



ISSUE BRIEF

Health Insurance for Active and Retired City Employees: Asheville, Denver, and Oklahoma City



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Public and private employers face the same challenge: how to control the continuing growth in health care costs? This issue brief takes a close look at three city governments and the strategies they have put in place to address current and future health care costs:

- Wellness programs
- Chronic disease management
- Employee clinics
- Cost shifting to employees
- Plan design changes
- Trust fund

All three cities offer retiree health care benefits and require retirees who are eligible for Medicare to enroll. Two of the three cities pay for retiree health on a pay-as-you-go basis, typical of American local governments. Denver has established a retiree health care trust fund with \$92.7 million in assets, giving it a strong base to fund retiree health care promises in the future.

Two of the most promising strategies to bend the cost curve are chronic disease management and wellness programs. The Asheville Project, established in 1996, matches employees with specific chronic health problems with a local pharmacist. The results are impressive. With more than 400 employees enrolled, the city has lower total health care costs. In addition, employees take fewer sick days and have increased satisfaction with pharmacist services.

To address growing costs, Denver increased premiums, focused on dependent eligibility, and established a wellness incentive program. Participating employees receive a premium discount in exchange for participation in specific wellness activities. Denver hopes its results will mirror what other local governments have experienced—a savings of more than \$3.00 for every \$1.00 in wellness program costs.

With an aging workforce and a growing ratio of retirees to active workers, governments recognize they cannot be complacent about a benefit as important—and costly—as health insurance. These case studies shed light on some of the strategies that show promise.

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A handwritten signature in black ink that reads "Elizabeth K. Kellar".

Elizabeth K. Kellar
President and CEO
Center for State and Local Government Excellence

Health Insurance for Active and Retired City Employees: Asheville, Denver, and Oklahoma City

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Introduction

Virtually all full-time local government workers are eligible to participate in employer-provided health plans, and many local governments also give their employees access to the same health plan in retirement. The rising cost of health care has rapidly increased the total expense of these benefits. This brief reviews recent changes in plans and policy options to help contain expenditures on health insurance.

The provision of health insurance to current and retired local government employees has become a major public policy issue in many cities. The combined forces of an aging public sector workforce, increases in the ratio of retirees to active workers, and the rise of medical expenses continue to drive up the cost of providing health insurance to active and retired local government employees. Increases in the annual cost of health insurance and the substantial growth in the unfunded liabilities associated with retiree health plans are forcing many municipalities to reevaluate their current programs and make fundamental changes to reduce current costs and future liabilities.

This issue brief examines how three municipalities—Asheville, North Carolina; Denver, Colorado; and Oklahoma City, Oklahoma—have responded to the rising annual costs of health care. We analyze the increase in the cost of providing health insurance to active and

retired workers and changes these cities have made to their health plans to slow the rate of growth of the costs of this employee benefit. The cities' plans for specific changes included the adoption of wellness programs and health savings accounts, along with requiring higher premiums, greater deductibles, and increased co-payments.

Background

Most full-time local government employees are covered by employer-provided health insurance. Typically, employees pay a small portion of the total premium for their own coverage and a larger percent of the total cost for spousal and dependent coverage. In addition to health insurance coverage while actively employed, most of these public employees also have the ability to continue their health insurance coverage in retirement. The premiums for retiree coverage are normally based on a combined pool of workers and retirees, which means the cost to the employer of offering retiree coverage is understated by the premium.

Until recently, the liabilities associated with extending subsidized access to a city health plan to retirees were not well understood or clearly quantified. Premiums are usually calculated using a common risk pool for spouses of both active and non-Medicare eligible spouses.¹ This risk pooling can lead to adverse selection of higher cost retirees and spouses into the plans and result in those retirees paying a lower premium than the true cost of this coverage for themselves and their spouses and dependents. This implicit subsidy is because active workers and their dependents are younger than retirees and tend to have lower health care costs.

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Many cities have modified their plan designs or established wellness programs in attempts to curb the growing health insurance costs. This brief

- considers the history and current status of health insurance plans for public employees and retirees in Asheville, Denver, and Oklahoma City;
- explores the actual and projected costs of health insurance;
- examines the policy implications of these costs and what changes these cities have made in response to rising costs;
- considers how these examples might inform the debate in other municipalities.

Asheville, NC

Asheville provides its active and retired employees the opportunity to enroll in a city health plan. As of December 31, 2009, there were 239 retirees and dependents receiving health benefits through the city, as well as 668 active general employees and 446 active law enforcement/fire officials.

In 2011, workers have the option of selecting from three health plans.

- The Standard Plan carries a high deductible of \$1,500 for an individual and 70/30 co-insurance for in network visits and procedures.
- The High Plan, an in network-only plan, has a low deductible of \$300 and a \$20 co-payment for medical services.
- The Premium Plan is a PPO and has a \$20 co-payment and a \$500 deductible for an individual.²

Employee premiums vary depending on the choice of plan; see Table 1 (p. 7) for plan characteristics for individual and family coverage. The total city contribution to the health plan for its employees in FY 2010–11 was budgeted at \$3.6 million. This was an \$812,074, or 30 percent, increase from the prior fiscal year budget (Fiscal Year 2010–2011 Adopted Budget).

Asheville offers a walk-in clinic for all city employees. The Health Services Office operates Monday through Friday and has registered nurses available to evaluate any health-related issue at no charge to the employee. With a \$5 co-payment, an employee may make an appointment with a physician on Tuesdays and Thursdays. The office averages 600 employee visits per month. The cost of this program is budgeted at \$230,131 for FY 2010–11, a decrease of \$46,692, or 16.9 percent, from the prior fiscal year. There are 2.13 full-time employees in the Health Services office (Fiscal Year 2010–2011 Adopted Budget).

In addition to the Health Services Office, Asheville offers another unique program to its employees. The Asheville Project was launched in 1996 to provide education and oversight to employees with specific chronic health problems, such as diabetes, asthma, hypertension, and high cholesterol. Patients are matched with a local pharmacist to ensure they are using their medications properly. This initiative is a purely voluntary program that has led to lower total health care costs, fewer sick days, and increased satisfaction with pharmacist services. As of March 1, 2008, approximately 400 city employees were participating in the project.

Health Insurance for Retired City Employees

Asheville administers a single employer defined health care benefits (HCB) plan for its retired employees. Any city employee with at least five years of service is eligible to receive a benefit if s/he qualifies for retirement benefits from the North Carolina Local Governmental Employees Retirement System (LGERS), as long as s/he does not have any other insurance available. These benefits include health care, prescription drugs, and vision benefits.

The city pays 100 percent of the Standard Plan retiree premium for retirees up to age 65 if hired prior to December 31, 2006. Employees hired after 2006 are eligible for the same benefit if they have worked for the city for at least 25 years. As long as they have worked for at least five years, a portion of their premium is covered. After age 65, retirees electing to remain on the plan must pay the full cost. Spouses and dependents are eligible to participate in the plan, but the retiree is responsible for the full cost of dependent coverage (CAFR 2010).

As of December 31, 2009, the actuarial accrued liability (AAL) for health care benefits was \$33.8 million. Asheville financed this plan using a pay-as-you-go method and has not established a trust fund for the program. Thus, the unfunded actuarial accrued liabilities (UAAL) of the plan were also \$33.8 million. The covered payroll was \$50.2 million, so the ratio of the UAAL to covered payroll was 67.5 percent (see Table 2). The actuarial assumption used to calculate the UAAL included a 4 percent discount rate to determine the present value of the future cost of retiree health insurance, and an annual medical cost trend increase of 10.5 percent initially declining one point per year to 5 percent by 2017. This includes a 3.75 percent inflation assumption (CAFR 2010). These assumptions are similar to those of other cities.

Policy Changes and Cost Shifting

For the fiscal year 2010-2011, the benefits for city employees are budgeted to be \$21,109,968. This is a \$2.5 million or 13.8 percent increase over the prior year. The annual increase in expenditures is driven by two factors:

- The state of North Carolina retirement system mandated that local governments increase the per employee amount they contribute to the retirement system; and
- continued inflation in health care costs.

To slow the increase in expenses, Asheville has made changes to its health care program. Beginning July 1, 2010, the city increased employee premiums by five percent. The coinsurance and deductibles were increased, also to lower costs. Even with these changes, the city's burden was projected to increase by \$1.7 million (20.5 percent) for FY 2010–11 (Fiscal Year 2010–11 Adopted Budget).

These changes in plan design were projected to save close to \$1 million. However, cost increases for the health care program were still estimated to be three to four percent. Despite the changes, costs are trending about six percent higher than the prior year according to the Quarterly Financial Report of the First Quarter of the 2010–2011 Fiscal Year.

Denver, CO

In 2011, Denver offers its employees the option of enrolling in one of four health plans. Three of the plans are HMOs and one is a high deductible plan. All three HMOs have no deductibles.

- The first HMO offers a \$35 co-payment for most services³ and also offers some unique programs, including up-to-date information on nutrition, physical fitness, and mental wellness; an exclusive clinic (Level One Physicians Clinic) that provides primary care; and discounts on various weight loss and education programs.
- The second HMO carries a \$30 co-payment for most services⁴ and offers a Total Health Assessment that gives members a personalized plan to help them attain a healthier lifestyle.
- The third HMO plan has a \$35 co-payment for insurance.⁵
- The PPO plan is a high deductible health plan⁶ with an in network deductible of \$2,000 and out of network deductible of \$5,000. After the deductible is met, the coinsurance is 80/20 for in network and 60/40 for out of network (see Table 1, pg. 7).

The city pays 85 percent of the premium for each plan. The first HMO costs the employee \$35.93 per pay period; the second HMO, \$32.68; the third HMO, \$31.26; and the PPO plan, \$49.47 (2011 Benefits Guide).

Health Insurance for Retired Public Employees

Retired city employees are eligible for health benefits as long as the employee has five years of credited service prior to reaching retirement age. Retirees younger than age 65 are eligible to enroll in the same plans as current employees. The Denver Employees Retirement Plan contributes a portion of the monthly premium based on years of service—\$12.50 for each year of service when the retiree is younger than age 65—with the remainder of the premium being the responsibility of the retiree.

After turning age 65, employees are allowed to enroll in a Medicare supplement plan. There are three choices of plans: two HMOs and one PPO. None of the plans have a deductible and all have a co-pay of \$15 for general services and varying co-pays for specialists. The first HMO carries a premium of \$183.00⁷; the second, \$188.74.⁸ The PPO (Humana Medicare Advantage PPO) carries a premium of \$254.00.⁹ The Plan contributes \$6.50 for each year of service when the retiree is age 65 or older (2011 Denver Employees Retirement Plans).

Denver has established a trust fund for its retiree health plan. In 2009, the fund had assets of \$92.7 million and actuarially accrued liabilities (AAL) of \$134.0 million. Thus, the total unfunded actuarial accrued liabilities (UAAL) for retiree health benefits in 2009 were \$41.3 million. The UAAL as a percent of covered payroll was 7.3 percent (see Table 2, pg. 8). This was up slightly from prior years, especially compared to that seen in other state and local government plans. In 2007, this figure was 6.8 percent, while in 2008 UAAL was only 5.9 percent of payroll (CAFR 2009). Before 2010, the city was not in compliance with the terms of GASB 45 because it did not disclose information about the implicit rate subsidy on retirees' post employment health benefits.¹⁰ The 2010 CAFR is in compliance; in 2010, the fund had assets of \$90.42 million and an AAL of \$141.64 million, leaving \$51.23 million in UAAL. The UAAL as a percent of covered payroll in 2010 was 10.1% up from the prior 7.3% (CAFR 2010).¹¹

Policy Changes and Cost Shifting

Denver is still offering a wide variety of plans, but there is an increase in premiums and some co-payments for 2011. The city also took two steps to keep costs down. The first is to start a Dependent Eligibility Program. The city estimates that coverage on ineligible dependents

costs close to \$3 million each year, according to the 2011 Benefits Guide. Employees will be required to submit documentation proving a dependent's eligibility for care.

The second step the city is taking is to continue the development of the DenverWellness Premium Discount Program, which encourages employees to complete a series of wellness-related tasks aimed at improving their lifestyles. According to the 2011 Benefits Guide, the city believes that one of the main reasons for increased medical costs is the treatment of illnesses that can be directly attributed to unhealthy lifestyles (e.g., diabetes, high blood pressure, back pain). It is hoped that this program will help bring down premiums by reducing medical claims. As an incentive, employees who completed the program in 2010 receive \$12 per month off their premiums in 2011.

Oklahoma City, OK

Oklahoma City offers a choice of two health plans for city employees. The first is a PPO called the Group Indemnity Plan.¹² The plan has an in network deductible of \$200 and 90/10 coinsurance. The out of network deductible is \$300 and carries 70/30 coinsurance. The other option is PacifiCare HMO of Oklahoma.¹³ This plan does not have a deductible and has a \$10 co-payment (see Table 1, pg. 8). The Group Indemnity Plan costs employees \$61.02 (20 percent of premium) per pay period while the PacifiCare HMO of Oklahoma costs \$39.20 (15 percent of premium) per pay period. The city pays the remainder of the premium (Employee Benefits Handbook). As of February 28, 2010, the city's annual cost per plan member was \$8,566, which is approximately 73.9 percent of the national average (Fiscal Year 2010–11 Annual Budget).

Oklahoma City operates a clinic that performs many services for employees. These include physical exams required before an individual begins employment with the city, police/fire health assessments, and vaccinations. The clinic is currently operating under a hiring freeze, but is still meeting all goals, including performing job-offer exams within two days of hiring (Five Year Forecast). The FY 2010–11 budget for the clinic is \$310,185, which is 0.2 percent higher than the prior year (FY 2010–11 Adopted Budget).

Health Insurance for Retired City Employees

The city offers three plans for retired employees. These include the two available to current employees, as well as a separate plan for employees on Medicare Parts A and B, called Secure Horizons. The retiree is responsible for 34 percent of the premium and the city pays

the rest (Retiree Benefits Guide). As part of an effort to reduce costs, Oklahoma City is paying a smaller percentage of the premium than it did in prior years. In 2009, Oklahoma City paid 70 percent of premiums; in 2010, it paid 68 percent. City employees are eligible for health benefits if they retire from the city at or after age 55 with five years of service, or at any age after 25 years of service (CAFR 2010).

Currently, the city is operating the benefits as a pay-as-you-go program. For the 2010 fiscal year, there were 3,188 active employees and 2,337 retirees and beneficiaries receiving benefits. The UAAL was \$471.6 million. The UAAL as a percentage of covered payroll was 267 percent (see Table 3, pg. 9). These calculations used a 4 percent investment rate of return and a health care trend rate of 4.5 percent (CAFR 2010).

Oklahoma City's AALs fluctuate substantially over the three years, 2008–2010, presented in Table 2 (pg. 8). The AALs increase greatly from 2008 to 2009 and then drop back down in 2010. These changes are not addressed explicitly in the GASB 45 or the CAFR. Most of the increase in accrued liabilities from 2008 to 2009 is due to the assumed discount rate being lowered from 7 percent to 4.5 percent.¹⁴ An assumption for 2010 that could explain some of the decrease in AAL (and UAAL) is that retirees' contribution to health care premiums will increase 2 percent per year for the next 10 years.

Policy Changes and Cost Shifting

For the past five years, employee benefits as a percentage of salary and wage expenses have hovered around 30 percent. Even with the continuing growth in health care costs, Oklahoma City has been able to maintain lower costs through a number of initiatives, which include higher co-payments, additional premium sharing, and other benefit changes (Fiscal Year 2010–11 Annual Budget).

According to the Five Year Plan for Oklahoma City, the city is planning to build a new clinic and replace some older equipment to lower the costs of the clinic in the long run. (The city currently leases space and believes that owning its own space will cut costs.) The city also hopes to hire an additional physician's assistant for the clinic and believes having a new facility will help attract good candidates.

Discussion and Conclusion

The cost of providing health insurance for employees and retired public workers continues to increase rapidly. All three of the cities discussed in this issue brief

have addressed these increasing costs by using various means such as increasing employee premiums, creating wellness programs, and increasing deductibles and co-payments.

In the majority of cities, the expectation is that the unfunded liabilities associated with the provision of retiree health insurance will continue to increase in coming years due to the lack of payment of the ARC and medical care cost trends used in the projections. Of course, if health care cost growth does not decline as some argue, future UAALs will be much higher.¹⁵

The primary determinant of the rising cost of providing health insurance to public employees is the rising cost of health care itself. This problem is not unique to any individual city and reflects the general growth in medical care spending in the United States. Many employers, both public and private, have recently instituted wellness programs that can take many forms

but often include annual physical exams or health assessments, individual counseling, seminars, weight loss and exercise programs, and smoking cessation programs. Baicker et al (2010) conclude that each dollar spent on wellness programs reduced medical costs by \$3.27.¹⁶ Adopting plans, such as consumer-driven health plans, which give employees a closer look at the true cost of health care, also help moderate medical care consumption.

Besides creating wellness programs and reducing the medical care expenditures of plan participants, the other main policy instrument available to any employer to reduce costs is cost shifting. An employer can shift a larger share of the cost of health insurance to employees and retirees, which ideally this would lead to a reduction in individuals' demand for health care services without resulting in a loss of overall population health.

Table 1. Health Plan for City Employees

Asheville, NC			
Costs	Standard (high deductible)	High (in network only)	Premium (preferred provider)
Premium (bi-weekly)			
Employee	\$3.15	\$11.55	\$16.80
Spouse	\$65.10	\$78.75	\$88.20
Deductible			
In network	\$1,500 indiv./\$4,500 family	\$300 indiv./\$900 family	\$500 indiv./\$1,000 family
Out of network	\$3,000 indiv./\$6,000 family	N/A	\$1,000 indiv./\$3,000 family
Co-pay/coinsurance			
In network primary	70% after deductible	\$20 co-pay	\$20 co-pay
In network specialist	70% after deductible	\$35 co-pay	\$40 co-pay
Out of network	50% after deductible	N/A	60% after deductible

Denver, CO				
Costs	United Healthcare Choice (HMO/EPO)	United Healthcare Choice Plus (high deductible)	Denver Health Medical Plan (HMO)	Kaiser Permanente (HMO)
Premium (bi-weekly)				
Employee	\$49.47	\$31.26	\$35.93	\$32.68
Spouse	\$113.50	\$71.62	\$75.72	\$74.89
Deductible				
In network	N/A	\$2,000 indiv./\$4,00 family	N/A	N/A
Out of network	N/A	\$5,000 indiv./\$10,000 family	N/A	N/A
Co-pay/coinsurance				
In network primary	\$35 co-pay	80% after deductible	\$35 co-pay	\$30 co-pay
In network specialist	\$60 co-pay	80% after deductible	\$50 co-pay	\$50 co-pay
Out of network	N/A	60% after deductible	N/A	N/A

continued

Oklahoma City, OK		
Costs	Group Indemnity Plan (PPO)	PacifiCare of Oklahoma (HMO)
Premium (bi-weekly)		
Employee	\$61.02	\$39.20
Spouse	\$54.18	\$49.01
Deductible		
In network	\$200 indiv./\$400 family	N/A
Out of network	\$300 indiv./\$900 family	N/A
Co-pay/coinsurance		
In network primary	\$5 co-pay + 90% after deductible	\$50 co-pay
In network specialist	\$5 co-pay + 90% after deductible	\$50 co-pay
Out of network	\$5 co-pay + 70% after deductible	N/A

Table 2. Actuarial Evaluation of Retiree Health Plans (in millions of dollars)

Asheville, NC			
Variable	2008	2009	2010
AAL	0	31.09	33.95
Assets	0	0	0
UAAL	0	31.09	33.85
UAAL/Payroll (percent)		80	67.5
ARC	0	2.84	3
Percent contributed		42.95	52.91

*Variables are for fiscal year ending June 30.

**Prior to 2009, the city did not contribute to retirees' health care costs. They could remain enrolled in the program, but had to pay the full premium.

Source: City of Asheville Comprehensive Annual Financial Report 2008, 2009, 2010

Denver, CO			
Variable	2008	2009	2010
AAL	128.61	134.00	141.64
Assets	96.46	92.68	90.42
UAAL	32.15	41.32	51.23
UAAL/Payroll (percent)	5.9	7.3	10.1
ARC	4.53	5.16	4.29
Percent contributed	93.9	88.3	68.2

*Variables are for fiscal year ending June 30.

Source: City of Denver Comprehensive Annual Financial Report 2008, 2009, 2010

Oklahoma City, OK			
Variable	2008	2009	2010
AAL	369.2	635.13	479.81
Assets	0	5.00	8.25
UAAL	369.2	630.13	471.55
UAAL/Payroll (percent)	185.8	367.6	276.1
ARC	29.15	47.83	35.61
Percent contributed	61.9	39.1	54.5

*Variables are for fiscal year ending June 30.

Source: Oklahoma City Comprehensive Annual Financial Report 2008, 2009, 2010

Table 3. *City Statistics, December 31, 2009*

	Asheville	Denver	Oklahoma City**
Total full-time employees	1,066	9,895	5,052
Population	79,973	610,345	560,000
City budget*	\$92,688,293	\$868,221,000	\$550,765,000
Covered payroll	\$50,164,033	\$564,987,000	\$176,563,546

*City's adopted General Fund Budget for FY 2010

**Oklahoma City's estimates are as of July 1, 2010

Sources: CAFR 2010 and CAFR 2009 Asheville; CAFR 2009 Denver; CAFR 2010 and CAFR 2009 Oklahoma City

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Endnotes

- 1 Cities usually require Medicare-eligible retirees and their spouses to enroll in Medicare; because Medicare becomes the primary payer, the cost of health insurance for these retirees is much lower than for younger retirees. As such, the premium for Medicare-eligible retirees is lower for both the retiree and the city.
- 2 The city of Asheville is self-insured. All city plans are insured through CoreSource.
- 3 The first HMO is the Denver Health Medical Plan (DHMP) and is administered by the Denver Health Medical Plan, Inc.
- 4 This plan is administered by Kaiser Permanente.
- 5 This plan is administered by United HealthCare.
- 6 This plan is administered by United HealthCare.
- 7 The first retiree HMO is the Humana Medicare Advantage HMO.
- 8 The second retiree HMO is the Kaiser Permanente Senior Advantage HMO.
- 9 The retiree PPO is the Humana Medicare Advantage PPO.
- 10 This information was provided by Kelli Bennett, CPA, in an email sent to Stephanie Riche on April 6, 2011.
- 11 All information for Denver is for both city and county employees. The 2010 CAFR is not yet available online.
- 12 The Group Indemnity Plan is administered by BlueCross and BlueShield of Oklahoma.
- 13 The PacifiCare HMO of Oklahoma is administered by United HealthCare.
- 14 In the projections by the actuaries, a lower discount rate increases the present value of expected payments for health insurance in the future.
- 15 Chernen et al. (2009) argue that spending on health care is not likely to continue to grow at the current high rate, since this would in turn allow for little growth in non-health care spending.
- 16 Baicker et al (2010) also find significant cost saving to employers from wellness programs due to reduced absenteeism.



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