Health-care has become an essential part of any budget conversation.

High-quality health-care coverage has been a staple in the compensation of public sector employees for generations, and for many years, it was the justification for paying public employees less than their private-sector counterparts earned. Many state and local governments recognized early on that it was desirable to have a healthy and stable workforce for whom health care would not be a driving employment concern, as it can be for workers who do not have coverage.

Over time, however, the cost of health-care coverage for employees and retirees has grown at an exponential rate. Health care has become an essential part of any budget conversation. The cost increases incurred over recent years, and the increases expected in coming years, require close management of every facet of employee and retiree health care, not just the purchase of insurance coverage.

Methods for containing health-care costs tend to focus on three primary areas: the plan itself (structure, purpose, and goals), how the plan is paid for (self-funded versus fully funded, as well as participant contributions), and the factors influencing demand (largely determined by the employee population). In each area, tools exist to manage cost increases and potentially control the scope and nature of benefits. One of the most commonly used tools is cost shifting — transferring some percentage of plan costs to the employees who use the services — which can reduce direct costs to the employer. Cost shifting does not directly reduce total costs of insurance, although it can influence participants’ behavior in ways that will reduce costs.

The most immediate way for employers to achieve direct cost reductions is through careful health-care plan design. This includes a number of options that run the gamut from minor changes to major renovations. Including some guiding principles will make any health-care plan more efficient and effective.

**SPECIFIC STRATEGIES**

A good place to start is with an eligibility audit of dependents, spouses, and retirees. Many employers find they are providing health-care to a number of ex-spouses, adult children, and other individuals who are not eligible for coverage. Full-time students should be required to document their eligibility annually. Another possibility is requiring spouses to use their employers’ coverage as primary, where applicable, and requiring participants who are eligible to use Medicare as their primary provider.

It is also important to verify that payments are being made according to existing plan provisions. Double-check that benefits are coordinated, in the case of employees who have another
primary provider; co-payments are being charged consistently across all participants and providers; recent changes are being observed, such as increases in employee co-payments or reduced vendor payments for specific services; and service contracts are current and non-renewed vendors are no longer being paid at contract rates.

Negotiating multi-year contracts provides stability, but at the same time, health-care plans need to issue requests for proposals regularly. Request price quotes every few years. Testing the market ensures that the plan is getting competitive pricing for all components, including third-party administration, prescription drug coverage, stop-loss insurance for self-insured plans, etc. Further, keeping the proposal requirements current will make it easier to adapt to sudden changes in the marketplace such as new legislation or products.

Aggregation — either by using fewer vendors to deliver benefits or by combining the purchasing power of several organizations — can help get better pricing from vendors. Some states allow local governments to participate in state master agreements. Intergovernmental agreements for prescription drug purchases, for instance, can provide additional protection against skyrocketing prices. Vendors can be amenable to longer terms and lower prices in exchange for more consistent purchasing levels and payments provided through a consortium or joint contract.

Prescription drug costs comprise a significant portion of overall health-care expenses. Employers can cut costs substantially by increasing the number of prescriptions that are filled by generic equivalents rather than name-brand drugs. There are ways to encourage use of generic drugs, most commonly through tiered copayments, which help keep participants aware of drug costs. Providing favorably priced mail-order options and/or multiple-month dispensing under a single co-payment can also help lower costs, along with requiring special dispensation for use of brand-name drugs.

Contracts with physicians and hospitals can include incentives for high-quality medical outcomes, tying spending to the quality of care a vendor provides (e.g., higher payments for more successful ratings). Insurers and third-party administrators can conduct routine analysis of claims trends to determine what components of the plan are in most demand and which could be trimmed. For example, if there is a large increase in maternity claims, the plan should be offering complete preventative pediatric coverage; or a reduction in severe diabetic reactions might warrant shifting more resources from catastrophic coverage to continued preventative coverage.

Large-case management helps control costs associated with the care of participants who have long-term or catastrophic illnesses or injuries. This and other components of managed care can help coordinate care to improve the continuity and quality of care a participant receives while also lowering costs. A prime example is in the provision of homecare and social worker support for cancer patients instead of hospital admission.

It is also important to clearly articulate any distinctions between retirees and active employees, both in plan design and funding. Analysis of the two groups should be conducted separately, as they tend to have different needs and make use of different services. For example, heart disease may be more common in the retiree group, diabetes will likely spread across both populations, and maternity costs are limited to the active employee group.

**PAYING FOR IT**

Employers should not assume the measures put in place years ago are still best for the plan, or even still affordable. The methods of paying for health-care coverage should be reviewed frequently.

Cost-sharing measures might be in order. Increasing employee co-payments for doctors’ visits and services encourages plan participants to be wise consumers and pay more attention to how those services, as well as shifting some costs to the individual making use of the service. Similarly, many health-care plans are instituting or increasing premium contributions by employees and retirees. The idea is to focus attention on the cost of care and encourage thoughtful evaluation of options. At the same time, employers must carefully evaluate these increases, as studies have shown that cost-sharing can cause plan participants to forgo needed medical care, which can have negative effects on participants who have chronic conditions, in particular.

At least every two years, employers need to conduct analysis of self-funding versus full-funding (putting money into a trust to pay claims, and keeping any profits to offset future expenses, versus paying an insurance company to pay claims, and keep any profits). Factors to analyze include number and type of participants (mem-
bers, dependents, retirees, retiree dependents, or terminated vested, as well as age, sex, dependent count, income, turnover percentage, median career tenure, etc.) , the government’s ability to accept risk, and the availability of stop-loss coverage (insurance to protect self-funded plans from catastrophic loss). Long-term projections are essential in determining the viability of the program as well as the preferred funding mechanism.

Directly allocating benefits costs to all departments keeps the relationship between staff positions and costs clearly documented. When departments pay the full cost of positions, including salaries and benefits, in their individual budgets, it is a more accurate representation of the cost of the services provided. Although it can be easier, especially in a self-funded environment, to bundle costs into an internal service fund, it is important to clearly articulate the costs associated with decisions made in operations so there are transparent effects.

Some employers might want to consider health savings accounts (HSAs) and health reimbursement arrangements (HRAs). HSAs are tax-advantaged medical savings accounts for employees in high-deductible health plans (which have lower premiums and higher deductibles than traditional health-care plans). Because employees make the contributions and own their accounts, HSAs encourage plan participants to save for their future health-care expenses and to make more informed consumer choices. HRAs are similar to HSAs, but the employer makes the contributions instead of the employee, and the program can exist without a companion insurance plan.

**INFLUENCING CONSUMER DECISIONS**

Consumer decisions drive many of the cost increases in health care. Therefore, influencing those decisions is essential to managing cost increases.

The role of education cannot be overstated. Employees and retirees — and, by extension, their families — need information about healthy living and how to improve habits and behaviors that affect their health. Many vendors provide materials at little to no cost as part of their services.

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Consider entering into partnerships with vendors or other agencies to offer health risk appraisals and health fairs that make it convenient for participants to get individual assistance. Online tutorials and information about certain illnesses can also be very helpful. Many conditions can be prevented or managed with minimal medical intervention if employees understand what they need to do.

Employees need to be informed and empowered to make decisions about using lower-cost alternatives when addressing health issues. Choice pamphlets that address specific symptoms and instruct employees about how to react at each stage or progression of the condition are very popular and have proven helpful in reducing emergency room visits for colds.

Employee behavior can be directed by setting price-points for co-payments. Examples include higher charges for emergency room visits that could be effectively addressed at urgent care facilities or a doctor’s office at a much lower cost. Health-care costs decrease when participants use the lowest-cost alternative and address conditions before they progress into bigger issues.

Financial incentives can be effective in modifying behaviors. Paying employees to lose weight can be difficult, but providing convenient, low-cost incentives and opportunities can be effective. For example, an employer might bring subsidized classes to the work site to increase participation.

Being active contributes to wellness. Encourage employees to engage in activities that encourage them to move. Walking clubs, hiking trips, helping with the senior center workout at lunch, and walking the dogs at the animal shelter all provide opportunities for healthier behavior, as well as encouraging community interaction. Employees often value sincere praise for such activities more than financial compensation. Recognizing them for making the effort — and helping them by making it convenient to do so — can be as effective as a bonus.

**COMMUNICATION IS KEY**

Above all else, communicate. Employees and other participants make far better decisions and are more supportive of changes when timely and clearly articulated information is available. Participants should receive briefings at least once a year about the
Benefit plan provisions, including limitations, changes, employee and employer costs, and the value to employees. It also helps to develop an education guide that communicates this information to elected and appointed officials as well as the public. Including labor groups, employees, and other agencies in communications improves health and creates a more holistic environment.

CONCLUSION

Employers face many challenges in providing stable, sustainable health-care benefits. Managing these costs can include both incremental changes and major initiatives to establish an efficient and effective structure. The Government Finance Officers Association’s Committee on Retirement and Benefits Administration (CORBA) recently issued two recommended practices (RPs) to help employers in this regard: Strategic Health-Care Plan Design and Communicating Health-Care Benefits to Employees and Retirees. Both RPs are available on the GFOA’s Web site at www.gfoa.org.

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