Performance Audit of Human Resources, Benefits Division-Health Care Trust Fund
Audit No. 23-02
May 16, 2023

Report Highlights	Page(s)
• Health Care Trust Fund has a deficit of $13.6M	5
• The city's Accounting Division report and consulting report give different assessments of the Health Care Trust Fund	5
• City Council is not receiving annual reports	12

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May 16, 2023

Councilman James Green
Chairman, Shreveport City Council

Dear Councilman Green:

Subject: Audit No. 23-02 – Audit of The Department of Human Resources–Benefits Division-Health Care Trust Fund

Attached please find the report mentioned above. Management comments are included in the report.

Sincerely,

Leanis L. Steward

Leanis L. Steward, CPA, CIA
City Internal Auditor

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EXECUTIVE SUMMARY
PERFORMANCE AUDIT OF
THE DEPARTMENT OF HUMAN RESOURCES, BENEFITS DIVISION-HEALTH CARE TRUST FUND

Why We Did This Audit

We have completed an audit of the Department of Human Resources–Benefits Division-Health Care Trust Fund. This audit was conducted as one of our regularly scheduled audits included in the Annual Audit Plan developed by the City Internal Auditor. Our objectives were to assess the financial position and sustainability of the healthcare plan and assess whether plan administration complies with applicable City Ordinances and other laws and regulations.

What We Recommended:

- Develop and implement well-documented procedures for assessing the plan's financial position
- Explore opportunities for cost-savings
- Review Retiree Data on a monthly Basis
- Provide Annual Reports to the City Council
- Create policies and procedures for the Benefits Office and update Ordinance

What We Found

To cover medical and dental care claims for active employees, retirees and dependents, the City maintains a self-insurance program and self-funds it through employer, active, and retiree contributions. The City records the program's expenses in the Employees' Health Care Trust Fund. The Health Care Board governs the benefits, employee contributions, and employer contributions, which can be changed annually by the board.

We have identified the following areas that need improvement:

- The Health Care Trust Fund has a deficit of 13.6M as of 2021
- The retiree data needs to be reviewed on a monthly basis
- There are no annual reports provided to the City Council
- There are no policies and procedures maintained for the Benefits Office

Auditors Note: *During the audit, the Benefits Office has moved from the Finance Department to the Human Resource Department.*

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Introduction

The Healthcare Board of Trustees (**Board**) oversees the planning, designing, and administering of the City of Shreveport's self-insured pay-as-you-go benefits plan, which is supported through the Employee Healthcare Trust Fund **(HCTF)**. The Board delegates the operational responsibility of the plan to the Human Resources Department Benefits Division **(Benefits)**, who manages participant benefits eligibility verification, enrollment, and termination. The Benefits Division also updates and maintains participant coverage records. The City has also contracted with a benefits consultant **(Consultant)** to provide benefits management consulting services. Medical, dental, and vision insurance are offered to all full-time employees (working 30 or more hours per week) and retirees during open enrollment each year.

This audit will focus on the HCTF activities from 2017 to 2021. This report contains four findings with five recommendations. Appendix A contains the risk descriptions for the recommendation risk levels throughout the report.

Chart 1 reflects the estimated percentage of each group of participants as of December 31, 2021.

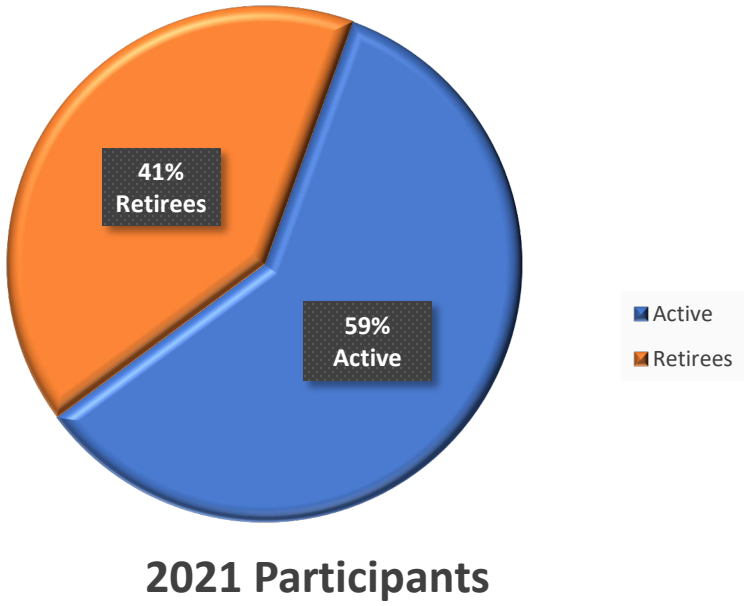


Chart 1

The objectives of this audit were to:

- Assess the financial position and sustainability of the healthcare plan.
- Assess whether plan administration complies with applicable City Ordinances and other laws and regulations.

Scope and Methodology

The scope of this audit includes Board oversight of the HCTF activities and Benefits healthcare plan management for active employees and retirees. The period reviewed was January 2017 – December 2021. To answer our objectives, we reviewed relevant internal controls and developed audit procedures that included, but were not limited to, the following:

- Interviewing Benefits staff to enhance understanding of the process.
- Observing Board meetings
- Reviewing City Ordinances and regulations
- Reviewing and performing analyses of healthcare plan and healthcare fund census and financial data and any other applicable documentation

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings, conclusions, and recommendations based on our audit objectives.

The Internal Audit Office expresses appreciation to the management and personnel of the Human Resource Department, Benefits Division for their cooperation and assistance provided during the audit.

Objective: Assess the financial position and sustainability of the healthcare plan.

Finding 1: The Healthcare Trust Fund has a deficit

A deficit in the Healthcare Trust Fund (HCTF) may not be sustainable as it impacts other governmental resources. When there is a deficit in the HCTF, money is transferred from the general fund to cover expenses. Because the General Fund is the City's primary operating fund, accounting for all of City Government's finances, except for those that must be accounted for in another fund; the HCTF deficit consumes resources that could otherwise be available to fund operations and provide other city services.

CITY ORDINANCES SEC: 66-136

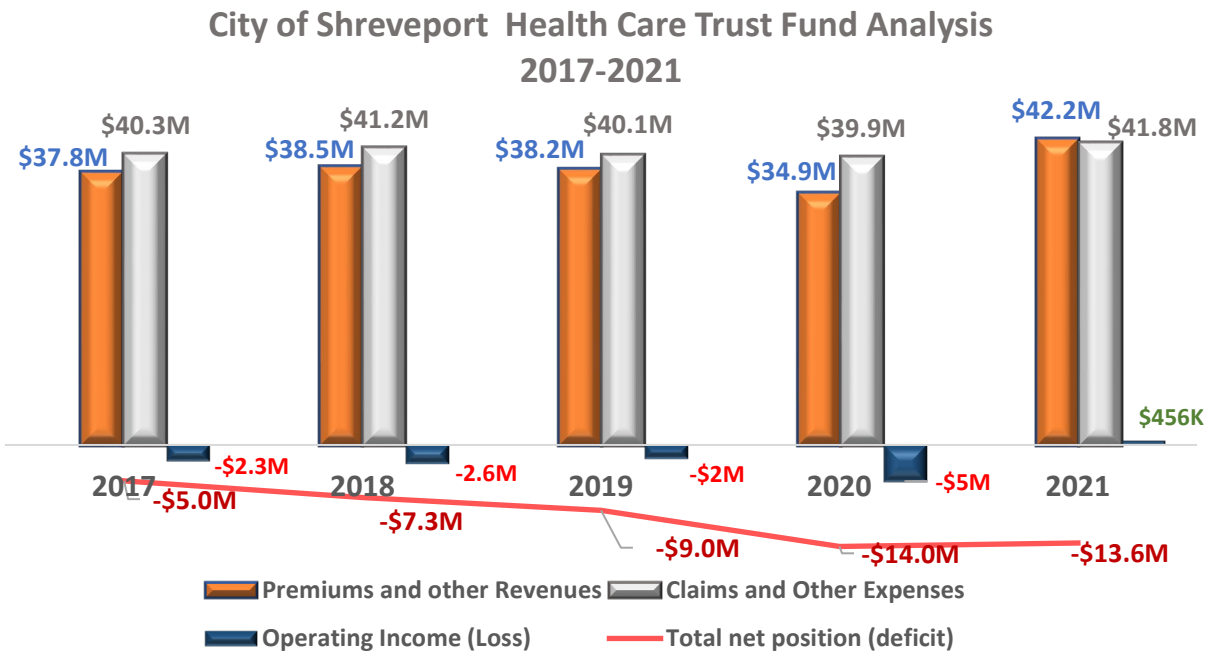
"The board of trustees shall keep, or cause to be kept, in convenient form, such data as shall be necessary for analysis of the various programs of the health benefits plan, for checking the claims experience of the plan, for assessing the financial condition of the plan, for determining the rates of contribution required, and for evaluating the costs/savings of changes in benefits and alternative benefit delivery programs."

Assessing the financial condition of the plan

The Healthcare Trust Fund (HCTF) accounts for City self-insurance activities involving medical and dental care claims for City employees, retirees, and their dependents. In observing Board meetings, we did see that the City's Accounting Division of Finance provides the Board with a report of revenues and expenses for each month. We also identified a year-to-date claim analysis prepared by the consultant[1] for each calendar year 2016-2021. These reports give contradicting assessments of the HCTF.

[1] *The "consultant" reference throughout the report is the city's prior consultant Gallagher.*

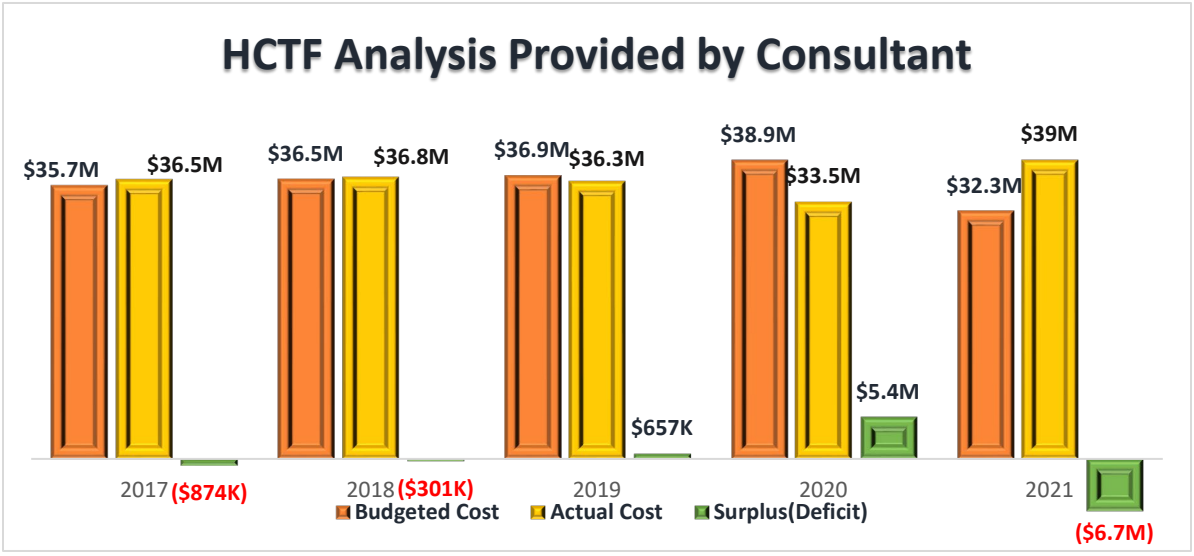
The reports prepared by accounting reflect an increasingly negative net position as plan outflows are consistently greater than inflows each year 2017-2020 (Chart 2).



Source: Annual Comprehensive Financial Report and Accounting Division

Chart 2

The Consultant's report provides financial analytics such as month-to-month enrollment, dollar amount and percentage of total claims paid by type, cost per enrolled participant, percentage of large claims (over $100,000) to total claims paid, and budget-to-actual costs. The Consultant's analysis shows a HCTF balance that improves from a $874,000 deficit in 2017 to a $5.4M surplus in 2020 but declines in 2021 to $6.7M deficit. (Chart 3).



Source: Year-to-date Analysis Report

Chart 3

Why does one report a surplus and the other report a deficit? In calculating the net position (surplus or deficit), each report uses a different set of data. The revenues reported by the accountant are real dollars paid into the HCTF from City contributions and employee paycheck withholdings. This amount is required to equal the City's budgeted amount plus or minus five percent. Operating revenues (total plan contributions) less expenses (claims paid and other fees) plus the beginning net assets (position) for the year result in the net plan assets (position). Whether the expenses are less than or greater than, revenues will determine if the net position there is moving in a positive or negative direction respectively.

Each year the Consultant's actuary uses participant demographics, plan statistical data, and other relevant facts to estimate the cost of healthcare claims for the next year(s). The net surplus/(deficit) on the Consultant report is the difference between the estimated "budgeted cost" and claims paid "actual cost" by the plan. Hence, the result is more a measure of how reasonable the actuarial assumption is than a measure of the financial health of the plan.

Which report is more useful? The report prepared by the consultant gives a very detailed analysis of actual claims expenses for each month during the year. This is useful when identifying the trend in type and amounts of claims as well as extrapolating information about large claims. The Consultant's report is not helpful for fund budget-to-actual analysis because it does not incorporate the HCTF budgeted revenues. Another limitation of the consultant's report is that all the expenses that must be paid out of the fund are not taken into consideration when projecting annual costs, therefore the budgeted cost presented by the consultant each year is insufficient in determining the required monthly premiums.

Determining the rates of contribution required

The changes that were implemented from 2017-2021 did not meaningfully improve the deficit. From 2017 to 2018 the monthly healthcare premiums increased for both employees and retirees ranging from 3% to 7%; however, the plan deficit grew by $2.3M. Premiums increased for employees in 2019 while the plan deficit increased by $1.7M. In 2020 the employee healthcare premiums increased by 5%, while the retiree healthcare premiums fluctuated ranging from -4% to 11%; and the plan deficit grew by another $5M. In 2021 premiums saw no change while the plan deficit improved by $400K.

	2017		2018		2019		2020		2021	
	Premium Increase (Decrease)	Change in Plan Deficit	Premium Increase (Decrease)	Change in Plan Deficit	Premium Increase (Decrease)	Change in Plan Deficit	Premium Increase (Decrease)	Change in Plan Deficit	Premium Increase (Decrease)	Change in Plan Deficit
Employee	N/A	N/A	3%	($2.3M)	2.5%	($1.7M)	5%	($5.0M)	0%	$400K
Retiree	N/A		5% - 7%		0%		-4% - 11%		0%	

Source: Benefits Office-Benefit Plans in New World

-4.49% in HD, 4.5% to 5% increase in base plan, 8.9% to 11.24% increase in Widow Med, 9.20 % Widow HD

Chart 4

We did not find well-documented procedures for assessing the plan's financial position, reviewing claims and expenses for accuracy and/or ways to reduce costs. We did not find any guidelines and standard methodologies used for calculating and/or adjusting participants' premiums and employers' contributions.

There also appears to be an over-reliance on the benefits consultant and the health insurance carrier for verifying correct charges for claims and consultant fees. Even if employers hire third-party service providers, they are still duty-bound to monitor the payments made from their plan funds.[2] Relying on the insurance carrier to process claims, invoice for consultant fees, and notify the Benefits Office when they themselves have made a mistake inherently increases the likelihood of fraud and human error.

A detailed monthly and/or quarterly analysis of plan transactions and review of plan data will strengthen controls over the plan costs and allow for immediate intervention and errors being identified early in the payment process, before overpayments accrue too large. Such analyses/reviews should include but are not limited to:

1. Review plan census, at least quarterly to ensure that listed participants have documented enrollment for the current year.
2. Review monthly invoices and claims from insurance carrier and consultant for assurance that charges are correct, and services provided are covered.
3. Analyze frequency of claims above average cost but just under stop-loss limit to determine if stop-loss coverage is appropriate.
4. Census retiree birthdays for Medicare eligibility and encourage or require enrollment for those who are eligible for Medicare.
5. At least monthly, run a report of employees on unpaid leave and on the healthcare plan to ensure correct and timely premium payment is made.
6. At least monthly verify that plan members social security numbers are active with the Social Security Administration.

Evaluating the costs/savings of changes in benefits and alternative benefit delivery programs

We reviewed Board meeting minutes for the period under review and did not identify any documented evaluation of the costs/savings in benefits and alternative benefit delivery programs. In a July 2020 meeting there was discussion about comparison of a true high deductible (HD) plan to the current plan, but there is no reference to a detailed cost-benefit analysis. In 2019, the Board voted to switch insurance carriers for 2020 open enrollment with an expected savings of $400,000 in administrative fees, however, the administrative fees were $50K more in 2020 than in 2019.

[2] Smartlight News Desk. "Who's Watching the Money? - The Expanding Cost and Responsibilities of Employer-Sponsored Healthcare." October 28, 2021.

Examples of cost-saving strategies that should be explored are described in detail in Appendix B and include:

1. High-deductible health plans
2. Tiered networks
3. Direct contracting
4. Incentive programs

Recommendation 1: Develop, implement, and document guidelines to use to set plan premiums and contribution rates and to control and monitor plan expenses in accordance with City Ordinance. (*For example, Employee data such as plan enrollment, date of birth, unpaid leave, etc. stored in the existing* accounting financial system *can be downloaded in a spreadsheet and used to perform plan-related census review*). Risk: Medium

Recommendation 2: Explore opportunities for cost-savings strategies (e.g., tiered networks…) through changes in benefits and alternative plan design. Risk: Medium

Auditor Note: *The City moved to a 3-Tiered network that will be effective January 1, 2023. The Health Insurance Programs also have incentive programs to discourage unhealthy behavior, such as charging participants who use tobacco or don't participate in a wellness program (e.g., seeing your primary* health care doctor). *The City also offers a High Deductible Health Plan Option which offers a lower premium with a higher annual deductible.*

Administration Management Response:

Recommendation 1: AGREE

The Administration's intent is to work with the Board to recommend plan designs and premium rates to the City Council that will, at a minimum, work toward reducing the deficit that exists in the Fund. This deficit appears to be the result of several years of well-intentioned decisions made by the Board and affirmed by the City Council to keep premium increases to a minimum, by having the City absorb a higher percentage of the total premium cost and by not setting rates sufficient to cover all projected costs. We are mindful that these decisions have impacts on people who depend on us to provide them with health care coverage and will do our best to keep their interests in mind as we undertake this task.

We have already begun working with the City's consultant (HUB) to develop an approach toward the 2024 plan design and rate structures that will, if adopted by the Board and affirmed by Council legislation, result in premiums, which will keep the deficit from getting larger and which could continue the positive trend the Finance figures show for 2021 and 2022.

The Administration must point out that the Health Care Board has nine members, only four of whom are members of the executive branch. Four others are elected by active and retired plan participants. The designated City Council representative is potentially the deciding vote on some issues. We always encourage the Council's representative, who can change from year to year, to be an active participant in Board meetings throughout the year.

We should also point out that the City Council has the ultimate authority over plan design and the division of premium costs between the City and the plan's participants. These decisions have often been made after much controversy. We will be working with Council members to keep them aware of the issues they may be asked to decide and the effect those choices could have on both the plan participants and the City's finances.

Due Date: 6 to 12 Months

Recommendation 2: AGREE

We have been working with HR, Finance and our HUB consultants to gather data that will allow us to present these kinds of options to the Board later this year. HUB has provided the Board with benchmarked data that will assist in this effort. The data shows that our plan, in general, matches up well on benefits and costs per participant. The issues it raised mostly apply to the insurance we offer to retirees and their dependents. The intention is to give the Board and ultimately the Council recommendations on how we can bring our offering more in line with the benchmarks while still providing quality health care coverage.

Due Date: 6 to 12 Months

Finding 2: Data Quality

Improving data quality could aid in the assessment of the overall health and sustainability of the plan. Poor data quality diminishes the ability to rely on the results of using that data. Outdated data can lead to unnecessary costs and waste of resources.

Some of the characteristics that define data quality are:

1. Accuracy and precision – These refer to the exactness of the data. It cannot have any erroneous elements and must convey the correct message without being misleading.
2. Legitimacy and validity - Requirements governing data set the boundaries of this characteristic. For example, nine digits for a social security number. The people in each department in an organization understand what data is valid or not to them, so the requirements must be leveraged when evaluating data quality.
3. Reliability and Consistency - There must be a stable and steady mechanism that collects and stores the data without contradiction or unwarranted variance.
4. Timeliness and Relevance - Data collected too soon or too late could misrepresent a situation and drive inaccurate decisions.
5. Completeness and Comprehensiveness: Gaps in data collection could lead to a partial view of the overall picture to be displayed. It's important to understand the complete set of requirements that constitutes a comprehensive set of data to determine whether the requirements are being fulfilled.

Medicare[3] enrollment data was neither precise nor complete. In reviewing a report of plan participant demographic data and isolating all participants 65 years and older, we could not clearly identify who had enrolled in Medicare and who had not. A "Medicare" identifier of "yes" within the Benefit Management system meant that the participant had notified the Benefits Office of their Medicare enrollment. The absence of the "Medicare" identifier, however, did not mean that the participant was not enrolled in Medicare, just that the Benefits Office was unaware of a Medicare enrollment.

Upon further inquiry, we learned that the Benefits Office sends a letter to notify the retirees and dependents in their household on the City's plan that they are eligible for Medicare. The participant is to notify the Benefits Office once they have enrolled by sending a copy of their Medicare ID. However, a retiree is not required to enroll in Medicare or disclose Medicare enrollment, and the Benefits Office does not follow-up. In an instance where Medicare would be the primary payer, Medicare enrollment would reduce the amount the HCTF would pay for claims.

Recommendation 3: Perform monthly review of participants' Medicare[3] eligibility and verify and document Medicare enrollment. Consider requiring all who are eligible to enroll in Medicare to continue coverage on the city's plan. Risk: Medium

Human Resource Management Response:

Recommendation 3: The Benefits Division is currently working on a process to perform a monthly review of participants' Medicare eligibility and verify and document Medicare enrollment. We anticipate having this fully implemented by the end of the year.

Due Date: In Progress

[3] ***Auditor Note:*** *We are referring to the Original Medicare, not Medicare Advantage, a Medicare plan type that is an option a member can choose if enrolled in Medicare.*

Objective: Assess whether plan administration complies with applicable City Ordinances and other laws and regulations.

Finding 3: Annual Reports

The Board is responsible for annually reporting to the City Council:

- ***The fiscal transactions of the health benefits plan for the preceding year and the amounts of accumulated cash and securities in the various accounts of the plan,***
- ***the last balance sheet showing the financial condition of the health care trust fund,***
- ***a statement of changes in the plan design adopted during the preceding year, and***
- ***a claims experience projection for the current year.***

City Ordinances: Sec. 66-137

The City Council receives the Annual Comprehensive Financial Report (ACFR) which includes financial statements and information regarding the HCTF. The HCTF Board does receive information regarding annual claims analysis from the Consultant. However, we could not confirm that the entire City Council received this report for any year during the period under review. While the report that the Board receives does show revenues and expenses in the fund for the current and previous years, it does not include a balance sheet, a statement of changes, or a claims experience projection for the current year. The City Council provides legislative oversight. The annual report would make the Council aware of whether plan occurrences comply with the Ordinances; or if Ordinances need to change to align with plan needs.

The Consultant report discussed in Finding 1 has not been presented to the Council consistently each year, but it does provide insightful claims-related details. For example, the report identifies that the top 11 large claimants account for 44% of the total gross claims in December 2021.

Recommendation 4: Review the ACFR report and determine what should the HCTF board provide to the City Council to avoid redundancy and if Ordinances need to change to align with plan needs/operations. Risk: Low

Administration Management Response:

Recommendation 4: AGREE

We will work with the Finance and HR Directors to determine what information should be provided, if any, in addition to that which is contained in the ACFR.

Due Date: 6 to 12 Months

Finding 4: Policies and Procedures

"The board of trustees shall promulgate a detailed plan of benefits which shall include policies and procedures relative to eligible participants, employee and dependent coverage, coverage for retired employees, termination of coverage, exclusions from coverage, coverage for dependents after an employee's death, continuation of benefits after termination, and any other matters as may be necessary."

City Ordinances: Sec. 66-134

Though the Healthcare Plan documents that set covered services, service cost limits, and fees paid to the third-party administrator and benefits consultant exist, there are no written Standard Operating Procedures for the Benefits Office. The Board has neither developed nor delegated the development of policies and procedures to the Benefits Office.

Policies and procedures provide a roadmap for day-to-day organizational processes and set the standards against which to measure operational performance and results. The absence of policies and procedures leads to a lack of standardization and objectivity and opens organizations up to process bias.

The plan documents state the definition of, "*Retiree/Retired Employee – A retired city Employee, if he retires under one of the City's retirement programs and is receiving a monthly pension check, and legal Dependents."* The Annual Comprehensive Financial Report states*, the City provides medical, dental, and life insurance coverage through a cost-sharing single-employer defined benefit plan that can include non-City employees as described under the Employees' Retirement System for any retiree who receives a monthly retirement check from one of the City's retirements plans and their legal dependents.* The ordinance (Chapter 66 Article III) does not specify the eligible participants. This ambiguity can possibly lead board members to allow employees with deferred compensation (who do not receive monthly pension checks) access to benefits based on judgment and not a set policy.

At a minimum the operational policies should address:

1. Who maintains controls and has access to employee health and claims data?
2. Who qualifies as a retiree participant and are they eligible to participate in the Health Care Plan (e.g., a retiree is not specifically defined within the ordinance)?
3. Who is responsible and what is the process for adding, updating, and removing employees' benefits in LOGOS HR system?
4. What are the open enrollment notification and follow-up procedures?
5. What are the nature and frequency and who should perform analytical procedures to assess plan health?
6. How are "catch-up" premiums handled when employees have unpaid leave, having no premium withdrawals for one or more pay periods?

Recommendation 5: Develop and implement policies and procedures for daily operations of the Benefits Office. Also, clarify and coordinate with the City Council to amend the Ordinance to define who qualifies as a retiree and their eligibility to participate in the City Health Care Plan. Risk: Low

Human Resource Management Response:

Recommendation 5: The benefits division is in the process of developing policies and procedures of the daily operations of the Benefits Office (both healthcare and pension). We anticipate having this implemented by the end of the year.

Due Date: 6 to 12 Months

Administration Management Response:

Recommendation 5: AGREE in principle.

We will ask the City Attorney for guidance on this. We are considering a rather extensive rewrite of the portions of Chapter 66 of the Code which deal with health care and pensions, since they seem to contain language which is no longer relevant to how those plans operate.

Due Date: 6 to 12 Months

Prepared by:
Nadia Dunams

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Staff Auditor I

Approved by:
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City Internal Auditor

nd:ts

c: City Council
Clerk of Council
Mayor
Chief Administrative Officer
Carr Riggs and Ingram
City Attorney
Director of Human Resources

Appendix A: Findings Risk Ranking Criteria

The chart below summarizes our evaluation of risk for the recommendations outlined in the report. Each recommendation was assessed at a high, medium, or low risk level based on a qualitative assessment of exposure and/or corrective action priority.

Risk Levels	Risk Description
High Risk	Represents a **significant** level of risk exposure to city assets, public safety, or achievement of objectives or mission. Corrective action should have the highest priority.
Medium Risk	Represents a **moderate** level of risk exposure to the city from extensive operating inefficiencies or high-level non-compliance issues. Corrective action should occur expeditiously.
Low Risk	Represents a **minimal** level of risk exposure to the city from inefficiencies or low-level non-compliance issues. Corrective action should occur as appropriate.

Appendix B: Health Plan Cost-Savings Strategies

Strategy 1: Share costs with employees

High-deductible health plans

High-deductible health plans (HDHPs) require employees to take on greater cost-sharing responsibility up front before employers begin to pay for medical claims. Employers typically offer health savings accounts (HSAs) in conjunction with HDHPs to help with upfront out-of-pocket expenses.

To meet the IRS definition, a HDHP must have:

1. A minimum annual deductible of $1,400 for an individual or $2,800 for a family, and
2. A total yearly out-of-pocket expense (including deductibles, copayments, and coinsurance) limit of $7,050 for an individual or $14,100 for a family.

The IRS defines HSA contribution limits as:

1. $3,650 for individuals with self-only HDHP coverage, and
2. $7,300 for individuals with family HDHP coverage.

An HSA is a pre-tax account created for or by employees covered under HDHPs to save and pay for qualified medical expenses. Contributions to HSAs can be made by the employees, their employer or both.

Pros

+ HDHPs can **lower plan's costs** while **still providing broad network coverage** for employees

+ HSAs can help employees who don't use much healthcare save up for future medical costs, since they're **able to roll over unused funds from year to year**.

+ **Funds contributed into employee HSAs are taxfree**. If structured properly, the tax savings from HSA contributions combined with service cost savings from HDHPs can provide **substantial value for both employers and employees.**

Cons

- HDHPs and HSAs are often new to employees, requiring **more time and resources to help employees understand how they work** and get the most value out of them.

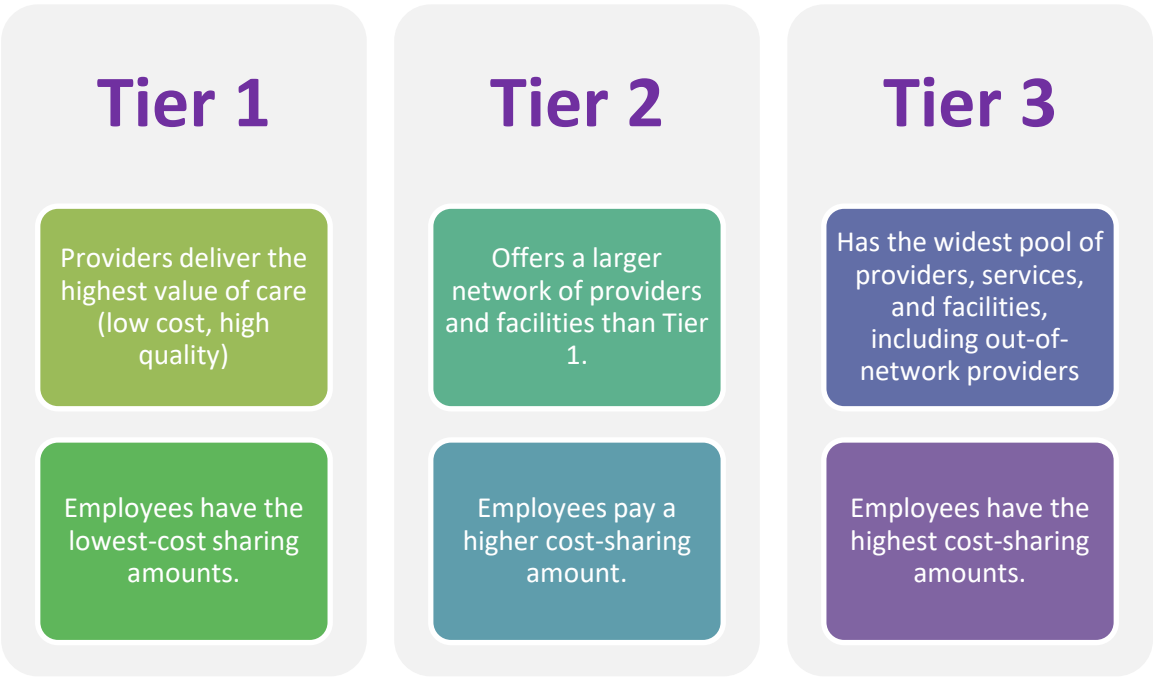
- Employees are responsible for paying for care until the deductible is reached, so HDHPs **aren't a great option for employees and dependents with chronic medical conditions** or **above-average healthcare needs**

- Research suggests the savings associated with lower healthcare spending are primarily due to decreased use of care and not because enrollees chose lower-cost providers, which can have **negative impacts on long-term employee healthcare habits and outcomes**.

Source: Faulkner Diane, Cost-saving levers for self-insured health plans, Amino, 2021

Tiered networks

Strategy 2: Explore creative health plan designs



Tiered networks divide providers into tiers based on the cost and quality of care they offer.

Pros

+ Plan members have incentives to choose lower-cost, higher quality providers

+ Cover a broad pool of providers for people who don't mind paying extra to stick with existing doctors or facilities

Cons

- Decision-making can be complicated as employees must pay close attention to which tier a provider is in when searching for care

- Some geographic regions may not have enough providers or sufficient competitive dynamics to support tiered networks

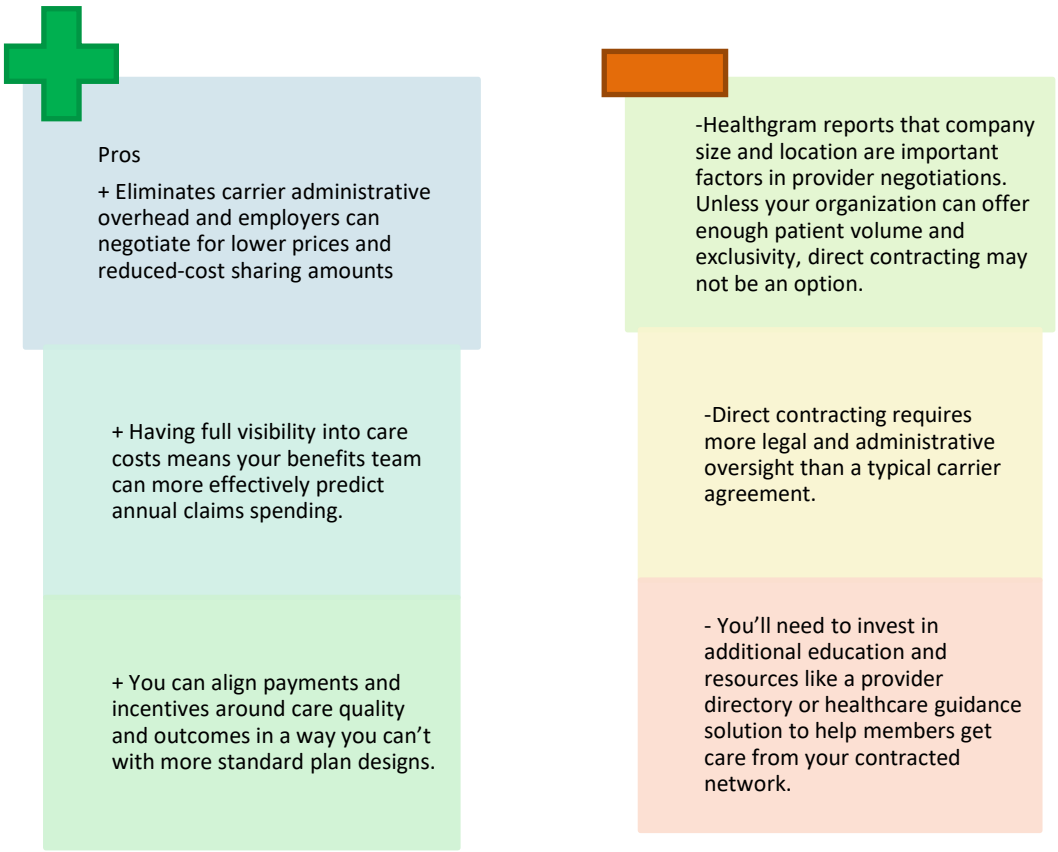
Source: Faulkner Diane, Cost-saving levers for self-insured health plans, Amino, 2021

Direct Contracting

Direct contracting is an agreement between an employer and a provider group or hospital system to provide care for plan members in a specific geographic area. A benefits team (broker/consultant) determines the reimbursement costs for specific services, prescriptions, and medical equipment, unlike a traditional payer arrangement where the carrier handles all the negotiations for these costs. This type of design allows the employer to control claims spending and allows employees to know in advance what they are going to be paying for care.

Direct contracts employ one of two models:

1. A traditional fee-for-service, or
2. An alternative payment model such as pay-for-performance, shared savings, bundled payments, or global capitation



Source: Faulkner Diane, Cost-saving levers for self-insured health plans, Amino, 2021

Strategy 3: Prevent expensive Health episodes

Incentive programs

Incentive programs are a great way to encourage healthy behaviors, decrease unnecessary spending, increase productivity, and raise morale among employees. Participants must be enrolled in a company healthcare plan. As with the other programs, there must be alternatives available to employees who cannot meet the initial criteria. These programs come in many forms, but as a general rule will fall under one of four types:

Type 1: General educational or participatory programs	Type 2: Health plan-related participatory programs	Type 3: Health plan-related, activity-only programs	Type 4: Health plan-related, outcome-based programs
These are predominantly educational materials and non-mandatory classes related to health and wellness topics. They must be made available to everyone, not just employees who are eligible for your company's healthcare plans.	This type of program is open to all employees enrolled in their employer's health plans. Like Type 1 programs, Type 2 programs are participation-based, not outcome based, and aren't mandatory. These programs are good for companies that want to incentivize preventive care activities covered by their health plans.	Type 3 programs provide rewards to participants based on the completion of certain health and wellness activities, regardless of health outcome (weight loss, lower blood sugar levels, etc.).	Type 4 programs provide rewards to employees based on certain programs specific outcomes. These programs include rewards such as a reduction in employee healthcare contributions for achieving a body mass index score of below 30 or quitting tobacco use.

Pros

+ Incentive programs can reduce sicknessrelated absenteeism.

+ Incentive programs can improve employees' self-management skills and help them achieve personal health and wellness goals.

Cons

- Incentive programs are highly regulated, requiring close coordination with your compliance team and broker-consultant.

- Incentive programs can take years to have a measurable impact on your population's health. External factors can also contribute to long-term health changes that may slow progress.

Source: Faulkner Diane, Cost-saving levers for self-insured health plans, Amino, 2021