LAW ENFORCEMENT MANAGEMENT INSTITUTE

THE MERITS OF A MUNICIPALITY PROVIDING FOR THEIR EMPLOYEES MEDICAL EXPENSES COVERAGE AS OPPOSED TO THE TRADITIONAL HEALTH CARE INSURANCE

A RESEARCH PAPER

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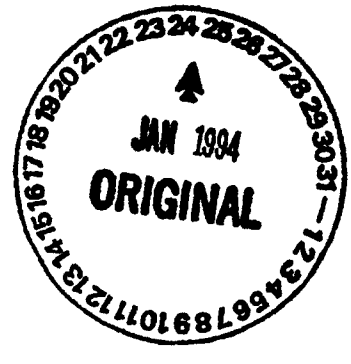

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INTRODUCTION

A growing concern in this country, which has taken on national magnitude, is the problem of the ever-rising cost of health care. From the President of the United States to the elderly retired individual on a fixed income, health care and its ever-spiralling costs is at least one of the problems that loom foremost in the minds of the majority of the people of this country. The vast majority of employers, in both the private sector and in the public sector, provide some type of health care benefits for their employees and, therefore, share the same concerns regarding rising costs.

Most people have at least one theory concerning the reason(s) for the problem. Some say the cost of health care is skyrocketing because of the increased incidents of malpractice suits, and blame the courts and attorneys (Coughlin,1993). Others attribute it to the cost of developing and implementing the advanced technology in medicine (Gilfillan,1993). Still others blame the insurance companies for charging more for less coverage(Paul and Townsend,1992). If one wanted to look at the issue purely from the viewpoint of the insurance companies, one could hold that much of the population pays the insurance companies to cover the risk of providing health care while accepting no responsibility themselves for maintaining good health on the one hand (Mulcahy,1993) and on the other hand abusing the service by means of false claims and unnecessary treatments (Wojcik,1990).

At face value, these assumptions all seem valid as the most prominent contributors to the cost increase in health care. Certainly, when one considers that every party to the process of providing health care to the public is a member of free enterprise, running their business with one primary issue in mind, that is, profit, then it is no wonder that the cost of health care is increasing much the same as the cost of living in general. One could argue that the cost of health care is rising the same as the cost of living, which only indicates that our quality of life is improving.

However, while it is true that the quality of health care existing in this country is better than it has ever been in the history of mankind, there is a vast difference to most of the country's population in the quality of health care in existence, and the quality of available health care. For the majority of the population, the best health care in existence is not available because it is not affordable. For instance, heart and liver transplants represent some of the best health care in existence, but are available to only the few in this country who can afford the high costs associated with those procedures. Moreover, for a large number of the people in this country, even minimal health care is unaffordable and, therefore, not available.

With recent developments in the area of health care reform, it appears that one of the areas of focus is the requirement of employers to provide their employees with quality health care cost coverage. While, for most employers the only obvious effect this will have is to change a voluntary policy to a required policy, it will likely limit their freedom to choose the quality of health care provided. For instance, at present an employer may

choose whether to provide his employees with $200.00 deductible health insurance or $500.00 deductible, (or for that matter any other deductible, or no insurance at all if he chooses). Arguably, every employer who provides any form of health care for their employees, should want to provide the best that is affordable, but they still have the freedom to choose that which they feel is affordable. The health care reform package now before congress, may well remove that option from the employer. Many employers are already looking for alternate methods of providing better health care coverage for their employees at a more affordable cost.

The traditional method has been purchasing from an insurance company a blanket policy, whereby the insurance company assumes all the risk involved in covering the cost of all the health care provided for the company's employees. With this traditional method of "shifting the risk" the employer forfeits the ability to be an active party in the decision making process of the profit margin of the health care provider and, for the most part, the health care cost provider, i.e., the insurance company. The insurance company calculates the risk factors in providing the cost of health care for the group, may (or may not) negotiate prices with the health care provider, and sets the premium to charge the group's employer. The employer's choices are limited to which insurance company to use and which program offered by the insurance company to buy.

When considering that as much as six and one-half percent of a city's total expenditures, or ten percent of the employee's benefits, are spent providing health care for the employees, it is clear to see a need for an employer to assume more control over the

decision making and negotiating process in providing this benefit (Bishop,1993). Most employers have apparently been reluctant to assume that control because of the risk involved in the decision-making process. However, "people facing 'risks' are not necessarily defenseless, a statement which leads to the discussion of the molding of 'risks' which includes the shifting, spreading, and conditioning of 'risks', the last a rather neglected phenomenon" (Hammond,1968:40).

Since shifting risks has already been discussed, we turn our attention to spreading risks, which refers to grouping into large groups the incidents of possible occurrences so that each member of the group pays a small part of the cost of the incidents that do actually occur. In this case, each person in a group stands a risk of needing health care which is accompanied by a cost factor. The odds are that only some of the members of the group will actually incur unaffordable health care costs in a given time; therefore, if all members of the group pay an equal share of the costs incurred by the few, then each member of the group pays an affordable price to have the health care available when needed. This, perhaps, is an oversimplification of the theory of insurance but should serve even the casual reader.

Conditioning the risks or, perhaps more appropriately, managing the risks would deal with factors involving activities that manipulate or reduce the probability of the undesirable incidents occurring. This topic will be discussed in more detail later in this paper.

- Once an employer understands the magnitude of savings that can be realized when willing to assume some risks, and further realizes that the nature of such risks can be measured with some degree of accuracy, hence predicted, and that a certain amount of control can be exercised over the risk factors, the next logical step would be to explore the alternatives in providing better health care for less cost.

While municipalities are not organizations concerned with realizing a profit, they have, nevertheless, a dual responsibility with regard to this issue: (1) a responsibility to provide the best services for the city at the lowest cost, and (2) a responsibility to their employees to provide the best health care benefits available. Moreover, as a major part of the municipal structure, a major concern of most police departments across the country is the budget. There is always a need for more resources, whether it involves manpower, equipment, or capital outlays, all of these expenses must be met within a set budget. It appears that this need for more resources is increasing over the years. In 1985 municipal governments in Texas spent 16.6 percent of their total budget for criminal justice (Sorensen,1988). From interviews of officials from several Texas city governments it was learned that a representative city allocated 29.2 percent to police from their 1993-94 budget (Schindler, 1994). Included in the manpower budget, or personnel budget, is the cost of health care benefits. It seems clear that police administrators, mayors, and city managers would be interested in exploring options which would lead to more cost-efficient health care programs.

Quite naturally, understanding the nature of the theory of insurance and spreading the risk, it should be easy to see while reading this research paper that, although tailored for a small city or corporation with less than five hundred total employees (since larger groups can safely spread their "risks" without doing anything more) larger cities or corporations could realize some of the same benefits by exploring the possibilities for adoption. The primary focus of this paper, however, is how a municipal government and police department of a city with fewer than five hundred total employees can benefit by adopting an alternative method of providing their employees with health care at a savings to both the city and their employees.

EXAMINING THE ALTERNATIVES

Before examining the alternatives available, it might be advisable to define the goals in terms of end result and in terms of managing the risks. Optimally, the goals in terms of end result are to provide the employees with the best health care available, and to save the company and the employees as much money as possible in doing so. The first of these appears to be quite simple while the second is every bit as complicated as the first is simple. Ideally the "best health care available" should be synonymous with the best health care existing. However, when we turn our attention to the idea of saving money by "risk management" a need for definition is apparent. For purposes of this research paper we shall define "risk management" as "any action taken by the decision maker that reduces the probability of occurrence of the undesirable event at risk." When considering the alternatives from that point of view, it is apparent that one is limited only by one's imagination and any laws that might exist prohibiting some choice. For example, in the unlikely event that an employer chose to kill any employee who became ill, there are laws that prohibit that conduct. Even if an employer elected to fire an employee simply because he contracted some catastrophic illness, there are civil case laws that provide the employee with a reasonable amount of protection. There are, however, a number of alternatives that have already been tried by some municipalities as well as some private organizations.

Managing the risk can be approached from different angles and by attacking different areas of risk factors. A popular method of decreasing the risk exposure in providing health care for a group of persons is by negotiating the cost of health care with the health care provider. While it is true that hospitals have only one price list for the services and supplies which they provide, those prices are negotiable down to the last piece of gauze or tape (Brown,1993). In fact, one might be surprised at just how negotiable those prices are. Speaking from personal experience, the negotiated price can be as low as twenty percent of the list price. The negotiated price could depend on variables such as numerical size of the negotiating group, financial strength of negotiator guaranteeing payment of fees for services rendered, or even the skills of the negotiator, as well as the concessions available to offer. Even if by negotiating prices the cost could only be cut in half, it can be readily seen that negotiating prices is certainly worth the time.

To give attention to another area that is a more indirect method of managing risk per se is to cut cost by cutting out the middle man. Presumably, every person or entity in the chain of any business transaction gets a piece of the pie. In some cases cutting out the middle man could have a negative effect. Arguably, an insurance company might be able to more successfully negotiate prices with the health care provider than a city manager of a small city group. In such cases if the insurance company passed that savings on to the city it might not be the correct move to cut out the insurance company, even if the insurance company was not also providing the other service of risk assumption. A better

illustration of this is the concept of a third party administrator which will be discussed later.

Nevertheless, one alternative that should be seriously explored is the option of becoming self-insured or at least some modified version of a self-insurance program. With this option a city or private organization would assume the risk of providing their employees with the cost of their health care needs as opposed to paying an insurance company a premium to assume that risk. Understandably, an insurance company is in business to realize a profit, so the premiums they charge are greater than the aggregate of health care claims they pay, plus their own operating costs. These profits alone would amount to a substantial savings, but only if the risks are managed successfully in the other areas. The city of Denton became a self-insured city and after two years and several catastrophic illnesses resulting in extremely high claims, abandoned the self-insurance program and returned to the traditional method of providing health insurance for their employees (Darnell,1993). When asked if they had attempted to manage the risk in any other areas, it was learned that they had not. That is not to say that it would be impossible for a small city to have a successful self-insurance program without a risk management program, nor is it guaranteed that if an employer used every possible form of risk management tools, this would be successful, but certainly one can increase the chances of success if one is able to manipulate the odds in their favor.

The City of Huntsville adopted a self-insurance program ten years ago and has been quite successful with it, in that they have maintained a claims rate experience of an

amount less than what they would have paid in premiums if they were simply providing health care insurance for their employees. And, they provide better coverage ($250 deductible) as opposed to the ($500 deductible) when calculating premiums for comparison (Schindler,1993). They have manipulated their risk exposure by purchasing a high deductible coinsurance policy covering any catastrophic illness that exceeds a cost of thirty thousand dollars per occurrence. This type of insurance can be purchased at a much lower premium than standard health insurance. Huntsville also found that hiring a third party administrator to manage their claims enhanced their program and actually cut the program's total cost. A third party administrator (usually an insurance company) is generally better equipped with the knowledge, facilities, and contacts to investigate, process, and validate claims, thereby cutting costs by refusing to pay unauthorized claims. The employer can easily monitor these savings by having all claims filed with their company, recorded, and then sent to the third party administrator for disposition. The employer knows the amount of claims filed by their employees, then after the third party administrator pays out a month's claims and adds to it the fee for administration and presents it to the employer, the employer tabulates the difference between the actual claims filed by their employees and the cost of having the claims processed and paid.

The City of Palestine provides a counter example regarding self insurance. In 1989 the city adopted a self-insurance program and purchased one hundred thousand dollar deductible insurance to cover the cost of catastrophic illness expenses in excess of the one hundred thousand dollars. After two years and more than one claim whose

amount was greater than one hundred thousand dollars, they abandoned the program and went back to the traditional means of providing health care insurance.

Still another option an employer might explore is the adoption of an HMO program. This is a contract with a health care provider whereby the provider becomes a health maintenance organization and the employer pays the HMO a set fee per month per employee. The employees, then, get all their health care provided for an affordable, prepaid set price. The HMO assumes much or all of the risk of providing health care and in turn manages that risk by providing "health maintenance" for the group in an attempt to encourage them to stay healthy and to make regular visits to the doctor, based on the idea that outpatient care is cheaper than in hospital treatments.

The HMO concept has been around for a number of years, gaining most support in the 70's (Crane,1980:290). Certainly, a health maintenance program, as distinguished from a health maintenance organization program, should be desirable for any group; however, the downside of an HMO program is that since the health care provider is assuming some or all of the risk in terms of cost of treatment, it is easy to see how a conflict of interest might easily develop. If a doctor who decides what form of treatment is necessary for a patient is also the one who will have to absorb some of the cost of that treatment, the potential for the doctor to decide on the conservative treatment over the more costly treatment is evident. It seems apparent that if one's goal is to obtain the best health care available, one might shy away from the HMO program. However, if one's

goal is to obtain adequate health care for the lowest cost, an HMO program is worth looking at.

One area of risk management that has apparently been largely ignored is the idea of improving the odds by altering the variables. It is doubtful that anyone would argue that the chances of a person who consumes large quantities of cholesterol, fat, tri-glycerides, and other foods that clog your cardio-vascular system and maintains a high level of stress stands a greater of risk of heart attack than his counterpart who eats and lives healthily and maintains good stress maintenance. If an employer can subscribe to that line of thinking and realizing from observations of the health programs on television, health foods on the shelves in our grocery stores, and the growing numbers of health clubs, that the trend in America towards better health is gaining in popularity, the idea of having a successful physical fitness program for employees might seem not only attractive but feasible.

If an employer could get his entire group to buy into a physical fitness program, the overall cost of health care for his group would almost certainly decrease. For years large corporations have spent countless dollars on risk management with much of their efforts aimed at areas other than insurance, such as safety programs (Vaughan & Elliott,1978:31). But there seems to have been very few employers, until recently, that have ventured into the area of physical fitness. Some police departments have included a physical fitness program in their training program for recruits, but most departments do not provide any ongoing fitness program for their officers once they are out of training.

not provide any ongoing fitness program for their officers once they are out of training. Likewise, fitness programs are often not linked with the monitoring of health care costs.

In addition a comprehensive fitness program for a group that would encompass all areas of good physical and mental health should produce even more positive results than just cutting health care costs. Not only should it reduce lost time from work for illnesses, thus increasing productivity, it should increase production for time spent on the job as well. If one feels good both physically and emotionally one is likely to produce more work than when one feels bad.

Although it would be reasonable to assume that the rewards of feeling good, enjoying good health, and a promise of a longer life would be sufficient to get anyone to participate in a physical fitness program, history and human nature lend overwhelming evidence to the contrary. Americans are notorious junk food junkies and couch potatoes whose idea of a good diet regimen and exercise program consists of lifting the beer, chips, and cigarettes from their lap to their mouth and flipping the channels with the remote control from one football game to another.

All this is to say that an employer who wishes to initiate a physical/mental fitness program would also be wise to consider incorporating with such a program an incentive program aimed at getting the members of the group to buy into the program as completely as possible; completely, that is, in terms of getting all the employees involved and all being totally involved. Chances are no employer would ever be able to get all of the employees to buy into such a program, but the more individuals who did buy into the

program, the better would be the odds of reducing overall health care costs. Any incentive program incorporated into the fitness program should also produce another positive effect. It should encourage the members to not abuse the health care program, which in turn would generate a further savings.

One other option that an employer would want to at least consider is more of a tool used when negotiating with a health care provider regarding the cost of services provided. The plan is called a preferred provider organization plan (PPO). The employer or customer negotiates with a health care provider and obtains lower costs for services, supplies, and use of facilities by designating the provider as being the preferred provider organization. The employer then offers to the employees a better percentage rate (say 80-20 as opposed to 50-50) and lower or no deductible if the employee uses the PPO instead of some other health care provider. This gives the individuals the option of using their own personal physicians if they are willing to pay the difference. This type of program is attractive because either way the employer realizes a savings, and the employees still have the option of choosing their own health care provider.

One other organization that has become self-insured and succeeded is a private manufacturing company with 420 employees. They have become self-insured in health care and worker's compensation. They have incorporated an incentive program aimed at reducing accidents, and sick time. They have incorporated a PPO plan with the North Texas Health Care Facilities Organization that includes their local hospital and several of the more popular hospital facilities and doctors in the nearby Dallas area . They

started out with $100,000 deductible per occurrence in 1991 and have since increased that deductible to $225,000. Their estimated savings for the three years they have been into the program is $800,000 per year (Brown, 1993). It should be noted that, although they had an incentive program in place, it did not include a physical fitness program.

FACTORS TO CONSIDER

There are a number of factors that an employer should consider in determining which type of health care plan will best suit the needs and abilities of the company as a whole:

1. Financial stability of the organization.
2. Options available to the organization.
3. Risk factors.
4. Needs of the members of the pool.
5. Size of the work force.

The financial stability of the organization can, in most cases, be readily determined, but is no less an important factor to consider. The idea that, if an organization is already providing health insurance for its employees, it would automatically be qualified for adopting a self-insurance program is foolhardy. A company that is not financially stable enough to suffer some peril that would create some unexpected expenses, and be able to continue to operate, would probably be better off not assuming any additional risk. Most successful businesses try, or should try, to maintain some assets in reserve to cover such unexpected perils, especially if considering accepting the kind of risks involved in a self-insurance program.

Most of the options available to an employer have already been discussed in previous sections of this paper. One option mentioned but not discussed is the option to simply not provide any health care benefits at all for the employees. This option may not be open very long, considering the possibility of the Health Care Reform Bill being passed. However, to capsulize them, they are listed below:

1. Providing no health care benefits at all.
2. Providing some health insurance for the employees.
3. Providing HMO for the employees.
4. Adopting a PPO program.
5. Becoming purely self-insured.
6. Becoming self-insured with a coinsurance policy.
7. Adopting a wellness program.
8. Adopting an incentive program.
9. Negotiating prices.
10. Incorporating two or more of the foregoing into a comprehensive healthcare program.

Obviously, some of these programs could be incorporated while others could not. It is possible to incorporate an insurance policy with either a PPO plan or an HMO program; however, that would be more the decision of the insurance company than that of the employer. The employer could negotiate prices with the insurance company, but

would not be in a position to negotiate prices with the health care provider, if the insurance company is paying the bills. If the first two options are rejected the employer is fairly free to build his own plan tailored to fit the employer's needs and abilities and the needs of the employees.

Whereas an organization large enough to have a broad risk base can operate a pure self-insurance program, it would be inadvisable for an organization with fewer than five hundred employees to attempt it. In order to understand the significance of the numbers in a group, it would help to know that the insurance theory is based on two principles: the probability theory and the law of large numbers. The probability theory is concerned with measuring the likelihood that something will happen with some regularity even though it appears to occur by chance and can, therefore, be predicted. For instance, if one were to flip a coin, the probability of the coin coming up heads is .5, that is, it has a fifty percent chance of being heads. That is not to say that if the first time the coin is tossed it comes up heads then the next time it will come up tails. Each occurrence stands alone, but we know from the law of large numbers that the observed frequency of an event will approach the underlying probability as the number of trials increases (Vaughan and Elliott:19-20). It is not that simple when predicting the frequency of illnesses among a particular group, but some predictions can be made with a reasonable degree of accuracy. The one thing to remember is, the smaller the group, the less reliable the predictions. When predicting the future medical expenses of a group, probably the most reliable measurement is the past claim rates of the same group, and the longest period of history

available for that group would be the most reliable. Keep in mind the law of large numbers.

Other factors to consider when attempting to predict future medical expenses is the health factors of the members of the group. Insurance companies take into consideration the sex, age, lifestyle, and pre-existing conditions of each member of the group when calculating premiums (Cates, 1994). One of the reasons that sex and age are contributing factors to one's medical expenses is that young adult females eighteen to thirty-five are considered at childbearing age, which increases the likelihood that they will incur some additional medical expenses. Older males are more at risk of heart attack than older females. Lifestyles considered are whether one is a smoker or non-smoker, drug abuser or not, and single or married. Pre-existing conditions, of course, refers to chronic illnesses, diseases, or handicaps, that may or may not require ongoing treatment. For example, some heart patients are on a medication program that the cost of the medicines alone exceed the average cost of health insurance for a normal healthy individual, not to mention the fact that they are an extremely high risk, or a person with a kidney ailment might require an expensive dialysis treatment on a regular basis.

When considering the needs of the members of the pool the employer should consider the ability of the members to pay a portion of their own expenses and what portion they can be expected to pay without placing them in financial ruin. A company whose employees' income is considerably above the national average might want to provide a higher deductible than one whose employees make little more than minimum

whose employees' income is considerably above the national average might want to provide a higher deductible than one whose employees make little more than minimum wage. A "meaningful" deductible, one that has some impact short of financial ruin, should help prevent most employees from abusing the program.

The size of the work force has already been discussed and with some understanding of the law of large numbers should not need further discussion.

After all the factors have been considered and properly assessed in terms of the needs and capabilities of the agency and individuals in the group, a program should be carefully developed so that the alternatives available can be properly selected tailoring a program that will provide the best health care for the employees and dependents, if any, at the least cost and risk to the agency.

DEVELOPING A PROGRAM

Once an employer chooses to develop a program that is an alternative to providing traditional health insurance for their employees, the first step is to look at all the options available and choose the ones that could be incorporated into a comprehensive program that the employer thinks will work for the organization. It should be understood that for the first one to five years of the program the organization should set aside for health care an amount at least equal to, if not slightly greater than (to consider inflation), the current amount.

The next step is to gather the necessary data to conduct a comprehensive planning session out of which should come a well developed program carefully tailored to fit the entire organization. Both the completeness and accuracy of the data and the thoroughness of the planning are vital to the development of a successful program. One of the first pieces of data needed is the current dollar figure being spent for traditional health care for the entire group. Next, shop around and determine if there is any comparable insurance available at a better price. Presumably, in most, if not all, cases this has already been determined. When all the data is gathered and calculations made and the program plan is developed and the future health care expenses are predicted and added to the cost of administering the program, plus any other costs incurred by adopting the program, the sum of those figures are then compared to the amount currently being spent. There should be an indication of a substantial savings to be realized, in order to

make the program feasible. (It should be noted that the savings mentioned here is not moneys that will be freed up initially for use in other areas.) Other data needed is the group's historical claim experience (as far back as is available), the risk contributing factors of each member of the group (age, sex, lifestyle, and pre-existing conditions), and the number of members in the group.

If there is a sufficient number of years of data on the group's claims experience, and no pre-existing conditions among the group that creates a prohibitive peril or expense, the calculations are relatively simple. In the absence of a sufficient database on the group's claims experience calculations would have to be made on the same basis that an insurance company would use. There should be some computer software available, that would provide those calculations.

When the calculations of predicted future claims rates are completed for a fiscal year, the next step is to determine the cost of administering the program. Much of this can be accomplished by shopping prices with the insurance companies available, unless it can be determined that the organization has someone equipped with the knowledge and ability to cost effectively administer the program. One might also explore the possibility and feasibility of hiring an experienced insurance claims adjuster/investigator to administer the program. The organizations that were checked and found to be successful, have found it to be more cost effective to simply contract that to an insurance company (Brown,M., 1993;Schindler, 1994). However, it is suggested that, if using a TPA, it

would be wise to monitor that portion of the program with the purpose of determining if the program can be administered in house more efficiently and at a lower cost.

Next the administrator should calculate the costs of additional options to be incorporated into the program. For instance, one option that every employer should want to include in their program is some type of wellness program. The cost of such a program could vary greatly, and there are far too many types of wellness programs to discuss completely here.

Still another option that should be considered is a co-insurance or high deductible insurance policy for catastrophic illness or injury. Quite naturally, the cost of this is going to be largely determined by the limits of the deductible (Cates, 1994). There is an indirect relationship between the amount of the deductible and the cost of the premium for it. A higher deductible insurance policy will cost less than a lower deductible policy. The decision of selecting a policy with the right amount of deductible to start out with is perhaps the most critical part of the planning. This is the one factor the employer has control over that will play a major role in determining how much savings can be realized, as well as preventing the program from failing. If the deductible is too high and the group suffers more catastrophic illnesses in the first year than the organization can afford to pay, the program is likely doomed. If, on the other hand, the cost of the insurance is so great from selecting too low a deductible that, when coupled with the other costs of the program, the overall cost of the program is greater than providing health insurance, the

program is not feasible. This is where consideration of the organization's financial stability plays a vital role in the planning process.

A wellness assessment of the entire group would also be an invaluable planning tool during this phase of the process. Knowledge of the presence or absence of any high risk members for heart attack or some other major disease or illness, would provide the ability to better predict one's needs in terms of co-insurance. The factors that are a must in considering the limits of the deductible in a co-insurance policy are: The upper limits of the organization's ability to cover unexpected losses, the general condition of the group as a whole, with attention to specific conditions of any individuals within the group that have adverse pre-existing conditions, and what the total cost of the program is predicted to be, as compared to the current cost of traditional health care insurance for the same group.

Having mentioned the term "wellness assessment" it might be well to discuss the concept in more detail: A physical examination can cost as little as fifty dollars and as much as several hundred dollars, Satyu,1993. From a relatively simple examination, an individual's risk factor can be determined for such illnesses as heart attack, cardio/vascular disease, diabetes, stroke and respiratory disease, and provide indicators that would identify an individual who might need a more thorough examination. When considering conducting a wellness assessment on a group, the first thing to remember is to shop prices and negotiate.

A wellness assessment should be fairly standard, in that, all should assess roughly the same health conditions and risk factors. Keeping in mind that all prices are negotiable there is no need to pay an unreasonable price for a relatively simple assessment procedure. It might be well to note that this type service could likely be contracted with a college or university that has a medical program or even one that has a kinesiology program and get equal service for a fraction of the cost as from a medical facility. The college or university could gain from such a contract by being provided with needed subjects to use in their training and experimental work.

A wellness assessment should check one's blood for things such as cholesterol, sugar, tri-glycerides, and other indicators of the existence of danger signals. Blood pressure, heart rate (both at rest and rapid) and percentage of body fat are but a few of the other areas normally checked during a wellness assessment. If there is a wellness assessment included in the program, there are other uses for it that are also of value to the program: It provides the individuals of the group with vital information about their physical status and is the first step toward getting the members to buy into a wellness program. The wellness assessment could also provide a goal for the individual. "This is where you are now, and this is where you should be." This goal setting could very handily be incorporated into any type of incentive program. "If you reach your goal, as dictated by the wellness assessment, you get the reward." Incorporated into the assessment should be some information for the individual on "how to reach your goal", in other words, the corrective measures a particular individual needs to take, depend

primarily on the deficiencies found during the assessment, and the wellness assessment should include providing each individual with the necessary corrective measures that should be taken to achieve the optimum level of fitness for that individual. Goals should not only be realistic, they should be readily attainable. If a goal appears to be unattainable to the individual trying to reach it, the chances of the goal ever being reached are greatly reduced. To offset that, one might set a series of mini-goals leading up to the main goal, with a reward for achieving each mini-goal along the way.

In order to better illustrate the process, an imaginary city was created and some realistic figures used to show how an organization would develop such a program:

Averagetown Texas is a city with a population of fifteen thousand per the last census. There are a total of one hundred and fifty employees and forty five family units included in the insurance plan that Averagetown has been operating with for the past three years. The city pays for the employees' insurance and the employees with participating family units pay for their respective families. The individual premiums were roughly $213 per month per employee, and approximately $355 per month per family unit. This amounts to a total annual premium of $576,000.00, of which the city has been paying $384.000.00, with the employees who had family units covered by the insurance paying the remaining $192,000.00, in premiums. The new city manager convinced the city council to let him proceed with the implementation of an alternative program to the traditional means of providing health care insurance for their employees. He examined the city's last five years' claim rates and discovered that they averaged

$35,000.00 per month or $420,000.00 per year. Sensing that $35,000.00 per month for a group that size might be unusually high, he checked with other cities of comparable size and also checked the individual claims filed by the city's employees and learned that their average was high when compared with other cities' and that the reason it was that high was because there had been five claims that had totalled nearly one million dollars.

When setting aside those claims and recalculating the claims rates he learned that the new figure amounted to approximately twenty thousand dollars per month, which was closer to the average of all the cities he had polled. When he checked, the city manager learned that of the five who had experienced the high claims, one had died, two had retired, one had left the employment of the city and only one was still employed. Checking still further, the city manager learned that the individual who was still with the city, had suffered a heart attack, undergone a triple bypass surgery, and was on a medication regimen that was costing approximately one hundred and twenty dollars a month. Otherwise, the doctors had given him a clean bill of health and he had been returned to full duty and had been working for the past three years with no significant illnesses. Concerned about the possibility of other "time bombs" within the group, he decided to conduct a wellness assessment of all the employees and decided to invite the spouses to participate as well. He checked with a couple of the local doctors and learned that he could have the entire group run through an examination for fifty dollars per person. Each doctor had agreed to a price if they were to conduct all the examinations.

Not sure whether the council would approve a ten thousand dollar expenditure he decided to call the university that was in a neighboring city. He reached an agreement with their medical college to have a complete wellness assessment conducted on the entire group and the only cost would be to pay the cost of the lab work for the blood, about seventeen dollars per person. He presented both proposals to the council (the use of a local doctor for fifty dollars a person and the use of the nearby university medical college for seventeen dollars per person) and the council readily approved the use of the university.

The city manager next arranged meetings so that he could personally address each and every employee, and invited their spouses. He fully and completely informed them of the plans for his own "health care reform package" for the group. His goals were simple: He wanted to provide for all the employees and their families the very best health care available . He wanted to do this with the least possible cost to the employees and to the city. He wanted to return much of the savings realized back to the employees. And, he wanted to see the entire group enjoy the best health possible. He spoke candidly, openly and honestly. He explained why he wanted each member of the group to participate in the wellness assessment program. In short he was able to get ninety-eight percent of the group to participate in the wellness assessment. No surprises came out of the wellness assessment program. The group as a whole was pretty average, in terms of health status. Some had higher than desired cholesterol levels, a couple of the officers had high blood pressure, one considered dangerously so. However, overall the group was considered

average, in that all of the members fell into an age risk group within ten years of their actual age with the exception of three who fell into age risk groups of ten to twenty years higher than their actual ages. Each member was provided with the information about what their health status was and what it should be and what they needed to do to reach their desired health status. The city manager got a compiled form of the data and was able to determine that a more realistic estimate of the projected medical expenses of the group should be more in line with the average of the other cities polled, that being approximately $20,000.00 per month. He arbitrarily decided, however, to stay with the claims rates experience for the first year. He also decided that no matter what, he would set aside for the first year the same $576,000.00 that the city had been paying by the traditional method, and collect the same $192,000.00 from the employees for their families so he allocated from the budget the same $384,000.00 for health care as in the past.

He also decided to offer the employees and their spouses $250.00 deductible instead of the $500.00 the insurance company had been providing. He found an insurance company who agreed to become a TPA for seven percent of the claims paid, and the insurance company already had in place a PPO program with the North Texas Health Care Facilities Organization which included the local hospital and a number of major hospitals in the neighboring metropolitan area, as well as several local doctors. The PPO agreement called for the city to pay eighty percent of all costs over the deductible at any PPO facility and fifty percent over deductible if the employee chose to

use a non-participating facility or doctor. In turn the cost of services at any of the PPO facilities was approximately twenty-five percent of the list price. He also agreed to purchase a $35,000.00 deductible co-insurance policy from the same insurance company for an annual cost of $60,000.00. He made the following calculations:

Estimated claims	$420,000.00
Co-insurance	60,000.00
TPA	29,400.00
Emergency	28,000.00
Incentive/fitness	20,000.00
Reserve	19,400.00
Total	$576,000.00

He had estimated his claims the same as they had been for the past five years' average, which gave him the calculation for the TPA. If it turns out the claims are consistent with the city's past average, there is only a nominal savings, however, he would have still provided better coverage for his employees, and having manipulated the risk by coverage in the event of a catastrophic illness with a co-insurance plus setting aside the additional amount to completely cover such an incident should it occur, he has reduced his risk to a minimum. If the claims rates are more in line with the average of other cities, the reserve would be closer to $240,000.00 for the first year. During the first year a set of exercise equipment was purchased and an incentive program was developed aimed at providing incentives for improvements in two areas: The first was for each

member to obtain their recommended health status, and the next was aimed at deterring abuse of the program and sick time. The department heads in the city government bought into the incentive programs and developed their own incentive programs and began competing between departments. Through the efforts of the majority of the group as a whole the program was a success. The first year the claims rates were down to $25,000.00 per month and the city realized a savings of more than $150,000.00 much of which was held in reserve for emergencies for the next year. The next year the claims rates had even dropped further to twenty thousand dollars per month and larger sums of money were channelled into the incentive programs and still better health care coverage was provided the employees. The group as a whole were generally healthier and morale was higher than it had ever been.

Early in the third year two officers were involved in a major automobile accident and both had long hospital stays with countless expensive surgeries. The hospital bills mounted to well over half a million dollars. As the city manager contemplated over how although the idea of a co-insurance was a good one he was very thankful for the fact that the city still had Worker's Compensation Insurance.

CONCLUSION

By exploring the alternatives available in providing health care to a group and learning that some of the alternatives promise to afford a considerable savings hopefully this effort will provide police chiefs and other managers with another tool to be used in the never ending problems associated with managing the budget. It is understood that in almost every case, a police chief would not be in the position to have the final word in the decision making process for this subject, however, if armed with enough compelling information a chief might present a convincing argument even to the most skeptic city manager or council.

Although the primary purpose of this paper is to serve police chiefs with a new managing tool, the nature of the subject matter renders it impossible to write it without it becoming equally applicable, and of interest, to managers of any organization of any size, more especially those with fewer than five hundred employees.

If this paper has not provided enough detailed information to convince the reader that a modified version of a self-insured program is a viable way of saving money and providing a group of employees with better health coverage than they are presently receiving, hopefully it has succeeded in at least piquing one's interest enough to cause an employer to at least explore the subject further as a viable consideration before discarding the idea.

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