Containing Health Care Costs

Proven strategies for success in the public sector

Government Finance Officers Association

Colonial Life®

Making benefits count.

Foreword

The cost of employee health-care benefits has increased rapidly over recent years, contributing to the budgetary stress that governments are already facing as a result of declining or stagnant revenues and escalating costs in other areas. While public employers are under pressure to contain employee benefit costs, they are also motivated to provide benefits that help them maintain a healthy and productive workforce and attract the best employees to public service.

The GFOA, with a grant from Colonial Life, conducted independent research to identify the most innovative and effective strategies local governments can employ to meet the dual goals of containing costs and managing the quality of employee health-care benefits. Our study included a survey of GFOA members, case studies, and secondary sources. The findings and resulting publication were reviewed and approved by an independent panel of GFOA members who are experienced in employee benefit management.

We found that public employers have a range of potential strategies available, each of which relies on different underlying approaches to containing costs and preserving benefit quality. For example, wellness programs reduce employees' need for costly medical interventions and increase quality of life by focusing on preventative strategies like nutrition and fitness. Onsite clinics direct public employees toward a low-cost provider while increasing accessibility to care. High deductible health plans have the potential to significantly reduce employer premiums by introducing a consumer approach into employees' decisions about how they use their health benefit, while putting more money in the pockets of employees through a health savings account.

Of course, a change to health benefits can be an emotional and potentially controversial topic because it can affect the well-being of employees and their families. This report also provides advice for considering which strategies to pursue. It also suggests ways of building support for the selected strategies among elected and appointed officials and public employees.

It is our hope that public officials are able to use this report as they consider ways to manage costs and maintain effective benefit programs for their employees.

Anne Spray Kinney
Director, Research and Consulting Center
Government Finance Officers Association

Patrick McCullough
Assistant Vice President, Public Sector Practice Leader
Colonial Life

Colonial Life.
Making benefits count.

Credits

This paper is a product of a partnership between GFOA and Colonial Life. You can learn more about the GFOA at www.gfoa.org. Colonial Life is a market leader in providing insurance benefits for public-sector employees and their families through the workplace. You can learn more about Colonial Life at www.coloniallife.com.

This paper was written by Shayne C. Kavanagh, Senior Manager of Research for the GFOA's Research and Consulting Center in Chicago, Illinois. He can be reached at skavanagh@gfoa.org.

GFOA would like to recognize the following individuals for contributing their experiences to our research case studies:

John D. Sullivan, Director of Risk Management and Purchasing, Anoka County, Minnesota
Randy Hutchison, Finance Director, Bexar Appraisal District, Texas
Johanna Ray, MPH, ACE, Health and Wellness Manager, Cabarrus County, North Carolina
Darin Schulz, Director of Finance, Chautauqua County, New York
Susan Iverson, Director of Finance and Administrative Services, City of Arden Hills, Minnesota
Victoria A. Runkle, Finance Director, City of Arvada, Colorado
Cheryl Walker, Health and Wellness Manager, City of Asheville, North Carolina
George M. DeHority, CPA, CGFM, Finance Director, City of Havre de Grace, Maryland
Rick DeOrdio, Benefits Supervisor, City of Irving, Texas
Max S. Duplant, Chief Financial Officer, City of Irving , Texas
Z. Ike Obi, Strategic Resources Administrator, City of Irving , Texas
Heather Hunter, MBA, Finance Director, City of Lewiston, Maine
The City of Ludington, Michigan
Don Simons, Director of Finance, City of Mesquite, Texas
James A. Hanson, CPA, Director of Finance, City of Montgomery, Ohio
Michael A. Hermanson, CPA, Pension and Benefits Administrator, City of Tucson, Arizona
Carolyn Williams, Benefits Manager, Clackamas County, Oregon
Linda D. Quinley, Chief Financial Officer, Columbia Public Schools, Missouri
Susan Vinson, CPA, Director of Finance, Corpus Christi Regional Transportation Authority, Texas
Carol L. Caviness, C.E.B.S., Assistant Director, Elkhart County Personnel Office, Elkhart County, Indiana
Thomas P. Durkin, CPA, Chief Financial Officer, Lackawanna County, Pennsylvania
Nelia Larson-Mann, SPHR, CBP, Manager, Employee Benefits & Risk Management, Loudoun County, Virginia
Kristi Kordus, Finance Director, Marathon County, Wisconsin
Rhonda Foster, S.P.H.R., Human Resources Director, Monroe County Government, Indiana
Robert M. Bendzick, CPA, CGFM, Chief Financial Officer, Olmsted County, Minnesota
Dave Sherden, Benefit Coordinator, Olmsted County, Minnesota
Susan Smith, Executive Director, Texas Municipal League Intergovernmental Employee Benefits Pool
Michael W. Griffin, Clerk-Treasurer, Town of Highland, Indiana
William St. Amour, President, Cobalt Community Research

GFOA would like to recognize the following individuals for the review and guidance of the research:

Catherine Walker, Assistant Chief Executive Officer, Alameda County Employees Retirement Association
Barbara Avard, Administrator, Charlotte Firefighters Retirement System, North Carolina
Patsy K. Cantrell, Administrator, Retiree Health Care Systems, City of Farmington, Michigan
Christopher Morrill, City Manager, City of Roanoke, Virginia
Carolyn H. Glover, Director of Human Resources, City of Roanoke, Virginia
Michael A. Hermanson, CPA, Pension and Benefits Administrator, City of Tucson, Arizona
J. Virgil Moon, CPA, Support Services Director, Cobb County, Georgia
Patrick McCullough, Assistant Vice-President, Public Sector Practice Leader, Colonial Life Insurance
Barrie Tabin Berger, Assistant Director, GFOA's Federal Liaison Center
Anne Kinney, Director, Research and Consulting, GFOA's Research and Consulting Center
Christopher S. Sears, Partner, Ice Miller LLP
Kate Clarke Buch, Finance Director, Town of Darien, Connecticut
Marcy Boggs, Managing Editor, GFOA's Research and Consulting Center

The survey research was conducted using www.surveymethods.com.

Colonial Life.
Making benefits count.

Contents

Introduction 1
The Leverage Points of Health Benefit Cost Management.....2
1. Change Level of Benefit Provided 2
2. Manage Participants' Choice of Providers 3
3. Share Cost with Employees 4
4. Reduce Employees' Use of Health Care Services 6
5. Right-Source Health Benefit Services 12
6. Maximize the Value Received for the Health Care Dollar 15
From Ideas to Action 17
Considering Strategies 17
Building Support 18
Conclusion.....20
Appendix 1.....21
Notes 23

Sponsored by the Government Finance Officers Association and Colonial Life.
GFOA received a grant from Colonial Life to study best practices for employee health benefit cost management strategies for public employers. GFOA used the grant to conduct independent research using a survey of GFOA members, case studies, and secondary sources. The findings and resulting publication were reviewed and approved by an independent panel of GFOA members with experience in managing employee benefits.

Copyright 2011 by the
Government Finance Officers Association
203 N. LaSalle Street, Suite 2700
Chicago, Illinois 60601
www.gfoa.org

Colonial Life.
Making benefits count.

INTRODUCTION

The escalating cost of employee health care benefits has been an intractable problem for employers, both public and private, across the United States. Health insurance premiums have grown a cumulative 138% between 1999 and 2010. This compares to cumulative wage growth of 42% over the same period.[1] Unfortunately, this trend is not expected to abate in the near future – employer health care cost trends are projected to increase by an average of 8.5% in 2011, up from 8% in 2010.[2]

What is behind this budget-busting trend? A number of factors are thought to be at work. The leading ones include increasingly sophisticated (and expensive) medical technology and an aging population.[3] Other reasons might include provider consolidation (decreasing competition) and cost-shifting from Medicare and Medicaid to private insurance plans as reimbursements from these federal programs fails to keep up with rising costs and providers look to make up the difference elsewhere.[4]

Public employers might not be able to do a lot to counteract these kinds of forces, but GFOA's research has found that there are still important leverage points for public employers to manage and contain the cost of employee health care benefits, while still promoting a healthy workforce. This paper describes these leverage points and includes specific cost management strategies within each point. The discussion focuses on the strategies that have been found to have the most profound effects and that have proven successful in the public sector.

The paper focuses on more innovative strategies, though the tried-and-true are discussed too. Wherever possible, the we cite concrete return-on-investment estimates. Of course, strategies with profound impacts will often require multiple years to yield their full benefit, so the paper also highlights "fiscal first aid" tactics that can be used to help control costs in the short term.

The paper concludes with a discussion on how to move from strategy to action, including selecting specific strategies to implement and build support for changes to the benefit plan.

About our Sources

GFOA and Colonial Life surveyed a sample of GFOA members, conducted case study interviews of public managers who reported successful use of innovative cost management strategies, and reviewed secondary research. The survey has a margin of error of +/- about 6%.[5]

THE LEVERAGE POINTS OF HEALTH BENEFIT COST MANAGEMENT

GFOA research identified six primary leverage points governments can use to manage employee health care benefits costs. These are:

1. **Change the level of the benefit provided**. Modify how many and what type of benefits the plan provides and who they provide them to.
2. **Manage participants' choice of providers**. Direct or even limit health plan participants' choices to lower-cost providers.
3. **Share cost with employees**. Structure the health plan so that employees bear part of the burden of benefit costs.
4. **Reduce use of health care services by employees**. Address the economic incentives and actual need for health care services.
5. **Right-source health benefit services**. Use the right combination of outsourced service providers and providers within a network to deliver health benefits.
6. **Maximize the value received for the health care dollar.** Rather than just minimizing costs, consider the benefit received per dollar spent on health benefits.

1. Change Level of Benefit Provided

Employers can control how many and what type of benefits the plan provides and who they are provided to. Of course, the more benefits a plan provides and the greater the number of participants in the plan, the greater the total cost of the plan will be.

As such, a public employer can consider reducing the benefit level provided to contain costs. This could include, for example, making dental, vision or other non-core coverage a voluntary option for which the employee would bear the full cost. This strategy was sparsely used by GFOA survey respondents (33%), but 86% of those respondents would recommend it, and 70% would recommend it highly — mainly because it allows employees access to expanded benefits without increasing the cost to the employer.

Certain types of services could also be dropped from the plan. For instance, one city in GFOA's research dropped bariatric surgery. However, eliminating core benefits is a rarely used strategy, according to GFOA's survey: Fewer than 5% have eliminated benefits for active employees. Indeed, eliminating benefits is a blunt instrument for cost containment, as it can decrease the quality of the benefits offered. Benefits have often been considered an important part of the attraction to public sector work, so this is not an insignificant consideration. In fact, about a quarter of the survey respondents cited the negative impact on employees as a reason for not eliminating benefits, while another 30% cited the lack of familiarity with the impacts as a reason for avoiding the technique.

The ROI All-Stars

Within the six leverage points, GFOA's research found that these strategies had the best return on investment potential. These strategies will be discussed in detail in the paper:

- **Onsite clinics**. Direct employees toward a low-cost provider while increasing satisfaction with care.
- **Variable premium contributions**. Structure employee premium contributions as a percentage of the total premium or a flat employer contribution where employees must cover the balance.
- **High-deductible health plan and health savings account**. Introduce a consumer-driven mentality to employee health care in order to reduce excess usage.
- **Wellness program**. Take a structured approach to improving employee health and, therefore, reduce need for more costly health care interventions.
- **Self-insurance**. Retain the risk associated with health insurance, as well as the profit.
- **Cooperative purchasing.** Pool with other employers to augment purchasing power.
- **Value-based insurance design disease management**. Use cost differentials to direct limited medical resources to their best effect.

Another option is to encourage employees to waive benefit coverage. For example, some governments offer cash incentives to employees to drop coverage, especially if they have coverage from other sources (e.g., a spouse), or to at least drop spousal coverage if the spouse has their own insurance. The Village of Romeoville, Illinois, for example, offered employees cash payments ranging from $2,000 to $4,000 per year to waive coverage.[6] However, this sort of strategy was not often used by GFOA's survey respondents (only 35% used it), but 76% of those that did would recommend it to others. Reservations about this strategy centered around the potentially small number of employees who would take the incentive and the possibility of the most healthy employees opting to drop coverage, thus leading to an increase in premiums.

Fiscal First Aid: Health Benefit Eligibility Audit

An audit of the health benefit plan could reveal that a number of participants aren't technically eligible to participate. This could include, for example, dependents who are over age or who aren't blood relatives or a spouse. Also, former employees may not have been removed from the plan. For example, the City of Montgomery, Alabama (population 205,764), found a potential annual savings of over $1.3 million when it discovered that 288 dependents, or 8.9%, were ineligible for benefits coverage. Smaller governments can also realize savings. Upon an initial audit, a town of 20,000 people found $20,000 in potential savings on an annual $1.2 million budget for employee health benefits.

Federal health care reform might reduce the yield available from eligibility audits because it expands coverage requirements for dependents, but audits will still remain an important cost management technique.

2. Manage Participants' Choice of Providers

Employers can take steps to direct or even limit health plan participants' choices to lower cost providers. Most public mangers are familiar with the trade-offs between plan cost and degree of insurance provider control in health care delivery. A health maintenance organization (HMO) will typically cost less than a preferred provider organization (PPO) because it manages care more tightly.[7] A "narrow network HMO" will reduce costs more by further restricting choice in available providers. However, less choice typically translates into less perceived benefit on the part of employees.

One strategy to manage choice of providers while improving the quality of the health benefit for employees is on-site health centers, also known as on-site clinics. An on-site clinic is essentially a doctor's office that is provided by the public employer, on or near the employer's premises. Staffing varies with expected use of the clinic, from only nurse practitioners and physician assistants to a full medical staff. The services offered range from just immunizations and limited acute care to physicals, lab work, behavioral health services, and even pharmacy services. A variety of management models is available for clinics, but GFOA's case study research suggests that most governments favor relying on a third-party vendor to manage the clinic on their behalf. That's because doing so, if contracted properly, reduces the government's responsibility for regulatory compliance and liability concerns that would otherwise come with operating a clinic.

An on-site clinic provides savings to the employer through the following advantages:

- On-site clinics can provide services more cheaply than commercial providers.[8] To provide one example, Elkhart County, Indiana (903 employees and 756 plan participants), performs a full panel blood draw at its clinic as part of its wellness program.[9] Elkhart pays about $10 for each test, while a private provider might charge up to $100 to a patient for a comparable service.
- Because an on-site clinic is more accessible to employees than commercial providers (i.e., closer and cheaper), employees seek treatment for minor conditions before they become major conditions that are more costly to treat.

- Employees take less time off from work both because they don't need to travel to get medical attention and because scheduling is usually better integrated with the employer's needs.

Research has found that on-site clinics offer a substantial return on investment (ROI): figures range from $1.60 to $4 saved for every dollar invested.[10] The experience of GFOA's cases study research confirms substantial benefits are available. For example, Cabarrus County, North Carolina, offers a full-service clinic to 1,300 employees and dependents and realized a net cost savings of $624,000 over a four-year period.

Research has found that on-site clinics offer a substantial return on investment: figures range from $1.60 to $4 saved for every dollar invested.

Of course, an on-site clinic does not have guaranteed returns. First, to be effective, a clinic must have a certain number of potential patients — about 800 to 1000.[11] This does not mean that on-site clinics are an impossibility for smaller employers — multiple employers can share a clinic. In Texas, the City of Mesquite is on the border of what is required to run a cost-effective clinic (1,148 employees), so it joined with the Mesquite School District (4,700 employees) to offer a full-service clinic. Corpus Christi Regional Transit Authority (213 employees) contracted with a local physician group to provide preferential rates at their clinics (see sidebar below).

Once in place, employees must have an incentive to visit the clinic instead of a commercial provider. GFOA's case studies used a number of enticements to make the clinics less expensive and more convenient than other alternatives:

- Waive or substantially reduce co-pays when visiting the clinic.
- Provide convenient scheduling options such as web-based appointment setting. Employers can also negotiate wait time standards with the managers of the clinic to ensure visits are expeditious.
- Develop advantageous time-off policies for using the clinic, such as not requiring the use of sick time to visit clinic or allowing flexible work scheduling.
- Make sure the clinic staff is professional and friendly.
- Provide services that are focused but cover major employee needs. Clinics that provide only the most basic services will not see high utilization, and services that are too specialized will not enjoy economies of scale.

Fiscal First Aid: Urgent Care Clinics

The Corpus Christi Regional Transportation Authority used urgent care clinics to rapidly access some of the benefits of on-site clinics. Essentially, the CCRTA contracted with a commercial provider to give the Authority highly preferential rates for the urgent care needs of CCRTA health plan participants in exchange for directing plan participants to the clinic. The clinics are neither exclusive to CCRTA employees nor on CCRTA premises. Rather, the contracted physician group has thee separate clinics in different parts of the community, so is still convenient for employees. CCRTA found that the clinic showed a positive return in the first year because there were no start-up costs to speak of – the CCRTA just had to encourage employees to use the clinics.

3. Share Cost with Employees

Health care costs have escalated at a rate that far exceeds inflation. Sharing costs with employees is a way to share this burden. In addition to reducing the employer's cost, cost sharing should help make the case with employees for strategies that reduce the total costs of the health plan because employees become more cognizant of the trade-offs between increasing health care costs and other uses of resources (e.g., their take home pay). To

illustrate, restricting the plan participants' choices of providers decreases the quality of the benefit to employees, but research shows that employees typically prefer less choice to higher premium costs.[12] Hence, structuring employee contributions to premiums such that their contribution depends on the total cost of the plan they select gives employees an incentive to choose a less costly plan (e.g., an HMO over a PPO).

Increasing premiums, co-pays, or deductible are all forms of cost sharing. These methods were used by 47% of GFOA's survey respondents. Increasing deductible was slightly more popular, with 56% of respondents indicating they had used it. Among those that haven't used these strategies, the most important barrier was usually the negative impact on employees.

Increasing premiums, co-pays, or deductible are all forms of cost sharing.

While increasing an employee's cost-sharing might be a strategy, employers should also be aware that doing so could cause a loss of "grandfathered" status under the Patient Protection and Affordable Care Act of 2010 (PPACA). Under PPACA, an employer group health plan that was in existence on March 23, 2010, can retain grandfathered status and avoid several of PPACA's new coverage mandates that are applicable to group health plans (e.g., providing no-cost preventive care benefits and providing greatly expanded claims and appeals rights, including a right to an external appeal to an independent review organization). A group health plan can lose grandfathered status if it raises employees' coinsurance rates, raises fixed-dollar cost sharing (such as deductible, co-pays, or out-of-pocket maximums) by more than the increase in medical inflation plus 15%, or reduces the percentage of the plan's premium paid by the employer by more than 5% (all as measured from March 23, 2010). Many employer group health plans have already lost grandfathered status and have become subject to PPACA's full range of coverage mandates. However, plans that have not yet lost grandfathered status and want to retain it should carefully review the limits imposed by PPACA on increasing employee cost-sharing mechanisms.

For plans that intend to increase employee cost-sharing, one way to mitigate some of this negative impact on employees is to implement a health reimbursement account (HRA). An HRA is an account the employer funds for each employee, and it can be used to give the employee tax-free reimbursement for qualified medical expenses.[13] An HRA can be used to complement a traditional type of plan, like an HMO or PPO. If any employer is able to realize significant savings from the cost-sharing strategies described above, it can use part of the savings to fund HRAs. Because the money provided to employees through the HRA is tax-free, it can go a long way toward offsetting the increased out-of-pocket expenses they incur with the health plan. It should be noted that this strategy is, in some ways, similar to a health savings account (HSA) and high-deductible health plan (HDHP). However, the HRA strategy described here can be used when the deductible faced by employees are not high enough to qualify for an HSA, under IRS rules. HDHPs and HSAs are explained further in the next section of this paper.

Another option to help alleviate some of the potential for employees to experience higher out-of-pocket costs associated with cost sharing strategies (and higher deductible and co-insurance requirements in particular) is supplemental insurance. This supplement applies to higher cost, less common uses of medical services, like hospital confinement or outpatient surgery. The concept is that it will cost less to provide this more limited insurance than more comprehensive coverage, but employees still have some measure of protection. Hence,

Fiscal First Aid: Section 125 Plan Flexible Spending Account

A Section 125 or "FSA" allows employees to make before-tax contributions from their wages to a personal account that can be used for qualified expenses. In addition to providing a nice way for employees to make wages go further (perhaps reducing the bite of cost sharing strategies), it can also reduce the employer's payroll tax burden. For example, a community college in North Carolina (with about 1,000 employees) streamlined enrollment and enhanced communication of its FSA, increasing participation by 68%. This brought employees more than $100,000 in tax savings and $26,000 in FICA savings.

employees have the supplemental insurance to guard against exorbitant out-of-pocket expenses owing to uncommon use of services, while the employer saves money through the more advantageous employee cost-sharing arrangements for more mundane services.

4. Reduce Use of Health Care Services by Employees

The extent to which plan participants use benefits is a key driver of the cost to the employer. There are two main factors underlying participants' use of care. First is participants' economic incentive to use health care. The typical health insurance model provides an incentive to overuse health care services because there is not a very direct connection between participants' out-of-pocket costs and the actual cost of services. For example, if participants' only cost is a $30 co-pay, there is no incentive to choose a physician who charges $100 for an office visit over one who charges $150. In fact, total overuse of service in the health care system has been estimated at between 30% and 50%.[14] The second factor underlying participants' use of health services is their need for service owing to their health conditions. Chronic health conditions and employees' poor health habits are major contributors to the cost of an employer's health plan.[15]

Hence, employers can seek to: 1) create incentives for employees to make economically efficient choices when they need care; and 2) help employees become healthier so they need less medical care. The consumer-directed health care movement has evolved to address the first point, and employer wellness programs address the second.

Consumer-Directed Health Care

The basic premise behind consumer-directed health care is to make plan participants discerning consumers of health care services, including improved information on cost-effective choices and incentives to reduce spending. The overarching goal is to give participants a stake in containing costs. The practical incarnation of this philosophy with the greatest potential impact for an employer's bottom line is a high-deductible health plan (HDHP) paired with health savings account (HSA) or health reimbursement account (HRA).

Fiscal First Aid:
Multi-Tiered Drug Benefit

Providing a drug benefit that includes a smaller employee co-pay for generic drugs, a larger co-pay for brand name drugs, and perhaps an even larger co-pay for lifestyle drugs is consistent with consumer directed health care principles.

The most prominent feature of an HDHP is a very high deductible. To qualify as an HDHP, a plan must have deductible of a certain minimum size. The standards are set by the IRS each year and in 2011 are a bit more than $1,100 per year for individuals and $2,300 for families. However, in practice, HDHPs often have higher deductible than the IRS minimum – GFOA's case studies commonly reported deductible of between $2,000 and $5,000, but deductible as high as $10,000 are not unheard of in the private sector. Once a plan participant meets the deductible, the health insurance benefit is activated. At this point, the participant will have a coinsurance obligation, usually paying from 10% to 20% of the claims. This obligation continues until the participant reaches an out-of-pocket maximum, at which point the insurer becomes totally responsible for all covered claims. HDHPs can be designed to limit or expand the choice of providers, much like an HMO or PPO — a design feature that becomes most germane once the deductible is met.

An HDHP is usually accompanied by an HSA or HRA. An HSA can be used only with HDHPs; it is a tax-advantaged savings account that can be used to put aside money to pay for qualified medical expenses. Employees can make tax-free contributions to an HSA, and employers can contribute as well. A key difference between an

HRA and an HSA is that the employee has "ownership" of the money in the HSA upon separation from the employer. With an HRA, the employer is the "owner" and can design the plan to provide a former employee and qualified dependents access to the funds or to require the employee to forfeit the funds upon separation from service. GFOA's case studies demonstrated a strong preference for using HSAs over HRAs for supplementing an HDHP (though it is possible to use both[16]). This is because they believe that employee ownership of the HSA contributes to the "consumer driven" nature of the plan and to employee acceptance of HDHP.[17]

Because employees are completely responsible for health service costs up to relatively large amount with an HDHP, compared to a traditional plan, they will presumably will be more discerning about which health providers to use or whether to use services at all, and they might even scrutinize provider invoices more closely. This should translate into a lower claims experience for the employer and, hence, lower overall costs for the health plan.

Because employees are completely responsible for health service costs up to relatively large amount with an HDHP, compared to a traditional plan, they will presumably be more discerning about their health care usage, which should translate in to a lower claims experience for the employer.

It is, however, difficult to obtain a good estimate of total return on investment for an HDHP. One reason is that HDHPs have gained popularity only in the last few years, so there is limited data on which to base an evaluation. Second, because HDHPs have an important financial impact on employees as well as employers, a serious evaluation of ROI must encompass both parties. One study that attempts to overcome these two problems ran 24 simulated scenarios of HDHP/HSA against a more traditional plan and found that the total financial benefit (for both employee and employer) was greater under HDHP/HSA in 21 cases, with a total average differential of $2,019 in favor of HDHP/HSA over the entire simulated 40-year time period.[18] Furthermore, at the end of the simulated period, the employee had built up an average HSA balance of $35,147. This indicates that an HDHP/HSA shouldn't have a negative effect on employees and should even provide a net benefit.

With respect to just the employer's costs, other research indicates savings of between 12% and 30% of premiums.[19] Anecdotal evidence from GFOA's case studies seems to support the proposition that HDHPs can provide significant savings in at least some cases: [20]

- The City of Ludington, Michigan (population, 8,300, 53 full-time employees in the health plan), saved $100,000 in the first year.
- Chautauqua County, New York (population 135,000, 83 employees enrolled in HDHP), saved about $2,000 per participant.
- Columbia Public Schools, Missouri (2,550 full-time equivalent), reduced the total annual cost increases for its benefit plan to 5%, down from 9%, with only half of eligible employees choosing the HDHP option, (The rest remained in a traditional plan.)
- The City of Havre de Grace, Maryland (population 13,000, 130 employees), reduced premiums by more than $250,000 per year.

However, HDHPs have been subjected to three important criticisms. These concerns, along with the common responses of HDHP advocates, are presented below.

Cash flow challenges for plan participants. Some plan participants can experience cash flow problems if they don't have enough money available to meet the deductible for their medical expenses. The essential starting point for dealing with this problem is to pair the HDHP with an HSA and/or HRA so employees will have resources available to offset the higher out-of-pocket costs. For reasons explained earlier, HSAs were more preferred by GFOA's case studies.

Even with an HSA in place, the employee may not be able to put aside enough cash to make payments on deductible. To alleviate this concern, it was very common for the case study governments to "seed" the HSA for the employee each year. This contribution was often equal to the entire amount of the deductible, but was in all cases a substantial percentage of the deductible. This was seen as necessary to both alleviate cash flow concerns and, in cases where employees had choices between HDHP and traditional plans, to attract employees to HDHP. However, it should be noted that all of the case study governments were relatively new to HDHPs, so it was unclear if annual seeding will remain an ongoing trend or a limited-term tactic to build a cushion in employees' HSAs.

A last tool to help with cash flow concerns is a short-term loan program. Such a program is much like overdraft protection at a bank. Chautauqua County set up a small loan fund to help employees with problems meeting the deductible. Any loans made have to be paid back by the end of the year at a nominal interest rate.

Underutilization of preventative care. Given the incentive to minimize medical costs, plan participants may underutilize preventative services because they are often not perceived as an immediate, pressing need. This would, of course, lead to worse long-term health outcomes and higher costs for the employer. The commonly accepted solution is to provide for "first dollar coverage" for preventative services,[21] which means coverage is provided for certain services regardless of whether the HDHP deductible is met. This means that preventative coverage under an HDHP is comparable to that of traditional plans. Among the most common covered services are immunizations, well-baby and well-child care, mammography, pap tests, and annual physical exams and screenings.[22]

Health Care Reform and Preventative Care

It is worth noting that health care reform promotes preventive care by requiring non-grandfathered plans to provide specified preventive care services to plan participants without any employee cost-sharing. The preventive care services required by PPACA range from immunizations to screenings for various types of cancer to annual physicals and mammograms. The goal of the legislation is to encourage employees to seek preventive care by eliminating the employees' out-of-pocket costs for doing so.

Adverse selection. HDHPs are thought to hold the greatest attraction for younger and healthier individuals because they have less need for medical care and will therefore benefit from lower premiums and/or building up funds in an HSA. The other side of this coin is that less healthy individuals will gravitate toward traditional plans, thereby driving up the claims experience for these types of plans, making them even more expensive. Perhaps due to the relative novelty of HDHPs and HSAs (having only gained popularity in recent years) and the long time period over which adverse selection problems would manifest, GFOA could not find any definitive secondary research on whether adverse selection does in fact occur in employer plans or the impact of adverse selection on employer costs. GFOA's case study governments that offer traditional plans in addition to an HDHP have reported that adverse selection has not yet proven to be a problem, though they remain aware of the possibility.

Regardless of the potential gains for employees, HDHP can be a tough sell. Here are some suggestions from GFOA's case studies for making an HDHP a positive experience:

- **Do not reduce the overall scope of coverage under the HDHP compared to the traditional plan.** For example, if certain services are excluded from the HDHP, employees might associate the change with the very concept of HDHP (rather than just recognizing it as change in coverage levels that could have occurred under any plan type).
- I**f possible, offer the HDHP as an option with traditional plans**. This will allow a smoother transition. Be patient, though; for employers that offer multiple plans, reaching participation goals might take some time. Persistence and planning can pay off, however. Columbia Public Schools reached 55% HDHP participation in the first couple of years, though they were hoping for just 50%.

- **Complement the HDHP with an HSA and seed it**. Employees like having an individual account to which they can make tax-free contributions that earn them interest, and an account that they control and get to keep. An HRA does not offer these advantages to the employee. Once established, it is wise for the employer to make contributions to the HSA for the employee. This will build goodwill and shouldn't prevent the employer from realizing bottom-line savings.
- **Educate employees on what HDHP is and what its implications are**. Studies show that most people don't really understand HDHPs.[23] In-person meetings, printed materials, and online tools to help employees understand the individual financial impact an HDHP are all important. Our case studies advise not to assume too much when working with different employee groups. For example, the conventional wisdom is that low-wage employees would be least receptive to HDHP because of cash flow concerns. Columbia Public Schools, however, found that its lower-wage employees were among some of the most interested in the plan because of the opportunity to put more money in their own pockets through lower premium costs and an HSA.
- **Find good HDHP and good HSA vendors**. Some vendors specialize in HDHPs, so offering an HDHP may not be as simple as asking the current health insurance provider for an HDHP option. Selectivity is also important for the financial institution that acts as the custodian for the HSA. Our case studies reported that HSA administration can be a significant irritant to the employee, if not handled well. In particular, look for custodians that have low fee structures and high interest rates, easy access to funds (though a debit card option, for example), and customer service systems that are tailored to HSAs.
- **Make the cost of providing health benefits transparent**. Many of GFOA's case studies used employee benefit committees to keep employees informed of the cost of health care. This can make the rationale for going to an HDHP much more compelling, especially if the public employer already has a system for variable sharing of premium costs. In fact, in Ludington, Michigan, employees welcomed the HDHP as a way to escape the continuing concern about health benefits becoming totally unaffordable for the City and its employees.

Spend Money to Save Money

Wellness programs might actually result in increased utilization of preventative services. However, this should lead to lower utilization of more costly interventions over time.

Wellness Programs

Wellness programs are initiatives employers offer in an attempt to affect the overall health of employees (and sometimes dependents), decreasing health care costs and increasing productivity. Wellness programs can take a number of forms, including a health risk assessment (e.g., lifestyle questionnaire, biometric evaluation), self-help educational materials, individual counseling, educational classes and seminars, or behavioral modification programs such as coaching. Wellness programs can have a specific focus of intervention such as weight loss, fitness, or smoking cessation, or address multiple risk factors.

Wellness programs have generated a great deal of enthusiasm among public and private employers. Almost 80% of GFOA's survey respondents have undertaken at least some form of wellness initiative. Of those respondents, 90% would be willing to recommend it to others, and 65% would recommend it enthusiastically. These attitudes are consistent with those of private firms.[24] This enthusiasm is not misplaced. A number of rigorous studies have shown the significant ROI potential of wellness. One meta-study of ROI for large employers (defined as more than 1,000 employees) showed that for every dollar spent, the return was $3.27 over an average three-year period.[25] Other studies have found higher and lower ROIs, but it does seem clear that wellness programs have significant potential financial benefits, and not just for larger employers:

A number of rigorous studies have shown the significant ROI potential of wellness programs.

- The City of Arden Hills, Minnesota (pop 9,550, 25 employees participating in the health plan), improved its experience, leading to a $24,000 refund from their carrier and a 13% decrease in premiums.
- Since the City of Lewiston, Maine (pop 41,500, employees 443), implemented a wellness program in 2006, its health care premiums have decreased by $736,757 (through 2008). From 2007 through 2010, premiums have increased an average of 3.3%, less than the national averages of about 4.5% to 5% during that same period.[26]

Wellness programs sometimes have an additional ROI benefit for public employers that offer health care to retirees. The City of Irving, Texas (population 216,000, 1,800 employees), was able to reduce its GASB 45 unfunded actuarial accrued liability by 50% (from $52 million to $26 million) within two years of implementing a new retiree health insurance strategy that includes a comprehensive wellness program as a key component. The City of Irving's approach shows that wellness programs do not have to end when active employees retire.

Given that wellness programs are fairly well established in the public sector, this paper will not address the basics of such programs but will examine the best practices of wellness programs revealed by GFOA research:

Assess the population. ROI can be best achieved by focusing wellness activities on the areas of greatest need. Biometric evaluations, claims analysis, and employee surveys are all helpful sources of data. Seek to determine the most common types of claims, the most common predictive factors, and the highest cost diseases. This will enable the employer to develop a focused, limited program. For instance, Olmsted County, Minnesota (population 141,000, enrolled employees 930), found that weight loss was its most pressing need, so the City started there. It was then able to demonstrate clear positive results to the County Board (the initiative paid for itself in the first year, and employees who benefited testified in front of the Board), thereby paving the way for additional wellness activities.

ROI can be best achieved by focusing wellness activities on the areas of greatest need. Biometric evaluations, claims analysis, and employee surveys are all helpful sources of data.

Individualize the intervention. Wellness programs that rely solely on one-size-fits all interventions are less successful than programs that recognize and address participants at multiple risk levels and provide special support for those at greatest risk. For example, Olmsted County has two levels of weight loss support:

- **Intermediate**: This program is open to plan participants with a body mass index (BMI) of more than 25. The 12-week program takes place in a support group setting and features advice from personal trainers, dieticians, and health coaches. Also, the County's wellness coordinator reviews participants' weekly food journals and provides weigh-in opportunities.
- **Intensive**: The intensive weight loss program is open to plan participants with a BMI of more than 35, or more than 30 with one co-morbid condition.[27] The program can last up to 48 weeks, and it consists of individual sessions with a personal trainer and dietician, weekly food and physical activity accounting and weigh-ins, and consultations with a certified health coach.

As the Olmsted example illustrates, different intervention methods, like support groups, individualized counseling, and feedback, all have a role. Some research suggests that telephone counseling can be a particularly effective intervention because it is a low-cost way to provide individualized expert attention for plan participants.[28]

Incentives. Incentives are becoming an increasingly regular feature of wellness programs[29] and were in common use among the governments participating in GFOA's case studies. GFOA found several types of financial incentives in use:

- Employees in the City of Irving, Texas, can earn a monthly reward of up to $150 for meeting standards in physical fitness or biometric screening, and also accumulate premium credit for retiree health insurance premiums.
- Employees in the City of Lewiston, Maine, can reduce their share of monthly health insurance premiums from 25% to as little as 10% by meeting body fat composition goals, not using tobacco, following an exercise program, and completing a health risk assessment.
- Manatee County, Florida (pop. 322,000, employees 3,200), has a three-tier health benefit with significant differences in cost-sharing arrangements between each tier. To qualify for the most preferred plan, employees must complete an array of wellness activities.

Some research suggests that $100 for a single instance of behavior (i.e., completing a health risk assessment) is the point at which an incentive becomes meaningful to employees. Further, the reward should be paid soon after the activity is completed in order to maximize positive reinforcement.[30] Finally, rewards are often more effective if they are not included in the regular paycheck (e.g., a gift card).[31] However, an incentive program can work even if it does not follow these standards. In Lewiston, 86% of eligible plan participants take part in the wellness program, and a little more than 50% participate in Irving. In Manatee, 93% of employees completed the wellness actions necessary to qualify for the most advantageous plan.

Some research suggests that $100 for a single instance of behavior — for instance, completing a health risk assessment — is the point at which an incentive becomes meaningful to employees.

Incentives need not necessarily be monetary. For example, the City of Arden Hills found that a relevant gift — a pedometer— was effective for increasing employees' interest in the wellness program. Many of GFOA's case studies found that inter-departmental challenges were also useful. For example, departments can complete with each other to see which group of employees can lose the most weight, walk the most miles, or complete the greatest number of wellness activities.

Finally, more employers might begin considering disincentives for unhealthy behaviors more seriously.[32] For example, Elkhart, Indiana, assesses an "up charge" equal to 10% of the employee's monthly premium share if the employee fails to complete biometric screening. Other employers have started assessing tobacco users a surcharge on top of their existing contributions to the health benefit.

Design a program for the whole person. The wellness program should integrate various approaches to improving employee health. For example, Olmsted County found that it was necessary to address the psychological issues behind overeating to reach weight loss objectives. Another illustration is that a smoking cessation initiative should be accompanied by a weight management program.

Leading wellness programs are recognizing the importance of stress in employee health.[33] Programs address the drivers of stress and increase employee coping capabilities. Specific interventions can include stress management coaching, worksite exercise programs, discounted gym memberships, or massage therapy.

Track results. Employers should track the results of the wellness program over time and adjust the program accordingly. This includes both employee health results and financial impacts. The same sources of data used to originally assess the workforce can be used to gauge progress. Are claims decreasing? Are biometric results improving? Also, more timely data can be gathered, such as participation in wellness events. Wireless technology has the potential to greatly improve result tracking by monitoring employee exercise regimens and submitting information like calories burned or steps taken.[34]

Engage participants. Of course, for the wellness program to achieve the best results, plan participants have to participate and, ideally, participate enthusiastically .This starts with communication. An insight revealed by GFOA's case studies was that the human resources office needs to be seen as credible and trustworthy. If employees have little confidence that information from biometric scans, lifestyle questionnaires, etc. will be used properly, then they will be less likely to join the wellness program. Also, GFOA's case studies related that it can be helpful to have "wellness champions" throughout the organization to help communicate the program. It is usually not especially difficult to find a handful of employees who would be enthusiastic about the program and spread that enthusiasm to others.

Wellness programs must comply with a number of legal issues, so public employers must be careful with how programs are designed.

Perhaps the greatest challenge the case studies encountered with their programs was engaging dependents. Not only do dependents generate a significant portion of the claims in virtually any plan, but they can sabotage the employee's efforts to achieve personal wellness goals (imagine trying to lose weight when the rest of the family is not supportive). None of the GFOA case studies are completely satisfied with their solution to this problem, but many are trying. King County, Washington, provides an example of one approach.[35] Much like Manatee County, King County presents employees with three tiers of plans, ranging from the least cost-beneficial for the employee to the most. King County requires both the employee and the spouse to meet certain wellness objectives to quality for the best plan.

Remain aware of legal restrictions. Wellness programs must comply with a number of legal issues, so public employers need to be careful about how programs are designed. Some of the most important legal concerns include:[36]

- **Make the program voluntary**. The program must be voluntary in name and in fact. For example, employers can't set the rewards for participating so high as to be a significant part of compensation, or predicate participation in the health care benefit on participation in the wellness program.
- **Provide everyone with an opportunity for reward**. If a wellness program provides rewards based on health status factors, then the program must comply with requirements under the Public Health Service Act that are intended to make awards available to a broad range of participants, not just the healthiest.
- **Keep data secure**. Employers often collect a lot of health data through wellness programs, so privacy laws must be respected. This includes developing appropriate privacy policies and procedures as well as being mindful of using aggregate data, rather than individual data, to operate the wellness program.
- **Tax issues with incentives**. Some incentives, like gift cards, create a tax liability, while others, like reduced premiums, do not.

5. Right-Source Health Benefit Services

As with many services, third-party organizations can often provide health benefits more cost-effectively than in-house resources. However, this is not always the case. Governments have important opportunities to retain some parts of the work of providing benefits while still lowering their overall costs. Hence, a public employer needs to consider the opportunities and settle on the right mix of outsourced and in-sourced services, taking into account factors such as internal capacity, risk tolerance, and economies of scale. The largest such opportunity is self-insurance, so it will be the first point of discussion in this section, including considerations about moving to self insurance and what employers that are already self-insured can do to maximize the benefits of this strategy. Cooperative purchasing of health care benefits will be explored next, and finally, a number other right-sourcing strategies.

Self-Insurance

The largest potential gain from right-sourcing, for many employers, will come from self-insuring or self-funding the health plan. Self-insured employers assume the risk for providing health care benefits, rather than transferring it to a third-party insurer. Under this system, the employer pays for each claim as it is incurred, rather than paying a fixed premium to the health insurance provider. The financial benefits to self-insurance can be substantial — a reduction of approximately 10% in health care costs.[37] These savings arise from eliminating the profit margin of commercial insurers, being able to design the benefit plan to the employer's exact specifications, and avoiding legislative mandates that apply to commercial insurers, the costs of which are passed on to customers.

However, it should be noted that self-insurance has generally been regarded as the province of larger employers — generally those with more than 200 employees. This is confirmed by research that shows only 16% of private firms with fewer than 200 employees are self-insured, compared to 59% when all firms are considered.[38] Smaller employers usually aren't able to spread the risk or realize administrative economies of scale for processing claims and dealing with legal compliance requirements. However, smaller employers could gain the benefits of self-funding if they have the financial wherewithal (cash reserves) to withstand the variable expenses associated with paying actual claims as they are incurred or if they join a multi-employer benefit pool that is self-funded.

The largest potential gain from right-sourcing, for many employers, will come from self-insuring or self-funding the health plan.

Public employers that wish to pursue self-funding need to decide how to best use third-party (e.g., private contractor) assistance. As a first step, the employer should find a consultant experienced in self-funded plans to help with: evaluating how much risk the public employer is willing and able to retain versus transferring it to a third-party insurer; negotiating terms with other service providers; and assessing the need for stop-loss insurance.

Stop-loss insurance reduces the risks associated with self-insurance by reimbursing the employer for claims that exceed a specified level. Stop-loss coverage can be especially important for risk-adverse employers. Public agencies are generally thought to be risk adverse, and GFOA's survey bears this out, showing that only about 40% of respondents are self-insured. When looking at only respondents that have budgets of more than $50 million, the percentage of self-insured employers is still just 46% – making it appear that public agencies make significantly less use of self-insurance than private firms. Hence, a good stop-loss strategy might be essential to gaining acceptance of self-insurance among decision makers. Also, factors such as an aging workforce and increasingly sophisticated treatments are making high-cost claims more commonplace, which makes an even stronger case for stop-loss coverage.[39]

Stop-loss coverage can apply to individuals whose claims exceed a given ceiling in a single year, in order to protect against infrequent but severe cases. Stop-loss coverage can also apply to the employer's total costs for health care. The former is probably the more important of the two because it protects against impossible-to-predict events. The latter may be of interest to more risk adverse or smaller employers, but on average will be less beneficial because insurers typically set stop loss limits at a level of aggregate spending that is rather unlikely to be reached in any given year.[40]

A self-insured employer should consider the role of a third-party administrator. Self-insured employers can administer claims in-house or contract out to a third-party administrator.

Finally, a self-insured employer should consider the role of a third-party administrator. Self-insured employers can administer claims in-house or contract out to a third-party administrator. The tasks of an administrator could include enrolling employees, providing customer service, processing claims, reviewing and validating invoices, provid-

ing wellness programming, and analyzing claims data. Further, a third-party administrator handles many regulatory compliance issues, although employers should never forget that they — not their third-party administrators — are ultimately responsible for the legal compliance of a self-funded plan. As a result, it is critical that employers carefully review their contracts with their third-party administrators and ensure that they have legal protections if the third-party administrator fails to perform its duties properly. An administrator should be more than just an outsourced transaction processor, though; third-party administrators can save significant costs by providing additional analysis of invoices, spending trends, and claims patterns.

Beyond these fundamentals, there are a number of other ways that employers can optimize their self-insurance strategies:[41]

- **Carve out high-cost claims**. Claims that are rare but extremely costly can be covered by conventional insurance, thereby proving protection against low-frequency, high-cost claims. Examples include organ transplants and specialty pharmaceuticals.
- **Carefully manage high-cost areas**. Because a self-insured employer has more control over plan design, it can more rigorously manage high-cost areas. While the specific areas of greatest cost will vary for each employer, managing chronic diseases and conducting billing audits offer benefit for all employers.
- **Use data to drive wellness programs**. The previous section on wellness advocated analyzing claim to data to focus wellness activity. Self-insured employers typically have much greater access to claims data. In fact, GFOA's case studies with the greatest returns from wellness programs cited self-insurance as one of the keys to their success.

Cooperative Purchasing

Cooperative arrangements are a staple of government purchasing, and the same idea can be applied to health benefits. According to GFOA's survey, only about a third of governments use cooperative purchasing for health care, but of those that do, most (70%) recommend it enthusiastically. This suggests untapped potential. Cooperative arrangements can take a variety of forms, from pooling purchasing power, to negotiating with vendors, to implementing a self-insurance strategy for employers that are too small to do it on their own, to designing benefit packages, to providing specialized analysis and administration services.

Only about a third of governments use cooperative purchasing for health care, but of those that do, most recommend it enthusiastically.

Cooperative purchasing can have important benefits. The Texas Municipal League's Intergovernmental Employee Benefits Pool (with more than 150,000 covered lives in two separate pools) estimates that new members can save 5% to 20% on their premiums. Further, the Pool has the resources to design a plan to fit available budgets, so new members can reduce costs as much as they need. In another example, Marathon County, Wisconsin, gains access to benchmarking information and predictive cost modeling technology through its cooperative — resources it would not otherwise have.

Cooperative purchasing is not without its limits, foremost among which is the fact that public employers must be willing to sacrifice some flexibility when joining a pool. For example, if the cooperative decides to switch vendors for a given service, all members need to be ready to make the switch, even if they liked the old vendor. In addition, cooperative purchasing arrangements will not necessarily provide a benefit to all employers. Large employers might be better off self-insuring on their own. Also, depending on how the cooperative's rates are structured, employers with particularly good claims experience might find they can get lower rates outside of the cooperative. Finally, traditional insurers might object to the cooperative and raise their concerns with members of the government's governing board. Cooperatives obviously pose a threat to insurers' business model, so they might take steps to poison the idea.

Other Right-Sourcing Strategies

Moving to self-insurance or cooperative purchasing is a fairly significant change. Here are some other strategies to make sure a public agency is getting the most from third-party providers.

Re-bidding or renegotiating. It is no secret that government budgets are shrinking. Third-party providers can be asked to share the pain via re-bidding or renegotiating. Among GFOA's survey respondents, this was a common and well-regarded technique — 64% have used it, and 85% would recommend it. The benefits can be substantial. For example, Lackawanna County, Pennsylvania (pop. 214,000, 1,110 employees), regularly re-bids its insurance and recently saved $400,000 on its prescription drug plan over three years. However, this strategy can be used only so often (generally, every three to five years for medical benefits), and the organization must be committed to changing vendors, if necessary, lest the procurement process lose credibility.

Shift benefits education and communication expense to suppliers. Employers can transfer the cost of benefit plan communication (e.g., annual benefits booklet printing, employee benefit statement software, and educational websites) to the benefits suppliers. More than half of GFOA's survey respondents use this technique and about 83% would recommend it, while 70% would recommend it enthusiastically. Respondents cited the economies of scale and specialization the vendor brings as well as the opportunity to reduce the government's administrative costs. However, some governments found that this strategy wasn't cost effective. For example, larger governments that administer much of their plans in-house may already have the requisite scale and expertise.

Use an external service provider for benefits enrollment. Employers can use an outside party to supply an enrollment system and manage open enrollment on behalf of the employer, rather than maintaining and managing a system and processing fully in-house. The rationale for this strategy is much the same as for the strategy discussed above: economies of scale and specialized expertise can be accessed through a third party. The results of GFOA's survey were also somewhat similar. In this instance, just less than half use this strategy, of which 77% would recommend it, and 63% would recommend it enthusiastically. The survey again found that large, self-insured employers might already have in-house capabilities in this area, but it also showed that small governments might have less use for this strategy, given the small number of people who make any changes to their benefits each year.

6. Maximize the Value Received for the Health Care Dollar

Rather than just minimizing costs, the employer should also consider the value received from health care: the benefit received per dollar spent. A value-based approach seeks to maximize use of treatments that are of high value to patients and minimize the use of unnecessary or ineffective treatments. This should lead to a better long-term cost experience because the medical services used have the greatest impact both now and in the long term.

Rather than just minimizing costs, the employer should consider the value received from health care: the benefit received per dollar spent.

When applied to employer-provided health plans, a value-based approach to health care is known specifically as value-based insurance design (VBID). The premise of VBID is that high-cost and chronic cases account for the bulk of an employer's overall costs.[42] These kinds of patients usually agree to follow the course of treatment recommended by the provider.[43] Therefore, containing costs requires that providers recommend cost-effective treatments and that the patient then follow through on their agreement with the provider. For example, studies have shown that higher co-payments will reduce usage of drugs, even if the drugs are of high value and would lead to better long-term outcomes.[44] Hence, eliminating or lowering co-payments for high-value treatments eliminates an important barrier to patients' maintaining their treatment regimen. To illustrate, it is far better to subsidize an employee's $2-a-day drug cost for a high-value drug for a heart condition and potentially avoid a heart bypass surgery at more than $100,000 later on.[45]

In the most basic approach to VBID, the employer simply lowers or eliminates co-payments for drugs or treatments that are proven to have high value relative to other treatment regimens. An elaboration on this basic model is to have more individualized cost-sharing arrangements, depending on a plan participant's specific condition. For example, a plan participant with heart problems may have no co-payments for a drug with proven value for heart conditions, while another participant, who doesn't have a heart problem, would have to make co-payments if they sought to use the drug for another condition, where value hasn't been demonstrated. The crux of the idea is to adjust the out-of-pocket costs for health services based on how clinically beneficial a service is to a particular patient. This concept can also be extended to providers — employees can be given a financial incentive for using the most cost-effective providers. For example, a hospital with a lower rate of hospital-acquired infections would have lower co-pays than one with a higher rate.

VBID is still an emerging best practice in both the public and private sector. However, one notable long-term success is the City of Asheville, North Carolina (population 83,000, 1,130 employees). Since 1996, the City has run a highly successful disease management program that conforms to VBID principles. Asheville currently has five programs covering diabetes, asthma, depression, hypertension, and cholesterol. The program works as follows:

The City of Asheville has seen positive results from each of its five programs within one year and has received an ROI of about $4 for every $1 invested.

- A plan participant is identified as eligible and enrolls. Eligibility can be determined by a referral from a doctor, the City's on-site clinic, or self-referral. Once enrolled, the patient receives co-pay waivers for medications that are of proven value to treating the disease.
- Patients are assigned to pharmacist care manager and enrolled in an educational program. The program focuses on the importance of complying with the treatment regimen.
- The patient meets with the pharmacist care manager on regular basis and gets lab tests. This information is coordinated with the patient's doctor. All labs, drug co-pays, and pharmacist visits are 100% covered so long as the patient complies with the education classes, care manager visits, and lab draws. If patients fail to comply, they are removed from the program and must resume full co-payments.

The Asheville model is especially interesting because it has been widely studied and replicated. The City has seen positive results from each of its five programs within one year and has received an ROI of about $4 for every dollar invested.[46] The program results in fewer trips to the emergency room for participants, less time off from work, and, of course, lower costs for the City. To illustrate the hard-dollar cost savings, the city's program for hypertension resulted in a 46.5% reduction in cardiovascular-related medical costs during the period of one study.[47] It is notable that cardiovascular medication use increased three-fold during this same period, thereby illustrating the premise of value-based insurance design.

FROM IDEAS TO ACTION

This part of the paper addresses how public employers can implement the cost management ideas described earlier. The first section provides guidance about which strategies to pursue, and the second addresses how to build support for the required changes.

Considering Strategies

Employers have a number of leverage points available for managing the cost of employee benefits and an even greater number of specific strategies within those leverage points. The employer must choose which strategies to go with based on factors such as the organization's size, political environment, cost management goals, and impact on employee health and access to care. Below is a summary of the strategies with the most potential, based on GFOA's research, along with points germane to the consideration of each strategy.

Onsite clinic. Direct employees toward a low-cost provider while simultaneously increasing their satisfaction with the care they receive.

- ROI ranges from $1.60 to $4 saved for every dollar invested, including soft-dollar saving such as increased productivity.
- Must have approximately 800 to 1,000 potential patients to be cost-effective.
- Employees must be encouraged to choose the clinic over alternatives.
- Clinic can provide more accessible and cheaper services to employees.

Premium contributions that are variable with total premium. Structure employee premium contributions as a percentage of the total premium or a flat employer contribution where employees must cover the balance.

- Contributions rise with increases in premiums so the employer does not bear full burden of increases.
- Gives employees a stake in other strategies that will reduce premium costs.
- Could conflict with collective bargaining agreements.

High-deductible health plan and health savings accounts. Introduce a consumer-driven mindset to employee health care to reduce excess usage.

To reduce excess usage, introduce a consumer-driven mindset to employee health care .

- Saves between 12% and 30% of total premium costs.
- Might save employees money, especially if variable premium contributions are in place.
- Can produce unintended negative consequences if not designed properly.
- Higher deductible could conflict with collective bargaining agreements.

Wellness program. Take a structured approach to improving employee health and, therefore, reduce the need for more costly health care interventions.

- ROI for large employers averages $3.27 over a three-year period (includes soft dollar savings). Smaller employers can see a return on investment as well.
- The program can start with a limited scope of interventions or delivery mechanisms, but more comprehensive programs will have the greatest effect.
- Steps must be taken to encourage employees to participate.
- Wellness programs have clear health benefits for employees.

Self-insurance. Retain the risk associated with health insurance, as well as the profit.

- Can result in about a 10% reduction in health care costs.
- Self-insurance is generally effective only for cost-beneficial for larger employers (with at least 200 employees)
- Requires active management of risk (e.g., stop-loss insurance)
- Gives employer great flexibility to design the benefit. This provides the opportunity to design benefits that best meet employee and employer needs.

Cooperative purchasing. Pool with other employers to augment purchasing power.
- Can help reduce costs by approximately 5% to 20%
- Provides economies of scale and access to best practices that might not otherwise be available.
- Members of the pool must give up some flexibility for the pool to work.
- Some governments (e.g., larger jurisdictions and/or those with very good claims experience) might be better off outside of the pool.

VBID disease management. Use cost differentials to direct limited medical resources to their best effect.
- ROI of about $4 for every $1 invested, over a multi-year period (including soft-dollar savings).
- Can start with a focus on one or two diseases and expand from there.
- Improves health outcomes for targeted employee groups.
- VBID is perhaps the least common of the strategies presented here, but the Asheville Project provides a solid model.

Besides considering the individual strategies, employers should consider the potential for interactions among strategies, both positive and negative. Examples include the following:

Besides considering the individual strategies, employers should consider the potential for interactions between strategies, both positive and negative.

- GFOA's most successful users of wellness and disease management cited their self-insurance programs as crucial to their success. This is because self-insurance typically grants access to a greater amount of claims detail than would be available from many commercial insurers. The data can be used to tailor the program to the greatest needs and to track progress. Also, a self-insured arrangement means that the employer will capture the full monetary benefit of a wellness or disease management program.
- An on-site clinic can boost participation in a wellness program because it makes it much more convenient for employees to get blood screens, visit a medical professional, etc.
- A cooperative purchasing arrangement can provide the economies of scale necessary for strategies that are normally limited to larger employers, such as an on-site clinic or self-insurance.
- An on-site clinic that charges less than "market value" for services in order to entice employees to use it could run afoul of IRS rules for the types of health plans that HDHP employees are allowed to participate in. This would prevent employees or employers from making contributions to an HSA, for example.

Building Support

Changes to the benefit plan can be a controversial subject. Employees could see a change in the level of benefits as a change in their compensation, and a change in the benefit plan might reduce their total take-home pay. Decision makers (i.e., elected officials, executive management) are concerned with the job satisfaction of the government's workforce, the ROI of changes to the plan, and public perceptions. Below are strategies for working with employees and decision makers to build support for changes to the health care benefit.

Employees

A first strategy to consider for building support with employees is an employee benefit committee. A committee should include members drawn from collective bargaining groups, employees who aren't represented by collective bargaining, and management. The committee should be given substantive responsibility over the design of the benefit plan. For example, in Clackamas County, Oregon (population 375,000, 1,800 employees in benefit-eligible positions), the committee decides the level, scope, and design of benefit plans offered to employees for medical and vision coverage, dental coverage, and for disability and life insurance. However, the committee must also take responsibility for designing a plan that is affordable, including examining claims data to account

Unions: An Impediment to Health Benefit Reform?

Conventional wisdom is that unions are a serious barrier to cost containment of the health benefit. Indeed, GFOA's survey showed that collective bargaining restrictions were cited by about a quarter of respondents for not using strategies like increasing deductible, increasing employees' premium costs, or eliminating benefits. However, the survey also showed no relationship between the level of total savings experienced from all cost containment strategies and the extent to which the workforce is unionized. At least part of the explanation seems to be that the strategies where collective bargaining restrictions are most important are the same strategies that almost all employers would prefer to avoid as much as possible anyway. Also, strategies with high potential ROI, like wellness, on-site clinics, self-insurance, or disease management, typically would not run afoul of collective bargaining restrictions.

for high cost areas and respecting financial constraints the government is subject to. Further, committee members serve as ambassadors to the employee group they were drawn from by soliciting feedback on plan changes and helping to explain cost drivers and decisions. GFOA's case studies have found that benefit committees can go a long way toward building acceptance of benefit changes; however, the success of the committee depends on a collaborative spirit and transparency of information (e.g., claims, costs, available resources).

Another strategy is to educate employees about the value of their benefit so that they better appreciate the costs involved and the need for the benefit to be managed carefully. One popular tool is a benefit value statement. Benefits are significant piece of employee compensation, yet most employees don't understand the value of what they are receiving. A benefit value statement lists out the benefits that are available to the employee, along with the monetary value of those benefits. However, it is important that the benefit statement not just enumerate the employer's costs, but that it also helps the employee understand what benefits are available and how to get the best use of them. This makes it more likely that employees will read the information and even share it with their spouses. In addition, group and individual meetings around enrollment time can supplement the written statement, giving employers the opportunity to explain benefits in person and make sure employees understand what is available.

Many of the strategies discussed in this paper have potential value for employees. While the primary objective of these strategies is to control employer costs, GFOA's case studies have highlighted some examples of positive effects on employees:

- On-site clinics are convenient for employees and can reduce their out-of-pocket costs for medical care.
- If employees share a variable of the premium cost (e.g., a percentage of total), any strategy that reduces premium costs can put more money in their pockets.
- A health savings account and high deductible health plan could provide a means for some employees to start saving money, tax free, for the future.
- A wellness program or a disease management program can lead to better long-term health outcomes.
- Self-insurance allows the employer more freedom to design a plan that most precisely meets the needs of the workforce.

Decision Makers

Decision makers have multiple concerns when it comes to changes to the benefit plan. By following the guidelines above for gaining employee support, decision makers' concerns about workforce satisfaction can be alleviated. However, that still leaves concerns about public perceptions as well as return on investment.

Public employee compensation has been a hot topic in the news, so decision makers will naturally be cognizant of public perceptions. A first step is to do a total compensation study that compares the total value of compensation packages with those of comparable governments. Appendix 1 provides a table of employer costs per hour

worked for total employee compensation and costs as a percent of total compensation for state and local government workers, including by employer size and bargaining unit status. The table was provided to GFOA by the Bureau of Labor Statistics using unpublished data from the Bureau's National Compensation Survey. Appendix 1 also provides advice from the Bureau on using its National Compensation Survey data for comparative purposes.

In today's political climate, decision makers might also wish to compare compensation costs with regional averages for all employers of a similar size (public or private) to get better sense of the compensation of public servants compared to those they serve. While this is certainly a valid question, the Bureau of Labor Statistics cautions against using National Compensation Survey data for cross-sector comparisons, given differences in compensation structures and occupations. As such, public managers will have to undertake a more customized and nuanced analysis if they wish to address this question.

The final concern decision makers have is the ROI from pursuing health benefit cost containment strategies. The first step to achieving a positive ROI is to take a long-term approach. GFOA's best practice, *Strategic Health-Care Plan Design*, recommends that governments develop and adopt a formal multi-year plan to manage health care costs. This helps emphasize to all decision makers that the economics of many cost management strategies can take a while to fully develop, so a long-term commitment is required.

A long-term plan also makes it easier to take smaller steps toward a larger ultimate goal. An incremental approach limits the upfront investment and allows managers to assess the impacts of relatively small changes, and then make adjustments before proceeding further. It also limits the amount of change that employees will have to adjust to at one time. Many cost management strategies are compatible with an incremental approach. Here are some examples from GFOA's case studies:

- A wellness or disease management program can start off by focusing on just one or two particular types of intervention (e.g., weight loss, diabetes). Use an employee health risk assessment and/or claims analysis to suggest which intervention would offer the best ROI.
- A high deductible health plan could start off with a deductible at the IRS minimum and move up over time. Employers can seed the employees' health savings accounts, at least temporarily, to help them make the transition.
- An employer could self-insure the dental plan as a low-risk way to get experience with self-insurance. If it proves successful, self-insurance of other benefits could be explored.

Public employee compensation has been a hot topic in the news, so decision makers are cognizant of public perceptions. A first step is to do a total compensation study that compares the total value of compensation packages with those of comparable governments.

CONCLUSION

Public employers face relentless upward pressures on health care costs. This paper has identified six leverage points employers have available for managing costs, as well as specific strategies for each. The optimal strategies for any given employer will vary with size, political environment, and the needs of the employees. However, the positive experiences many governments across the United States have had with health care cost containment illustrates that success is possible. By selecting and sticking to focused strategies, public employers can begin to change their approach to employee health care, both saving money and preserving the value of the benefit for employees.

Appendix 1

State and Local Government Employer Costs per Hour Worked for Employee Compensation and Costs as a Percent of Total Compensation

The information in the appendix (see chart on the following page) was provided to GFOA by the Bureau of Labor Statistics, using unpublished data from the Bureau's National Compensation Survey.

What is the National Compensation Survey (NCS)?

- Comprehensive employer-based survey of approximately 36,000 establishments
- Represents almost all industries in the private sector and state and local government (note: the table in this appendix uses only state and local government data)
- Includes all employee size classes

Employer Costs for Employee Compensation

- NCS provides estimates of employer costs for wages and salaries and individual benefits
- Includes all major benefits but does not include low-cost benefits, items that are a cost of doing business, training, or payments in kind
- Estimates are expressed as a cost per hour worked (CPHW)
- Produced four times a year

Making Comparisons

- You can compare any grouping of employees to NCS data that makes sense for your purposes.
- Wages and salaries are calculated by:
  - Wages = Hourly wage rate
  - Salary = Pay divided by the hours worked for that specific time period
- Benefits are calculated according to cost per hour worked (CPHW)
  - CPHW = Annual cost divided by annual hours worked
  - Annual hours worked = Scheduled hours - leave hours (paid and unpaid) + overtime hours
- Avoid double counting and excluding costs
- Make apples-to-apples comparisons:
  - Government versus government
  - Occupation versus occupation

Exhibit 1: Employer Costs per Hour Worked for Employee Compensation and Costs as a Percent of Total Compensation: State and Local Government Workers, by Establishment Employment Size and Bargaining Unit Status, June 2011

Compensation Component			1-99 Workers				100 Workers or More						Bargaining Unit Status			
	1-99 Workers		1-49 Workers		50-99 Workers		100 Workers or More		100-499 Workers		500 Workers or More		Union		Non-union	
	Cost	Percent	Cost	Percent	Cost	Percent	Cost	Percent	Cost	Percent	Cost	Percent	Cost	Percent	Cost	Percent
Total Compensation	$29.92	100.0	$27.86	100.0	$33.28	100.0	$42.01	100.0	$37.11	100.0	$43.72	100.0	$48.95	100.0	$33.38	100.0
Wages and Salaries	$19.75	66.0	$18.61	66.8	$21.62	65.0	$27.43	65.3	$24.32	65.5	$28.52	65.2	$30.99	63.3	$22.65	67.8
Total Benefits	$10.17	34.0	$9.26	33.2	$11.66	35.0	$14.58	34.7	$12.79	34.5	$15.20	34.8	$17.96	36.7	$10.73	32.2
Paid Leave	$2.13	7.1	$1.95	7.0	$2.43	7.3	$3.16	7.5	$2.61	7.0	$3.35	7.7	$3.62	7.4	$2.54	7.6
Vacation	$0.93	3.1	$0.89	3.2	$0.99	3.0	$1.18	2.8	$0.99	2.7	$1.25	2.9	$1.25	2.6	$1.06	3.2
Holiday	$0.66	2.2	$0.63	2.2	$0.71	2.1	$0.91	2.2	$0.72	1.9	$0.98	2.2	$1.02	2.1	$0.76	2.3
Sick	$0.44	1.5	$0.37	1.3	$0.56	1.7	$0.84	2.0	$0.68	1.8	$0.89	2.0	$1.05	2.2	$0.56	1.7
Personal	$0.11	0.4	$0.07	0.3	$0.17	0.5	$0.23	0.6	$0.22	0.6	$0.23	0.5	$0.29	0.6	$0.15	0.5
Supplemental Pay	$0.24	0.8	$0.25	0.9	$0.22	0.7	$0.35	0.8	$0.29	0.8	$0.37	0.9	$0.45	0.9	$0.25	0.7
Overtime and Premium(1)	$0.12	0.4	$0.13	0.5	$0.11	0.3	$0.18	0.4	$0.17	0.5	$0.19	0.4	$0.26	0.5	$0.11	0.3
Shift Differentials	$0.02	0.1	$0.02	0.1	$0.02	(2)	$0.05	0.1	$0.03	0.1	$0.06	0.1	$0.06	0.1	$0.04	0.1
Non-production Bonuses	$0.10	0.3	$0.10	0.4	$0.09	0.3	$0.12	0.3	$0.09	0.2	$0.13	0.3	$0.13	0.3	$0.10	0.3
Insurance	$3.43	11.5	$2.94	10.6	$4.23	12.7	$5.05	12.0	$4.67	12.6	$5.18	11.9	$6.59	13.5	$3.39	10.2
Life	$0.04	0.1	$0.04	0.2	$0.04	0.1	$0.09	0.2	$0.05	0.1	$0.11	0.2	$0.13	0.3	$0.05	0.1
Health	$3.34	11.2	$2.86	10.3	$4.12	12.4	$4.89	11.6	$4.55	12.3	$5.01	11.4	$6.38	13.0	$3.29	9.9
Short-term Disability	$0.02	0.1	$0.02	0.1	$0.03	0.1	$0.03	0.1	$0.02	0.1	$0.03	0.1	$0.04	0.1	$0.02	(2)
Long-term Disability	$0.03	0.1	$0.02	0.1	$0.04	0.1	$0.04	0.1	$0.04	0.1	$0.04	0.1	$0.05	0.1	$0.04	0.1
Retirement and Savings	$1.98	6.6	$1.68	6.0	$2.47	7.4	$3.52	8.4	$2.90	7.8	$3.74	8.6	$4.46	9.1	$2.38	7.1
Defined Benefit	$1.71	5.7	$1.37	4.9	$2.25	6.8	$3.20	7.6	$2.64	7.1	$3.40	7.8	$4.21	8.6	$2.02	6.0
Defined Contribution	$0.28	0.9	$0.31	1.1	$0.22	0.7	$0.32	0.8	$0.26	0.7	$0.34	0.8	$0.26	0.5	$0.36	1.1
Legally Required Benefits	$2.38	8.0	$2.42	8.7	$2.32	7.0	$2.49	5.9	$2.32	6.2	$2.55	5.8	$2.84	5.8	$2.17	6.5
Social Security and Medicare	$1.50	5.0	$1.44	5.2	$1.60	4.8	$1.92	4.6	$1.71	4.6	$2.00	4.6	$2.16	4.4	$1.63	4.9
Social Security(3)	$1.19	4.0	$1.15	4.1	$1.25	3.8	$1.49	3.5	$1.32	3.6	$1.54	3.5	$1.66	3.4	$1.27	3.8
Medicare	$0.31	1.0	$0.29	1.1	$0.34	1.0	$0.44	1.0	$0.39	1.0	$0.46	1.0	$0.50	1.0	$0.36	1.1
Federal Unemployment Insurance	(4)	(2)	(4)	(2)	(4)	(2)	(4)	(2)	(4)	(2)	(4)	(2)	(4)	(2)	(4)	(2)
State Unemployment Insurance	$0.12	0.4	$0.13	0.5	$0.11	0.3	$0.11	0.3	$0.16	0.4	$0.09	0.2	$0.11	0.2	$0.11	0.3
Workers' Compensation	$0.76	2.5	$0.85	3.1	$0.61	1.8	$0.45	1.1	$0.45	1.2	$0.45	1.0	$0.57	1.2	$0.43	1.3

1 Includes premium pay for work in addition to the regular work schedule (such as overtime, weekends, and holidays)

2 Less than .05%.

3 Comprises the old-age, survivors, and disability insurance (OASDI) program

4 Cost per hour worked is $0.01 or less.

Note: The sum of individual items may not equal totals due to rounding.

Source: Bureau of Labor Statistics
National Compensation Survey

UNPUBLISHED DATA

Notes

1 Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits 2010 Annual Survey. Available online at http://ehbs.kff.org/.

2 PriceWaterhouseCoopers. “Behind the numbers: Medical cost trends for 2012.” March 2011.

3 See “Growth in Health Care Costs,” Congressional Budget Office testimony given by Peter R. Orszag, January 31, 2008.

4 PriceWaterhouseCoopers. “Behind the numbers: Medical cost trends for 2012.” March 2011.

5 The margin of error represents a 90% confidence level, which is to say that GFOA is 90% certain the true population statistic falls within the margin of error range.

6 Joseph Ruzich. “Romeoville, IL, offering cash for employees who opt out of health care.” Chicago Tribune TribLocal online service. October 2010.

7 A 2003 survey by the International City/County Managers Association showed about a 15% cost advantage for HMOs versus PPOs.

8 Xuguang Tao, MD, PhD; David Chenoweth, PhD, FAWHP; Amy S. Alfriend, RN, MPH, COHN-S/CM; David M. Baron, MBA, CISSP; Tracie W. Kirkland, MS, APRN/PNP; Jill Scherb, PAC; Edward J. Bernacki, MD, MPH. “Monitoring Worksite Clinic Performance Using a Cost-Benefit Tool.” Journal of Occupational and Environmental Medicine. Volume 51, Number 10, October 2009.

9 A full panel blood draw provides a variety of measures for cholesterol, glucose, liver function, etc.

10 See Xuguang Tao, et al. for a discussion of ROI. ROI figures often include soft-dollar savings like less sick time used and higher productivity. Xuguang and colleagues cite the most modest ROI figures; consulting groups and industry advocates cite higher figures. Differences likely stem from differences in how ROI is calculated (e.g., which benefits of clinics are included in calculation and how they are monetized) and the structure of the clinics being evaluated.

11 “Employers Implement On-Site Health Clinics to Manage Costs.” Hewitt Associates LLC, August 2008.

12 A. Mark Fendrick, MD. “Value-Based Insurance Design Landscape Digest.” Center for Value-Based Insurance Design at University of Michigan. July 2009.

13 The rules for HRAs are set by the IRS. See, for example, IRS publication 969.

14 Steve Neeleman. “Making Health Savings Accounts Work.” Compensation & Benefits Review. 2005 37:33.

15 One author estimates that 80% of an employer’s costs are caused by 10% of plan participants, due to chronic disease. Adapted from Samuel H. Fleet. “Self-Funding: Taking Control of an Employer's Health Benefits Destiny Under the Patient Protection and Affordable Care Act.” Compensation & Benefits Review. 43: 30. 201l.

16 While it is possible to use both an HRA and HSA, doing so creates many complications under IRS rules, so is uncommon in practice.

Notes

17 This belief is supported by research that showed a greater level of savings and participant engagement with HSAs than HRAs. See Joanne Sammer and Stephen Miller. "Consumer-Driven Decision: Weighing HSAs vs. HRAs." Society for Human Resource Management. May 201I.

18 Manoj Athavale, Stephen M. Avila, and Kevin M. Gatzlaff. "An Empirical Comparison of a Low-Deductible Health Plan with an HSA-Qualified Plan." Compensation & Benefits Review 2010 42: 102

19 Paul Brucker, in a white paper by Alliant Benefit Solutions titled "Is an HDHP/HSA the right prescription for your company?" quotes benefit consultants who estimate typical savings of about 30%, and as high as 40%. Other studies by United Health Group and Council for Affordable Health Insurance show savings of closer to 12%.

20 All figures are net of seed contributions made to employees' HSAs.

21 Research shows that more than 90% of group HDHPs offer first-dollar care. See "A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007." America's Health Insurance Plans. November, 2007.

22 "A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007," America's Health Insurance Plans, November, 2007.

23 In a study by Alliant, only 32% of survey respondents had heard of an HDHP if their company did not offer one. Another study by Guardian Life Insurance showed, for example, that 60% of workers do not realize they would own an HSA, and 55% aren't aware that spending for qualified expenses from HSAs is tax free.

24 Results from the Kaiser Family Foundation Survey of Employer-Sponsored Health Benefits, 2010, show that 81% of firms with more than 200 employees see wellness programs as effective in improving employee health, and 69% see them as effective in controlling costs.

25 ROI figures include soft-dollar savings like productivity gains and reduced absenteeism. See Katherine Baicker, David Cutler, and Zirui Song. "Workplace Wellness Programs Can Generate Savings." Health Affairs. February 2010.

26 National averages are based on information from The Kaiser Family Foundation and the Health Research & Educational Trust Employee Health Benefits Survey 2010.

27 A co-morbid condition is an illness that occurs along with obesity at greater rates than would be found in the normal population. An example is diabetes.

28 Such programs have been shown to have an ROI of 1.00 to 1.70 after three years. George Thomas DeVries III. "Innovations in Workplace Wellness: Six New Tools to Enhance Programs and Maximize Employee Health and Productivity." Compensation & Benefits Review. 2010 42: 46.

29 A 2008 survey of large employers by Watson Wyatt showed that 74% expected to be using incentives in 2009, up from 50% in 2008. See the 13th Annual National Business Group on Health/Watson Wyatt study "The One Percent Strategy: Lessons Learned From Best Performers."

30 Ha T. Tu and Ralph C. Mayrell. "Employer Wellness Initiatives Grow, but Effectiveness Varies Widely." Research Brief. National Institute for Health Care Reform. July 2010.

Notes

31 “Behavioral Economics: Seven Ways to Engage Employees in Health Care.” Towers Watson. March 2010.

32 “Trim staff, fat profits? American firms are offering staff carrots to stay fit. Soon they will wield sticks.” The Economist. July 30, 2011.

33 George Thomas DeVries III. “Innovations in Workplace Wellness: Six New Tools to Enhance Programs and Maximize Employee Health and Productivity.” Compensation & Benefits Review. 2010 42: 46.

34 Ibid.

35 King County was not investigated directly by GFOA, but its experience is described in: Ha T. Tu and Ralph C. Mayrell. “Employer Wellness Initiatives Grow, but Effectiveness Varies Widely.” Research Brief. National Institute for Health Care Reform. July 2010.

36 For more information, see Christopher S. Sears and Shalina A. Schaefer. “Legal Implications of Employee Wellness Programs for Governmental Employers.” Ice Miller, LLP. 2011.

37 Samuel H. Fleet. “Self-Funding: Taking Control of an Employer's Health Benefits Destiny Under the Patient Protection and Affordable Care Act.” Compensation & Benefits Review. 43: 30. 2011.

38 The Kaiser Family Foundation and the Health Research & Educational Trust Employee Health Benefits Survey 2010.

39 Fleet.

40 Ibid.

41 Adapted from Fleet, op cit.

42 One author estimates that 80% of an employers costs are caused by 10% of plan participants. Adapted from Fleet, op cit.

43 Peter R. Orszag. “How Health Care Can Save or Sink America: The Case for Reform and Fiscal Sustainability.” Foreign Affairs Magazine. July/August, 2011.

44 A. Mark Fendrick, MD. “Value-Based Insurance Design Landscape Digest.” Center for Value-Based Insurance Design at University of Michigan. July 2009.

45 Example taken from A. Mark Fendrick, MD. “Value-Based Insurance Design Landscape Digest.” Center for Value-Based Insurance Design at University of Michigan. July 2009.

46 These programs are collectively known as “The Asheville Project” and were extensively studied and written about in the Journal of the American Pharmacists Association. ROI figures include soft-dollar savings (e.g., productivity enhancements, less time off work, etc.).

47 Barry A. Bunting, Benjamin H. Smith, and Susan E. Sutherland. “The Asheville Project: Clinical and economic outcomes of a community-based long-term medication therapy management program for hypertension and dyslipidemia.” Journal of American Pharmacists Association. January/February 2008.