REDUCING HEALTH INSURANCE COSTS IN TENNESSEE CITIES

September 2007

Don Darden, Municipal Management Consultant

THE UNIVERSITY of TENNESSEE
MUNICIPAL TECHNICAL ADVISORY SERVICE

In cooperation with the Tennessee Municipal League

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The Municipal Technical Advisory Service (MTAS) was created in 1949 by the state legislature to enhance the quality of government in Tennessee municipalities. An agency of the University of Tennessee Institute for Public Service, MTAS works in cooperation with the Tennessee Municipal League and affiliated organizations to assist municipal officials.

By sharing information, responding to client requests, and anticipating the ever-changing municipal government environment, MTAS promotes better local government and helps cities develop and sustain effective management and leadership.

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MTAS provides one copy of our publications free of charge to each Tennessee municipality, county and department of state and federal government. There is a $10 charge for additional copies of "Reducing Health Insurance Costs in Tennessee Cities."

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REDUCING HEALTH INSURANCE COSTS IN TENNESSEE CITIES

INTRODUCTION

In the early days of health insurance, there were no cost controls. Cities either did not provide employee health insurance, as a matter of public policy, or they simply figured out ways to budget the cost as a necessary expense.

In the early 1970s, the federal government authorized the establishment of statewide health systems agencies and regional comprehensive health planning agencies to develop area-wide health systems plans, reduce over-construction of hospital facilities, and better use expensive equipment brought about by improved technology. All one need do today is look around your area or region and see the number of hospitals that have underutilized beds and expensive technology that is available to most every community hospital, and you will most likely even see a helicopter at more and more community hospitals.

The response of insurance carriers to significant cost increases included limiting the scope of health insurance coverage, shifting more of the cost to the employee through higher deductibles, initiating 80/20 hospital and medical coverage rather than 90/10 or 100 percent coverage. Out-of-pocket expenses for the employee were also increased as a means of helping shift more of the cost from the employer. The 1980s also saw the introduction of hospital admission authorization and testing, surgical authorizations, and utilization reviews, in addition to other cost-saving measures. In the 1990s came managed care with maximum fees for procedures, 100 percent coverage after copayments for medical services and prescription drugs, tiered benefits, provider networks with discounted hospital and medical charges, health maintenance organizations, and other similar strategies.[1]

Many of these strategies perhaps contributed to reducing the amount of cost, but healthcare costs continued to increase at an alarming rate. Much of what was done, however, amounted to something akin to "rearranging the deck chairs on the Titanic." Shifting costs from the employer to the employee may have temporarily reduced the amount of the increase in costs for the employer, but ultimately the increase in healthcare costs has driven the cost of health insurance. A consequence of shifting cost is that fewer employers and their dependents can afford insurance, and they may ultimately wind up among the uninsured. It is also generally recognized that those without health insurance may be in poorer health than those with coverage. The uninsured are less likely to seek preventive care and are more likely to wait until dire health circumstances force them to seek medical attention.

Experts report that the uninsured cost of medical and hospital services may add as much as a 20 percent markup.[2] In *The Tennessean* (April 4, 2005), a letter to the editor characterized individuals without health insurance as "shoplifters" because they choose not to be insured. Before we become too harsh with the uninsured, we need to make sure that we understand the plight of many in this category. First, a person who has no insurance because he or she was laid off by a previous employer may have exhausted COBRA coverage and may have been diagnosed with arthritis or some other serious disease. In this case, he or she may not qualify to buy health insurance at any price.

If a city employee makes $8 per hour ($16,640 per year) and has a spouse and two children, his or her yearly health insurance cost for family coverage under the state's Local Government Health Insurance Program would be $13,680 as a level two participant. That is 82 percent of his or her gross income, leaving $2,960 yearly for food, clothing, shelter, transportation, and utilities. The simple truth is that this person cannot afford health insurance. If this same employee made $16 per hour, he or she would still be spending 50 percent of his or her income for health insurance. This is still too high for even a meager budget for basic necessities.

An employee who is perfectly healthy may have a dependent child born with a serious deformity. If the employee is laid off and has used all federal extension protection, his or her insurance will expire. This employee may be confronted with thousands of dollars in hospital and medical bills and no health insurance. The choices people make do not always reflect their circumstances.

Among the major factors that increase the cost of health care are:

- Improved health care technology and prescription drugs
- Medical liability insurance and large jury awards
- An aging population
- Subsidizing the care of uninsured patients
- Over-construction of hospital facilities
- Inefficient use of hospital and medical equipment
- Over insurance as the result of poor plan design

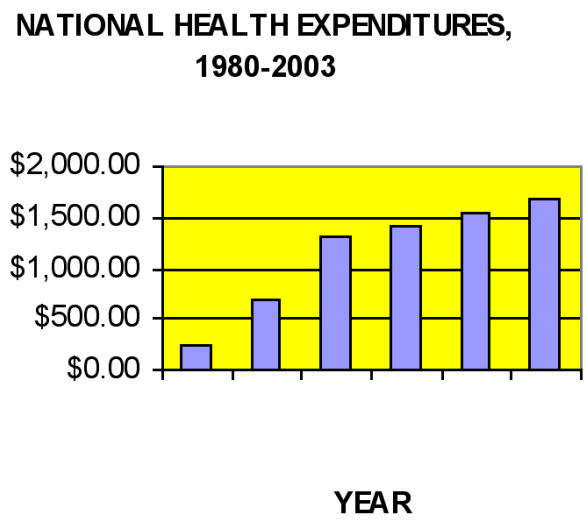
The Class Action Fairness Act of 2005 has the potential to help reduce amounts awarded in state courts for large class action suits. The new law requires that such suits be heard in federal courts rather than state courts where trial lawyers may shop for sympathetic judges. In addition to large suits and awards, physicians and hospitals are often pressured to provide unnecessary defensive medical tests as a way to reduce liability.

For many Tennessee cities, there is concern about the ability to manage health insurance costs. For the most part, they receive health insurance from a large established carrier or the state of Tennessee health pool, where individual city management strategies may be counter to their rules and procedures. A few of the larger cities have programs that are fully or partially self funded. It is imperative that cities contracting with insurance companies for health coverage seek to involve themselves with carriers that are receptive to changes that may well mean reduced health insurance costs.

HEALTHCARE EXPENSE

Americans spend a great deal on health care. It is estimated that 278.4 million people in the United States spent $1.7 trillion on health care in the year 2003. Chart 1 below shows that health expenditures in the United States increased from $245.8 billion in 1980 to $1.7 trillion in 2003, an increase of 579 percent, or an average of 25 percent annually. The chart also shows that the amount of increase was greater between 1980 and 2000 than between 2000 and 2003. Health expenditures increased by 7.7 percent in 2003, which is less than the 9.3 percent increase in 2002. On a per capita basis, health spending increased to $5,670. Out-of-pocket spending for health services grew 7.6 percent.[3] It is important to note that such averages may not be helpful in analyzing certain segments of the population. People over 65 years of age, for example, have health care expenditures that are three times more than those for people under 65.

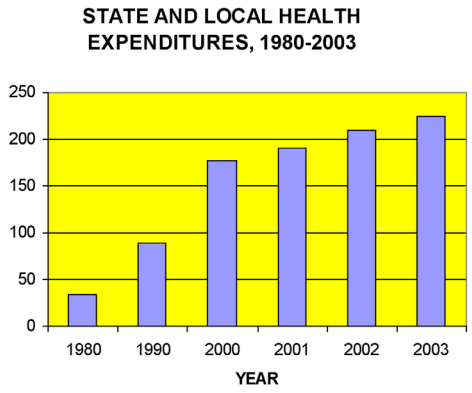
Chart 1



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census, February 2005.

State and local expenditures for health care experienced percentage increases similar to increases for the nation as a whole. Chart 2 below shows that state and local governments spent $33.5 billion on health care in 1980, and by 2003 this expense had grown to $224 billion, an increase of 569 percent or 25 percent per year. Here again the relative increase has been less than for the period from 1980 to 2000.

Chart 2



Source: U.S. Department of Commerce, February 2005.

An article in *The Tennessean* (September 15, 2005) reported that premiums for job-based health insurance increased by 9.2 percent in 2005, less than the previous double digit increases for the four previous years but about three times more than inflation. The news article noted that the average cost for family coverage is $10,880, which exceeds the income of an employee who makes the minimum wage. Single coverage costs $4,024 per year. The employee's share of the cost was 26 percent for family coverage and 16 percent for individual coverage. (The information was based on a survey of 2,995 randomly selected public and private employers from January to May).

HEALTH INSURANCE COVERAGE

In the United States 243.3 million people (84.4 percent of the population) have health insurance coverage.[4] This means that 45 million people (15.6 percent) are without health insurance coverage. Today 174 million people are covered by employment-based health insurance.[5]

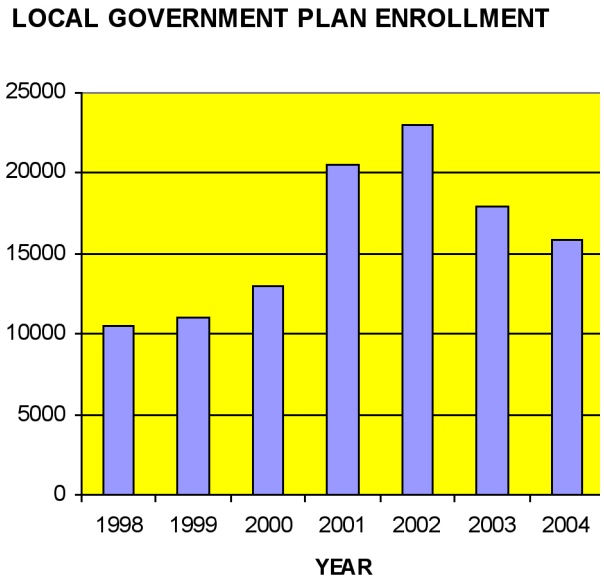
In Tennessee, census data indicate that 12 percent of the people are without health insurance. The absence of coverage seems to be related to (1) employment in an agency or firm where group coverage is not provided, (2) individuals who are self employed, (3) level of income, and (4) insurability.

Increasingly, both private businesses and government are having problems providing health insurance coverage for their employees due to significant increases in health care costs. Many local governments have experienced increases even greater, perhaps due to the size and health of their workforces and an aging population.

Tennessee's Local Government Health Insurance Program has seen annual cost increases averaging 19.3 percent for individual coverage and 21 percent for family coverage over the past five years. One

level two participating city in Middle Tennessee had premium expenses for individual coverage rise from $232.48 monthly in 2001 to $456.79 during 2005, an increase of 96.5 percent or 24 percent per year. Participants in that same city plan had monthly increases of from $552.77 to $1,140.45 for family coverage for the period of 2001 to 2005, an increase of 106 percent or 26.5 percent per year. Another Middle Tennessee city, with coverage provided by a different carrier, has family coverage costing more than $1,300 per month. The city pays $500 per month of this expense for employee coverage, and the employee pays approximately $800 for dependent coverage. Based on a salary of $29,000 this expense represents 39 percent of take home pay. Such increases are most likely a contributing factor in the reduction of enrollees in the Local Government Health Insurance Program since 2002. Chart 3 shows changes in enrollment in the Local Government Health Insurance Program for the period of 1998 to 2004. It can be seen that enrollment increased dramatically from 2000 to 2002 and then began a significant decline.

Chart 3



Source: Department of Finance and Administration, State of Tennessee, April 2005.

Larger cities are more likely to provide health insurance for employees and dependents. The latest (2005) MTAS salary and fringe benefit survey surveyed all 347 Tennessee cities. Depending on the question asked, 108 to 179 cities responded to the survey. This is a 51 percent response and is a good representative sample. For the purpose of this report, analysis is presented in the following areas:

- Cities with Health Insurance
- Wellness Programs
- Required Physical Examinations
- Deductibles
- Employee Contributions

CITIES WITH HEALTH INSURANCE

Table 1 below shows that of 178 survey responses, 138, or 77.5 percent, provide health insurance. Forty cities, or 22.5 percent, do not provide insurance. Table 1 shows that slightly more than half of cities with populations of less than 2,000 provide health insurance. All cities in the remaining groups, except for group IV (90 percent) provide health insurance. Based on this survey, it appears that 77.5 percent of Tennessee cities provide health insurance.

Table 1: Tennessee Cities Providing Health Insurance by Population Group

Population Group	Provide Health Ins.	No Health Ins.	% Providing Insurance
I (100,000+)	3		100
II (15,000-99,999)	20		100
III (8,000-14,999)	17		100
IV (4,000-7,999)	30	3	90
V (2,000-3,999)	26		100
VI (less than 2,000)	42	37	53
Total	138	40	

NOTE: 178 cities responding.

Source: *MTAS Salary and Fringe Benefits Survey*, 2005.

WELLNESS PROGRAMS

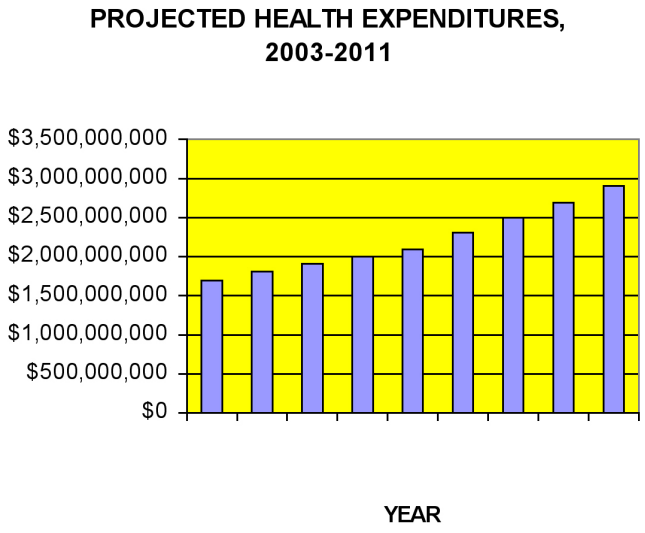
A wellness program is designed to encourage healthy lifestyle habits in diet and exercise so that employees are not likely to develop diseases and sickness as the result of obesity and lack of exercise. Many cities apparently do not use wellness programs because they do not see the connection between healthier lifestyles and the cost of health insurance. Sometimes they see financial incentive for participation in wellness programs as an unnecessary expense. Survey data indicate that larger cities with adequate financial resources are more apt to have wellness programs in place. Of 147 survey responses, 38 cities indicated that they had wellness programs and 109 do not have such a program. The data indicate here, too, that wellness programs are not extensively used in Tennessee cities. Only 25 percent of cities in Tennessee offer wellness programs.[6] Approximately two-thirds of those cities with populations of more than 15,000 offer such programs.[7] MTAS is aware of very few Tennessee cities with comprehensive wellness programs.

The bottom line for city governments is that the cost of employee health insurance coverage is fast becoming prohibitively expensive. As a result, an increasing number of cities in Tennessee do not provide health insurance, and those that do are likely to limit the amount of public funds that they are willing to spend. Cities are looking for ways to reduce the cost of providing health insurance for their employees. Smaller Tennessee cities, in many instances, are financially unable to pay the increased costs of health insurance and as a result, are unable to retain good employees, for which they have provided training and experience. The inability to retain trained employees is an added personnel cost for too many smaller Tennessee cities. This report looks at practical ways that cities can reduce the cost of providing health insurance for their employees today and in the future.

STRATEGIES FOR REDUCING HEALTHCARE COSTS

National healthcare expenditures are projected to amount to $2.8 trillion in 2011, with an average annual growth rate of 7.3 percent from 2001 to 2011.[8] According to new data from the Medical Expenditure Panel Survey, in 2000 the average annual health insurance premium in the private sector increased to $2,655 for single coverage and $6,772 for family coverage, an increase of 33.3 percent and 36.7 percent respectively since 1996.[9] Spending for health care increased at virtually identical rates in the public (6.9 percent) and private (7.0 percent) sectors.[10] Chart 4 shows the projected increase in healthcare expenditures based on a growth rate of 7.3 percent annually.

Chart 4



Source: Agency for Health Care Research and Quality, Rockville, Maryland, September 2002.

Several strategies have been used in recent years to reduce costs, including physician hospital organizations, different capitation schemes, and negotiated discounts for private insurers. Another cost-sharing strategy includes various tiered copayment systems for prescription drug benefits and hospital use. Other strategies are managed

care plans, fraud and abuse investigations of the Medicare program, and allowing inpatient hospital contracting under Medicaid.[11]

Private sector employers have responded by encouraging employees to enroll in managed care plans and restructuring benefits packages and contribution formulas, and providers have engaged in mergers and consolidations.[12]

Strategies that have reduced costs include:

- **Fixed employer contribution methods.** Employer premium costs were lowered by an average of $480 when employers offered employees more than two plans and made a fixed dollar contribution regardless of the plan chosen, compared to making a fixed dollar contribution and offering only two plans.
- **HMOs and competition.** HMOs reduced costs in highly competitive markets by substituting ambulatory care for hospital visits.
- **Managed care and a state mental health parity mandate.** Three years after an insurer introduced a managed behavioral health care plan, costs for mental health/substance abuse care dropped 39 percent.

Strategies with mixed results are:

- **Flexible spending accounts.** The tax exemption to individual users is estimated to reduce federal revenues by at least $8 billion. At the same time, FSA users spend money on medical services with relatively minor value in order to avoid losing funds.
- **Cost sharing.** Higher deductibles and copayments save money for insurers but lead to higher out-of-pocket consumer expenses. The burden falls more heavily on people with the lowest income, those with chronic health conditions, and Medicare beneficiaries without employer-subsidized supplemental coverage or Medicaid.
- **Hospital mergers.** One study showed a 7 percent reduction for consumers. A later study showed that the savings were considerably smaller, or even nonexistent, when the merging hospital was compared to rival hospitals competing in the same market.[13]

Local government managers and decision makers do not control the healthcare system. The best way for cities to affect health insurance cost favorably is to do a better job managing their existing programs and using all of the resources available.

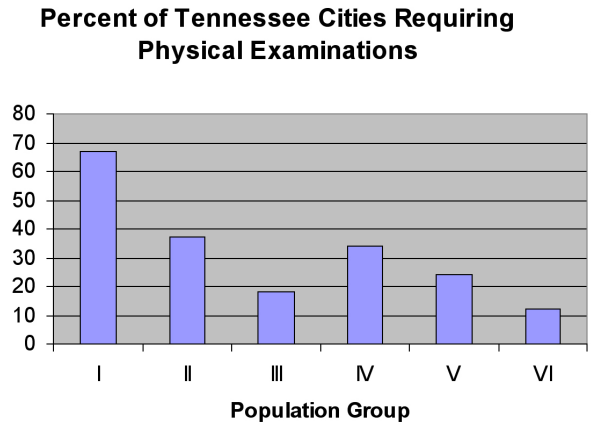
Strategies for managing health insurance cost in Tennessee cities include:

1. **Pay the insurance premiums regardless of the increased cost.** One way many cities have dealt with increased costs is to simply budget and pay the expense for health insurance.
2. **Make sure your existing plan is managed effectively.** Among management practices recommended by MTAS are:
   - *Enact mandatory retirement age* for public safety personnel.
   - *Eliminate duplicate coverage*. Some cities may have two employees, who are husband and wife, as the primary insured. One should be primary and the other the dependent for health coverage.
   - If your city has less than 20 employees, Medicare is generally the primary payer for all people with Medicare enrolled in the group health plan if the plan requests a Smaller Employer Exception to the MSP rules. Medicare is generally the secondary provider for cities having more than 20 employees.[14]
   - *Require post-offer employment physicals* for new employees. The city should not be specifically interested in blood pressure, cholesterol level, etc. The city needs to know if the employee is physically able to perform the essential functions of the job.

This requirement should eliminate prospective employees with chronic illness or preexisting injuries. It should also include a drug test. Some cities feel that they cannot afford the cost of post-offer employment physical examinations, yet it may be these same cities that employ a person with a long history of back problems or some other prolonged illness that significantly adds to the cost of health insurance and liability for the city. It would not be good public policy to hire a firefighter who could not lift more than 10 to 20 pounds or a police officer who is so physically unfit that he or she cannot perform the essential functions of the job. MTAS consultants see too many instances where a city sends a prospective employee to a doctor for a physical examination without any instructions from the city as to the specific purpose of the examination, which is to determine whether the employee "is physically able to perform the essential functions of the job." MTAS has a publication on physical ability and agility testing for police and fire that should provide helpful ways to aid in determining a prospective employee's ability to perform a job. Chart 5 shows the percent of cities in Tennessee by population group that require physical examinations.

- *Require annual physical examinations*. It is common practice in Tennessee for a city to require that a potential employee take a pre-employment physical, but after the employee is hired he or she may never be required to take another physical examination for the next 20, 30, or more years. Annual physical examinations may well identify health problems before they become critical and costly for both the employee and the employer.

Chart 5



Source: *MTAS Salary and Benefit Survey*, 2005.
(Note: there are only four cities in population group 1.)

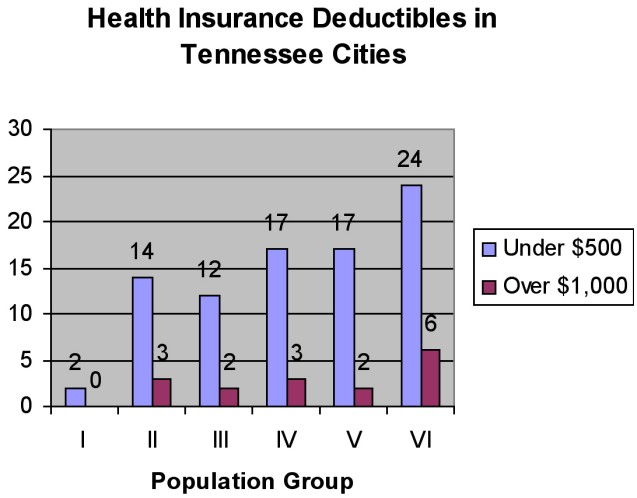
- *Increase deductibles and out-of-pocket expense*. This alternative is not popular with public safety and public works employees who are often among the lowest paid city employees. It is a traditional and effective approach to reduce costs for the employer that shifts a larger part of the cost of health insurance from the employer to the employee. Cities should be cautioned, however, that increasing deductibles will likely result in more uninsured workers.

  In Tennessee 84 percent of cities have a deductible for health insurance of $500 or less. Chart 6 shows the number of cities by population group with deductibles under $500 and those that are at least $1,000, based on a response from 102 cities. It is very difficult to explain to a firefighter, policeman, or public works employee making $27,000 and qualifying for housing assistance and other forms of relief that his or her deductible for insurance should be raised from $200 or $350 to $3,000. The dilemma is that the employee reasons that he or she cannot afford insurance with such a high deductible, and the city may have

reached the point where it cannot afford the excessively high premiums resulting, in part, from low deductibles. It is, however, easier for an employee to raise $3,000 for the deductible than it is for him to raise $115,000 for open heart surgery.

Only seven cities, as reported in the MTAS Salary and Benefit Survey, have deductibles of more than $1,000. Two cities are in group 1; two are in group 2; and three are smaller cities. One city reported a $4,000 deductible.

Chart 6



Source: *MTAS Salary and Benefit Survey*, 2005.

- *Establish a flexible spending program.* A flexible spending program allows the employee to spend pretax dollars for reimbursable medical expenses. The employee is not required to pay income and Social Security taxes on dollars spent for qualified expenses, and the employer is not required to match Social Security taxes for such expenses. Table 1 shows estimated savings for employers with from 25 to 400 employees based on conservative qualified expenses of $1,740.

Table 2: Tax Savings for Cities

Employees	Estimated Social Security Tax Savings
25	$ 3,327.75
50	$ 6,655.50
100	$13,311.00
200	$26,622.00
400	$53,244.00

Employees are sometimes reluctant to participate in flexible spending programs because they are not sure about what their estimated medical costs might be for a year. Once they have prepared the estimate, they must use all of the money estimated in the account. Failure to spend all the money in the account means the city keeps the balance at the end of the year. Recent changes in federal regulations allow the employee an additional 2.5 months to spend all the money in the account. An example of such an account is shown below:

Flexible Spending Account
Employee: John Doe

Qualified Expenses	(estimated)
Eyeglasses	$ 320
Eye Exam	$ 80
Dental	$ 580
Doctor visits (copay)	$ 160
Deductibles	$ 300
Prescription Drugs (copay)	$ 300
Total	$1,740

The employee saves 7.65 percent on Social Security taxes ($133.11) and, based on a 15 percent income tax rate, $261 for a total yearly savings of $394.11. The employer would save the matching share on Social Security, $133.11. It is important for the employee to understand that if he or she overestimates expenses by $100 and spends only $1,630, he or she will still save $294.11. There are all sorts of ways to legitimately add to expenses during the year. If, for example, it is the first of November and the employee still has $350 left in the account and is concerned that this may be left in his or her account, the employee can order an extra supply of contact lenses or a pair of prescription sunglasses or make similar adjustments for other expenses.

3. **Offer a core health insurance plan for catastrophic illness and a supplemental policy for expenses up to the amount of the deductible.** Peggy Gattis, metro mayor of Lynchburg/Moore County, advised MTAS that this very small metropolitan government saved money by increasing the deductible considerably for major illness then providing a supplemental policy. Variations of this alternative could be to:
   - Provide a catastrophic illness policy and a supplemental policy at city expense.
   - Purchase a catastrophic illness policy at city expense and a supplemental policy with the employee paying 50 percent of the cost.
   - Purchase a catastrophic illness policy at the city's expense and a supplemental policy at the expense of the employee. Here the employer might offer the employee more than one level of supplemental policy.
   - Other—percentages may be varied for both catastrophic illness and supplemental coverage.

4. **Purchase a catastrophic coverage policy with a $3,000 deductible at city expense and pay one-half ($1,500) of the deductible for qualified expenses up to the amount of the deductible.** In effect, the city would be self insuring $1,500 of each eligible claim of up to $3,000. The city would need to review claims and premium cost for the past five years to determine the feasibility of this strategy. The city would be comparing the cost of current and projected premiums to a $3,000 deductible health insurance policy and up to $1,500 for each insured claim.

5. **Decide what your city is willing to pay in premiums and pass the remainder of the premium cost on to the employee.** This alternative might offer more than one level of coverage at the employee's expense. An example of this alternative follows:

Employer pays	$400/mo. (basic)
Coverage Premium	
Employee supplemental @ 100%	$400
90% $350	
80% $300	
70% $250	

6. **Establish a partially self-funded insurance program.** For this program there would be two stop losses, one at the maximum out-of-pocket expense for the employee, for example, $1,500 and the other at the total budgeted for health insurance. Generally, a third-party administrator would pay claims from premiums for health-related expenses. Usually such plans provide for the employee to pay a deductible, after which the plan might pay 80 percent of expenses up to the maximum out-of-pocket expense. At that point the administrator would pay all of the hospital or medical claims. When all claims together reach the aggregate stop loss

amount, private insurance would pay the claims. This makes it possible for a city to budget a specific amount for health insurance with certainty that the expense will not exceed what is budgeted.

7. **Establish a health savings account plan.** The Medicare Prescription Drug Improvement and Modernization Act of 2003, which was signed into law by the president on December 8, 2003, authorizes health savings accounts. The act became effective on January 1, 2004, and provides tax incentives for health and retirement security. To date a very small percentage of businesses and governments have established such accounts. It is very likely that in the future health savings accounts will become the preferred way of providing health insurance for many employees and their dependents. To participate in a health savings account (HSA), the employee must have coverage under an HSA–qualified, high-deductible health plan. Generally this is insurance that does not cover first dollar medical expenses. Federal law requires that the health insurance deductible be at least $1,000 for individual coverage and $2,000 for family coverage. In addition annual out-of-pocket expenses may not exceed $5,100 for the individual and $10,200 for family coverage.

   Such plans may allow coverage for preventive care expenses, with or without a copayment, with a very small deductible for such things as routine prenatal and well-child care, child and adult immunizations, annual physicals, mammograms, pap smears, etc.[15] An account is established for the employee, and a monthly or other amount may be deducted from the employee's paycheck and deposited in the account. It is important to point out that the account belongs to the employee and not the city.

   The employee's HSA contribution each year may not exceed the amount of the high-deductible health plan (HDHP) but can be no more than $2,650 for the individual and $5,250 for family coverage.[16] The employer may also contribute to this account. The employee then uses funds in the account to pay for hospital and medical expenses that are below the deductible and up to the maximum out-of-pocket expenses. Funds deposited are not taxed. Funds in the account are treated very much like funds in a 401(k) in that the employee is entitled to all funds in the account plus investment earnings at age 65. Proceeds in the account distributed to the employee for other than medical expenses are taxable, just as with a 401(k).

   If the employee withdraws the funds prior to age 65, he or she is assessed a 10 percent penalty, as well as the taxes on investment earnings. HSAs are more in keeping with consumer choice in health care rather than with managed care. The employee must manage health care expenses with the exception of expenses for catastrophic illness.

   One of the criticisms of this program is that it is nothing more than an incentive for the employee to agree to pay a larger deductible. It truly is an incentive, and it can be a very attractive incentive for an individual or family that does not experience significant healthcare costs because funds that are deposited in the HSA are carried over from year to year and can represent a considerable savings.

An example of an HSA might look something like this:

Employer contribution—catastrophic coverage	$ 400/mo.
Employer contribution to employee's account	$ 200/mo.
Employee's contribution to account	$ 200/mo.
Total annual contribution to account	$4,800
Expenses for one year:	
Doctor visits 10 @ $60	$ 600
Prescription drugs 10 @ $40	$ 400
Physical exam @ $400	$ 400
Total Expenses	$1,400
Net to be carried over to the next year	$3,400

The employee would receive $3,400 plus investment earnings for an overall investment of $3,400.

8. **Establish a Wellness Program.** Although most Tennessee cities do not use a wellness program, its importance as a means of reducing healthcare costs should not be ignored. A wellness program may be defined as a program that seeks to maintain or improve health prior to serious problems arising. Such programs may be used to trim healthcare expenses, reduce absenteeism, and in some cases actually increase productivity. Too often cities dismiss components of a wellness program as a costly expense that is not worthwhile. The U.S. Department of Health and Human Services reported in a recent study that for every one dollar spent on wellness programs there is a positive benefit of from $1.49 to $4.91. The median benefit is $3.14 saved for every dollar spent.[17]

Kristi Reynolds manages perhaps the most comprehensive wellness program in Tennessee's public sector in Knox County. Kristi is facilitating health training for the University of Tennessee at various locations across the state. The program discusses reasons for a wellness program, benefits, design, and how it works, and also provides information for establishing a city wellness program. Cities interested in wellness programs are encouraged to review the Knox County Wellness program.

APPENDIX A

STATE'S LOCAL HEALTH INSURANCE PREMIUM RATES

LEVEL	HMO MEMPHIS	HMO NASHVILLE	BLUE CROSS PPO	BLUE CROSS PPO LIMITED
1 IND	$389.63	$400.05	$415.49	$312.02
1 FAMILY	$972.78	$998.77	$1,037.45	$779.02
2 IND	$428.62	$440.06	$457.12	$343.28
2 FAMILY	$1,070.09	$1,098.67	$1,141.23	$857.02
3 IND	$467.60	$480.08	$498.69	$374.49
3 FAMILY	$1,167.41	$1,198.57	$1,244.96	$934.92

	HMO CHATT.	J. DEERE POS EAST	HMO KNOXVILLE	HMO TRI-CITIES
1 IND	$427.57	$415.24	$427.57	$427.57
1 FAMILY	$1,067.55	$1,036.75	$1,067.55	$1,067.55
2 IND	$470.37	$456.79	$470.37	$470.37
2 FAMILY	$1,174.32	$1,140.45	$1,174.32	$1,174.32
3 IND	$513.13	$498.32	$513.13	$513.13
3 FAMILY	$1,281.02	$1,244.13	$1,281.02	$1,281.02

	BLUE CROSS POS MIDDLE	BLUE CROSS POS WEST
1 IND	$415.24	$415.24
1 FAMILY	$1,036.75	$1,036.75
2 IND	$456.79	$456.79
2 FAMILY	$1,140.45	$1,140.45
3 IND	$498.32	$498.32
3 FAMILY	$1,244.13	$1,244.13

NOTE: LEVELS 1, 2, AND 3 ARE BASED ON AGE OF GROUP AND CLAIMS EXPERIENCE.

FOOTNOTES

1. Employee Benefit Trends and Strategies, Presentation to the National Association of Manufaturers, by Margaret Flickinger, CE, Keller Benefit Services, Inc., January 27, 2005.
2. "Addressing the Needs of the Uninsured in a Challenging Economic Environment," Transcript of first session of a web-based teleconference held March 12, 2002, Agency for Health Care Research and Quality, Rockville, Maryland.
3. Centers for Medicare and Medicaid Services, Baltimore, Maryland, January 2005.
4. U.S. Department of Health and Human Services.
5. Ibid.
6. MTAS Salary and Fringe Benefits Survey, 2005.
7. Ibid.
8. Reducing costs in the Health Care System: Learning From What Has Been Done, Research in Action, Issue 9, AHRQ Publication No. 92-0046, September 2002, Agency for Healthcare Research and Quality, Rockville, Maryland.
9. Ibid. p. 1.
10. Ibid. p. 2.
11. Ibid. p. 3.
12. Ibid. p. 3.
13. Ibid. AHRQ, p. 4.
14. U.S. Social Security Administration, March 2005.
15. U.S. Internal Revenue Service, April 2005.
16. Ibid. IRS.
17. U.S. Department of Health and Human Services, September 2003.

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