

# Local Government Strategies to Address Rising Health Care Costs



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## EXECUTIVE SUMMARY

Although increases in health care costs have slowed recently, the continued rise in health care costs over the last decade has prompted many local governments to make changes to their plans and strategies. A nationwide survey, developed by the Center for State and Local Government Excellence (SLGE) with the International Public Management Association for Human Resources (IPMA-HR) and conducted in the summer of 2014, found that:

- Most local governments have seen their health care costs for employees and retirees increase moderately (between 6 and 15 percent) over the past five years. Increased claim and prescription drug costs, an aging workforce, insurance company price increases, and federal health care policy were cited as the key reasons for increases.
- Increased cost sharing of premiums paid by employees (57 percent), wellness programs and increased deductibles paid by employees (53 percent) were the top strategies adopted by local governments. Wellness programs that provide incentives and include a health assessment to identify health risks have shown good results.
- Nearly half of the respondents reported that their local governments have changed the way health insurance is provided: 19 percent of those reporting changes shifted employees to a high-deductible plan with a health savings account; 14 percent established a health reimbursement arrangement; and 12 percent shifted from a fully-insured plan to a self-funded plan.
- Retiree health benefits have changed, especially for new hires: 10 percent report that retiree health benefits for dependents were eliminated; 8 percent increased the years to vest in retiree

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health benefits; and 7 percent shifted from a defined benefit to a defined contribution plan for retirees. Jackson County, Michigan, introduced a retiree health savings account for new employees to replace the defined benefit retiree health plan for retirees. This made it possible for the county to offer retiree health benefits to more employees while decreasing the average lifetime cost for retiree health coverage from \$500,000 to approximately \$50,000 per employee.

Research conducted by SLGE identified a number of other promising practices:

- Disease management programs, on-site clinics, dependent eligibility audits, and regular review and rebidding of health care vendor contracts have shown significant cost savings. Asheville, North Carolina, reports it has saved \$4 for every \$1 invested in chronic disease management. On-site clinics are offered by 28 percent of survey respondents. Corpus Christi, Texas, reduced its health insurance costs by more than \$1 million in the first year after it conducted a dependent eligibility audit. The city's wellness clinic helped the city avoid another \$740,000 in health care costs.
- Helping current and former offenders access comprehensive medical care and related support services resulted in a decrease in reincarceration rates and total inmate population in Hampden County, Massachusetts. Helping inmates enroll in

Medicaid services is an important aspect of the Hampden County strategy. Diverting offenders with extreme behavioral problems into mental health services opened up capacity at the Buncombe County, North Carolina, Detention Facility for renting to crowded community jails, generating \$1,038,717 in revenue. Similarly, contracting for 24/7 medical screening at the detention facility has reduced on-site sick calls, off-site hospital emergency room visits, and other inmate care, helping the county avoid nearly \$200,000 in inmate health costs in FY 2013.

Local governments have found that giving easy access to health services at work sites not only supports employee wellness, but also reduces employee absenteeism and health care costs. Keeping the big picture in mind and being open to new partnerships and resources helps governments maintain good quality programs while controlling or containing costs.

## INTRODUCTION

It is not surprising that local governments are intensely focused on ways to reduce health care costs. The percentage of employee compensation that goes to health benefits has been steadily rising over the past 10 years, putting a squeeze on employee wages among other local government expenditures.

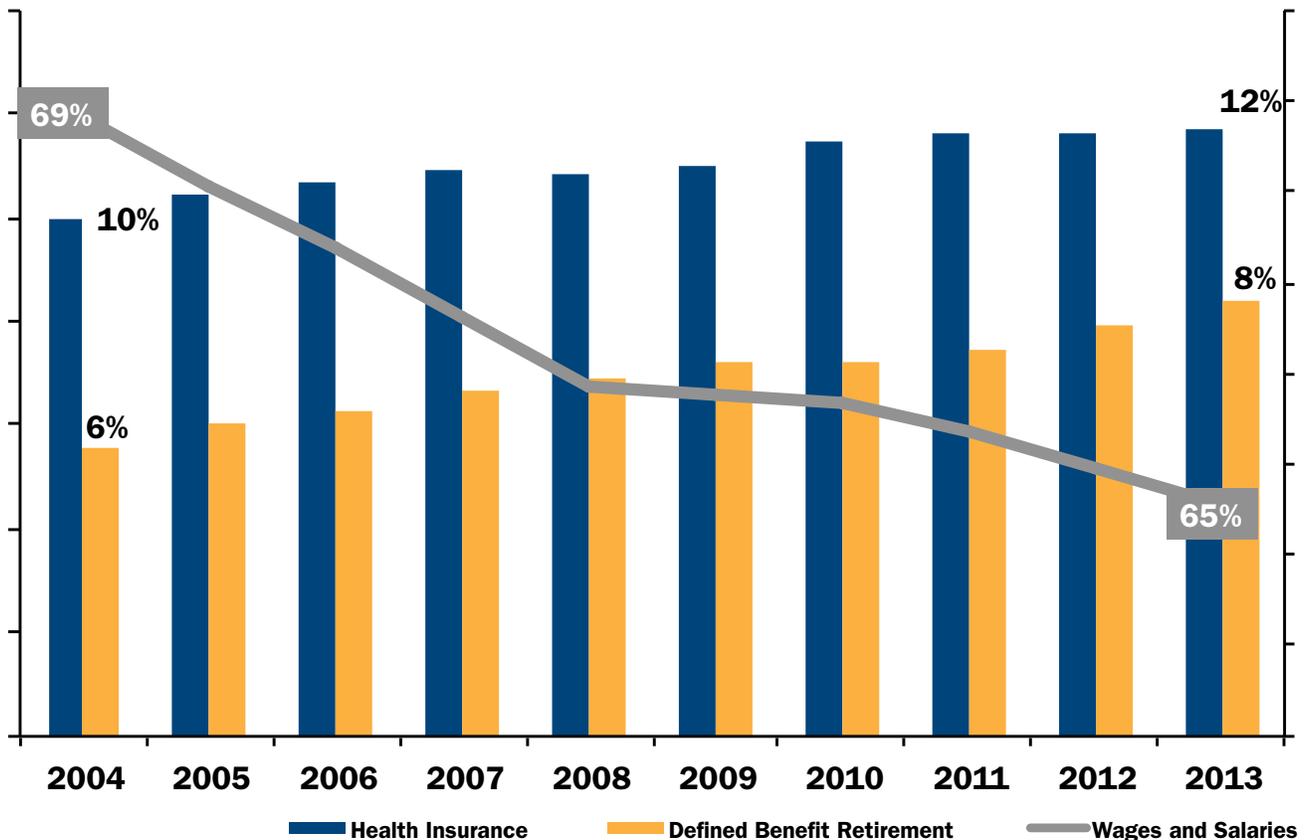
Because health care costs have been rising for some time, many local governments have made incremental changes in their health benefits. Others have made more dramatic changes. This report looks at what is driving the increase in health care costs and what local governments are doing about it. It includes findings from a nationwide survey, a summary of what local governments need to know about the Patient Protection and Affordable Care Act (ACA), and six case studies. The local governments selected for this report have implemented programs that have produced savings in their health benefit costs. Specific programs covered include wellness and chronic disease management programs, on-site

employee clinics, competitive bidding and streamlined processes, operational efficiencies, dependent care audits, and an active approach to help current and former jail inmates access health care.

SLGE undertook this research project at the request of the University of Tennessee Institute for Public Service (IPS), which provided guidance on the issues to address and helpful feedback on the report.

To collect data on changes in local government health benefits, the International Public Management Association for Human Resources (IPMA-HR) conducted a national survey for the Center for State and Local Government Excellence (SLGE) during the summer of 2014. The on-line survey was distributed three times to IPMA-HR members resulting in 252 responses from local governments across the United States. The total includes complete and incomplete responses. The survey covered a wide range of questions regarding health benefits, including what health plans and programs are offered, employer costs, cost drivers,

**Figure 1.** Overall Employer Costs for Employee Compensation



Source: SLGE analysis of BLS Employer Costs for Employee Compensation, 2013

communication strategies, and how local governments are containing health care costs. It also examined changes to health insurance over the past five years covering new hires, current employees, or retirees.

The report includes case studies that show how six local governments have successfully produced savings in their health benefit costs while supporting improved health and wellness.

The cases cover a range of approaches to meet diverse needs and serve diverse populations including:

- Increasing enrollment of jail populations in health coverage

- Focusing on chronic disease management
- Providing easy employee access to medical care through on-site clinics
- Seeking new health care providers to contain costs without changing benefits
- Consolidating and simplifying services to create operational efficiencies
- Using a dependent eligibility audit to reduce costs and improve internal controls
- Modifying retiree health benefits
- Engaging employees in examining claims and developing strategies to contain costs.

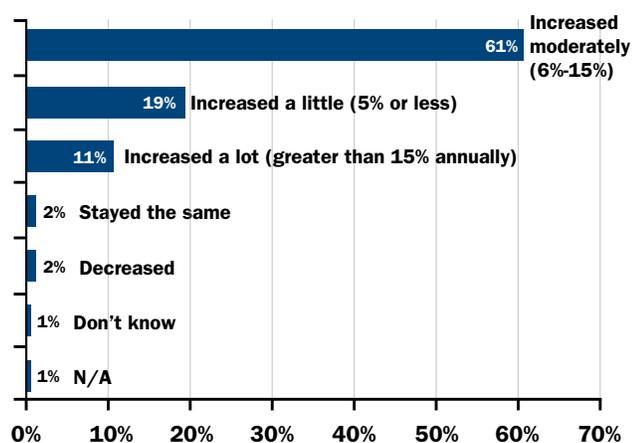
**Figure 2.** Number of Survey Respondents per State



## SURVEY RESULTS

Most local governments reported that their health care costs for employees and retirees have increased moderately over the past five years, in the range of 6 percent to 15 percent. Nineteen percent reported their costs increased less than 5 percent and 11 percent reported that their costs had grown by more than 15 percent annually.

**Figure 3.** *Increases to Employer Health Care Costs Over the Past Five Years*



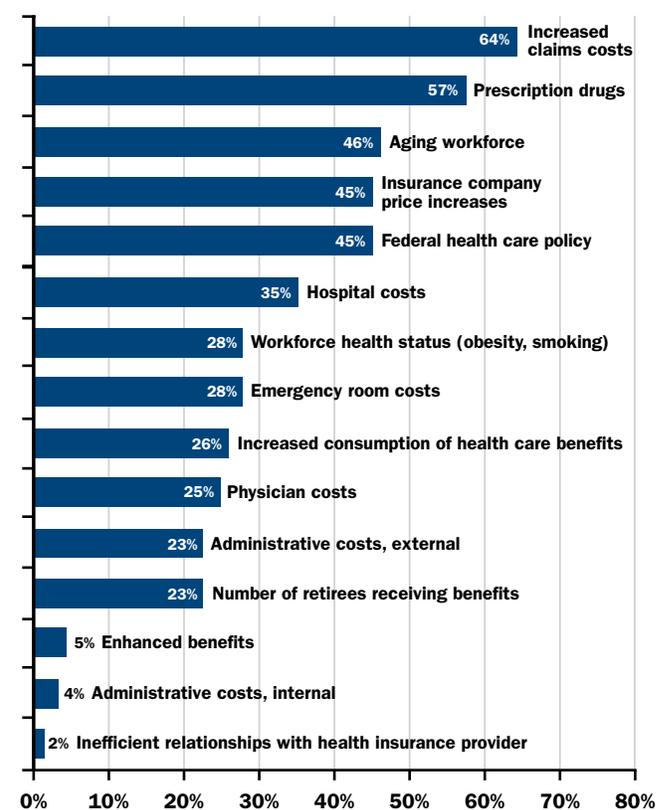
Most local governments reported that they offer medical insurance and prescription drug coverage to current and retired employees. At the same time, 18 percent of respondents reported that they do not offer insurance to retirees who are 65 years of age or older.

An encouraging trend is that more employees and retirees are getting engaged and educated about their health.

### Major Drivers of Increased Health Care Spending

For local governments across the country, the major cost drivers have been increased claim costs (64 percent) and prescription drug costs (57 percent). The next three cost drivers were an aging workforce (46 percent), along with insurance company price increases and federal health care policy, cited by 45 percent of respondents.

**Figure 4.** *Major Health Care Cost Drivers*



### Strategies for Containing Costs

The top three strategies for containing health care costs were increasing the share of premiums paid

by employees (57 percent); establishing wellness programs for current employees (53 percent); and increasing deductibles for current employees (53 percent).

Figure 5. Strategies for Containing Health Care Costs

	Current employees	Pre-65 retirees	65+ retirees
Increased co-payments	49%	35%	16%
Increased employees/retirees share of premiums	57%	35%	18%
Increased deductibles	53%	35%	14%
Increased cap on out of pocket expenses	27%	19%	6%
Changed the number of available plans	29%	19%	10%
Required more pre-certification (for hospital and/or outpatient)	7%	5%	3%
Changed how prescription drugs are administered (requiring prior authorization; clinical intervention; etc.)	15%	11%	4%
Established wellness program	53%	20%	10%
Implemented smoking cessation program with non-smoker premium discount	17%	5%	2%
Conducted Health Care Audits:	11%	5%	4%
claims payer	11%	7%	3%
hospital bill	8%	5%	1%
vendor	7%	5%	1%
dependent eligibility	28%	18%	8%
employee	10%	7%	2%

### Cost Containment Programs for All Employees

The programs most often offered by local governments to all employees as part of their overall cost containment plans were wellness and disease management programs, cited by 69 percent and 57 percent of respondents respectively. On-site clinics to provide easy employee access to health care were offered by 15 percent of respondents.

Few of the responding local governments have implemented regional partnerships (5.6 percent) or joined a consortium (7.5 percent) to provide health insurance.

Respondents offered comments on the impacts of their cost-saving initiatives.

- “Our on-site clinic saves approximately \$3 for every \$1 expended.”
- “Changing to a health savings account (HSA) and high deductible with additional claims review has saved us \$500,000 this year alone.”
- “Our wellness program...[is] a slow process, but trends in the right direction.”

- “More employees and retirees are getting engaged and educated about their health and are participating in more wellness activities and disease management.”

Figure 6. Cost Containment Programs

	Offers	Is considering	Is not considering	Did not answer
Wellness program(s)	69%	14%	2%	15%
Disease management program(s)	57%	8%	8%	27%
On-site physicians	7%	8%	33%	53%
On-site clinics	15%	13%	26%	46%
Reliance on pharmacists for chronic care assistance	5%	5%	35%	56%
Reliance on nurses and physician assistants for primary care	10%	9%	28%	53%

### Changes to Health Insurance Plans

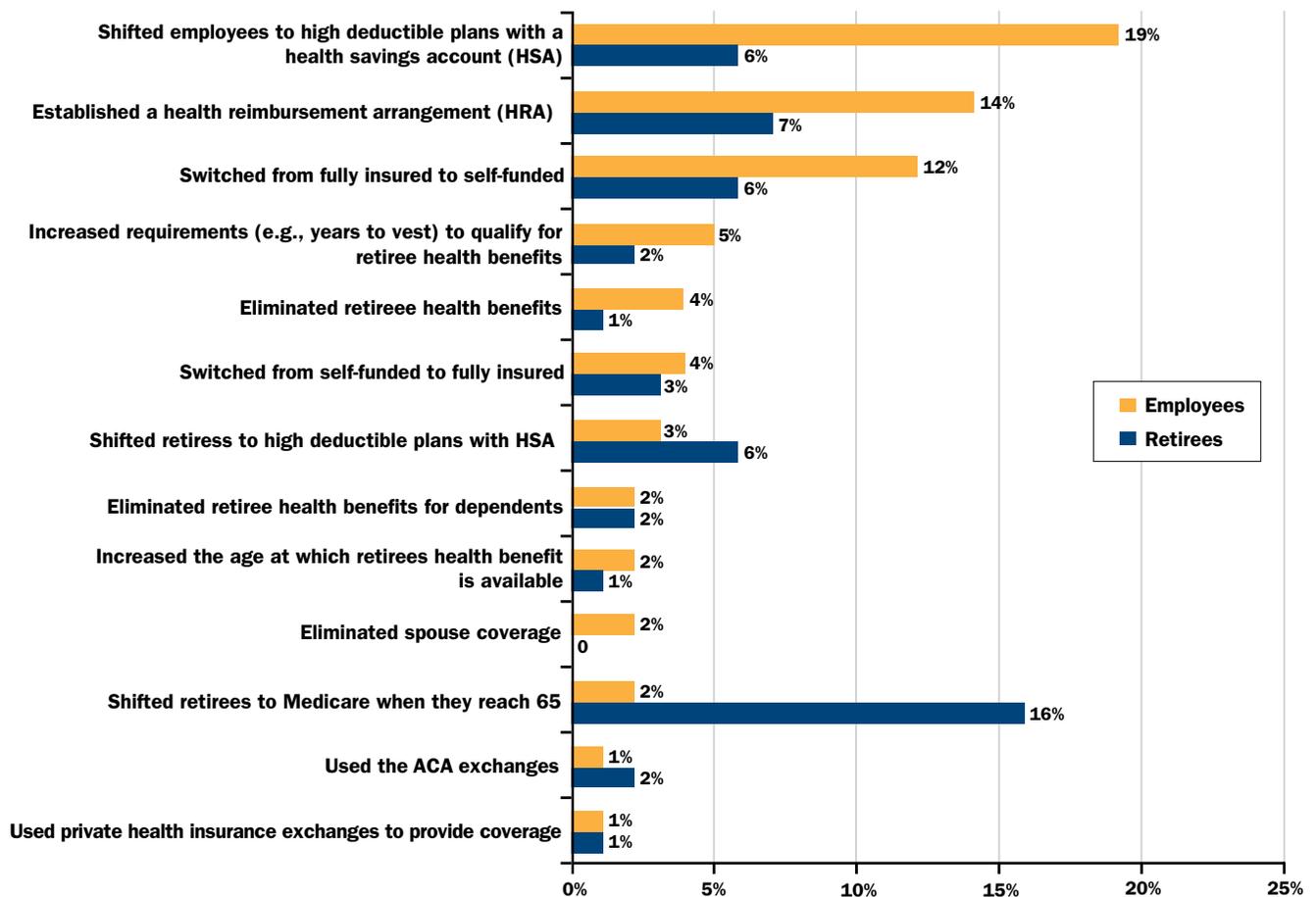
Nearly half of the respondents reported making changes over the past five years to the way health insurance is provided. Specific changes highlighted were:

- 19 percent shifted employees to high-deductible plans combined with health savings accounts

- 14 percent established a health reimbursement arrangement (HRA) for employees
- 12 percent switched from fully insured to self-funded health plans for employees.

More than 16 percent of responding local governments said they moved retirees to Medicare when they reached age 65 to contain costs.

**Figure 7.** Changes to Health Insurance Plans Over the Past Five Years



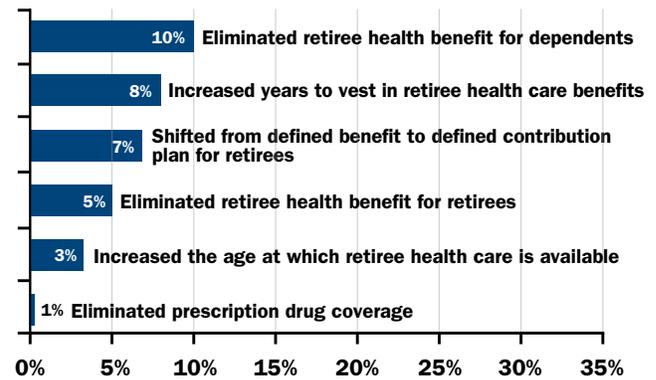
### Benefits Vary According to Hiring Dates

It is common for local governments to have multiple tiers of benefits depending on when employees are hired. For example, long-time employees may be able to cover spouses or dependents on the government health insurance plan, while newer employees may not be eligible for that benefit.

Respondents report the following changes over the past five years in health benefits for new hires:

- Eliminated retiree health benefits for dependents (10 percent)
- Increased years to vest in retiree health benefits (8 percent)
- Shifted from defined benefit to defined contribution plan for retirees (7 percent)
- Eliminated retiree health benefit for retirees (5 percent)
- Increased the age at which retiree health care is available (3 percent)
- Eliminated prescription drug coverage (1 percent)

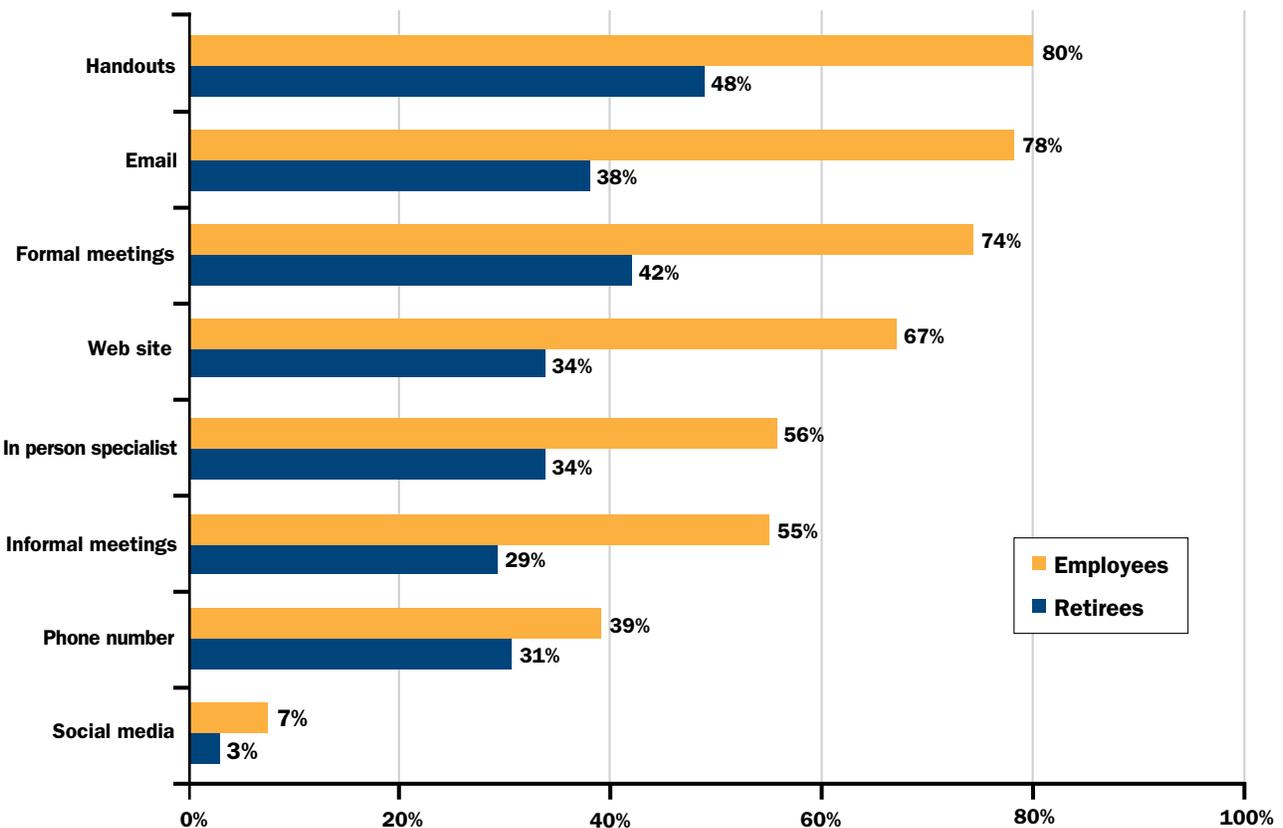
Figure 8. Changes to Benefits for New Hires



### Communicating with Employees and Retirees

Governments communicate with employees and retirees primarily through handouts, e-mail, formal meetings, and website information. In Tennessee, in-person specialists were a popular way to communicate with retirees.

Figure 9. Methods of Communicating about Health Insurance



# LOCAL GOVERNMENTS AND THE AFFORDABLE CARE ACT

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The Patient Protection and Affordable Care Act (ACA) provides opportunities and challenges for local governments as both employers and providers of public health services. On the employer side, the law includes a mandate for larger employers to provide affordable medical coverage that meets specific minimum requirements for most employees or face significant financial penalties. On the provider side, expansion of Medicaid eligibility and establishment of health insurance exchanges under ACA provide new coverage opportunities for millions of previously uninsured and vulnerable Americans including the nearly 12 million people who move through local and county jails annually.<sup>1</sup>

## ACA Requirements for Local Governments as Employers

While the ACA does not directly require businesses and governments to provide health benefits to their workers, larger employers, including state and local governments, face penalties beginning in 2015 if they do not offer affordable coverage that meets minimum essential standards to all full-time employees. The provision was included to ensure that employers maintained group insurance plans rather than dropping them in favor of individual entry into Health Insurance Marketplaces.

The following sections highlight components of the ACA that are important to local governments as employers.

### Eligible Employees

The law applies to employers with 50 or more full-time employees or full-time equivalents who work an average of 30 hours per week or 130 hours per month. In some cases, definitions of benefit-eligible employees under the ACA may expand the pool of covered employees, particularly for temporary full-time and seasonal employees who work the 30 hours per week. An expanded pool of covered employers under ACA could increase employer health care costs.

### Grandfathered Plans

Health insurance plans that existed when the ACA was signed into law on March 10, 2010, are eligible for grandfathered status which may exempt those pre-existing plans from some requirements of the health care law. However, if an employer makes significant changes to a plan's benefits, premiums, co-pays, or deductibles,

the plan loses its grandfathered status. The intent of the grandfather provision is to help ensure that employer-sponsored insurance plans that people like will stay in place.

### Self-Insured Plans and Risk Pools

The ACA does not change how cities and towns may provide employee health benefits. Local governments are still able to self-insure and participate in statewide risk pools, if desired. Employers that use these vehicles will need to demonstrate to the U.S. Department of Health and Human Services (HHS) that their plans are sufficiently funded to cover all medical claims.<sup>2</sup>

### Minimum Essential Coverage

All employer insurance plans must meet minimum coverage requirements updated annually by the Secretary of Health and Human Services. Current coverage categories include ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health, prescription drugs, lab services, wellness and chronic disease management, and pediatric services. In addition, employers should have already implemented several provisions in the law including prohibiting pre-existing condition exclusions for children, eliminating lifetime limits and restrictive annual limits, covering enrollees' dependent children until age 26, and eliminating waiting periods.

### Wellness Services

The law offers new incentives to expand preventive, wellness, and chronic care services. Non-grandfathered group health plans are required to provide in-network coverage for a range of immunization and screening services at no additional cost to participants meaning no co-pays, co-insurance, or deductibles. In addition, the law gives employers expanded flexibility to reward employees for participating in wellness programs. Investments in wellness can improve employee health, providing long-term individual and organizational benefits while also reducing employers' health care costs.

### Cadillac Excise Tax

Beginning in 2018, if the value of a local government's health care benefits exceeds \$10,200 for individuals and \$27,000 for families, the local government may be subject to a 40 percent excise tax on the amount that is over the threshold. The so-called "Cadillac tax" was

established to level or lower the costs of health care and encourage employers to favor wages over benefits in employee compensation. Local governments need to assess now whether they will be subject to the Cadillac tax in 2018, barring any changes in the scope of their benefits package, and how the cost will be covered.<sup>3</sup>

### **ACA Opportunities to Enroll Jail Populations**

The ACA creates important new opportunities for local governments to enroll jail populations in health coverage. The law gives states the option to expand Medicaid to all individuals under age 65, including childless adults with incomes up to 133 percent of the federal poverty level.<sup>4</sup> Additionally, under the ACA, incarcerated individuals awaiting disposition of charges can obtain private health coverage through public health insurance exchanges or maintain previous coverage in an exchange.<sup>5</sup> While federal law does not allow reimbursement of inmate medical care under Medicaid, states can bill Medicaid for care of inmates who are admitted for at least 24 hours to hospitals, nursing facilities, juvenile psychiatric facilities, or intermediate care facilities that are not part of the local correctional system.<sup>6</sup>

Getting jail populations enrolled in Medicaid coverage in a timely manner is important to local governments for several reasons:

- People in jail are often uninsured and disproportionately suffer from mental health and

substance abuse issues.<sup>7</sup> If these needs are not addressed, the chances for recidivism are high, with negative implications for individual health and well-being, public safety and health, and local health care costs.

- Time spent in jail represents a critical opportunity to connect people with health coverage so they can access the care they need to change the direction of their lives upon release.<sup>8</sup>
- Though people are not eligible for Medicaid while in jail, a high proportion of the justice-involved population is likely to be eligible upon release, particularly in states that are expanding Medicaid under the Affordable Care Act. Therefore, an important strategy for local governments that run jails is to initiate the Medicaid enrollment process immediately before release.

In the 27 states and the District of Columbia which have elected to expand their Medicaid programs,<sup>9</sup> an estimated 25 to 30 percent of people released from jails are eligible for Medicaid. About 20 percent of justice-involved individuals are eligible for coverage through public health exchanges.<sup>10</sup> In addition, it is projected that people who have spent time in jail will comprise about one-sixth of new Medicaid enrollees and nearly one-tenth of people with private coverage through the exchanges.<sup>11</sup> Thus, particularly in the states that have chosen to expand Medicaid, the program will be a major source of coverage for individuals after release from jail.

## Case Study 1:

### Hampden County, Massachusetts: Enrolling Jail Populations in Health Coverage

State and local governments bear a large share of the health care costs for justice-involved individuals, not only as providers of jail-based health care, but also through funding of uncompensated care by safety-net providers such as state and county hospitals and community health centers.<sup>12</sup> The ACA's Medicaid expansion and enhanced federal funding have the potential to address health care needs and coverage of jail populations before and after incarceration while also providing significant cost savings for state and local governments. Therefore, state and local government officials are beginning to consider new strategies to increase jail populations' enrollment in health coverage.<sup>13</sup>

Hampden County (population 467,319) has a long track record of successfully enrolling inmates in health coverage at its correctional center in Ludlow. Administered by the Hampden County Sheriff's Department, the Hampden County Correctional Center (HCCC) serves the Springfield-Holyoke metropolitan area, supervising approximately 1,500 offenders including pre-trial detainees and people sentenced for two and a half years or less at minimum-to-medium security.<sup>14</sup>

Since 1992, the county has taken a proactive approach to help jail inmates and former inmates access comprehensive medical care, behavioral health and social services, and the financial support they need to improve their life circumstances and ultimately become productive members of their communities. Facilitating timely enrollment in Medicaid is an important component of this strategy.<sup>15</sup> The following sections summarize the key elements of Hampden County's approach to supporting inmate access to health coverage and health services.

#### **Commitment to Address Inmates' Complex Needs**

Like most justice-involved populations, HCCC inmates have complex behavioral health and social service needs:

- Forty to 50 percent of men and 60-70 percent of women entering HCCC have serious mental illnesses including major depression, schizophrenia, and mood disorders. Personality disorders for which there are no effective

medications and for which the state does not provide treatment in community-based health facilities account for an estimated 20 percent of serious mental illnesses among inmates.

- Nearly all HCCC inmates (85–90 percent) have substance abuse problems.
- Virtually all inmates (85–90 percent) are uninsured.<sup>16</sup>

HCCC spent approximately \$7 million on inmates' medical care in FY 2013<sup>17</sup> and has a strong commitment to address the full range of inmates' needs to improve their lives. HCCC officials believe it is their job to send incarcerated people back into the community in better shape than when they first entered the correction system.<sup>18</sup>

#### **Support from the Top**

Hampden County Sheriff Michael Ashe has been the driving force behind HCCC's approach to promoting successful community re-entry and continuity of care for jail populations.<sup>19</sup> Ashe, who was trained as a social worker and has been sheriff for 38 years, recognizes that without effective intervention to help inmates make positive life changes, the chances for recidivism are high. To help inmates improve their life circumstances and avoid reincarceration, HCCC's correctional case managers connect them with GED classes, medical care, behavioral health and substance abuse services, job training and placement, transportation, housing, and any other support services they need. Jail-based correctional case managers coordinate with social work staff for the county's after-incarceration support program to ensure that inmates continue to receive the assistance they need post-release. HCCC leaders view medical care and, by extension, health coverage as essential elements of the comprehensive support inmates need to turn their lives around.<sup>20</sup>

#### **Case Management Staff Dedicated to Medicaid Enrollment**

Ensuring that jail inmates have health coverage upon release always has been a key component of HCCC's discharge planning program. HCCC tracks the release dates of all inmates and initiates the Medicaid enrollment process 30 days prior to discharge. At each facil-

ity, a MassHealth<sup>21</sup> case coordinator works one-on-one with inmates to complete the 29-page Medicaid application. The case manager faxes completed applications to the Massachusetts Medicaid office and monitors their status throughout the enrollment process. Completed applications generally are approved within three to five days.<sup>22</sup>

### **A Public Health Model for Correctional Health Care**

Based on success in addressing the HIV/AIDS epidemic in the early 1990s, leaders from HCCC and county health services worked together to develop a public health model for correctional health care.<sup>23</sup> Under the model, physicians serving community health centers in neighborhoods with high proportions of incarcerated residents also provide care in HCCC's facilities. Therefore, inmates who had been receiving care in community health centers prior to incarceration can see the same physicians while in jail and following release. HCCC's health and social service providers work together to ensure that inmates and former inmates receive comprehensive, high-quality medical, behavioral health, dental, and vision care.<sup>24</sup>

Partnering with community health center-based physicians has been critical to improving the health of justice-involved populations. Community health center doctors take a proactive approach to prevention and treatment of the many chronic diseases that are prevalent among jail populations, and they are committed to ensuring continuity of care for their patients following release.<sup>25</sup>

### **Post-Incarceration Support**

The timing of an inmate's release from jail can be difficult to predict. A person may enter the jail at 3 p.m. and be released on bail at 4 p.m. or a week later. Sometimes individuals are sentenced and then paroled unexpectedly. Regardless of how long an individual is in HCCC's custody, he or she is entitled to receive After-Incarceration Support Services (AISS), coordinated at a facility in nearby Springfield, Massachusetts. Jail-based correctional case managers connect inmates to AISS case managers for post-release follow-up. Case managers reach out to people following their release, and, if necessary, bring them into the AISS facility for assistance. Inmates who were unable to complete the Medicaid enrollment process before discharge are enrolled as soon as possible upon re-entering the community.

### **Maximizing Available Medicaid Coverage**

Because it provides comprehensive coverage with minimal cost sharing, Medicaid has been the primary source of health coverage for the HCCC population.<sup>26</sup> Massachusetts is among a subset of states that take advantage of federal law allowing states to bill Medicaid for the care of inmates who are admitted to hospitals, nursing facilities, juvenile psychiatric facilities, or intermediate care facilities that are not part of the local correctional system.<sup>27</sup> As a result of this practice, Hampden County saved approximately \$387,000 in FY 2013.<sup>28</sup> Additionally, under a new policy enacted as part of the state's FY 2015 budget, Massachusetts counties can suspend rather than terminate Medicaid benefits when individuals are admitted to jail.<sup>29</sup> Therefore, inmates who had Medicaid coverage before incarceration can re-enroll immediately upon release rather than go through the process of re-applying. Although this policy is allowed under federal Medicaid law, the vast majority of states have not adopted it.<sup>30</sup>

### **Effective Information Sharing**

Ongoing information sharing among correctional facilities, jail-based health facilities, and community-based health care providers is an important element of HCCC's strategy to promote continuity of inmates' medical care, behavioral health services, and health coverage. Two successful information components are:

- Electronic health records to promote continuity of care by enabling the sharing of inmates' health information—with patient consent—between jail- and community-based health care providers.
- A virtual electronic gateway to expedite Medicaid enrollment. The system transmitted eligibility information in real time to the state Medicaid office, which often approved completed applications on the same day, saving HCCC approximately \$410,000 in FY 2012 and \$276,000 in FY 2013. The gateway was suspended in 2014 because of technology problems associated with rollout of the Affordable Care Act in the state, and HCCC returned to a paper-and-fax system for Medicaid enrollment. HCCC staff expects the gateway system will be re-activated once the technical issues are resolved.<sup>31</sup>

### **A Spirit of Inter-Agency Cooperation**

Ongoing cooperation among corrections departments, the state Medicaid agency, and local community center staff has been critical to the county's success

in empowering inmates to re-enter their communities successfully. This cooperation provides not only better opportunities for inmates, but also significant cost savings for communities.<sup>32</sup>

## Results

HCCC has experienced decreases in both reincarceration rates and its total inmate population which officials attribute, in part, to its comprehensive efforts to help inmates and former inmates gain access to the resources and support they need to improve their life circumstances. Reincarceration rates for HCCC inmates are among the lowest in the country. According to the most recent data available, one year after being released in 2011, 14.3 percent of inmates were incarcerated for a new crime; and three years following release, the reincarceration rate was 31.7 percent.

Ten years ago, the one-year reincarceration rate for HCCC inmates was 20.2 percent, and the three-year rate was 43.6 percent.<sup>33</sup> By comparison, the most recent national data on the U.S. jail population indicate that in 2002, 41 percent of jail inmates had a current or prior violent offense, and 46 percent were nonviolent recidivists.<sup>34</sup>

From FY 2008 to FY 2014, the number of inmates in HCCC corrections facilities declined by approximately 29 percent, from 2,085 to 1,477. This decline was associated with a 7.5 percent reduction in the total jail budget—from \$72.2 million in FY 2008 to \$66.8 million in FY 2013—and a 27.4 percent reduction in the total medical budget—from \$9.58 million in FY 2008 to \$6.97 million in FY 2013.<sup>35</sup>

Nationwide, the total number of jail inmates fell by 6.9 percent, from 785,533 in 2008 to 731,208 in 2013.<sup>36</sup>

## Takeaways

- Taking a proactive approach to help inmates and former inmates gain access to comprehensive medical care, behavioral health and social services, and financial support contributes to improved life circumstances, lower reincarceration rates, and a decrease in the number of inmates.
- The availability of new federal funds under the Affordable Care Act (ACA) provides an opportunity for state and local governments to realize significant cost savings for justice-involved individuals who are admitted to hospitals, nursing facilities, juvenile psychiatric facilities, or intermediate care facilities that are not part of the local correctional system.
- Helping inmates complete the Medicaid enrollment process before discharge ensures that they will have health coverage after release which is important to sustaining progress on lifestyle changes initiated while incarcerated.
- Ongoing cooperation among corrections departments, the state Medicaid office, and local community center staff has contributed to this county's success in empowering inmates to re-enter their communities successfully.

## Case Study 2:

### Asheville, North Carolina: Four Strategies for Reducing Health Care Costs

The city of Asheville, North Carolina, (population 85,712) provides health care coverage to 1,042 employees and 994 dependents. The city has reduced its health care costs using four strategies:

1. Chronic disease management
2. Employee health center
3. Changes to retiree health benefits
4. New health care vendor

#### Chronic Disease Management

Asheville developed a structured approach to chronic disease management in 1997 when it began providing free medical assistance to 47 employees with diabetes. Initially designed to reduce the impact of diabetes on the health and wellness of city employees, retirees, and their dependents, the Asheville Project now also covers asthma, hypertension, high cholesterol, and depression and has approximately 340 participants including some enrolled for more than one condition.<sup>37</sup>

The city's chronic disease management program emphasizes collaboration among the employee/patient, a pharmacist care manager, and physician. All of the participants agree to work closely with a certified pharmacist care manager who provides coaching on diet, exercise, stress reduction, and medication management.<sup>38</sup>

The approach has provided significant benefits and cost savings to both the city and participating employees. The city saves about \$4 for every \$1 it invests in chronic care management. Savings include:

- Decreased hospital costs
- Fewer emergency room visits for asthma patients
- Reduced sick leave usage.<sup>39</sup>

While program participation is voluntary, enrollees also save significantly on expenses related to management of their chronic conditions through benefits that provide 100 percent coverage of:

- Co-pays for prescription drugs specific to the disease
- Supplies such as pumps and test strips
- Education classes related to disease management
- Visits to the pharmacist care manager
- Disease-related lab costs.

In addition to these financial benefits, the program has been successful in removing barriers that employees, retirees, and dependents sometimes encounter when seeking the medical care and guidance they need to manage their chronic diseases.<sup>40</sup>

Part of the continued success of the Asheville Project is the city's partnerships with individual physicians, the Mission Health System, the North Carolina Center for Pharmaceutical Care, the North Carolina Association of Pharmacists, and the Piedmont Pharmaceutical Care Network.

The Asheville Project has been replicated at more than 80 locations around the country.<sup>41</sup> Successful implementation of a chronic disease management program to reduce health care costs requires:

- Data on the cost and claims related to chronic diseases
- Data analysis to identify health trends within the employee population
- Services tailored to the employee population's health conditions.<sup>42</sup>

#### Employee Health Center

The city makes it easy for employees to access professional and quality health care through an Employee Health Center which is available free to all employees, retirees, and dependents over the age of 15 who are enrolled in the city's health plan. Services offered include:

- Annual health screenings
- Evaluation and care of work-related or personal injuries and illnesses
- Monitoring of blood pressure, cholesterol, blood sugar, etc.
- Strep tests
- Allergy injections
- Vaccinations
- Pre-employment screenings.

The Employee Health Center averages about 550 visits per month, and the city is taking steps to increase use by offering annual health screenings at the health center for employees who choose

to participate in the city's wellness program. The annual cost to operate the center is about \$600,000 which includes staff salaries and benefits, contracted services, medical and general supplies, rent, utilities, training, and fees. The clinic has a physician on staff 12 hours per week, a physician assistant 30 hours per week, two full-time registered nurses, and a medical secretary. If a health screening identifies a chronic medical condition, the patient is given information about the Asheville Project and encouraged to participate.<sup>43</sup>

### Changes to Retiree Health Benefits

To achieve further reductions in health insurance costs, Asheville also made changes to its retiree health benefits. Employees, including public safety personnel hired after July 1, 2012, are no longer eligible for retiree health benefits. Employees hired before that date may be eligible for some retiree health benefits, depending on years of service.<sup>44</sup>

Asheville now requires that retirees with access to Medicare be moved to the city's fully insured Medicare retiree plan which offers two options on premiums and out-of-pocket costs. Before this change, retiree monthly premiums for the city's health plan ranged from \$549 to \$708 per month. Under the new plan, premiums range from \$370 to \$465. All retirees who are covered under the city's employee health

plan have access to the city's Employee Health Center and are eligible to participate in the Asheville Project if they have one of the covered chronic health conditions. There are currently 167 retirees with 13 dependents in the Asheville retiree health plan.<sup>45</sup>

### New Health Care Vendor

In 2011, after an evaluation of existing contracts with the vendors used for various aspects of the health insurance program, the city issued a request for proposals (RFP) with a focus on identifying opportunities to contain costs, improve service, and possibly consolidate services without changing the benefit design. Based on responses to the RFP, the city entered into a contract with a different Third Party Administrator (TPA).<sup>46</sup> Before this change, Asheville used a number of different vendors for TPA services including health care network management, disease and case management, and pharmacy benefits management. The new partnership allowed the city to consolidate components of the health benefits program which simplified administration and provided some cost savings. The change also led to greater negotiated network discounts with medical providers and for pharmacy benefits which enabled the city to avoid any increases in employee premiums for three consecutive years.<sup>47</sup>

## Takeaways

- A strategic approach that combines employee wellness with program design efficiencies can produce significant savings in health care costs.
- An employer-sponsored chronic disease management program contributes to healthier employees and cost savings for both the employer and employees.
- The Asheville Project, a pioneer program in chronic disease management, has proven to be a successful model for employer investment in managing chronic care of employees and dependents.
- Easy access to health services at work sites further supports employee wellness which reduces employee absenteeism and health care costs.
- Regular review, rebidding, and/or restructuring of health care vendor contracts may produce additional savings.

## Case Study 3:

### Buncombe County, North Carolina: Focus on Results Produces Significant Savings

Buncombe County, North Carolina, with a population 244,490 and 1,400 employees, has long been a leader in analyzing how it delivers services and developing innovative approaches and efficiencies. These efforts to consolidate and simplify service delivery began in 1992 and have laid the foundation for the county's more recent efforts to tackle growing health care costs. The county passed resolutions in 2001, 2006, 2007, and 2011 to provide legal authority to make structural changes to support cost-saving efforts.

A key part of the approach is to identify core county services and then decide the most cost-effective way to deliver each service including partnership arrangements. As county leaders set goals, they emphasize stakeholder outcomes. For example, by contracting for adult and child primary care services for the uninsured and under-insured, the county gained additional patient access for less cost. Every service is scrutinized and adapted to provide better service at the same or a reduced cost.

The Health and Human Services Department uses a balanced score card to determine whether actions will:

- Improve outcomes for the people the county serves
- Achieve cost savings or leverage additional resources or revenues
- Improve internal business processes
- Enhance collaboration throughout the organization.<sup>48</sup>

#### A Long-Term Strategy

Buncombe County's commitment to consolidate and simplify services has produced significant results with long-term impacts. Some changes have focused on economies of scale while others have analyzed processes that could be improved. In order to identify areas for savings and cost avoidance, the county considers ways to provide a service differently, use competitive bidding, generate income, or leverage county dollars more effectively. Examples of major innovations and the savings they produced from FY 2011 through FY 2013 include:

- A fast-track Social Security Insurance disability application process established in 2010 for the disabled homeless that has saved an estimated \$15,754,680<sup>49</sup>

- Placing high users of jails and shelters in supportive housing saving \$495,000<sup>50</sup>
- Diverting offenders with extreme behavioral problems into mental health services which has opened capacity at the detention facility for renting to crowded community jails, generating \$1,038,717 in new revenue<sup>51</sup>
- Contracting for 24/7 medical screening at the detention facility to identify and address inmates' physical and behavioral health needs at booking which has reduced on-site sick calls, off-site hospital emergency room visits, and other inmate medical care needs, helping the county avoid nearly \$200,000 inmate health costs in FY 2013.<sup>52</sup>

#### Creating Operational Efficiencies

The county has also produced substantial savings by creating service partnerships, outsourcing and merging functions, and using performance-based contracts. In 2011, the county merged multiple agencies into an integrated Department of Health and Human Services (HHS). The merger made it possible to establish a single call center and a one-stop location for residents to access all of the services for which they are eligible. The county also has made effective use of technology to maintain a high level of service. For example, individuals seeking service can use a kiosk, select the language and service they desire, and be quickly linked to all of the services for which they are eligible. The database also highlights services the applicant or the family may need, but did not request, such as childhood immunizations.

Over a three-year period, the county's outcome focus has saved almost \$13 million from 30 different programs ranging from drug court support services to trip verification for Medicaid transportation to voluntary preventive services for possible child neglect. Another group of initiatives has emphasized improvements in service processes. While the cost savings from such efficiencies are difficult to measure, they contribute to overall service delivery effectiveness. Service improvement changes have included:

- A streamlined approach to staff scheduling
- A reduction of staff used for mail scanning

## Takeaways

- Keeping big picture goals in mind, such as health and wellness, produces bigger savings.
- Looking beyond details of individual programs to identify new resources and new partnerships may achieve more cost-effective service delivery.
- Using a systems approach and rigorously reviewing all programs has helped the county keep up with the demand for services at less cost.
- Monitoring results using tools such as balanced score cards and rebidding contracts periodically to ensure competitive pricing contributes to long-term success.

## Case Study 4:

### Corpus Christi, Texas: Dependent Eligibility Audit to Manage Health Care Costs

In order to identify ways to contain health care costs, the city of Corpus Christi, Texas, with a population of 316,863 and more than 3,000 employees, conducted a dependent eligibility audit of its workforce to ensure that all enrolled dependents met current plan rules.

Dependent eligibility audits are used to:

- Reduce health care costs by eliminating claims paid for ineligible participants
- Ensure that an organization can afford to offer a benefits package that will attract talented employees
- Provide internal controls to maintain legal and regulatory compliance
- Help reinforce the value of employer-sponsored benefit plans.<sup>53</sup>

Though city officials were initially skeptical that the process would yield significant savings, the audit found a large number of ineligible dependents, which reduced the city's health insurance costs by more than \$1 million in the first year.

#### Audit Implementation

In 2012, the city contracted with a national consulting firm that specializes in cost-containment strategies for health care programs, to carry out the dependent eligibility audit.<sup>54</sup> To maintain transparency and gain support for the process, city officials took several steps to ensure that employees were fully informed and well prepared before the audit's rollout in January 2013. The vendor provided a detailed implementation plan that established dates and timeframes for communicating with city employees throughout the process.

Six months before the audit began, the city:

- Told employees that the audit would take place
- Advised employees to remove any ineligible dependents before the audit was initiated
- Provided guidance to employees on potentially ineligible dependents such as a former spouse or a dependent who has reached the age of 27 and acknowledged that employees might not be aware of all eligibility rules
- Emphasized that there would be no financial penalties for employees found to have ineligible dependents on their plans.<sup>55</sup>

The audit had a 94 percent response rate from Corpus Christi employees, the majority of whom understood and accepted the purpose of the audit.<sup>56</sup>

#### Audit Results

The results of the dependent eligibility audit exceeded the city's expectations. Key findings were:

- Out of 3,367 total dependents reviewed, the audit found 368 ineligible dependents (10.9 percent).
- More than \$1.1 million in first-year cost avoidance was achieved.
- Including the cost of the audit, the city realized a 2,455 percent first-year return on investment.<sup>57</sup>

Through its 2013 dependent eligibility audit, as well as a successful on-site wellness clinic, the city reduced health care costs by \$1.84 million, significantly slowing the growth of expenditures for employee health care.<sup>58</sup>

#### Takeaways

- A dependent eligibility audit may produce significant savings by eliminating costs arising from the gradual aggregation of ineligible dependents.
- Careful and early communication with employees and deciding not to penalize employees who had ineligible dependents were essential to the audit's success, and positive employee feedback supports that view.<sup>59</sup>
- Going forward, the city plans to conduct dependent eligibility audits every five-to-seven years to maintain accurate dependent participation lists.
- While contracting with an outside vendor was beneficial for the first audit to establish the schedule and process, city staff may conduct future audits.

## Case Study 5:

### Jackson County, Michigan: Defined Contribution Retiree Health Care Plan Controls Costs

Jackson County, Michigan, (population 160,000) wanted to offer retiree health benefits to more employees while also controlling the costs of other post-employment benefits. To achieve both goals, the county introduced a retiree health savings account (RHSA) for new employees to replace the defined benefit retiree health plan. The new approach is expected to decrease the average lifetime cost for retiree health coverage from \$500,000 per employee to approximately \$50,000.

#### A More Cost-Effective and Portable Benefit

Jackson County has 575 employees, some of whom are represented by 10 unions. The average employee tenure is 11 years. In order to qualify for the existing defined benefit retiree health plan, employees needed between 15 and 21 years of service depending on the date of hire. Because of the extended time to vest, the majority of employees left county government before vesting. The county wanted to control its other post-employment benefit costs while also providing retiree health care benefits to more employees than previously were eligible for this benefit.<sup>60</sup>

To control costs, the county had taken incremental steps to reduce the retiree health benefit including:

- Eliminating spouse and dependent coverage for employees hired after January 1, 2007
- Removing caps on premiums for employees hired after January 1, 2010
- Raising the vesting period from 15 to 21 years of service for 75 percent coverage for employees hired after January 1, 2010.<sup>61</sup>

Even with these plan changes, the county faced significant unfunded retiree obligations that could become unsustainable.

In December 2010, Jackson County introduced a defined contribution retiree health care plan to replace its defined benefit plan. Once the new plan was approved, the county bought non-union employees out of their defined benefit health plan and moved them to the new plan with immediate vesting. It also made a lump-sum contribution to the new plan based on what the city would have contributed to the defined contribution plan had it been in place when the employee was hired. Union employees remained in the defined benefit plan.

All new hires, both union and non-union, were put into the new defined contribution retiree health plan with a three-year vesting period.<sup>62</sup> Because there is no state law requiring employers to provide retiree health benefits and no contractual requirement for the county to maintain retiree health care benefits in perpetuity, county leaders decided that a defined contribution retiree health savings plan would help employees save for their post-employment health costs in a way that could not be revoked by the employer and would be portable.<sup>63</sup>

#### Retiree Health Savings Account Structure

Under the health savings account, the county contributes \$1,750 annually and employees contribute \$750 annually. Employees cannot choose to contribute more than the established amount in any year.<sup>64</sup> The plan requires a \$100 automatic escalation of the employer contribution and a \$50 automatic escalation for employee contributions every five years. Like a defined contribution pension plan, employees choose how to invest their assets among the funds made available by the plan based on the employees' risk tolerance and time horizon.<sup>65</sup> When employees enroll, they can choose either a target-date fund based on age or another default investment option and can make changes any time.<sup>66</sup>

The administrator of the Jackson retiree health program<sup>67</sup> is responsible for educating employees and retirees about their investment options. The health savings accounts are estimated to cost the county \$50,000 per employee, assuming a 25-year career in county government.<sup>68</sup>

#### Results

Instead of ever-increasing long-term retiree health care obligations, Jackson County now pays for retiree health care for new employees each year, eliminating future post-employment obligations. At the same time, the county is better able to fund its outstanding obligations for other post-employment benefits. The financial savings from the new retiree health savings plan are expected to begin showing results as soon as 2015.<sup>69</sup>

Auto escalation is an important feature of the retiree health savings plan. It establishes future contribution increases at the outset to ensure the long-term adequacy of the benefit.<sup>70</sup> Lastly, one unexpected outcome

of the plan change has been increased willingness to hire new employees because the retiree health savings plan reduces the long-term financial obligations associated with new employees.<sup>71</sup>

## Takeaways

- A defined contribution approach to retiree health benefits provides an affordable, sustainable, and portable way for local governments to provide post-employment health care coverage.
- Controlling costs for retiree health care helps the government fund its outstanding obligations for other post-employment benefits.
- Building in an automatic escalation for both the employer and employee contributions ensures the long-term adequacy of the benefit.
- Regular education for both employees and retirees about their investment options is essential to help maximize savings growth.

## Case Study 6:

### Montgomery, Ohio: Employee Engagement and Claims Analysis Drive Down Costs

Montgomery, Ohio, (population 10,292) relies on a combination of employee engagement and hard data to tackle its health care costs. In 1999, employee health care costs made up 3 percent of Montgomery's annual budget and were rapidly increasing. To tackle this problem, the city established a Health Care Benefits Committee (HCBC) to examine claims and other data and make recommendations on how to contain costs.

#### Committee Ensures Employee Engagement

Representatives from all city departments serve on the HCBC and work closely with the city's health care provider to analyze claims and develop programs to reduce costs. The committee also examines data from health risk assessments and the EasyAppsOnline process which is updated by each employee.<sup>72</sup> Because the city has three bargaining units, any changes that affect union contracts must be negotiated.

The HCBC represents employee's health care concerns, negotiates with insurance providers to maintain comprehensive coverage, and communicates with each work group about key health care issues. Information is shared through monthly citywide staff meetings, departmental updates from committee representatives, and e-mails, articles, and wellness presentations. All employees are invited to committee meetings in order to listen to discussions and raise questions or issues.

Early in the process, the HCBC changed the structure of Montgomery's health insurance program from 100 percent city-paid coverage to sharing premium costs with employees and establishing co-pays. Every year, the committee develops proposals for insurance renewals, solicits employee feedback, and submits a renewal package to the city manager and city council for review and approval. Because health care costs remain one of the largest line items in the city's budget, ongoing changes have been necessary. With only 135 covered individuals, including dependents, a substantial cancer claim or other catastrophic event can cause rate increases.

#### Wellness Program Requires Active Employee Participation

To get employees more involved in improving their health and containing costs, the committee established

an incentive program. Employees can earn between \$200 and \$500 per year for taking an annual health-risk assessment and participating in sanctioned wellness activities on their own time. All employees participate in some wellness activities. In 2013, 71 percent of covered individuals put forth enough effort to earn financial rewards. This level of participation has held steady since the program began in 1999.

While individual privacy is protected, the committee receives an aggregate report of the health risk assessment that allows it to target top risk factors that can be better managed. Identified health risks have included high cholesterol, high blood pressure, tobacco use, more than two alcoholic drinks a day, or a body mass index (BMI) greater than 25 percent. The city's wellness provider<sup>73</sup> reaches out to individuals privately if they have any serious health issues. Citywide health risks are addressed in activities, health fairs, and educational forums.

Wellness program elements include:

- Physical participation in workouts or other activities designed to improve aerobic conditioning and strength
- Education programs such as attendance at lunch-and-learn lectures and health fairs
- Preventive check-ups such as dental cleanings, comprehensive physical exams, and eye exams
- Participation in health-related team-building events.

The wellness program remains a core strategy for the city after 15 years because it promotes preventive care, detects many conditions early while they are easier to treat, and reduces absenteeism.

#### Tackling Prescription Drug Costs

The city recently initiated a partnership with the city's health insurance broker<sup>74</sup> to reduce prescription drug costs as well as the use of urgent care and emergency rooms. When the committee learned that some medicines could be purchased directly for a lower cost than through the insurance plan, it urged employees to find out the cost of the medications without insurance. Employees learned that they could save money for themselves and the city by purchasing some medications directly. Before the committee was established the employee mindset might have been, "What is the

city going to do for me?” Now employees have a vested interest in improving the city health insurance plan to reduce their own costs.

### Turning Around Accountability

Instead of accepting a significant insurance cost increase from a vendor without question, the city seeks explanations for any proposed increases. In addition, the city may point out when it has had a great claims experience and ask the vendor what service improvement or price accommodation can be made to reward the city for this result.

If the Health Care Benefits Committee learns of a problem that an employee has had with insurance coverage, the issue is raised directly with the insurer while protecting the privacy of the individual or work group.

### Pioneering a High-Deductible Plan

At one time, the only insurance plan offered to employees was a preferred provider option (PPO). Later, the city added a high-deductible plan option, combined

with a health savings account (HSA). The city provided seed money for the HSA to employees who chose that option. Some employees were uneasy about the change largely because the HSA concept was unfamiliar. The city has collective bargaining agreements with its unions, so changes were negotiated and some contract language had to be modified to implement the program.

For a family plan that has a \$5,000 deductible, for example, the city contributes \$1,800 to the HSA and the employee contributes \$700 through payroll deductions. The employee is responsible for the additional \$2,500 in deductible costs, if needed. However, if the employee does not spend the \$2,500 in the HSA, the money can roll over to future years. Employees like the fact that they retain the money in the savings account permanently.

Because these issues were openly discussed with the Health Care Benefits Committee and broadly communicated to all employees, there was a shared understanding that employees and the city would face significantly higher costs if they retained the PPO as the only option.<sup>75</sup>

## Takeaways

- Local governments must adapt to the health care marketplace and should not shy away from facts about cost drivers.
- A good place to start the process of examining cost-containment options is with the local government’s health care provider or broker. Providers often offer free or subsidized resources that may be useful.
- Buy-in from employees is essential. Health care cost containment cannot be an “us versus them” conversation.
- Year-round education is essential.

## APPENDIX: HEALTH CARE COST CONTAINMENT SURVEY QUESTIONS

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1. Name of government/state
2. What health plans do you offer to current employees, retirees (pre-65), retirees (65 +)? Check all that apply.
  - a. Medical insurance (PPO, HMO, POS, indemnity, high deductible with HRA/HAS)
  - b. Pharmacy
  - c. Dental
  - d. Vision
  - e. Single employee
  - f. Employee plus one
  - g. Family
  - h. Do not offer insurance
3. Over the past 5 years, your employer costs for providing health care to employees and retirees have:
  - a. Increased a lot (greater than 15 percent annually)
  - b. Increased moderately (between 6 and 15 percent)
  - c. Increased a little (5 percent or less annually)
  - d. Stayed the same
  - e. Decreased
  - f. n/a
  - g. Don't know
4. If costs are going up, please identify the major cost drivers impacting your health care spending. Check all that apply.
  - a. Insurance company price increases
  - b. Administrative costs, internal (your government and employees)
  - c. Administrative costs, external (service providers)
  - d. Increased claims costs
  - e. Prescription drugs
  - f. Hospital costs
  - g. Physician costs
  - h. Emergency room costs
  - i. Aging workforce
  - j. Number of retirees receiving benefits
  - k. Workforce health status (incidence of obesity, smoking, etc.)
  - l. Enhanced benefits
  - m. Increased consumption of health care benefits
  - n. Inefficient relationships with health insurance provider
  - o. Federal health care policy (example: Affordable Care Act)
5. To contain costs over the past five years has your government (check all that apply):
  - a. Increased co-payments
  - b. Increased share of premiums
  - c. Increased deductibles
  - d. Increased the cap on out-of-pocket expenses
  - e. Changed the number of available plans
  - f. Required more pre-certification (for hospital and/or outpatient)
  - g. Changed how prescription drugs are administered (requiring prior authorization; clinical intervention; etc.)
  - h. Established a wellness program
  - i. Implemented a smoking cessation program with non-smoker premium discount
  - j. Conducted health care audits
    - i. claims payer
    - ii. hospital bill
    - iii. vendor
    - iv. dependent eligibility
    - v. employee
6. In the last five years, has your local government changed the way health insurance is provided? Check all that apply.
  - a. Used the ACA exchanges
  - b. Switched from fully insured to self-funded
  - c. Switched from self-funded to fully insured
  - d. Shifted employees to high-deductible plans with a health savings account (HSA)
  - e. Shifted retirees to high-deductible plans with HSA
  - f. Shifted retirees to Medicare when they reach 65
  - g. Increased the age at which retiree health benefit is available

- h. Eliminated prescription drug coverage
  - i. Eliminated retiree health benefits
  - j. Eliminated retiree health benefits for dependents
  - k. Used private health insurance exchanges to provide coverage
  - l. Increased requirements (e.g. years to vest) to qualify for retiree health benefits
  - m. Established a Health Reimbursement Arrangement (HRA)
  - n. Eliminated spouse coverage
7. Over the past five years, has your government made changes that affect new hires only? Check all that apply.
- a. Increased years to vest in retiree health care benefit
  - b. Increased the age at which retiree health care is available
  - c. Shifted from defined benefit to defined contribution plan (e.g., health savings plan) for retirees
  - d. Eliminated retiree health benefit
  - e. Eliminated retiree health benefit for dependents
  - f. Eliminated prescription drug coverage
8. Is your government offering or considering the following options:
- a. Wellness program(s)
  - b. Disease management program(s)
  - c. On-site physicians
  - d. On-site clinics
  - e. Reliance on pharmacists for chronic care assistance
  - f. Reliance on nurses and physician assistants for primary care
9. Over the past five years, has your government implemented the following options? Check all that apply.
- a. Regional partnerships (e.g., pharmacy programs)
  - b. Joined a consortium
10. How do you communicate with employees and retirees about their health insurance? Check all that apply.
- a. Handouts
  - b. Website
  - c. Social media
  - d. Phone number
  - e. In-person specialist
  - f. Formal meetings
  - g. Informal meetings
  - h. E-mail

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- 39 Ibid.
- 40 The Asheville Project, [www.theashevilleproject.net](http://www.theashevilleproject.net)
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- 43 Ibid.
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