White Paper

State Government Employee Healthcare Benefits

National Association
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Background and Focus on COMMUNICATION

No matter how you look at healthcare, it cannot be overlooked as a huge overall expense for state governments as well as all large employers—General Motors recently announced that $1,500 of the average cost of per vehicle sold is attributed to employee healthcare costs. Starbucks spends more on employee healthcare than it does on coffee beans. In state governments, an additional 9-16 percent of total payroll goes toward providing healthcare for employees. The Central States Compensation Association reports that with an average salary of $19.16 per hour for its member state workforces, an additional average of $2.16 is spent on healthcare or 11 percent. Southeastern States Compensation Association reports a salary of $14.94 and an average of $1.98 per hour for healthcare or 13 percent. From a total compensation standpoint, healthcare trails only cash (salary, wages) as state governments largest cost factor in most states and is the most administratively complex.

The strength of the National Association of State Personnel Executives is communication among its members. Healthcare benefits, the overall cost, how costs are shared between the state and its employees, coverage, and program design, are challenges that each state faces. This white paper reflects the NASPE vision to serve as a conduit between members and enhance connections. The strategies that states are using to address the escalating costs of health insurance benefits have been a NASPE priority for several years now.

The healthcare challenge has many facets in state government. For some HR directors, benefits administration is a division of their office and one of their direct responsibilities. For other directors, the issue is not their responsibility, but the impact to the total compensation package has been so dramatic, the problem is now squarely in front of them. Other state directors face the provision and costs as part of labor relations and collective bargaining. Many members, regardless of their direct connection to the issue, look to NASPE for comparative research on the details.

Two years ago, the NASPE Healthcare Taskforce designed a survey to collect data from states. The goal was to identify costs, data, and strategies to help states share best practices. What we found was that no two states appear to be alike. We also found that even simple questions regarding the healthcare benefit cost or design resulted in complex answers. In other words, the data was difficult to capture in a way that allowed meaningful comparisons among states due to the vast differences in each state in terms of the plan structures, administration of the plans, included populations in the plans and a multitude of other differences. The required research and complexity of answers limited state participation in the survey. Even simple data needs to be examined for underlying details and rationale before comparison.

We did find that certain "realities" play a significant role in healthcare benefits design, including:

- Healthcare benefits are expected with the state's size as an employer
- Eligibility and coverage details may be influenced by political and socially driven factors versus pure business case
- Benefit levels may be born of social, family friendly policy preferences, i.e. lower cost family coverage and/or coverage for domestic partners
- States face the burden of uncapped Medicaid expenses, and consequently tend to offer state sponsored employee health coverage to extended populations such as retirees and local government employees.

This white paper builds on the work of those involved with the survey, and offers an expansion of the issues that effort brought to the forefront.

During the summer of 2005, the Executive Committee of NASPE formed a new Healthcare Taskforce. The goals of the taskforce were to:

- assist the members and state governments who are wrestling with managing healthcare issues; and
- address some of the unique challenges state human resource managers face in the healthcare arena.

The taskforce concluded that focusing on issues that are unique to state governments as employers and issues that create greater challenges for state governments than for large private sector employers would be the greatest value to the NASPE membership.

However, no one seems to have the "silver bullet" that will resolve the multitude of difficult challenges facing employer sponsored healthcare plans. Regardless, we can keep these challenges out in front and monitor various state governments for how they deal with the challenges in the years ahead. NASPE is in a good position to do this with 46 states and US territories being active members.

The taskforce quickly reached consensus that communicating state government employee healthcare issues to governors, legislators, employees and all other stakeholders is paramount.

The private sector clearly focuses on the business necessity of offering competitive total compensation packages to its employees. That competitive value can vary greatly between industries; for example the fast food market competes for young, short time, low-paid labor with little or no experience while automakers, heavily steeped in collective bargaining tradition, compete for skilled, higher-paid labor. The need and level of healthcare from a competitive standpoint varies equally.

In state governments, social issues around healthcare often creep into the business policy within a competitive employment market. State governments often have to expand the reasons for being in healthcare to include groups outside the state government such as local governments, retirees and even the uninsured of the state. State governments frequently are expected to model an ideal program to other employers in the state.

A number of trends in the large employer group market have been noted in recent years, including a shift away from paternalism toward self-directed care in which employee/patients not only share more of the cost, they also participate in the healthcare decision-making. Evidence is in the rapid increase in consumer-driven health plans such as Health Savings Accounts (HSAs).

Another notable trend is employer interest in trying to influence employee behaviors that bear on healthcare costs, such as offering incentives for participation in smoking cessation programs or health risk assessments. Information technology has been leveraged to provide high-quality health information and personalized services and targeted messaging to support wellness, disease management and case management programs. Predictive modeling is now commonly used to identify potential risks before they manifest themselves as new claims, enabling preemptive changes in resource allocation.

Employers are finding their voice and power in coalitions that demand more accountability from providers and vendors. Provider compensation is under scrutiny and incentives are being realigned to reward physicians for improved health outcomes. Employers are demanding value with better cost-to-benefit ratios and transparency in pricing. The benefits consulting market is growing as employers outsource previously labor-intensive administration to consultants with high-powered computers and sophisticated software.

Aligning and Communicating Total Compensation

Many states have incorporated all health/life/dental benefits into their central HR function. Others have health/life/dental in completely separate agencies and view them as separate financial and contract management functions. While neither NASPE nor this taskforce is suggesting that there is a particular, optimal organizational structure for health/life/dental benefits we are suggesting that they need to be closely aligned and valued within a total compensation package for the state's workforce.

State governments overall tend to provide a higher level of employer contribution toward healthcare than do large private sector employers. Large private sector employers contribute an average of around 80 percent of the total premium and have been steadily trending downward over the past few years; state governments average above this amount and up to 100 percent of the premium. While this fact is not necessarily good or bad, it does need to be carefully valued in an integrated total compensation philosophy.

Cash, healthcare, retirement and paid leave benefits at a minimum should be valued together as a total compensation package in order to truly analyze and value the competitiveness within the job market. However, a true "valuation" of total compensation is often difficult and expensive. While a number of large, national consulting firms have valuation formulas and techniques, this taskforce is not aware of any that have been truly successful in comparing the total compensation of state government workforces to the compensation of the overall workforce within the appropriate job markets and recruitment areas. However, some level of valuation analysis is necessary for state governments to develop an integrated total compensation philosophy.

Taken in its entirety, total compensation of state government employees tends to be more competitive than viewing salary alone. However, the often-higher level of healthcare benefits and leave packages are usually not communicated well to employees. Total compensation calculators are relatively inexpensive to develop and can be helpful for employees to get a truer picture of the total investment being made by the employer. However, these calculators do not take into account the true valuation of all total compensation components including leave policies, retirement plans, healthcare plan structures and benefit levels.

Higher employer costs do not necessarily equal more value to employees. Generation X expects a healthcare benefit as part of the compensation package working for a large employer. The belief that state healthcare benefits are more generous than the private sector may have to be reexamined due to the differences in the workforce demographics. In other words, state healthcare plans simply cost more because of the demographics, which is meaningless to employees and prospective employees who are only concerned with the actual benefits and out of pocket expenses. Identical plan designs for Microsoft and the state of Washington will cost significantly more for the state healthcare plans.

Demographics

There are a number of unique demographic factors that have profound effects on state government's provisions for healthcare coverage for their employees. These factors can cost an additional 20 percent to overall healthcare costs, which is reflected in premium and/or co-pays and deductibles.

The average age of a state employee hovers around 45 in each state. This is the oldest average work age of all the jumbo employers. This demographic factor has a profound effect on healthcare premiums because this age group tends to utilize healthcare at a significantly higher rate than younger employees, including those in the core childbearing years.

In the late 1990s it was widely believed that the average age would significantly drop as large numbers of state employees became eligible for retirement. Most states currently have 30 to 40 percent of their workforce eligible for some level of retirement over the next five years. However, statistics over the last few years have contradicted the assumption that the average age would begin to drop as large numbers retire. First, there is a definite trend for state employees to remain on the job longer through their retirement eligible years; and, second, the average age of new hires tends to be in the upper 30s to lower 40s. Also, after the stock market corrections a few years back, retirement eligible staff no longer had defined contribution retirement plan balances and/or personal savings to adequately supplement their pensions. If these trends continue, it could be decades before state governments see a significant change or lowering of the average age of their workforces.

A major concern and significant cost driver for many state governments is the cost of continuing to provide medical coverage for retirees of the state. The average age of retirees in state government healthcare plans is around 70. Some states continue to fund coverage for retirees while others may cut contribution levels or simply coordinate with Medicare.

State and local governments providing healthcare benefits for retirees face unfunded liability issues that go far beyond those associated with defined retirement plans.

Louisiana is a good example of some of the complexities and issues that states experience when retirees are included in their healthcare plans. Louisiana provides coverage to approximately 45,724 retirees. Of this total, 26,886 have coverage under Medicare and 18,838 have no Medicare coverage. For those retirees with Medicare coverage, the state healthcare plan is the secondary carrier and coordinates benefits with Medicare. (Until the recent passage of the Medicare Reform Bill introducing Part D prescription drug coverage for Medicare eligible members, the state was the only provider of prescription drugs for this group.) The result is the state picks up these individuals on the state healthcare plans.

However, for those 18,838 retirees without Medicare coverage, the state healthcare plan remains the primary insurer. Some persons in this group have no Medicare coverage because they have not yet reached the age to become Medicare eligible. However, a significant portion of this non-Medicare group will never have Medicare coverage and Louisiana will remain their primary insurer forever. (Persons hired prior to the mid-1980s were not required to pay into Social Security. Thus, they may not have their 40 quarters of coverage for Social Security eligibility and are therefore not eligible for Medicare.)

To add to this cost, by statute Louisiana's contribution for most retirees' health premiums is the same as for active employees; 75 percent. The cost of retiree coverage is a significant, recurring component of the state's benefit costs.

Another unique demographic factor of state governments in general is the geographic location of its employees. State governments are either the largest or among the largest employers in every state. Collectively, state governments employ close to 2 million people nationally. While we do not have the actual number, we would estimate that about double this amount, or 4 million lives, are covered under state healthcare plan including family members, local government and retirees. Not only are state governments considered "jumbo employers" in regards to providing healthcare, the very nature of state governments requires them to have employees dispersed in every county or region of the state - this factor is very uncommon for most other employers.

Close to 50 percent of state workforces reside outside of major population corridors. This creates a heavy reliance on what can be more expensive rural healthcare systems. For many states, this factor creates inconsistencies around access and provider choices for rural versus the urban state employees. For example, closed HMO models similar to Kaiser Permanente typically do not exist outside major metropolitan areas - PPO models or slight variations are often the only rural alternative. Higher rural costs result from the lack of competition and provider networks that are willing to significantly reduce fee structures and hospital care costs. Provider networks in rural areas are limited and can generally count on the same business with or without significantly discounted fee structures. Typically, rural networks do not have the flexibility in their cost structures or profit margins to offer discounts often available in the urban markets. Although lack of competition is a factor, it may not always be the primary factor driving rural healthcare costs. Many rural providers serve a disproportionate number of Medicare beneficiaries. To the degree that reimbursement rates do not cover actual costs, such providers must shift costs to other payers. Rural providers are less likely to be in group practice and do not benefit from economies of scale in overhead and staffing costs.

The fairly common practice of expanding correctional facilities into rural state areas, for example, has significantly impacted the rural issues in providing healthcare. The end result is that urban employees often subsidize their rural counterparts from a total compensation standpoint; and, at the same time, these rural employees have significantly reduced choice and access. Rural state employees are often burdened by having to travel significant distances for healthcare—particularly for specialized care.

Employees requiring services from specialty provider practices in rural areas can find themselves particularly at risk during network negotiation battles with healthcare providers. Employees and legislators often call upon state government plans to intervene in negotiations for higher reimbursement levels to a sole oncology or obstetric practice that has left the network. This practice of intervention that can prove to be disastrous to network stability and cost control is of little interest to someone undergoing cancer treatment or experiencing a high-risk pregnancy or to legislators responding to the emotional intensity of such a situation.

Risk/Purchasing Pools

While some of the largest states such as California have created regional healthcare plans, the vast majority of states have created statewide plans that cover the entire state workforce combined into a single risk pool. Most states, philosophically and where possible, want uniform benefits for their entire workforce. Rates typically are blended, combining both the rural and urban sectors of the workforce. Though this practice creates somewhat uniform plans and costs, it can often create communication challenges. For example, policy makers may criticize the state government healthcare plans for being considerably more expensive than those compared to large city governments. The difference, of course, is that large cities have most of their workforces located in competitive urban healthcare markets compared to the blended rural and urban rates of state governments.

States vary widely as to the groups included in their healthcare plans. It is often difficult to determine what is an optimal size and scope of a purchasing pool. Though some states limit these to active state government employees, others include retirees, local government employees and school districts, and otherwise uninsured populations. Virginia does both, limiting participation in its state employee plans to active employees and retirees, but also offering local government and school districts the opportunity to participate in a separate program that provides access to the buying power of the state plan.

Although these inclusions may be compartmentalized into separate risk pools, structuring healthcare plans for such large populations can be extremely difficult, at best, and may go well beyond any optimal sized purchasing pool. Policy makers may mistakenly believe that economy of scale always increases purchasing power when limited provider capacity and incongruent risk pools may severely limit effects of large pooled purchasing and create overly complex administration systems.

These larger purchasing pools typically have an advantage for smaller local governments or other smaller groups when combined with state government plans since they achieve more advantageous discounting with providers. The larger purchasing pools typically do not save anything for the large state government employer since the economy of scale is usually achieved with around 20,000 participants. Additionally, although larger purchasing pools may seem to resolve some healthcare issues outside the core state government business, private sector providers may fear the “800 pound gorilla” concept of the purchasing power of extremely large purchasing pools and may vigorously oppose them.

Louisiana has certainly seen the impact of this concept. For example, the state could be reaping considerable additional savings on prescription drug costs by offering an incentive for their members to utilize mail order services to a greater extent. The state can negotiate much greater discounts, lower administrative costs and greater rebates from mail order distributors. However, the impact of fearing the purchasing power, retail pharmacies persuaded the state legislature to pass a law several years ago prohibiting them from offering incentives for any member to use a mail order pharmacy.

Healthcare Cost and Structure

There are basically four major cost factors state governments must consider in developing, delivering and evaluating their healthcare structure: employer contribution; plan design/structure and level of benefits; total cost of premiums; and total cost of out-of-pocket expenses to employees. Each of these requires complex analysis and decision making in designing competitive healthcare benefits for employees.

State governments vary widely as to the amount they contribute to employee healthcare plans. Two extremes may be seen with Colorado and Minnesota. Minnesota contributes 100 percent of the monthly cost of single (employee only) health coverage and 85 percent of the monthly cost of family coverage. It also has a mandatory primary coverage requirement. On the other hand, Colorado contributes an average of 68 percent of total premium and about 30 percent of the benefit-eligible employees do not take state offered plans.

There usually are clear philosophical and strategic differences that account for the wide variances among states. In the above example, Minnesota is pursuing significant quality improvements in their healthcare delivery while aggressively tackling utilization costs. In order to achieve this goal, they wanted to first have 100 percent participation in their program and have basically one plan for all participants. Colorado, however, had a long-standing policy of paying salaries that were tied to the prevailing practice of large private sector employers in their competitive labor market. While Colorado has generally maintained this salary philosophy, they fell well behind the same market in providing competitive healthcare. Now, Colorado is on the fourth of a five-year strategic plan to bring its healthcare plans within line of the private sector employers.

The following excerpt is from "2005 State Employee Benefits Survey" by Workplace Economics, Inc., pages 71-72. All of the information reflects policies in effect in each jurisdiction as of January 1, 2006.

> The average total premium paid for active employee health insurance continued to increase in 2006, reaching $445/month for single coverage and $1,017/month for family coverage. On average, state employers paid for 91.4 percent of the premium cost for single coverage and 80.62 percent of the premium cost for family coverage for active employees. Thirteen states pay the full cost of health insurance coverage for an individual employee—the employee pays nothing—and in three other states the employee has the option of selecting a plan that will be fully paid by the employer. Four states pay the full premium for family coverage and in two other states the employee has the option of selecting a plan that will be fully paid by the employer. In most states, the amount paid by the employee varies by the plan and coverage option selected by the employee. In Illinois, Kansas, New Mexico, Rhode Island and West Virginia, the portion of the premium paid by the employee also varies by salary.
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> All states provide or make available health insurance for pre-Medicare retirees, and 48 states provide or make available health insurance for Medicare-eligible retirees (age 65 or older). Indiana and Nebraska do not provide retiree coverage in the state health plan for retirees beyond age 65, although retirees in Indiana may now purchase a Medicare complementary plan through the state. In a number of states, the retiree's share of the health insurance premiums varies by characteristics such as date hired, date retired or years of service at retirement.

For further information on state healthcare plan variations, go to www.workplace-economics.com.

Employer contribution levels not only have a significant effect on employee out of pocket expenses and plan designs, they also drive employees to certain types and benefit levels of plans creating adverse selection issues within the plans. For example, because employees bear a much larger cost of their plans in Colorado, high cost, generous plans with low out of pocket costs attract high utilization employees - the end result is often a death spiral for the particular plan choice because the adverse selection of mostly high risk employees. In Minnesota, there is no adverse selection impact because the state has basically one plan for all eligible employees. Employees are required to participate in the plan and the state pays the full share of single premiums for eligible full-time employees.

Minnesota's mandatory health coverage arrangement for state employees not only eliminates concerns regarding adverse selection but also is less complex and less costly to administer and communicate. The state also benefits from fewer employee relations issues that could arise under voluntary coverage arrangements if an employee inadvertently or incorrectly "opted out" of health coverage and later sought coverage because of an unexpected illness or accident.

These issues create a constant balancing act for state governments when looking at plan design and overall structure. States also must constantly balance the cost to employees derived by overall premium costs versus out-of-pocket expenses derived from co-pays and deductibles. Current and prospective employees are generally concerned about plan structure, including choices and access to providers, level of benefits, and out-of-pocket expenses. They typically are less interested in how much the state may be spending on healthcare, or whether the state is an innovator in containing health care costs and improving quality. The importance of these factors becomes amplified in tight-budget years when states may forgo salary increases and employees' natural desire to maintain their level of total compensation comes into play.

Besides out-of-pocket costs, change is usually the biggest cause of consternation for employees. Changing plan designs that involve networks including primary physicians, available hospitals, prescription drug formularies, etc., are often seen as punitive by employees or as simply cost savings for the plans. Changes and the clear reasons behind them need to be communicated to employees well before the changes actually take place.

The balancing act among healthcare plan design, premium contribution levels, and overall costs can be even more complex when employee health benefits are part of collective bargaining. As noted in a recent *Health Affairs* article,

> Unions' direct impact is particularly strong through collective bargaining agreements that preclude major benefit changes except at renegotiation, which could be at two- and three-year intervals, locking in benefits for extended periods of time. Also, most public employers have multiple unions, often with staggered renewal dates, which further limits employers' capacity to engineer substantial and abrupt modifications.

There are numerous other health coverage bargaining-related issues as well. States with multiple unions that have differing goals or needs may have to negotiate different benefits designs and coverage arrangements. This in turn may result in a variety of health plans or delivery mechanisms, reducing the state's purchasing clout and increasing administrative costs. As also noted recently in *Health Affairs*, public unions can also "have powerful indirect effects on employee benefits through political activities" that are designed to retain the status quo or provide improvements.

Effective communications and working relationships with public sector employee unions are essential to address the challenges above. The collective bargaining process can be viewed as both an impediment and an asset to achieving these goals. In some situations, heightened visibility of the bargaining process and differences between the parties may add to tension and difficulties working through issues. On the other hand, collective bargaining may best focus and illustrate key trade-offs—for example, trade-offs between meeting rapidly rising health care costs and desires for increases in wages. Collective bargaining may also lead to new options or creative solutions to problems that may not have been considered otherwise.

In 2000, when Louisiana's contribution toward a member's health premium was 50 percent, only 54 percent of eligible civil service employees elected coverage.

A 2003 statute, raised the state's contribution for premiums 75 percent. On July 1, 2005, 70.9 percent of those civil service employees eligible for coverage took it. As expected, there is certainly a direct corollary between the election of coverage and the amount of participation by the employer.

Pennsylvania and the unions representing state employees created a trust fund in 1988. This trust fund eventually became the Pennsylvania Employees Benefit Trust Fund. A 14 member board of trustees controls it. Seven board members are union representatives and seven board members represent the state. This board hired a director to administer the plan. Pennsylvania, through collective bargaining, established a per person contribution each month toward healthcare. The board was empowered to set the benefit levels, exclusions, premiums and other conditions of participation in the plan. So, the benefit plan was truly jointly administered. The unions had just as much determination of benefit levels as management. The state could not unilaterally change the benefit or premium structure.

Because of this structure, until very recently Pennsylvania state employees did not pay anything for medical coverage for themselves and their families. This included medical, dental, prescription drug and hearing aid coverage. Both sides of the table had to decide on the implementation of wellness programs, disease management programs and all the other cost savings programs to keep coverage affordable.

Virginia pays 82 percent of the overall cost of coverage for active employees, and pays 100 percent of the cost of the commonwealth's new high deductible health plan. Employee participation is high, with more than 90 percent of employees enrolled in one of the health plans offered.

Minnesota is a good example of a state with a largely unionized state workforce, with over 90 percent of its 48,000 workers are represented by one of 13 bargaining units. The state established a Joint Labor Management Committee (JLMC) on health plans in the mid-1980s, to provide for ongoing information sharing and discussions of health benefit issues outside the formal negotiating arena. An outgrowth of JLMC has been a decision between the state and its unions to bargain health benefits on a coalition basis that involves all bargaining units. Coalition bargaining was adopted to encourage a more systematic, full-scale approach to healthcare issues, especially those affecting most or all state employees. The process has resulted in the state retaining its purchasing power in the market, with a single health benefits program for all Minnesota state workers, and the same benefit design and employer contributions across all bargaining units. The coalition bargaining process also has resulted in a number of other significant changes and innovations over time.

Utilization

The reality of the 20/80 rule: Twenty percent of the population uses 80 percent of the healthcare financial resources. Ten percent consume 70 percent of the resources and five percent consume 50 percent. In any one year, 1 percent of the population consumes 30 percent of the dollars.

Relating back to the age demographic of state employees, state government health plans experience a relatively large utilization of the healthcare resources around medical issues resulting from obesity, diabetes, heart disease and muscular/skeletal disorders.

It has long been known that a small percentage of health plan members account for a disproportionately large percentage of medical costs. There is no way for state governments to appreciably lower overall costs without addressing these utilization figures. Administrative costs can and should be minimized; however, they impact only about 5 to 8 percent of overall self-funded healthcare budgets. The potential for significant savings around administration simply do not exist.

Despite the difficulty in doing so, employer healthcare programs must be aggressive in driving down cost and avoidable over utilization or they run the risk of turning into or remaining “legacy” programs much like the auto industry models that many view as utilization/entitlement nightmares.

What has not been known is how to predict who will generate large claims and how to keep such claims from becoming so costly. Traditionally, health plans have identified those who exceed a certain dollar amount in a given amount of time as medical management issues, but at that point it is often too late or they return to being a low cost member because of successful medical treatment.

State governments are now just beginning to use sophisticated software to analyze data about plan members. Known as predictive modeling, such analysis may add together a series of healthcare events by a member (e.g., medication prescribed, emergency room visits) and predict much larger future costs on the horizon for the individual. Predictive modeling is primarily used to forecast future expenses, but it may be used to trigger a host of interventions such as health coaches, health navigators and other proactive interventions for members determined to be of high risk for future expensive treatment. However, even though a tremendously large amount of data is becoming available, experts differ widely on definitions of predictive modeling and whether healthcare plan members will really buy into the concept. Unless the long-term benefits are effectively communicated, members likely will resist this approach as being overly intrusive and disparate treatment.

Slightly less intrusive are voluntary health risk assessments and disease management plans which some states are now planning or actively implementing.

Health risk assessments usually are voluntary but tied to some sort of an incentive to encourage plan member participation. They usually are designed to identify risk factors in individuals with follow-up consultation by medical providers to encourage risk prevention plans and positive changes in behaviors to avoid unnecessary risk. The theory: a plan can save $80,000 through early intervention that prevents even a single cardiovascular by-pass procedure.

However, modest incentives may not be enough to convince employees to complete health risk assessments, divulge life style information to healthcare providers albeit confidential, or to change behavior as a result of the assessment. In Colorado, for example, the state offered all enrolled employees $10 to complete a healthcare assessment and only 15 percent participated. In Minnesota, on the other hand, employees who participated in a health risk assessment were granted a one-year reprieve from a $5 increase in co-pays - 73 percent of the members participated and their scores given on the assessment became a voluntary and common topic of conversation among members.

There is not much data available within state governments on the success of health risk assessments. By themselves, they appear to be of minimal value; however, aggressive programs that include health risk assessments in other segments of the employer sponsored healthcare industry are claiming some impressive results though it is sometimes very difficult to measure the effect of these programs.

Disease management initiatives also have garnered much national attention over the past few years. Medical data is clear that the proper management of treatment plans such as medications, exercise, diet, behavior and rehabilitation regiments for diseases such as diabetes, cardiovascular disorders and muscular/skeletal disorders can produce huge cost avoidance. Most large medical service providers now offer these programs for targeted diseases and demonstrating successful results.

Once again, the challenge for state government plans is getting all members to participate willingly. In order to aggressively implement disease management programs and realize their cost savings, some private sector employers are creating significant positive (or negative) member incentives around participation in disease management programs—in other words, non-participation is going to cost the member one way or another. Outside of collective bargaining, large private sector employers have a much easier time setting strict conditions on participating in their healthcare plans. The current climate of state government workforces and scrutiny these plans receive make them easy targets for claims of disparate treatment and much more difficult to mandate.

Most state governments continue to incorporate wellness programs in one form or another into their overall healthcare plans. Many have been extremely successful from a participation standpoint and they often show an aggressive approach in attempting to address utilization and proactive member good health. They also provide members with easy access to programs that they have a desire to access. Few would argue that wellness programs do not have a lot of value; however, a clear return on investment (ROI) is difficult to quantify. These programs also tend to attract health conscious plan members and do not typically attract members who would not otherwise seek exercise, lifestyle, behavior and nutritional education. In Colorado, the state has a well-equipped fitness and aerobics center within a few block area of more than 8,000 state employees—only 200 are members of the center. The Council of State Governments recently published a report, “State Official’s Guide to Wellness.” To access a copy of this report and additional information go to: www.healthystates.csg.org/Publications.

Employers are beginning to implement and evaluate broader absence management programs, which state governments may want to examine. These integrated approaches manage absences and health-related benefits (e.g., health risk assessments, incentives, wellness, disease management and workers compensation). Employers have these programs but typically do not integrate them to manage the full cost of health risks. According to Secova, a consultant and provider of HR and benefits management services, medical costs, including care, hospitalization, workers compensation and pharmacy, comprise 33 percent of the full cost of health-related productivity. A traditional leave management program that integrates all absences and coordinates with short-term disability has an ROI of 3:1 to 6:1. Health improvement programs like disease management/wellness have an ROI of 2.5:1. When integrated under absence management, the projected ROI is 5:1 to 8:1. Identifying risk at the point of absence can trigger health interventions and minimize the duration and severity of absence, as well as better manage future health and absence issues. Getting integrated data that connects the health of the population to absences can target intervention strategies and can measure frequency and duration of absences, costs and success of health enhancement programs. A William M. Mercer case study showed: 15 percent reduction in frequency of health-related absence, 7 percent reduction in duration, 50 percent reduction in proportion of employees still out after three months of absences. According to Secova, more and more states are interested because of sheer size.

There are downsides, such as the need for a uniform process and system for leave management, so streamlining is essential. In addition, unions add complexity for reasons discussed earlier. Communication again becomes the key. What works in private industry should work in state government when states get key policy makers to buy in to the idea.

Finally, there is a clear movement toward consumer driven health care to help address healthcare utilization costs—most notably, Health Savings Accounts (HSA). While most states have long offered flexible spending accounts, some states are now offering HSA qualified plans and other states are seriously considering them or planning to offer them in the near future. Once an HSA qualified plan is established the state may contract with a federally qualified financial institution for members to chose to administer their HSA or members may choose their own qualified financial institution.

Early lessons learned with state government qualified HSA plans are that they require a significant amount of member education as to their intent and benefit levels. These plans may attract employees, but they are not well suited for many members (e.g., those requiring high cost maintenance prescriptions versus high cost treatments). Additionally, states wanting to contribute toward HSAs should examine other vehicles since HSAs allow members to take these contributions with them when they leave employment.

Administration

Administering state government employee healthcare plans is complex and requires a careful balance of internal and external resources. Complicating these issues is the fact that most state governments are designing and managing their own self-funded healthcare programs.

According to a 2002 survey conducted by William M. Mercer, 32 percent of government plans sponsor self-fund HMO coverage and 64 percent self-fund PPO coverage. Among all large employers, 9 percent self-funded their HMO coverage in 2002 and 92 percent self-funded their PPO plans.

Fewer fully insured plans are offering adequate choices given the unique demographics of state government workforces. Self-funding offers access to critical utilization data and greater control over both plan designs and cost containment measures that are worth the manageable risks involved.

Using fully insured products, however, mitigates the “risk” for state governments, which can be considerable if adequate fund balances are not maintained, and/or if some level of expensive “stop loss” insurance is not used to cap the risk for any one individual under self-funding. Fully insured products also eliminate the need for a great deal of the customer support, transactional and other administrative functions that the state must provide when they literally become the insurance company under the self-insured model.

Some of the reasons for self-funding include:

- Ownership and control;
- Flexibility;
- Statewide uniformity;
- Cost management;
- Long-term financial savings with no differences between expected and actual trend;
- Elimination of adverse selection among plan offerings;
- Flexibility to implement performance driven healthcare; and
- Ability develop innovative cost containment measures such as aggressive disease management programs and centers of excellence.

Broadly, there are two major organizational competencies that need to be in place to effectively manage self-funded employee benefit programs. Some level of knowledge and ability is necessary from internal staff within the organization, but additionally there are outside sources for certain areas of specialization. The two core competencies are:

1. Vendor management, with knowledge of insurance principles and operations; and,
2. Financial management, with knowledge of insurance principles and operations.

With self-funded plans, state governments must manage the risk and protect the integrity of the plan because they are now the insurer of the plan. Accordingly, oversight of the plan and choice of administrators should balance cost management and administrative costs with the right choice of internal administration and external expertise. Clear and meaningful metrics need to be developed to evaluate how the health plans are performing and help states identify the expertise that they need to acquire to effectively and efficiently administer the plans.

Most states use a third party administrator to handle claims processing. More and more, states are turning to other outsourcing options such as open enrollment and other transactional business and customer service centers. Colorado, for example, now out sources all of its healthcare transactional business and customer service. Florida has gained much attention nationally in their outsourcing of all HR transactional business including the compete outsourcing of all their benefits administration. While the outsourcing of these traditional state run business practices continues to foster debate and controversy, from a business practice, it warrants a close analysis since these are often areas that states have difficulty in developing the necessary administrative expertise and information technology support.

Self-funding is not a panacea for the challenges faced by employers and employees in healthcare, but as a general rule it is a preferred approach to delivering group medical and dental benefits for employers the size of state governments.

In addition, the organizational structure of benefits administration is worthy of examination. In some states, an office of insurance handles the contract design and execution. However, due to the extraordinary costs and impact to the total compensation package, healthcare benefit decisions and the communication of those decisions have evolved into an HR function. No longer a purely contract administration and business function, healthcare administration impacts employee relations, recruitment, retention and total compensation. In addition, the training programs relating to employee education, health and wellness further push health care issues into HR management. States with separate entities managing personnel and benefits may find a more integrated structure would improve effectiveness and efficiency.

Conclusion

The strength of NASPE is the connection of our members and the communication of shared challenges and solution strategies.

As healthcare provision challenges our nation, the pressure is squarely on our state governments to provide an acceptable benefit package to the workforce and address the exploding costs of Medicaid and the impact of the uninsured.

This white paper was designed to build a foundation to spark more dialogue on the challenges and strategies in state HR management. As NASPE members face those challenges head-on, the connection of state leaders will continue to strengthen the success of our efforts.

For More Information

NASPE will continue to collect current and best practices in state government benefits administration and will share these on the NASPE website at www.naspe.net. You may also contact NASPE at 859-244-8182 or at lscott@csg.org for more information.