Updating Health Plan Designs Can Cut Short-Term Costs and Long-Term Liabilities
Local governments face a critical moment. Although the economy shows signs of recovery, community leaders are dealing with more than minor belt tightening, and 2011 and 2012 will be years of significant budget cuts.

According to the 2010 National Survey of Local Governments, recently released by Cobalt Community Research, the revenue and employment expectations of local governments continue to reveal challenges:

- 50 percent of responding local governments expect their revenues to decline over the next year, and 16 percent expect the decline to be greater than 5 percent. Interestingly, a greater percentage of respondents from larger governments expect revenues to decline than respondents from smaller governments.
- 19 percent of responding local governments expect employment levels to decrease over the next year.
- 26 percent of responding local governments expect workforce changes through consolidation/shared services.
- 23 percent expect employment declines through attrition.

It's a huge problem, according to the nonpartisan Employee Benefit Research Institute (EBRI). Governments tend to have more comprehensive benefits than private-sector employers, so their costs are higher, and they are slower to change. Jurisdictions that are constantly running deficits, however, need to consider making some changes to address sustainability.

**STRATEGIES TO ADDRESS HEALTH COSTS**

With shrinking budgets and fewer staff, local government officials are closely examining the costs of employee and retiree health care. Health-care costs might not be their biggest expense, but current and future employee and retiree costs are exerting growing political and financial pressure as elected officials target employee benefits and rating agencies reexamine bond ratings.

In 2010, the non-profit Cobalt Community Research (a research coalition created to help schools, local governments, and other 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) gathered more than 1,950 responses from local governments across the county that shared the changes they are making. Now in its fourth year, the study offers an extensive menu of potential changes that communities can consider. Some improve quality of care. Some reduce coverage.

The most frequently used methods for controlling health-care costs include:

- Increasing deductibles and copays
- Increasing the employees’ share of premium costs
- Implementing wellness programs
- Expanding use of generic drugs
- Implementing health savings accounts and health reimbursement accounts
- Negotiating lower costs with current carriers
- Educating employees and retirees to make better health-care decisions.

Fewer than 4 percent of respondents plan to close health plans to new employees or eliminate coverage for employees, retirees, or dependents. But local governments appear to be shifting a higher share of premium costs to early retirees. These are individuals who retire from their employer, but are not yet eligible for Medicare (see Exhibit 1).

While many local governments are implementing cost-containment strategies, several untapped strategies hold promise, such as implementing disease management initiatives. There is growing focus on preventative care and managing chronic illnesses, a major driver of health-care costs. Wellness and disease management programs can be reasonable approaches to controlling overall health-care costs while improving quality. The challenge is that many small and medium-sized governments do not have a large enough group or solid analytics to convince people that these strategies are effective.

Many local governments are just now looking at practices that have been successful in the private sector. Value-based benefit design is one example. According to the University of Michigan, the strategy helps align patients’ out-of-pocket costs, such as copays and premiums, with the value of health services. By reducing barriers to high-value treatments (through lower costs to patients) and discouraging low-value

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treatments (through higher costs to patients), these plans can achieve improved health outcomes. Studies show that when barriers are reduced, significant increases in patient compliance with recommended treatments and potential cost savings result.

It’s important for people with chronic conditions to follow the treatment, and if they skimp on care, it’s not good for the person or the employer. Change doesn’t happen quickly with many local governments, but a value-based benefit design for conditions such as diabetes, asthma, and hypertension can have an impact on both cost and quality.

An example is the City of Ashville, North Carolina, which saw positive results right away from this approach. The total costs for individuals with diabetes fell immediately, as did the use of sick days. The city gradually saved between $1,200 and $1,872 per patient per year, according to research published in the Journal of the American Pharmaceutical Association.

Despite the potential of these approaches, the Cobalt study shows these areas as opportunities for improvement. Only 8 percent of jurisdictions have implemented disease management programs over the last two years, and only 21 percent have implemented wellness programs. There is clearly potential to do more, such as implementing plan design changes that go beyond basic deductible and copay changes.

What gets in the way of making these changes? The answers vary by state and size of government, but union contracts were flagged as the main issue. The next most popular answer: “No change is needed.” (See Exhibit 2.)

**ENGAGING RETIREES AND EMPLOYEES**

As local governments address what can be painful budget choices, it is no longer practical to leave benefits alone to grow at high historical rates, as revenue continues to fall. An
emerging strategy is to actively engage employees and retirees in modifying a benefit package to optimize the perceived value of benefit provisions for the dollars available. Cobalt offers an employee engagement program, for instance, that looks at an individual community’s benefit package and, based on employee feedback, plots employee satisfaction and the perceived importance of each component. Exhibit 3 shows a sample graph, with the cost of each component represented by bubble size.

The program also allows local governments to review elements of plan design to reduce costs while maximizing value. For example, Exhibit 4 shows a chart of potential health plan design components.

Both types of analysis allow the data to be filtered based on job type (e.g., public safety, public works), years of service, employment status (i.e., part time, full time, retired) and age.

In Michigan, two jurisdictions provide examples of possible cost-cutting actions:

- A 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 copay/deductible, or lower levels of coverage.

The Wayne County Airport Authority moved to a defined contribution style of funding for retiree health costs. Existing employees had the option of leaving the employer-provided retiree medical insurance program. The authority makes annual pre-tax deposits into individual health accounts for those who chose to opt out, along with new hires. 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.

GASB 45

An important goal for the Cobalt study is tracking awareness of Governmental Accounting Standards Board (GASB) Statement No. 45, Accounting and Financial Reporting by Employers for Postemployment Benefits Other than Pensions (OPEB). This statement, issued in 2004, created a national standard for measuring and disclosing state and local govern-
ment OPEB liabilities, especially in the area of health care for retirees. When Cobalt began tracking awareness in 2008, only 74 percent of local governments that provided retiree health care were aware of the GASB 45 requirements. In 2010, that increased to 87 percent. Today, nearly all larger communities are aware, although about 35 percent of small communities still need to learn more (see Exhibit 5).

When jurisdictions think about the long-term costs of providing retiree health care, they are also thinking about ways to prefund them (see Exhibit 6). Prefunding (also called advance funding or actuarial funding) offers several significant benefits — it makes budgets more stable over time, reduces overall OPEB liability, and builds community assets and bond ratings.

### Exhibit 5: GASB Statement No. 45 Awareness

The Health and OPEB Funding Strategies: 2010 National Survey of Local Governments report is based on responses from more than 1,950 city, county, township and special district governments across the county, which were randomly polled in 2010. 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 Tegrit Financial Group. The survey results are available at www.CobaltCommunityResearch.org.

### Exhibit 6: Effect of Prefunding Health-Care Costs

Initially, costs are higher than actual health costs to build a reserve. Over time, interest earned from the reserve pay the largest share of health costs, making budgets more predictable.
Unfortunately, in the current economic environment, it is becoming more difficult for local governments to find the extra dollars to prefund or partially prefund their OPEB liabilities (see Exhibit 7).

If health cost and revenue trends continue, we will likely see higher deductibles and copays — tools local governments have been using in the past and will continue to use. Employees and retirees are likely to pay a higher share of the premium; however, strategies such as preventative care, disease management programs, and education have the potential to reduce costs while increasing quality of care.

**CONCLUSIONS**

For many local governments, changing benefit levels is a challenge because of contractual obligations and perceived benefit promises made to retirees. It is helpful, though, to consider a broad range of adjustments available to address health costs. The Cobalt study provides a benchmark of what is going on and what people are doing about health care costs. Changes today soften harder choices down the road.

An emerging strategy is to actively engage employees and retirees in modifying a benefit package to optimize the perceived value of benefit provisions for the dollars available.

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Changes Governments Are Making

According to Cobalt’s 2010 survey, jurisdictions are making a number of changes to their health-care plans.

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

Contribution changes:
- Increase deductibles for out-of-network care
- Increase health copays except for preventative care
- Increase drug copays 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 — higher-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 have a biometric screening, users who take a health risk assessment completion activity, and for users who complete an annual dental prevention activity.
- Pay incentive to employee to waive insurance and obtain other coverage elsewhere.
- Pay tax-free incentive to choose a health savings account, to which the jurisdiction will contribute
- Fix contribution amounts on the choice of the most economically efficient health plan, but allow employees to use their own funds to “buy up” to a less economically efficient health plan

Design changes:
- Decrease health copays for preventative services to zero — reduce 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 account and fund a pharmacy credit amount
- Eliminate zero premium plans except for health savings accounts
- Create funding incentive for employees to enroll in flex spending accounts (IRC section 125)

- Reduce benefit levels especially for lifestyle prescriptions (Viagra, etc.)
- Offer a Medicare wraparound plan
- Offer a Medicare Advantage plan
- 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/guarantees
- Implement a special drug network
- Motivate employee use of 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 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 self-insured trust fund
- Negotiate lower costs with current carrier, health plan, and/or third-party administrator
- Re-bid or change carrier, health plan, and/or 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 and/or vision for active employees, pre-Medicare retirees, or Medicare-eligible retirees
- Require employee or retiree to pay 100 percent 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

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