City of Knoxville Risk Manager Creates a Culture of Personal Responsibility in a Health Plan

GARY EASTES NAMED 2012 PUBLIC RISK MANAGER OF THE YEAR

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Knoxville Member is PRIMA’s 2012 Public Risk Manager of the Year

GARY EASTES RECEIVES PRIMA’S TOP HONOR

By Jennifer Ackerman, CAE

When Gary Eastes came to the City of Knoxville in 2003, the entity boasted an annual workers’ compensation cost of $5.3 million per year. This amount had risen steadily over the previous three years. Liability costs for the city had also reached an all-time high.

As the city’s new risk and benefits manager, Eastes was tasked with lowering workers’ compensation costs as well as the health care costs of the city’s employees. Eastes seized this opportunity to make substantive changes to his entity’s program by creating a new way of managing rising health care costs.

Eastes’ hard work and research helped the City of Knoxville break out of the status quo of managed health care HMOs and create a new way for employees to take responsibility for their health. Eastes’ My Health plan allows city employees and their families to earn rewards for taking a pro-active approach to their health. Employees and their families also have the added benefit of access to an on-site health clinic, where they can receive well care as well as participate in programs aimed at improving their health and wellness.

Eastes’ innovative approach has earned him the Public Risk Management Association’s 2012 Public Risk Manager of the Year award.

Eastes was chosen as this year’s Public Risk Manager of the Year by a panel of his peers.

“Gary’s commitment to the health and safety of his entity and his peers made him a standout candidate in a very competitive field this year,” said Marshall Davies, PhD, PRIMA executive director. “His programs have made a difference to the City of Knoxville and its employees, even going so far as to save lives.”

Eastes was chosen for his notable accomplishments, which include:

- Reducing the city’s per-employee medical costs to 26 percent below the national average.
- Lowering workers’ compensation costs from more than $5 million annually in 2004 to $2 million in 2010.
- Cutting the number of total injury cost days in half between 2004 and 2010.

The Public Risk Manager of the Year award was established by PRIMA in 1994 to honor a risk manager who has effectively coordinated and managed a risk management program for a public entity facing out-of-the-ordinary challenges.
By Gary Eastes and Christine Stickler

From 2001 through 2005 the City of Knoxville’s medical insurance cost rose 141 percent. In 2004, the city elected a mayor from the private sector, who brought a finance director charged with stabilizing the city’s finances. The mayor’s management style, which focused on seeking consensus, helped develop an atmosphere of cooperation among the city council. Fortunately, these things combined to make the timing right for beginning significant change in the city’s health program.

In the 1980s, the city had been self-insured for medical insurance. The lack of adequate reserves combined with unpredictable leaps in claim costs in the 1990s forced the city into a state-operated medical insurance pool. The 141 percent increase had occurred while part of the insurance pool.

The average city employee was four years older than the typical Tennessee employer, and like many cities, the employee population was heavily weighted with males over 40 in high-risk occupations. The city’s medical claims per member were 28.3 percent above the average Tennessee employer. Prevalence of chronic disease among health plan members was also 40 percent above the norm for employers in Tennessee.

The city had operated an on-site medical clinic for many years. It was staffed by two registered nurses and a receptionist, who were city employees. There was also a contracted part-time physician. The senior RN had been allowed to run the clinic with almost total independence. While the quality of the services was widely regarded as poor, employees had developed a sense of entitlement to the free services, and too many employees relied on the clinic as their only medical care.

The city recognized two aspects of personal responsibility that needed to be reinforced as part of its health plan: (1) personal responsibility for managing one’s own health, and (2) personal responsibility as a purchaser of medical services. The status quo made it obvious that a majority of employees would not voluntarily accept personal responsibility; the plan design would need to motivate them to do so. At the same time the city had to consider two factors in designing a health plan to motivate employees to assume personal responsibility: the fact that many city employees are low income and using cost shifting as the primary tool to force personal responsibility on employees was not reasonable; and the political reality that city employees have a level of influence with city council members and citizens so there needed to be buy-in from a significant percentage of employees before a plan could be implemented. These factors were not considered negatives. Rather, they increased the importance of making changes in measured steps and creating buy-in along the way. The timing of changes was important; so was a consistent and persistent message about the importance of employee health and personal responsibility.

**PHASE I**

**2004:** Management pressure to improve the quality of services resulted in the resignation of the contracted physician and retirement of the senior RN at the on-site clinic. This created the right atmosphere for the city to issue a request for proposals for providing medical services, which resulted in the city contracting with a local physician group. The more traditional services (annual medical exams for uniformed employees and treatment of work-related injuries) were to be provided at the group’s existing offices. Quality requirements were built into the contract. Annual exams for uniformed employees were extensive, including not only occupational tests, but preventive health testing, such as lipids, PSAs and thyroid tests. The contract also provided for a full-time, on-site RN to provide health screenings for non-uniformed employees, which included the same lab work the uniformed employees received. An RN rotated between offices at each of the three largest city facilities as well as several other employee locations to be as accessible as possible. The on-site medical facility itself
A vision of health “needs to be perceived as a priority business asset and has to be recognized as having a big and important impact on the ultimate success of the enterprise. It has to be viewed as critical to the strategy of the organization.”

Dr. Catherine Baase, Global Director of Health, Dow Chemical Company

was closed, due to the contracted physician group being unwilling to operate it. While this created some controversy, the improved quality of services was obvious. No additional funding was required.

2005: The city began providing cash incentives for employees to participate in regular physical activity, to be tobacco free and for participating in an on-site disease management program if they had one of five chronic diseases. The disease management program consisted of submitting monthly logs dependent on the specific disease (glucose, weight, blood pressure, pulmonary function) that were reviewed by the RN. Participating in the annual health screening was required to receive any of the incentives. This was possible because the mayor and finance director bought into the belief that these incentive programs would result in long-term savings. Approximately 35 percent of employees participated in the first year.

PHASE II

2006: The city left the state-operated insurance pool in order to give the city more flexibility to design programs to improve employee health, and allow the city to receive the financial benefits from improved employee health. The HMO, which had been the most popular health plan in the state pool, was no longer offered. Instead, only a PPO was offered with either a $300 or $1,000 deductible. HMOs were based on the premise that a personal physician/gate-keeper would keep patients healthier. The reality was that the traditional medical system has done an outstanding job of extending lives even as the prominence of chronic disease has exploded, but it has been a failure at preventing chronic disease because physicians are neither trained nor paid to prevent chronic disease, but only to treat it. The intent of personal responsibility is to place responsibility for individual health on the individual and not encourage the individual to rely on a personal physician to keep them healthy.

Employees could also choose between a broad and a limited provider network. The range in premiums created by these choices was significant, and emphasis was placed on employees having choices to manage their costs. Spouses were included in the incentive programs, and incentives were provided as Health Reimbursement Account (HRA) contributions rather than cash, in order to provide tax advantages and keep the focus on making responsible choices. An additional incentive/compassionate contribution was added for lower-income employees who participated in the annual health screening. The city also removed disease management from the medical insurance administration contract, believing the telephonic service was ineffective; and declared the on-site disease management program was the disease management program for the health plan.

2007: The city issued a new request for proposals for medical services. We contracted with a much larger physician group (Summit Medical Group, with approximately 200 physicians) to reopen the on-site medical facility (now called the Health, Education and Wellness Center—The Center) and provide all the contracted medical services on-site. Obesity and hyper-lipid were added to the disease management program. The contract provided incentives to Summit Medical Group for increasing participation in the incentive programs and for lowering average A1C scores for those in disease management. These incentives were renegotiated each year to ensure they remained effective. Treatment for acute illness/injury was provided to employees at The Center, but a minor co-pay was charged and employees were required to phone for appointments (usually same day). Allowing walk-ins and free acute care would make it impossible for The Center to be efficient in providing the range of expected services.

2008: The city added over-the-counter and step-therapy programs to the pharmacy benefit program. The city also added what became one of the most clearly successful
components of the health plan. Prescriptions for Oxycontin beyond 60 days had to be pre-authorized. With concern about abuse of narcotics, the city became aware that many scripts for Oxycontin were being written by physicians who were not allowed in the PPO network because of their practice patterns. The first requirement for pre-authorization beyond 60 days was that the prescribing physician had to be a network physician. Medical necessity was also a criteria, with cancer diagnosis being automatically approved. The pharmacist for the insurer advised against the requirement, arguing the insurer and the city would receive substantial criticism from physicians and employees. However, only one complaint was recorded during the first year, from an anonymous employee who argued his pain specialist was more qualified than the physicians who were in the network.

2009: The city added hypertension to the disease management program, reduced copays for chronic disease medications for those in disease management and changed the disease management program from submitting logs to participating in face-to-face health coaching. A second full-time RN was added to help provide the coaching.

2010: A new contract was negotiated with Summit Medical Group, which significantly expanded the staffing and the occupational services. Health coaches now included a nutritionist/certified diabetic educator and a fitness trainer/physical therapy assistant. The city expanded the Oxycontin preauthorization to all schedule 2 narcotics. The insurer’s pharmacist had been highly complimentary of how effective the program had been for Oxycontin and the absence of controversy. But she advised against expanding the program, arguing that while there had not been criticism previously, there would be when it was expanded. Again the controversy did not occur, and input from some physicians indicated they appreciated having an additional tool for declining to write such prescriptions. Acute care was expanded to covered retirees and dependents. The additional staffing and services resulted in no additional budgeting due to the reduced expenses of purchasing services from disparate vendors.

PHASE III

2011: The focus now was on simplifying the program, which had allowed employees and spouses to separately choose among the incentive programs they preferred and had become very time intensive to administer. The complexity of incentives and requirements was discouraging participation. Additionally, under the smorgasbord incentive program, the more chronic diseases an employee and their spouse had, the more rewards they were eligible to earn due to the disease management incentive. Some employees saw this as appropriate because managing those diseases held down everyone’s premiums, but some saw it as unfair or illogical. Rather than medical insurance and incentives being kept as separate components of the health plan, going forward employees were given the choice of choosing either:

- My Health, a health/insurance plan including all incentive programs and wellness requirements, or
- Medical Only, an insurance plan that includes no incentive programs or wellness requirements, (but does include a pharmacy benefit).
Logically, "paying people cash incentives to lose weight, quit smoking, lower their blood pressure or engage in other healthy behaviors should work. But it doesn't. Or at least, not in the long run."

Linda K. Riddell, Health Economy, LLC

Employees in My Health receive lower premiums as well as contributions to an HRA account. They also receive lower co-pays for chronic disease medications and free chronic disease monitors and diabetic supplies.

My Health is all or none. You must comply with all requirements and you receive all the rewards. Not only the employee, but spouses and children covered by the insurance must participate as well. This keeps some employees who want to participate from doing so, because their spouse refuses, but it was impractical to allow employees and their dependents to choose different health plans.

<table>
<thead>
<tr>
<th>If you:</th>
<th>You receive in HRA dollars:</th>
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<tbody>
<tr>
<td>Are in the My Health Plan</td>
<td>$32/month or $384/year (employee only) $64/month or $768/year (employee + one or more dependents)²</td>
</tr>
<tr>
<td>Additionally, if you:</td>
<td></td>
</tr>
<tr>
<td>Earn less than $30,805</td>
<td>$150/year</td>
</tr>
<tr>
<td>Earn $30,805–$41,455</td>
<td>$75/year</td>
</tr>
<tr>
<td>Or your covered dependent participates in the City's prenatal program (must enroll by 10th week of pregnancy)</td>
<td>$200 upon delivery of baby</td>
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Many employees have concluded that carrots alone are not broadly effective. In one study, it was found that professional golfers took entirely different approaches to a putt for birdie than the same putt for bogie. The effect on the golfers' score is the same for either putt, but the golfers played the birdie puts more cautiously, because gaining a stroke on par (instant reward) was not mentally viewed as important as avoiding losing a stroke on par (instant punishment). Earning rewards is not as important to the human psyche as avoiding punishment. While reduced premiums can be communicated as earning a reward, in employees' perception paying more in premiums not to be in My Health is a punishment to avoid. The result was a higher participation (more than 75 percent) in the first year of My Health than anticipated. Cash incentives simply did not have as much impact as the differentiation in premiums, though My Health has both. Using increased premiums allowed communicating reward but with the impact of punishment.

There are many compromises and differences of opinion in the design of incentives and requirements. The physical activity requirement is almost completely honor system; participants submit an online affidavit each month stating they have met the requirements. There is a concern about...
dishonesty; plus the physical activity requirement is low—only one hour per week. But it is our experience that those who are not willing to participate in even a low physical activity requirement also will not take the time to fill out an online affidavit. Those who do are also meeting requirements that are measurable, making it less likely they are being dishonest. The reason the physical activity requirement is low is that we do not want to focus on increasing activity levels of those who are already active, but to get those who are not active at all to some level of activity. Once they begin, most will increase the level on their own. It is important to determine the target employees you want to reach and have a goal for that target group that is realistic. You can have more individual impact on a small target group, or less individual impact on a larger group. We have focused on a larger group with the expectation that as time goes by, we can gradually raise the expectations/requirements.

BOTTOM LINE

While the disease burden of those who participate in My Health and those who choose Medical Only are almost identical, the medical claims per employee for those in Medical Only are 55 percent higher than the claims per employee in My Health. Absenteeism is significantly less for My Health participants, with a projected savings of $78,000 per year in reduced sick leave use. Surveys of participants indicated improved productivity with My Health participants. Biometric measures show improvement in My Health members in cholesterol and A1C, and significantly better compliance regarding gaps in care. My Health members have significantly reduced emergency room visits and claims costs for chronic disease.

In 2008, the city's per-employee medical costs were 14 percent below Mercer's average for large employers. The difference has increased each year, and in 2011, the city's per-employee costs were 26 percent below Mercer's average.

By comparison with other employers, the city’s health plan is clearly a success. But being realistic, we are far from being able to claim success. Though we have numerous success stories of employees losing weight, even over 200 pounds, we have not measurably reduced the average employee BMI. The increase in diagnosis of diabetes is frightening. We continue to have a high-risk employee base, and do not expect that to change. There is evidence that we have had an impact in changing the culture, but not nearly enough. We are also warily watching an increase in claims trend, knowing bad periods are inevitable no matter how good your program may be.

The bottom line is we have to continue to improve the health and well-being of our employees. It can only occur by continuing to take timely steps to increase the level of personal responsibility in our health plan.

Gary Eaton is the risk and benefits manager for the City of Knoxville. Tran, Christine Stickler is the benefits coordinator for the City of Knoxville, Tenn.