



Fiscal First Aid Quick Reference

Healing Health Costs - Ideas to Slow Spending

By William SaintAmour, Executive Director, Cobalt Community Research, and Michael Schaiberger, contributing

Local leaders face the most severe financial challenges in a generation. Nearly half of the nations' cities, counties, and townships expect less revenue this year, and 21% expect fewer employees. About 26% expect increased consolidation of local services. For many, next year will be even tougher.

With shrinking budgets and fewer staff, local officials are taking several approaches to containing costs of employee and retiree health care.

More than 1,500 local governments told Cobalt Community Research about the changes they are making. What did we find? There is room to do more. Only a quarter of local governments made changes in the past two years.

The most frequent changes:

- Increasing deductibles and co-pays
- Increasing employees' share of premium costs
- Implementing wellness programs
- Expanding use of generic drugs
- Implementing health saving accounts (HSAs) and health reimbursement accounts (HSRs)
- Negotiating lower costs with current carriers
- Educating employees and retirees so they can make better health-care decisions.

The survey data cited in this document comes from ***"The Health and OPEB Funding Strategies: 2009 National Survey of Local Governments."*** The report is based on responses from more than 1,500 city, county, township, and special-district governments across the country, which were randomly polled in 2009. It was sponsored by Gabriel Roeder Smith & Company, the Government Finance Officers Association, the International Foundation of Employee Benefit Plans, the Municipal Employees' Retirement System of Michigan, the National Conference on Public Employee Retirement Systems, the Employee Benefit Research Institute, and Tegrity Financial Group. For a free PDF of the survey results, visit www.CobaltCommunityResearch.org/CCSS.

Even so, a long menu of potential changes are being left on the table. Some improve quality of care, and some reduce coverage. Below are a number to consider.

Eligibility changes:

- Close plan to new hires
- Increase age and service requirements
- Prorate benefits based on years of service
- Close plan to dependants with other coverage
- Delay or extend enrollment coverage date (waiting period)

Contribution changes:

- Increase deductibles for out-of-network care
- Increase health co-pays except for preventative care
- Increase drug co-pays except for preventative care
- Increase employee share of premium costs
- Increase employee out-of-pocket limits for out-of-network care
- Increase employee share of premium costs
- Cap employer contributions
- Prorate employer contributions based on years of service
- Drop or raise employee share of premium costs based on wage level (more highly paid employees pay more, and lower paid employees pay less)
- Eliminate employer contributions to family coverage and part-time employees
- Establish premium incentives for non-tobacco users, users who take biometric screenings, users who take a health risk assessment completion activity, and for completion of annual dental prevention activity
- Pay incentive to employees to waive insurance and obtain coverage elsewhere
- Pay tax-free incentives for choosing health savings accounts



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- Fix contribution amounts on the choice of the most economically efficient health plan, but allow employees to buy-up with own funds to a less economically efficient health plan if they choose to do so
- Decrease health co-pays for preventative services to zero, reducing barriers to care
- Decrease co-pays for using designated economically efficient and high-quality specialty networks
- Decrease drug co-pays for generic drugs and preventive maintenance drugs
- Establish pharmacy health reimbursement arrangement accounts and fund a pharmacy credit amount
- Eliminate zero-premium plans except for health savings accounts
- Create funding incentives (such as seed money for an initial contribution) for employees who enroll in flex spending accounts (IRC section 125)

Design changes:

- Reduce benefit levels, especially for lifestyle prescriptions (Viagra, etc.)
- Offer a Medicare wraparound plan
- Offer a Medicare Advantage plan (require vendor bids)
- Require Medicare Part D coverage for eligible retirees
- Implement disease management initiatives for diabetes, cardio, asthma, and obesity
- Implement wellness initiatives such as on-site clinic and pharmacy, on-site fitness center, on-site mobile dentistry, mammography, and prostate cancer screening
- Implement health savings accounts or health reimbursement arrangements in general medical, pharmacy, or both
- Tighten provider networks and negotiate performance incentives or guarantees
- Implement a special drug network (prescription carve out)
- Motivate employees to use generic drugs
- Implement a drug formulary and retain drug rebates
- Offer only catastrophic coverage
- Offer alternative medicine coverage
- Consolidate the employee assistance program and behavioral health contract
- Carve out the prescription and behavioral health benefit and contract from the general medical contract

Purchasing changes:

- Join a health purchasing coalition or pool
- Shift from fully insured to self-insured coverage and retain savings in employer's self-insured trust fund
- Negotiate lower costs with current carrier, health plan, third-party administrator
- Rebid or change carrier, health plan, third-party administrator
- Educate and motivate employees and retirees to make better health-care purchasing decisions
- Change responsibility for administering benefits to a union group, and put the union at risk for the short-term and long-term funding outcomes
- Seek to cap contractor cost increases in return for longer term contract
- Seek performance guarantees and performance incentives for wellness activity performance, administrative activity performance, and employee satisfaction performance

Benefit elimination:

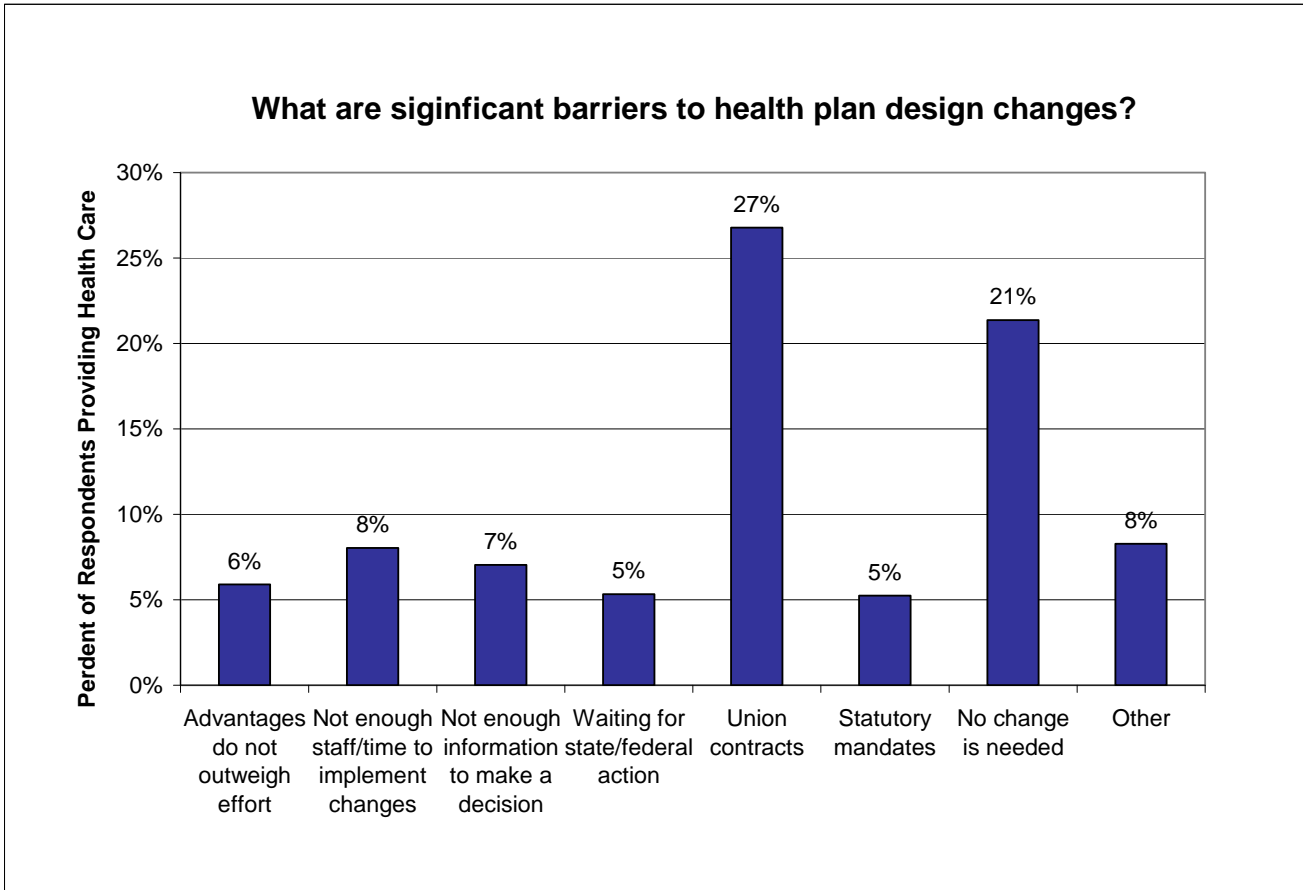
- Eliminate health benefits for active employees, pre-Medicare retirees, or Medicare-eligible retirees
- Eliminate family coverage for active employees, pre-Medicare retirees, or Medicare-eligible retirees
- Eliminate dental/vision for active employees, pre-Medicare retirees, or Medicare-eligible retirees
- Require employee or retiree to pay 100% of family coverage premium
- Eliminate subsidy for retiree coverage
- Eliminate blending retiree utilization rate with active employee utilization rate
- Pay off tax-free unused sick-leave accruals and or early retirement incentives into a VEBA health account upon employee retirement

What gets in the way of going further with health-care cost containment and pursuing some of the foregoing options more aggressively? The answer varied by state and size of government, but union contracts were flagged as the number one barrier. Number two: "no change is needed." (See chart below.)



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The data are from early 2009. As we face the reality of shrinking budgets and a slow recovery, few local leaders believe “no change is needed,” and union groups are finding reasonable adjustments to be in the best interest of their members and their communities.

Consider two examples from Michigan, where local units have become experts in cutting budgets.

A mid-Michigan school district negotiated a cap in the employer share of the health plan. When rates went up, employees and the union had to work out the benefit design changes to address it: higher employee premiums, higher co-pay/deductible, or lower levels of coverage. The employer could stay out of the debate while limiting higher costs.

The Wayne County Airport Authority moved to a defined contribution style of funding for retiree health costs. Instead of continuing retiree health coverage for new hires and existing employees who opt out of employer-provided medical insurance, the authority began annual pre-tax deposits into such employees' individual health accounts. The accounts are invested tax-free, carry over annually, and are payable at retirement or separation. The distribution is tax-free for health insurance premiums or other IRS-approved medical expenses. Nearly 150 Michigan communities have signed up for this new vehicle to replace or offset retiree health costs.

The bottom line: There are many adjustments available to address health costs. Local leaders have a window of opportunity to make them. Changes today soften harder choices down the road.



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Cobalt Community Research is a 501(c)(3) non-profit coalition created to help governmental and non-profit organizations measure, benchmark, and manage their efforts through citizen and employee engagement surveys, budget allocation surveys, and planning workgroups using audience-response technology. For more information, call 877-888-0209.

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