of health insurance • Ohio’s coverage landscape • What it means to be uninsured • How health insurance works

What is health insurance?
Health insurance is a contract between an individual or group and a health insurance issuer (i.e., health plan issuer), where premium payments are made to the issuer in exchange for the issuer’s payment of healthcare expenses for individuals covered by the issuer’s health plan (also referred to as covered individuals or health plan enrollees). A health plan issuer is a licensed health insurance company that is subject to state insurance regulation.

Health insurance benefits can also be provided by employers to employees through a health benefit plan. An employer may contract with an insurance company to administer a health benefit plan, with the employer being responsible for paying an employee’s healthcare claims (see Private Health Insurance Basics fact sheet 5 for more information).

Purpose of health insurance
The primary function of health insurance is to transfer the risk of financial loss resulting from healthcare expenses to an insurer in exchange for a monthly premium. Health insurance protects people against the uncertainty and high cost of healthcare expenses, making healthcare costs more predictable and limiting a person’s out-of-pocket spending. Individuals with health insurance coverage are more likely to access needed care due to the reduced cost burden health insurance can provide.

Private health insurance coverage
Private health insurance includes non-group (individual/family) and small or large group health coverage provided through an employer, another organization (such as an association or union) or purchased directly from a private insurance company. Private health insurance does not include federal, state or locally funded government programs such as Medicare, Medicaid and military or veteran coverage.

Health coverage landscape in Ohio
The private health insurance market is comprised of three segments: non-group (individual/family), small group and large group coverage. The small and large group market refers primarily to employer-sponsored health insurance coverage (ESI).

As of 2015, the majority of the state’s population — nearly 6.5 million Ohioans (57.4 percent) — had private health insurance coverage either through non-group health insurance or through ESI (see Figure 1). About 4.2 million Ohioans (36.6 percent) had public health insurance coverage through Medicaid, Medicare or other government programs.

Six percent of Ohioans were uninsured in 2015. The number of uninsured Ohioans decreased by half from 2013 to 2015, falling from about 1.4 million Ohioans in 2013 to 681,400 Ohioans in 2015. The drop in the number of uninsured Ohioans between 2013 and 2015 was largely due to the extension of Medicaid eligibility to more Ohioans, with enrollment in Medicaid increasing 28 percent from 2013 to 2015.

What does it mean to be uninsured?
Uninsured individuals have no health insurance coverage and are often billed higher charges for the healthcare services they receive. As a result, uninsured individuals are at greater risk for medical bankruptcy than those who are insured. People who are uninsured may delay or forgo needed care (see figure 2), receive care at hospital emergency departments, rely on limited services from free clinics and federally qualified health centers or experience severe financial hardship from medical debt.

Certain federal and state laws, including the Emergency Medical Treatment and Labor Act (or EMTALA) and the Disproportionate Share Hospital (DSH) program (administered as the Hospital Care Assurance Program in Ohio), ensure that people with low incomes receive emergency and critical healthcare services regardless of ability to pay. However, these laws do not provide health
What's inside?

- What is health insurance?
- Purpose of health insurance
- Ohio’s coverage landscape
- What it means to be uninsured
- How health insurance works
6.6 million
(57.4 percent)

Ohioans receive coverage through **private** health insurance

4.2 million
(36.6 percent)

Ohioans receive coverage through **public** health insurance
Private health insurance market segments

Non-group (individual/family)  Small group  Large group

Employer-sponsored health insurance coverage
Health insurance coverage for Ohioans, 2013 through 2015

Note: Enrollees in the Affordable Care Act health insurance marketplace are included in the non-group (individual/family) coverage category.

Source: Census Bureau’s March Supplement to the Current Population Survey, as compiled by the Kaiser Commission on Medicaid and the Uninsured.
Uninsured Ohioans, 2013 through 2015

Uninsured rate decreased by half from 2013 to 2015 falling from 1.4 million to 681,400 Ohioans

Source: Census Bureau’s March Supplement to the Current Population Survey, as compiled by the Kaiser Commission on Medicaid and the Uninsured
### Barriers to health care by insurance status in the U.S., 2014

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No usual source of care</td>
<td>52%</td>
</tr>
<tr>
<td>Postponed seeking care due to cost</td>
<td>32%</td>
</tr>
<tr>
<td>Went without needed care due to cost</td>
<td>27%</td>
</tr>
<tr>
<td>Could not afford prescription drug</td>
<td>19%</td>
</tr>
</tbody>
</table>

**Source:** Kaiser Family Foundation analysis of 2015 National Health Insurance Survey data. “Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2014.”

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**Top reasons people remain uninsured:**

- High cost of health insurance coverage
- Not being eligible to receive subsidized or public health insurance coverage
Private health insurance basics 2016

State regulation of private health insurance
Health insurance is primarily regulated at the state level. State regulations address issues including health insurer licensing, business practices, market conduct, rate review, benefit mandates, and consumer protections. However, the breadth and scope of health insurance regulations vary by state.

Ohio Department of Insurance
The Ohio Department of Insurance (ODI), Ohio’s insurance regulatory agency, has authority to ensure that consumers receive the benefits in their health plan or policy. While ODI does not set health insurance plan premiums or rates, the Department reviews plan rates to ensure they are within legal limits.

Figure 1. Consumer process to appeal a health plan issuer decision

1. Consumer contacts health plan issuer to begin internal appeal process.
2. Issuer agrees to reverse its decision.
3. Issue is reversed.
4. Consumer contacts issuer to begin external review process.
5. Request is forwarded to:
   - Ohio Department of Insurance (ODI) (issuer’s decision does not require medical judgment)
   - An independent review organization (IRO) for a review by a medical professional

6. Issuer’s decision requires medical judgment or involves experimental or investigational service.
7. ODI or IRO agrees to reverse the decision.
8. The requested service or payment is provided.
9. The review process is complete. The consumer has the right to file a private lawsuit and may request another review of the decision only if new medical or scientific evidence is available and submitted to the health plan issuer.

Source: Adapted from the Ohio Department of Insurance “How to Appeal a Decision by Your Health Plan Issuer” flowchart.
Private health insurance regulation

What's inside?

• State regulatory functions
• Consumer appeals process for health plan issuer decisions
• Federal laws and regulations
Private Health Insurance Basics 2016

Summary of Affordable Care Act reforms

What’s Inside? Affordable Care Act reforms on:
- Obtaining and maintaining coverage • Premium rate setting • Covered services and cost sharing • Consumer protections

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, established a series of minimum federal standards governing the issuance of and access to private health insurance coverage and health plan benefit structures, and outlining consumer protections. The majority of the ACA health insurance reforms took effect on Jan. 1, 2014.

ACA reforms do not apply uniformly across all health plans and can vary by market segment (e.g., non-group, small group and large group). The table starting on page 2 provides a summary of ACA reforms, identifying the market segment(s) to which each reform applies. However, market reforms do apply uniformly to individual and small group health plans offered inside and outside of the ACA health insurance marketplace. Key terms

Grandfathered refers to health plans that were in effect at the time the ACA was passed (i.e., individuals were enrolled in the health plan prior to enactment of the ACA) and that are exempt from many of the ACA reforms. Grandfathered health plans have limits on the changes they can make to their plan benefit structure and requirements around employer contributions, access to coverage and cost-sharing. If certain changes are made, a health plan can lose grandfathered status. The Summary of ACA reforms table identifies which ACA reforms apply to grandfathered plans.

Grandmothered refers to health plans that can be renewed by consumers under the federal government’s transitional policy outlined in 2013. The transitional policy allows certain consumers in the individual and small group markets to renew their non-ACA compliant and non-grandfathered plans through 2017.* More information on these plans can be found in the Insurance Standards Bulletin Series – Information – Extension of Transitional Policy through Calendar Year 2017.

Fully insured health plan refers to a plan purchased by an employer from an insurance company for which the employer pays claims and assumes the risk of providing health coverage to covered employees.

Self-Insured health plan refers to a company that assumes the full risk of providing health coverage to its employees and pays employees’ healthcare claims to providers through its own funds.

A number of key ACA reforms not included in the table are addressed in other Private Health Insurance Basics fact sheets, including:
- Individual mandate (fact sheet 4)
- ACA health insurance marketplace (fact sheet 4)
- Employer mandate (fact sheet 5)
What's inside?
• Obtaining and maintaining coverage
• Premium rate setting
• Covered services and cost sharing
• Consumer protections
Private Health Insurance Basics 2016

Non-group (individual/family) coverage and the Affordable Care Act health insurance marketplace

What's inside?
- Non-group coverage landscape
- What is the Individual mandate?
- Overview of the ACA marketplace

Non-group (individual/family) coverage
Individuals and families can purchase non-group health insurance coverage from:
- A private health insurance issuer
- An insurance agent, broker or online
- A private exchange
- The federally-mandated Affordable Care Act (ACA) health insurance marketplace ("exchange")

Non-group coverage accounted for only six percent of insured Ohioans in 2015. Although several market reforms implemented in 2014 under the ACA were intended to increase non-group health insurance coverage, the percent of Ohioans with non-group coverage has remained relatively stable over the past few years (see Figure 1).

Individual mandate (individual shared responsibility provision)
As of January 2014, U.S. citizens and legal residents are required under federal law to maintain minimum essential coverage for each month of a taxable year, or be subject to a penalty. Minimum essential coverage refers to most types of private and public health insurance coverage (e.g., Medicare, Medicaid, non-group coverage, or employer-sponsored), but excludes certain coverage that provides limited benefits, such as stand-alone dental and vision insurance and limited benefit Medicaid programs.

Exemptions to the mandate are granted under various circumstances including qualifying religious objections, financial hardship, issues of affordability, unlawful presence in the U.S., incarceration or membership in a designated group (such as a federally-recognized Indian tribe).3

Figure 1. Non-group coverage trends in Ohio, 2013-2015

Non-group (individual/family) coverage and the Affordable Care Act health insurance marketplace

What’s inside?

- Non-group coverage landscape
- Individual mandate
- ACA health insurance marketplace data and trends
Non-group coverage accounted for less than six percent of insured Ohioans in 2015.

Source: Total insured and non-group coverage data: Data from the Census Bureau’s March Supplement to the Current Population Survey, as compiled by the Kaiser Commission on Medicaid and the Uninsured. “Health Insurance Coverage of the Whole Population.” Kaiser Family Foundation.

Marketplace coverage data: Data from the Federally Facilitated Health Insurance Marketplace, as compiled by the Office of Enterprise Data and Analytics. “Quarterly Marketplace Effectuated Enrollment Snapshots by State.” Centers for Medicare & Medicaid Services.

Note: Marketplace coverage represents effectuated enrollment as of December for years 2014 and 2015 and as of March for 2016.
Non-group coverage accounted for less than six percent of insured Ohioans in 2015.

Health insurance marketplace type by state, 2016

Source: Data compiled through review of state legislation and other marketplace documents by the Kaiser Family Foundation.
Notes: (1) Arkansas, Mississippi, and Utah operate the small business health options program (SHOP); the federal government operates the individual marketplace in these states. (2) On Dec. 30, 2015, Kentucky Gov. Matt Bevin informed CMS that he will dismantle the state-run marketplace, Kynect, and transition to the federally facilitated marketplace. The transition will likely take effect for 2017. (3) New Mexico operates the SHOP.
There was a 4 percent increase from 2015 in number of Ohioans selecting ACA marketplace plans.

Source: Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report, State Level Excel Data Tables. Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services.
Ohio has the fifth highest bronze plan enrollment and the fifth lowest silver plan enrollment among FFM states.
Private Health Insurance Basics 2016

Employer-sponsored health insurance (ESI)

What’s Inside?
- Fully insured versus self-insured coverage
- ESI trends
- Employer mandate
- Cadillac tax

Employer-sponsored health insurance coverage

Employer-sponsored health insurance (ESI) is offered by employers to their employees and sometimes their spouse and dependents as part of an employee’s compensation package.

In 2015, a majority of Ohioans—5,974,700 (52 percent) —had ESI coverage. More than 90 percent of people with private health insurance coverage in Ohio had ESI coverage in 2015.1 The percentage of Ohioans with ESI coverage has remained relatively stable over the past few years (see Figure 1).

Fully insured vs. self-insured coverage

There are two general categories of ESI—fully insured and self-insured health plans. With fully insured health plans, an employer purchases a plan from an insurance company that pays claims and assumes the risk of providing health coverage to covered employees.2

Through self-insured health plans, an employer assumes the full risk of providing health coverage to its employees and, through its own funds, pays healthcare claims to providers.3 Self-insured coverage is generally administered through a contractual arrangement between the employer and a third-party administrator (TPA), in which the TPA assists the employer with tracking premiums, processing insurance claims and managing related plan paperwork.

Some companies offer a hybrid plan that combines elements of fully insured and self-insured coverage. A hybrid plan may protect an employer from some of the risk associated with self-insured plans and can be attractive to smaller employers.4

Figure 1. Employer-sponsored health insurance trends in Ohio, 2013–2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Ohioans insured</th>
<th>Ohioans covered by employer-sponsored insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>10,055,500 (88%)</td>
<td>5,883,900 (52%)</td>
</tr>
<tr>
<td>2014</td>
<td>10,677,700 (92%)</td>
<td>5,777,000 (50%)</td>
</tr>
<tr>
<td>2015</td>
<td>10,749,400 (94%)</td>
<td>5,974,700 (52%)</td>
</tr>
</tbody>
</table>

Source: Data from the Census Bureau’s March Supplement to the Current Population Survey Annual Social and Economic Supplement, as compiled by the Kaiser Commission on Medicaid and the Uninsured.
What’s inside?

- Fully insured vs. self-insured coverage
- ESI trends
- Employer mandate
- Cadillac tax
Majority of insured Ohioans have employer-sponsored health insurance (ESI) coverage.
Large employers are more likely to offer ESI than small employers.
High-wage workers are more likely to be offered ESI coverage than low-wage workers.

ESI offer rates also vary greatly by a worker’s full-time or part-time status.
Private Health Insurance Basics 2016

Current policy issues impacting the private health insurance market

What’s Inside?
- High deductible health plans
- Paying for value
- Network adequacy and transparency
- Risk programs
- Mergers and consolidations

Policy issues related to health insurance coverage and affordability are primarily driven by rising healthcare costs, changes in market competition and implementation of Affordable Care Act (ACA) reforms. This fact sheet outlines policy issues impacting the private health insurance market, including affordability and access to coverage.

Affordability of non-group (individual/family) coverage
Affordability of health insurance coverage remains a concern for many consumers. A 2015 survey of uninsured consumers found that 79 percent of people who shopped for health insurance coverage decided they could not afford a plan after considering monthly premiums, deductibles, co-payments and co-insurance.Early information on 2017 premiums in the U.S. indicates that health insurance premium rates will increase for coverage in 2017 and premium increases for plans offered on the ACA health insurance marketplace will be larger than years past.1

Ohioans may see an average premium increase of 12 percent for non-group plans sold on the ACA marketplace.2 Subsidies available for marketplace plans may minimize the impact of these increases for some, but people ineligible for subsidies will likely absorb the full impact of these increases.

Proliferation of high deductible health plans
An increasing number of U.S. consumers are enrolled in high deductible health plans (HDHPs) with a total of 19.7 million HDHP enrollees in 2015, up from 17.4 million in 2014.3 Moreover, average deductibles for employees with employer-sponsored health insurance (ESI) coverage in the U.S. have almost tripled in the past decade, jumping from $584 in 2006 to $1,478 in 2016.4 HDHPs have a higher deductible compared to a traditional health plan, but can typically be purchased for a lower monthly premium.5 With some exceptions, such as for preventive services, individuals enrolled in HDHPs are required to cover up to 100 percent of their healthcare costs up to a set limit before being able to receive the full benefits of their health insurance coverage.

The impetus for this increase in HDHPs is two-fold. First, as healthcare costs have risen, health insurance issuers and employers have sought ways to reduce their financial liability. Second, increased cost-sharing is intended to direct a consumer towards more cost-effective utilization of healthcare services, including reducing excess utilization, seeking care in appropriate settings and improving personal health behaviors.

While a number of studies suggest that HDHPs are effective at both reducing cost and healthcare utilization, research also suggests that HDHP enrollees are more likely to delay or forgo necessary care.7 As a result, HDHPs could lead to greater utilization of high cost healthcare services in the long run.8 With deductibles increasing at a rate nearly six times faster than workers’ earnings from 2011 to 2016, there is also concern that HDHPs may disproportionately impact low-income individuals and families.8

Although about 40 percent of employees in Ohio with ESI coverage are in HDHPs, this percentage jumps to 61 percent for employees working in small companies with fewer than 50 employees.9 Compared to other states, Ohio had the fourth largest total HDHP enrollment with 841,970 enrollees in 2015, an increase of nearly 27 percent from 2012 (see Figure 1).10 Ohio also experienced a sharp increase in HDHP enrollees from 2013 to 2014. This increase largely can be attributed to the establishment of the ACA health insurance marketplace (see Private Health Insurance Basics fact sheet 4 for more information on the ACA marketplace).
Current policy issues impacting the private health insurance market

What's inside?
- High deductible health plans
- Paying for value
- Network adequacy and transparency
- ACA risk programs
- Mergers and consolidations

Fact sheet 6

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Increase in HDHP enrollees from 2013 to 2014 can largely be attributed to the establishment of the ACA health insurance marketplace.

Ohioans in high deductible health plans, 2012-2015

Source: America’s Health Insurance Plans Center for Policy and Research Census of Health Savings Account – High Deductible Health Plans

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Private Health Insurance Basics 2016

Glossary and resources

Actuarial value: The percentage a health plan will pay towards covered medical expenses based on a standard population. For example, in a health plan with an actuarial value of 70 percent, the consumer will pay approximately 30 percent of the total billed healthcare services and the insurance company will pay the rest.

Adverse selection: Occurs when less healthy people disproportionately enroll in a health insurance plan. Generally, this occurs because individuals with higher than average risk of needing health care are more likely to purchase health insurance than healthier individuals.

Affordable Care Act (ACA) marketplace: Refers to the health insurance marketplace established by states in accordance with the ACA.

Balance billing: Occurs when out-of-network providers bill consumers directly for the difference between the self-pay rates and the contracted rate paid by the consumer’s insurer. For example, an out-of-network anesthesiologist working on a surgery may bill $1,000, but the insurance company may only pay their contracted rate of $250. The anesthesiologist may then balance bill the patient directly for up to $750.

Billed services: Healthcare services provided to a patient that are billed to the individual or the individual’s insurance company.

Cadillac tax: An ACA provision that implements a 40% excise tax on high-cost employer-sponsored health insurance coverage. The tax will be assessed on the entity providing coverage (rather than the employee), which can include health insurance issuers, employers or other entities administering plan benefits. The Cadillac tax was set to begin in 2018 under the ACA; however, Congress delayed implementation until 2020.

Co-insurance: A method of cost sharing in which the consumer is required to pay a defined percentage of their medical costs, often after their deductible has been met.

Contracted rate: The amount insurance companies agree, usually through negotiations, to pay providers for healthcare services.

Co-payment: A flat rate dollar amount paid by a consumer directly to the provider at the time of receiving a covered healthcare service.

Cost sharing: The portion of the cost of healthcare services received that consumers are required to pay. Cost-sharing expenses include co-payments, deductibles and co-insurance.

Cost-sharing subsidies: Subsidy to reduce out-of-pocket expenses incurred (such as co-payments, co-insurance and deductibles) for the lowest-income ACA marketplace plan enrollees. These subsidies increase the actuarial value of a health plan for the consumer.

Coverage tiers: The ACA requires that all qualified health plans are categorized based on actuarial value. Coverage tiers are named after precious metals and often referred to as “metal levels” of coverage.

Deductible: A set amount that a consumer pays during a benefit period or plan year for covered services before the insurer begins to make payment toward those covered services. Some plans cover certain services before a deductible is applied, such as preventive services. A health plan deductible does not refer to tax deductions.

Employer shared responsibility provision: An ACA provision that requires certain large employers with 50 or more full-time equivalent employees in the preceding calendar year to pay a shared responsibility tax (penalty) if they do not offer ESI coverage to their full-time employees and their dependents. Also referred to as the employer mandate.

Employer-sponsored health insurance coverage (ESI): ESI is offered by employers to their employees, and in some cases their spouse and dependents, as part of an employee’s compensation package.

Episode-based payment: A healthcare payment model designed to pay for value in outcomes and cost across an episode of care. Episodes of care include all care related to a defined medical event. In Ohio, certain providers may share in savings if their average costs for an episode of care are below a set benchmark and quality targets are met. Providers with average costs above an acceptable level may be penalized.

Essential health benefits: A core set of 10 broad benefit categories outlined by the federal government that health plans sold in the individual and small group markets are required to offer.
Questions
Panelists

Patty Starr
Health Action Council
Executive Director

Dr. Craig Thiele
CareSource
Chief Medical Officer

Marie Curry
Community Legal Aid
Managing Attorney
Upcoming HPIO forum

What’s on the horizon for state health policy?
Acting on priorities from the state health assessment

Thursday Dec. 8, 2016
9:30 a.m. to 2:30 p.m.

Ohio Statehouse Atrium
1 Capitol Square
Columbus, OH 43215

For more information or to register, visit
http://bit.ly/2e0Pjf1
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**Thanks!**