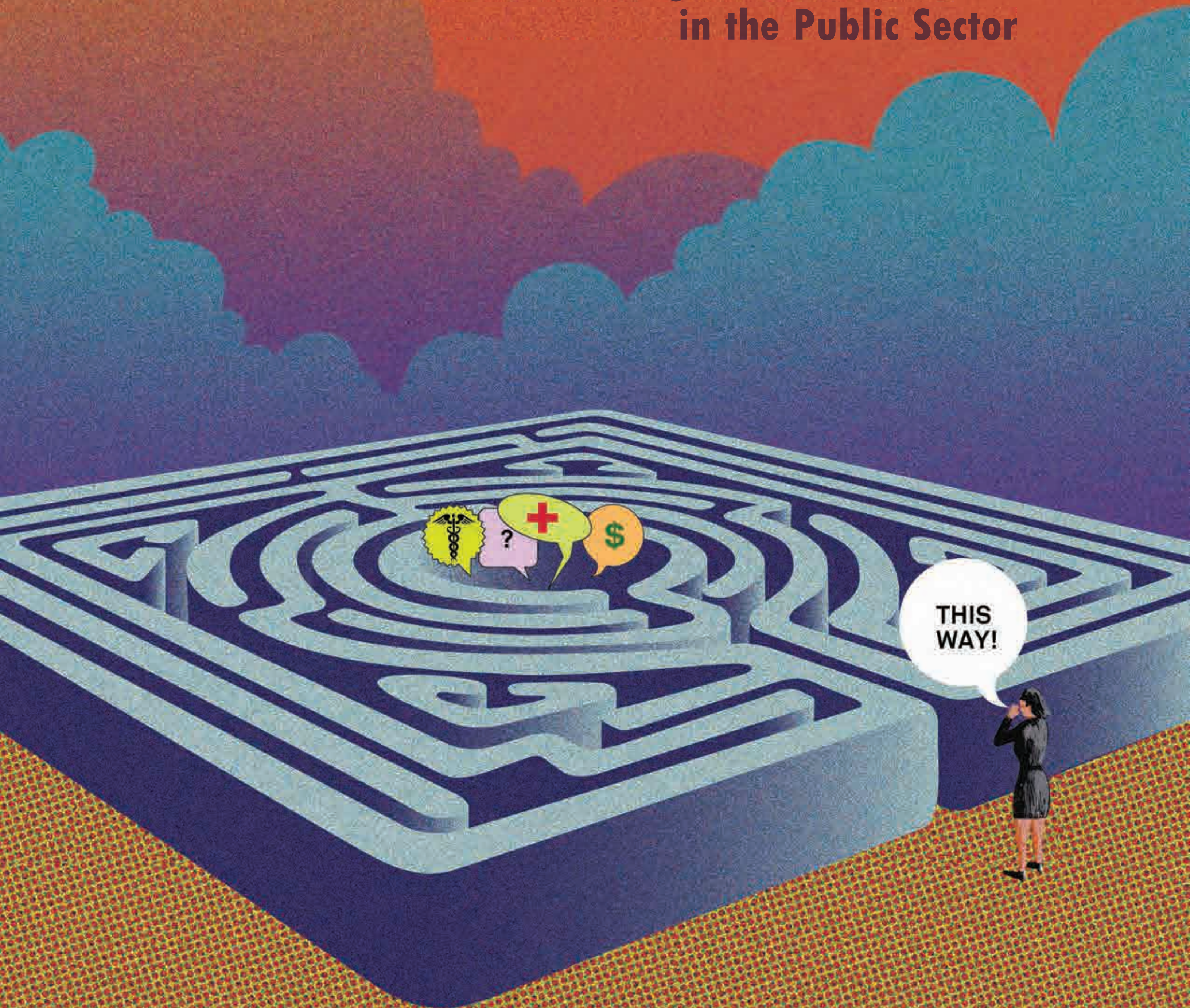
CONTAINING HEALTH-CARE COSTS

Proven Strategies for Success in the Public Sector



BY SHAYNE KAVANAGH

This article is an excerpt of Containing Health-Care Costs: Proven Strategies for Success in the Public Sector, *an in-depth research report produced through a partnership between GFOA and Colonial Life. The complete report, which provides additional information about the techniques covered in this article and describes other cost-containment techniques, is available at www.gfoaconsulting.org/research.*

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 percent between 1999 and 2010, while wages have grown a cumulative 42 percent over the same period.[1] And employer health-care cost trends are projected to increase by an average of 8.5 percent in 2011, up from 8 percent in 2010.[2] This is largely attributable to increasingly sophisticated (and expensive) medical technology and an aging population.[3] Other reasons might include provider consolidation (less competition) and cost-shifting from Medicare and Medicaid to private insurance plans — as reimbursements from these federal programs fail to keep up with rising costs, providers attempt to make up the difference somewhere else.[4] While there may be little a public employer can do to counteract these kinds of forces, a number of techniques can help employers contain the cost of employee health-care benefits while promoting a healthy workforce.

Research has found that onsite clinics offer a substantial return on investment (ROI): from $1.60 to $4 saved for every dollar invested.

This article presents four techniques that have the potential to contain costs while preserving the value of the benefit for employees: onsite clinics; employee wellness programs; consumer-directed health care; and value-based insurance design. The information presented comes from interviews with a sample of GFOA members, case-study interviews of public managers who reported successful use of innovative cost management strategies, and secondary research. Wherever possible, the research sought concrete return-on-investment estimates.

ONSITE CLINIC

An onsite clinic is essentially a doctor's office that is provided by the public employer, located on or near the employer's site. The premise is to provide employees with a low cost alternative to a commercial clinic while also improving the customer experience. Clinic staffing varies with anticipated use, from nurse practitioners and physician assistants to a full medical staff. The services offered range from immunizations and limited acute care to physicals, lab work, behavioral health services, and even pharmacy services. A variety of management models are available for clinics, but research suggests that most governments rely on a third-party vendor to manage the clinic on their behalf. Doing so reduces the government's responsibility for regulatory compliance and liability concerns that would otherwise come with operating a clinic.

An onsite clinic saves the employer money through the following advantages:

- Onsite clinics can provide comparable services more cheaply than commercial providers.[5] For example, as part of its wellness program, Elkhart County, Indiana (which has 903 employees and 756 plan participants), performs a full panel blood draw[6] at its clinic. Elkhart pays about $10 for each test, while a private provider might charge up to $100 to a patient.
- Because employees find an onsite clinic more accessible — that is, closer and less expensive — than commercial providers, they are more likely to 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 onsite clinics offer a substantial return on investment (ROI): from $1.60 to $4 saved for every dollar invested.[7] Research confirms that substantial benefits are available. For example, Cabarrus County, North Carolina, which offers a full-service clinic to 1,300 employees and dependents, realized a net cost savings of $624,000 over four years.

Of course, onsite clinic returns are not guaranteed. First, a clinic must have a certain number of potential patients to be cost effective: about 800 to 1000.[8] This does not mean that onsite clinics are impossible for smaller employers, since multiple employers can share a clinic. For instance, the City of Mesquite, Texas, which was just on the edge of what is required to run a cost-effective clinic with 1,148 employees, joined with the 4,700-employee Mesquite School District to offer a full-service clinic. Using a different approach, the Corpus Christi (Texas) Regional Transit Authority, with 213 employees, contracted with a local physician group to provide preferential rates at their nearby clinics.

Another thing to consider is that employees must have an incentive to visit the clinic instead of a commercial provider. A number of enticements can be used to help make a clinic less expensive and more convenient than other alternatives:

- Waive or substantially reduce co-payments at 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 for visits or allowing employees to use flexible work scheduling.
- Make sure the clinic staff is professional and friendly.

Fiscal First Aid: Health Benefit Eligibility Audit

Auditing the health benefit plan can reveal a number of participants who aren't technically eligible to participate, including, 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 more than $1.3 million when it discovered that 8.9 percent of participants, or 288 dependents, were ineligible for benefits coverage. Smaller governments can also realize savings. An initial audit found a town of 20,000 people $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 remain an important cost management tool.

- Provide services that are focused but comprehensive of major employee needs. Clinics that provide only the most basic services will not be used frequently, and services that are too specialized will not be able to take advantage of economies of scale.

EMPLOYEE WELLNESS PROGRAMS

Employers offer wellness programs to affect the overall health of employees (and sometimes dependents), in an attempt to decrease costs and increase productivity. Wellness programs can take a number of forms, including health risk assessments such as lifestyle questionnaires and biometric evaluations, self-help educational materials, individual counseling, educational classes and seminars, or behavioral modification programs such as coaching. The program can have a specific focus of intervention such as weight loss, fitness, or smoking cessation, or it can address multiple risk factors.

Wellness programs have generated a lot of enthusiasm among public and private employers. Almost 80 percent of GFOA's survey respondents have undertaken at least some form of wellness initiative; 90 percent of them would be willing to recommend it to others, and 65 percent would recommend it enthusiastically. The 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 a return of $3.27 for every dollar spent over an average three-year period.[9] Wellness programs can benefit smaller employers, too. For example, since Lewiston, Maine, implemented a wellness program in 2006, the city (which has a population of 41,500 and 443 employees), it reduced health-care premiums by $736,757 (through 2008). From 2007 through 2010, premiums increased an average of 3.3 percent, less than national averages of about 4.5 percent to 5 percent during that same period.[10]

Given that wellness programs are fairly well established in the public sector, this article will not address the basics of such programs. Instead, below are some of the best practices of wellness programs. (See the full research reports for additional practices.)

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. Determine the most common types of claims, the most common predictive factors, and the diseases that generate the most claims. This information helps employers develop focused, limited programs to start with. For instance, Olmsted County, Minnesota (with a population of 141,000 and 930 enrolled employees) found that weight loss was its most pressing need, so it started there. The initiative paid for itself in the first year, and employees who benefited testified in front of the county board. This clear evidence of positive results paved the way for additional wellness activities.

Individualize the Intervention. Wellness programs that rely solely on one-size-fits all interventions will be less successful. The program should recognize and address participants at multiple risk levels and provide special support for those at greatest risk. For example, Olmsted County has two different 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.[11] The program, which can last up to 48 weeks, 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 such as 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 plan participants with individualized expert attention.[12]

Incentives. Incentives are becoming an increasingly regular feature of wellness programs.[13] Jurisdictions use a variety of financial incentives:

- 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, as well as accumulating 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 percent to as little as 10 percent by meeting body fat composition goals, not using tobacco, following an exercise program, and completing a health risk assessment.
- Manatee County, Florida (with a population of 322,000 and 3,200 employees) has a three-tier health benefit design, with significant differences in cost-sharing arrangements. To qualify for the most preferred plan, employees must complete an array of wellness activities.

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Incentives might also affect spouses. King County, Washington, presents employees with three tiers of plans, ranging from the plan with the least cost benefit 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.

Finally, more employers might start more seriously considering disincentives for unhealthy behaviors.[14] For example, Elkhart, Indiana, assesses an "up charge" equal to 10 percent of an employee's monthly premium share if he or she fails to complete a biometric screening. Other employers have started assessing tobacco users a surcharge on top of their existing contributions to the health benefit.

> A value-based approach to health care seeks to maximize use of treatments that are of high value to the patient and minimize the use of unnecessary or ineffective treatments.

Design a Program for the Whole Person. The wellness program should integrate several approaches to improving employee health. For example, Olmsted County found that to reach weight loss objectives, it was necessary to first address the psychological issues behind overeating in order. 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.[15] 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.

CONSUMER-DIRECTED HEALTH-CARE

The basic premise of 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 a health savings account (HSA).

A HDHP is a medical benefit plan with a very high deductible. To qualify as an HDHP, a plan must have deductibles of a certain minimum size. The standards are set by the Internal Revenue Service (IRS) each year and are now a bit more than $1,100 a year for individuals and a bit more than $2,300 for families. In practice, however, HDHP deductibles are often higher than the IRS minimum: often between $2,000 and $5,000, but deductibles 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 percent to 20 percent of the claims 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.[16] An HSA, which can only be used with an HDHP, and 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 also contribute, and the employee keeps the money in the account upon separation from the employer — an important factor in gaining employee acceptance of HDHPs.

Because employees are completely responsible for health service costs up to relatively large amount with an HDHP, as compared to a traditional plan, they will presumably be more

Fiscal First Aid: Section 125 Plan Flexible Spending Account

A Section 125 flexible spending account, 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 reduce the employer's payroll tax burden. For example, a community college in North Carolina (which has about 1,000 employees) streamlined enrollment and enhanced communication of its FSA, increasing participation by 68 percent. This brought employees more than $100,000 in tax savings, along with $26,000 in FICA savings for the college.

discerning about which health providers to use and whether to use services at all; they might even scrutinize provider invoices more closely. This behavior should translate into a lower claims experience for the employer and, hence, lower overall costs for the health plan.

It is difficult, however, to obtain a good estimate of total return on investment for an HDHP. These plans have gained popularity only in the last few years, so there is limited data. Also, 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 different 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.[17] 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 negatively affect employees and should even provide a net benefit.

As far as employer-only costs, some research indicates savings between 12 percent and 30 percent of premiums.[18] Anecdotal evidence seems to support the proposition that HDHPs can provide significant savings, in at least some cases:[19] For instance, the City of Ludington, Michigan (with population of 8,300 and 53 full-time employees in the health plan) saved $100,000 in the first year. Columbia (Missouri) Public Schools (with 2,550 full-time equivalent positions) reduced the total annual cost increases for its benefit plan to 5 percent, from 9 percent, with only half of eligible employees choosing the HDHP option (the rest remaining in a traditional plan).

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

Cash Flow Challenges for Plan Participants. Some plan participants may 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 so employees will have resources available to offset the higher out-of-pocket costs.

Even with an HAS, employees might not be able to put aside enough cash to make payments on deductibles. To alleviate this concern, case study governments commonly "seed" the HSA each year. This contribution is 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 could choose between HDHP and traditional plans, to attract employees to the HDHP. All the case study governments were relatively new to HDHPs, however, so it was unclear if annual seeding will continue, or it will be used over a limited time to build cushion in employees' HSAs.

Not Enough Preventative Care. Given the incentive to minimize medical costs, plan participants don't always make sufficient use of preventative services because they are often not perceived as an immediate, pressing need. Of course, this leads to worse long-term health outcomes and higher costs for the employer. The commonly accepted

Wellness programs that rely solely on one-size-fits all interventions will be less successful.

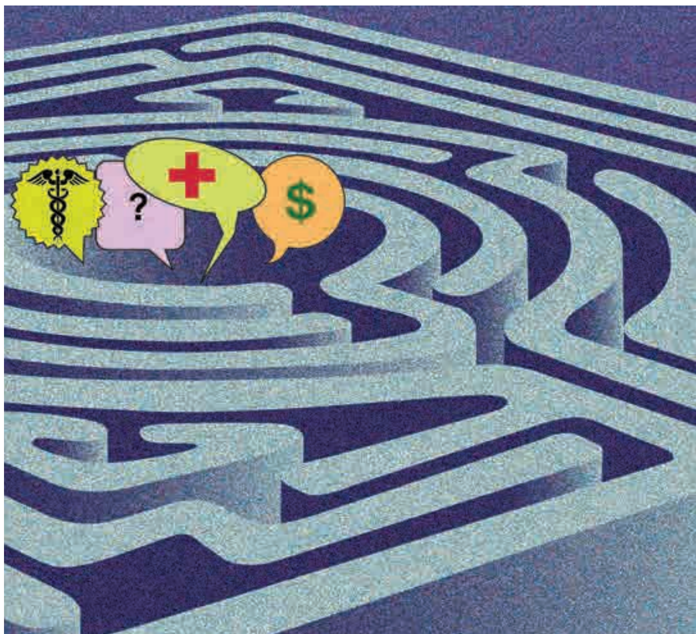
solution is to provide "first dollar coverage" for preventative services,[20] which means coverage is provided for certain services regardless of whether the HDHP deductible is met, making preventative coverage under an HDHP comparable to that offered by traditional plans.

Adverse Selection. HDHPs are thought to hold the greatest attraction for younger and healthier individuals who have less need for medical care and will therefore benefit from lower premiums and building up funds in an HSA. The other side of this coin is that less healthy individuals will gravitate toward traditional plans, driving up the claims experience and making these plans even more expensive. Perhaps due to the relative novelty of HDHPs and HSAs, which have gained popularity only in recent years, and the long time period over which adverse selection problems would manifest, the GFOA case study governments that offer both a traditional plan and an HDHP have not reported any problems with adverse selection, although they are aware of the possibility.

Regardless of the potential gains for employees, HDHP can be a tough sell. GFOA's complete research report provides advice on how to make HDHP attractive to the workforce, drawing on the experience of governments that have successfully done so.

VALUE-BASED INSURANCE DESIGN

Rather than just minimizing costs, employers need to 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 the patient and minimize the use of unnecessary or ineffective treatments. This should lead to a better long-term cost experience because the medical services used make the greatest impact, both now and in the long term.



When applied to employer-provided health plans, a value-based approach 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.[21] These kinds of patients usually agree to follow the course of treatment recommended by the provider.[22] 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.[23] 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 than to potentially pay for heart bypass surgery at more than $100,000 later on.[24]

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 might have no co-payments for a drug with proven value for heart conditions, while another participant who doesn't have a heart problem would make co-payments if he or she took 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 to use 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 sectors. 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 has five programs covering diabetes, asthma, depression, hypertension, and cholesterol. The program works as follows:

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

The overarching goal of consumer-directed health care 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 paired with a health savings account.

The Asheville model is especially interesting because it has been widely studied and replicated. The city saw positive results from each of its five programs within one year and has received an ROI of about $4 for every dollar invested.[25] 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 percent reduction in cardiovascular-related medical costs during the period of one study.[26] The use of cardiovascular medication increased three-fold during this same period, which illustrates the premise of value-based insurance design.

CONCLUSIONS

Public employers face relentless upward pressures on health-care costs. This article has identified four ways employers can manage costs, along with specific strategies for each. The optimal strategies for an employer will vary, given 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. Selecting and sticking to focused strategies allows public employers to begin changing their approaches to employee health care, saving money and preserving the value of the benefit for employees.

Notes

1. Employer Health Benefits 2010 Annual Survey, Kaiser Family Foundation/Health Research and Educational Trust.
2. *Behind the numbers: Medical cost trends for 2012*, PriceWaterhouseCooper's, March 2011.
3. See "Growth in Health-care Costs," Congressional Budget Office testimony given by Peter R. Orszag, January 31, 2008.
4. PriceWaterhouseCooper's.
5. Xuguang Tao, David Chenoweth, Amy S. Alfriend, David M. Baron, Tracie W. Kirkland, Jill Scherb, and Edward J. Bernacki, "Monitoring Worksite Clinic Performance Using a Cost-Benefit Tool," *Journal of Occupational and Environmental Medicine*, Vol. 51, No, 10, October 2009.
6. A full panel blood draw provides a variety of measures for cholesterol, glucose, liver function, etc.
7. See Xuguang Tao, et al. for a discussion of ROI. ROI figures often include soft-dollar savings such as less sick time used and higher productivity. The authors cite the most modest ROI figures; consulting groups and industry advocates cite higher numbers. Differences likely stem from the ways 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.
8. *Employers Implement On-Site Health Clinics to Manage Costs*, Hewitt Associates LLC, August 2008.
9. ROI figures include soft-dollar savings such as productivity gains and reduced absenteeism. See: Katherine Baicker, David Cutler, and Zirui Song, "Workplace Wellness Programs Can Generate Savings." *Health Affairs*; February 2010.
10. National averages are based on information from The Kaiser Family Foundation and the Health Research & Educational Trust Employee Health Benefits Survey 2010.

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11. 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.
12. Such programs have been shown to have an ROI of 1.00 to 1.70 after three years; see 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.
13. A 2008 survey of large employers by Watson Wyatt showed that 74 percent expected to be using incentives in 2009, up from 50 percent in 2008. See "The One Percent Strategy: Lessons Learned From Best Performers," from the 13th Annual National Business Group on Health study, Watson Wyatt.
14. "Trim staff, fat profits? American firms are offering staff carrots to stay fit. Soon they will wield sticks," *The Economist*. July 30, 2011.
15. DeVries.
16. An HDHP could also be paired with a health reimbursement account; this is a less common practice, and it is covered in the full report.
17. 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.
18. Paul Brucker, "Is an HDHP/HSA the right prescription for your company?," Alliant Benefit Solutions. Brucker quotes benefit consultants who estimate typical savings of about 30 percent and as high as 40 percent. Other studies by United Health Group and Council for Affordable Health Insurance show savings of closer to 12 percent.
19. All figures are net of seed contributions made to employees' HSAs.
20. Research shows that more than 90 percent 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.
21. One author estimates that 80 percent of an employer's costs are caused by 10 percent of plan participants. 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*, 2011 43:30.
22. Peter R. Orszag, "How Health-care can Save or Sink America: The Case for Reform and Fiscal Sustainability," *Foreign Affairs Magazine*, July/August, 2011.
23. A. Mark Fendrick, *Value-Based Insurance Design Landscape Digest*, Center for Value-Based Insurance Design at the University of Michigan. July 2009.
24. Example from Fendrick.
25. These programs, collectively known as "The Asheville Project," 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.).
26. 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.

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