Texas Public Policy Foundation

Policy Perspective

October 2006

Surveying State Employee Health Benefit Plans

How Texas' State Employee Health Benefits Compare to Other States

by Mary Katherine Stout, director of the Center for Health Care Policy Studies

When the Texas Legislature passed the state budget for 2006-07, it included $2.1 billion for the group insurance program covering state employees, retirees, and their dependents.[1] The state's appropriation to the State Employees Retirement System (ERS), the agency administering the benefit programs for state employees and retirees, increased by a total of $400.2 million over the previous biennium, $327.2 million of which—or 82 percent of this increase—was consumed by the increasing cost of the group benefits insurance program.[2] From the 2004-05 biennium to the 2006-07 biennium, the appropriation for the state's group insurance program climbed from $1.7 billion to $2.1 billion, approaching a 20 percent increase in the cost of providing these benefits alone.

While the state grapples with the rising cost of providing health care through Medicaid and the Children's Health Insurance Plan, it often neglects to consider the increasing cost of providing a generous package of health benefits to state employees. Unlike Medicaid, which is governed by a number of federal laws that limit the state's flexibility to manage the program, Texas can take steps to better manage the health benefits for state employees—though it has rarely exercised its full discretion or obligation to do so.

As the Texas Legislature prepares to write a budget for the 2008-09 biennium it would be prudent to consider the landscape of state employee health insurance programs in states around the country, in addition to other private sector employers. Although civil service employees are traditionally considered to have the richest of benefits packages, some states have shed that image to reflect the changes occurring throughout health benefits today. For many states, the days of no deductibles and limited or no cost sharing are being replaced by higher deductibles, shared premiums, and a focus on wellness and disease management.

Texas State Employee Benefits

Since 1971, the state has contributed to state employee health insurance coverage.[3] Today ERS covers approximately 504,000 members in the state's group benefits plan, the majority being covered in the state's HealthSelect plan and the remaining members receiving coverage under a number of HMO plans around the state.[4] The state covers the full cost of the health insurance premium for state employees and retirees, and half of the premium cost for dependent coverage.[†]

As health care expenditures in the HealthSelect plan have climbed amid generally increasing health care costs and expenditures on prescription drugs, so have the premiums for employees and their dependents (Figure 1-next page). In 1996 and 1997, premium rates and the state's contribution remained flat in both years of the biennium. Premiums and the state contri-

CONTINUED ON NEXT PAGE

[†]Note that the plan is self-insured and does not actually pay premiums, but instead pays claims. The ERS reported total premiums combine the state's share and the employee contribution, to reach the anticipated plan expenditures. All figures are based on ERS annual reports on health premium rates, which report the amount and cost sharing for "premiums."

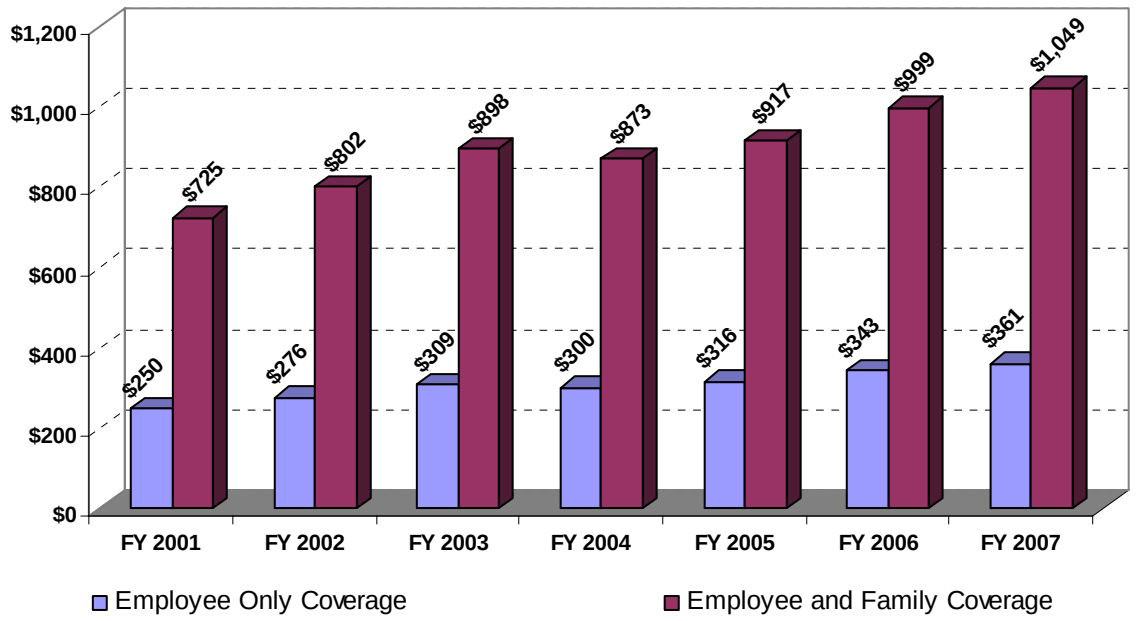
bution rose slightly from $186.31/month in 1996 and 1997 for individual coverage to $190.73/month in 1998.[5] In 1999, the state contribution remained unchanged despite an approximate 5 percent increase in the premium, which ERS offset with a supplement.[6]

Although premiums remained flat or rose modestly from 1996-1999, they increased an average of 12 percent a year from 2000-2003, increasing 16 percent from 2000-2001 alone.[7] By the start of Fiscal Year 2003, premiums for individual coverage were almost $309/month, up from a mere $186/month in 1997.

In ERS' 2004-05 Legislative Appropriations Request, the agency predicted cost increases of 13 percent in each year of the biennium and requested an additional $385.3 million for health insurance cost increases to maintain the benefit without any changes.[9] Upon convening in Austin in 2003, however, legislators were under immediate pressure to balance the state's budget due to a nearly $10 billion budget shortfall. In response, legislators enacted significant changes to the state employee health plan to begin in FY 2004, while ERS exercised its authority to make other non-statutory program changes in an effort to generate immediate cost savings in the middle of the fiscal year (discussed later in this section). As a result, on May 1, 2003 a new premium rate took effect, dropping premiums by roughly 11 percent in the middle of the year.[10]

Although premiums increased at the start of FY 2004 over the lower, adjusted mid-year premiums in FY 2003, the plan changes made by the 79th Legislature resulted in an overall decrease of roughly 3 percent between the premiums at the start of FY 2003 to the start of FY 2004 (as shown in Figure 2-next page).[11] Each year since, the premiums have continued to climb, increasing from just under $250/month for employee-only coverage in FY 2001 to just over $360/month in FY 2007—an increase of almost 45 percent overall.[12] Again, Figure 1 shows the annual increase in premiums for both employee-only coverage, and employee and family coverage from 2001 to 2007.

FIGURE 1
HealthSelect Total Monthly Premiums FY 2001- FY 2007
(rounded to nearest dollar)



Source: Texas Employees Retirement System, "2005 Comprehensive Annual Financial Report," 101.

Cost Containment and Plan Changes in 2003

During the early to mid-1990s, the state undertook a number of cost containment strategies, but, arguably, none were as significant as those made in 2003 for the 2004-05 biennium. As Texas convened the 78th Legislative Session in 2003, higher health care costs and increased spending on prescription drugs dominated the discussion on state employee benefits.

In May 2003, ERS began implementing administrative changes that did not require statutory approval in order to achieve cost savings in that fiscal year; changes requiring legislative approval through Senate Bill 1370 were effective on September 1, 2003, the first day of FY 2004. Among the administrative changes to the plan were:

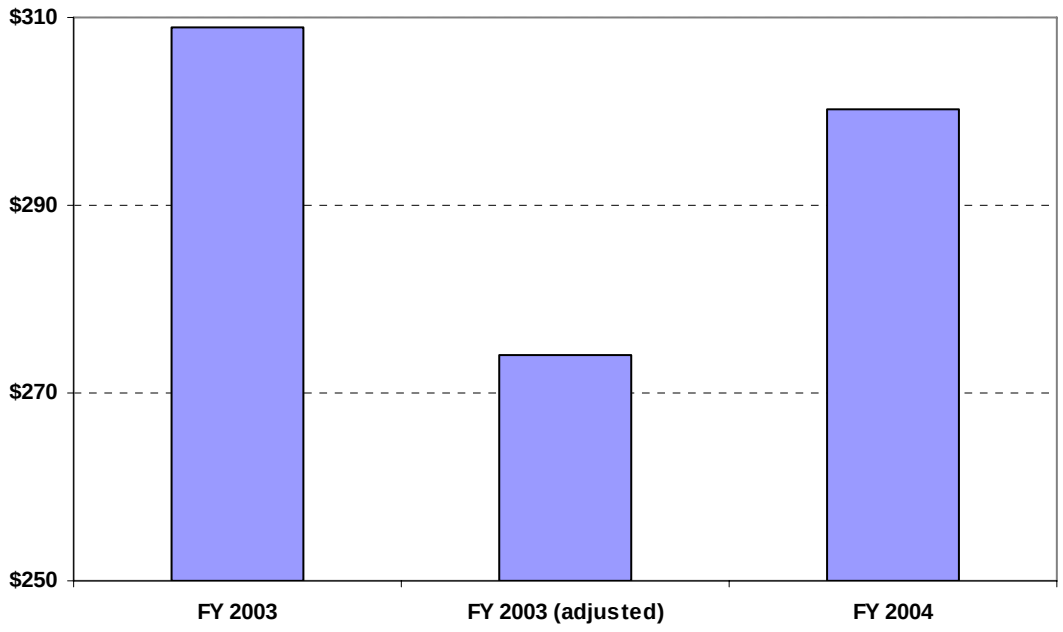
- increases in copayments for primary care and specialist visits from $15 to $20 and $10 to $30, respectively, as well as for emergency room visits;
- the addition of an inpatient copayment per day of a hospital stay, up to five days;
- an increase in co-insurance rates; and
- a number of changes to prescription drug benefits, including mandatory mail order for maintenance drugs, a prescription drug deductible of $50, and an increase in copayments.[13]

In addition, HealthSelect Plus, a self-funded HMO option, was discontinued.

Statutory changes made through Senate Bill 1370 instituted a 90-day waiting period for new state hires, adjusted the eligibility for retiree insurance, and reduced the state contribution for coverage for employees working less than full time and graduate teaching assistants.

Despite these changes to generate cost savings in the ERS group health insurance program, costs have continued to increase. In its Legislative Appropriations Request for 2006-07, ERS asked for an additional $544 million to provide for cost increases in its exceptional request.[14] Now, as the Texas Legislature prepares to convene in 2007, ERS has projected cost increases of more than 6 percent a year in each year of the 2008-09 biennium.[15]

FIGURE 2
Comparison of Total Premium Cost for Individual Coverage
FY 2003 and FY 2004



Source: Texas Employees Retirement System, "2005 Comprehensive Annual Financial Report," 101.

Now, as the Texas Legislature prepares to convene in 2007, ERS has projected cost increases of more than 6 percent a year in each year of the 2008-09 biennium.

How Texas Stacks Up to Other States

Each of the 50 states operates a health insurance program for its employees. In most states, employees have limited choice in the health insurance coverage with one or even two plans that provide coverage to most state employees, with other regional plans that cover a smaller share of state employees.

Making comparisons between states can be difficult as each state varies its plan design, eligibility, and the share of the premium split between the individual and the state. Some states require their state employees to participate in the state's program and may require the employees' dependents to participate as well. The type of coverage may also vary, in some cases including vision and dental coverage in the package. In some states, the share of the premium paid by the employee depends on the salary schedule for the employee, the age of the employee and their dependents, or even the geographic region of the state. In addition, some states that have undertaken significant cost containment steps, vary the employee's share of the premium based on when they first went to work for the state, effectively grandfathering some existing state employees into a program with a more generous state contribution.

Employee-Only Coverage

Texas is one of approximately 15 states that covers the entire cost of the individual employee's health insurance premium, and just over half of the states cover 90 percent or more of the individual employee's health insurance premium. Some states pay a set percentage of the premium. In New York, for example, the monthly premium for individual coverage is almost $458 and the state pays 90 percent of the cost.[16] In other cases the state establishes a defined contribution, fixing the state's contribution to a dollar figure, without respect to the total cost of the premium. In these cases, the insured employee chooses a benefit plan that may be entirely or partially covered by the state's contribution. For instance, in 2006 Colorado paid $190.20/month[17] and Arkansas $242.96/month[18] to pay premiums for employee-only coverage. This represents anywhere from approximately 52 to 83 percent of the monthly premium for the plans offered in Arkansas, or 50 to 94 percent of the monthly premium for plans offered in Colorado.

Oklahoma, by contrast, establishes a benefit allowance of $433.55/month for 2006, enough to cover most employee-only health plans and additional supplemental coverage for dental or vision care.[19]

In terms of cost—at approximately $341/month in 2006—Texas' employee-only coverage is near the national median. Alaska, which requires all employees and their dependent spouses or children to be covered by insurance, allocates the most of all states at $835/month for the "economy plan" to cover individual employees and any dependents, without distinguishing between individual or group coverage.[20] At $155.42/month, the employer contribution from the state of Hawaii is among the lowest state contribution for employee-only coverage in sheer dollars, covering roughly 60 percent of the total monthly premium.[21]

Family Coverage

A state employee benefits survey from the National Conference of State Legislatures (NCSL) compared standard benefit packages (defined as the lowest-cost, full service HMO available) across states from 1999 to 2006. In 1999, the average total cost for family coverage among 49 of the states was $465.78, more than doubling to $1,012.67 for coverage in all 50 states in 2006.[22]

According to the 2006 data from NCSL's survey, five states paid the full cost of insuring employees and their families, including New Hampshire, New Jersey, North Dakota, Oklahoma, and Oregon.[23] Maine covers 100 percent of the premium cost for individuals, but ranks at the bottom of NCSL's list in terms of the percentage of the total premium it covers for family coverage, paying just over a quarter of the total monthly cost of family coverage.[24]

Other Trends in State Employee Benefits Programs

As states look to control the cost of state employee benefits, many have implemented new health plans, programs, and strategies aimed at making employees more cost and health conscious. In many cases, states employ more than one of the cost containment measures, layering new plan offerings with incentives for a more healthy lifestyle.

Plan Options

In the past, states sought to control cost by changing existing plans, typically establishing a small deductible or increasing the copayment for certain services. However, the creation and introduction of Health Savings Accounts (HSAs) into the public employee market now offers an alternative for states looking to contain costs.

HSAs refer to the combination of a high deductible health plan and a tax-advantaged savings account that can be used to meet the deductible. Flexible Spending Accounts are a tax-advantaged savings vehicle common in most state health plans, but the remaining balance is swept at the end of the year and does not carry forward. By contrast, balances in an HSA are owned by the individual and roll forward from year to year, allowing people an interest bearing savings vehicle for health care expenses. In addition, the savings account is entirely portable and the funds are accessible to the individual even if they end participation in a high deductible insurance plan.

Rather than providing a high premium, low or no deductible insurance policy, states have begun offering employees an opportunity to accept a higher deductible in exchange for a lower premium. When the 79th Legislature considered House Bill 1795, which if passed would have directed ERS to offer state employees an HSA option, only a handful of states offered their state employees an HSA. Today, there are at least 10 states with an HSA option for their state employees in place or planned for their next enrollment period: Arkansas, Colorado, Florida, Georgia, Indiana, Kansas, Mississippi, South Carolina, South Dakota, and Utah.

In each of these states, the premium for the high deductible health plan (HDHP) component is lower than the premium for the state's traditional plan. Out of these 10 states, only Mississippi covers the entire cost of the premium for both individuals in the traditional plan and those who elect the HSA option. Mississippi is unique in this regard, as HSA/HDHP plans have emerged in states with existing premium-sharing expectations.

> Arkansas' HSA option for state employees can save individuals almost $170/month in out-of-pocket premium payments for individual coverage and almost $450/month for family coverage.

By participating in an HSA, employees who bear some of the cost of their monthly health insurance premium have the opportunity to share in the savings. In the case of Arkansas, for example, the state continues its defined contribution of $242.96, but the high deductible plan premium is only $291.58 versus $460.92 for the highest cost plan through BlueCross BlueShield, saving almost $170 in monthly out-of-pocket premium payments for individual coverage.[25] The savings are even more apparent for family coverage, where participation in the HSA option rather than the highest cost plan saves families almost $450/month in premium payments.[26] Any HSA option for state employees, which will be explored in more detail in a forthcoming publication from the Foundation, allows employees the opportunity and incentive to better control their health care dollars, both through savings from lower premiums and savings in the tax-advantaged account.

Health and Wellness Programs

As tobacco use and obesity have begun to drive health care costs higher, health care experts and human resources specialists have discussed the merits of health and wellness programs that provide both support and financial incentives for people to eliminate unhealthy behaviors. Although health and wellness programs are not in place in every state, there is a clear trend as states—like many private employers—establish such programs in hopes of reducing long-term cost.

Some states have established an incentive for participation in health and wellness programs and screenings by providing a discount on monthly premiums. For example, Arkansas offered state employees the opportunity to participate in a voluntary Health Risk Assessment in 2004 and 2005, offering a reduction in the employee's monthly premium for their participation. The assessment, completed by 56 percent of eligible employees in 2005, helped the state identify possible wellness programs.[27] In addition to a smoking cessation program implemented in 2004, in July 2006, Arkansas also began a weight management program after finding that more than 70 percent of respondents would be considered overweight or obese.[28] Non-tobacco users completing one of the assessments could save as much as $20/month on their monthly premium, and two-non tobacco users (employee and covered dependent spouse) completing two assessments could save as much as $40/month. Assessment participants that self-reported tobacco use still saved money for participating, but were only eligible to save half as much as non-tobacco users.[29]

South Dakota also offers state employees $50 simply for taking a health screening.[30]

As another option, some states have created health and wellness programs in which participants earn extra money. For example, Utah has taken steps to control costs by creating a series of programs, including wellness programs and health tests, in addition to a rebate program that makes cash payments for documented health activities and improvements. As an added incentive, the state offers state employees three hours of annual leave for Healthy Utah participation.

Healthy Utah's rebate program pays state employees a one-time payment for healthy living. For instance, by going to the gym 100 days in a year (reported on the honor system), individuals can earn as much as a $60 rebate.[31] Weight loss and six months of weight loss maintenance earns up to a $150 rebate and the reimbursement of a small class fee if applicable; reducing cholesterol and blood pressure each offer a $50 rebate; diabetes management offers a $100 rebate; and current tobacco users who quit for a year can earn $100.[32]

Additional Charges

In addition to health and wellness programs, many states have opted to encourage health and wellness by charging members more if they participate in certain unhealthy behaviors. In particular, many states have singled out tobacco use, which states identify as a major cost driver in their health insurance program.

Georgia charges state employees using tobacco products an additional $40/month[33] and may terminate their health insurance for a year if the employee is found to be lying about their smoking status. South Dakota charges an additional $40/month per person for employees and covered dependents using tobacco.[34] Kentucky, which offers certified non-smokers a credit on their premium, and Alabama both tack on an extra $15 and $20, respectively, for tobacco use among employees, and doubles that if a covered dependent/spouse uses tobacco also.[35]

Recommendations

As the Texas Legislature prepares to meet in 2007, it is likely that state employee health insurance will again require new money to continue to keep pace with the current benefit levels and increases in cost. This growth, however, is within the state's control if it introduces consumer-driven health care models and shares both the cost and savings with state employees.

Texas state employees participating in the state's group insurance plan should share in the cost of the premium for individual coverage. The state should also consider changing the share the state pays for dependent coverage.

Texas is one of a small number of states that pays 100 percent of the cost of coverage for individuals. ERS' Legislative Appropriations Request for 2008-09 projects cost increases of more than 6 percent each year of the upcoming biennium, requiring an increased appropriation from the state's general revenue of almost $290 million.[36] Continued cost increases at even 5 percent a year, the amount by which the individual premium increased between Plan Year 2006 and 2007, would put the state's monthly contribution for state employee insurance at almost $400/month for Plan Year 2009. These annual increases cannot be sustained, and are not well controlled with the current plan design which pays premium first-dollar coverage.

The state should fix its contribution for both individual and dependent coverage, requiring state employees to share more in the cost of their coverage. Such a move

would not only fix the state's responsibility for the future, but would also be prudent in an effort to avoid another round of plan design changes in the future.

Furthermore, the current premium payment structure obviates the distortions that arise when employees are compensated more due to the number of family members they cover rather than for their work. Indeed, since the state pays half of the coverage for dependents, employees whose families are covered under the state plan actually receive a higher total compensation than a single person working for the state at the same salary. As the cost of benefits increases, these individuals effectively subsidize an increase in compensation for another state employee and their family at the expense of the individuals own earnings. The emphasis on employer sponsored health insurance in general creates significant distortions in the way employees are compensated for their work, which is exacerbated when an employer covers family members at a generous rate as well.

The state should offer a Health Savings Account option to state employees.

During the 79th Session, state employees lobbied for a pay raise from the Legislature, claiming the 77th Session was the last time the Legislature gave state employees a raise. While state employees may have been correct that they had not seen an increase in cash wages, they did experience annual increases in total compensation as a result of increasing health insurance premiums. The option of an HSA would allow the state to better control cost and utilization, as well as potentially offer state employees a greater measure of control and ownership of the monies spent for these benefits.

Coupled with a more defined contribution approach to state employee health insurance premiums, individuals could experience savings in their out-of-pocket costs by choosing the HSA option. In fact, employees covering dependents today could experience a significant reduction in their monthly premium by choosing the higher deductible, low premium option.

HSAs offer the state an opportunity to contain costs in the future, with a benefit to the individuals who choose them.

The state should provide state employees with an annual statement showing the total compensation package including salary and the value of their benefits.

The state should offer an online health and wellness assessment for state employees to determine the impact of both tobacco use and obesity in the workplace.

The state should consider additional premium savings for individuals who do not use tobacco products.

Special recognition to the Foundation's research interns Megan Wilson, Kelly Frindell, Ben Williams, and Courtney Smith who collected and verified premium and plan data on each of the states.

Note on methodology: In collecting data on state employee health insurance plans we used plans considered to be the primary insurer of state employees in each state. If such a determination could not be made, we selected the statewide plan that best matched the plan offered under HealthSelect in Texas. If a statewide plan could not be identified, we used the regional plan covering the capital area of the state.

Note that most states offer their employees several options and the cost of coverage may differ between plans and employees. Accordingly, the data used to compare the benefits package in Texas to the packages offered in other states should be used as a guide. In addition, this publication identifies benefit trends in some states, but is not a complete list of participating states or innovative plans.

*An online appendix (*http://www.texaspolicy.com/pdf/StateEmployeeBenefitsPremiums50States.pdf*) Is available with plan cost for individual/employee-only and family coverage in each of the 50 states. Note that this appendix may be updated as additional information for 2006 coverage is available.*

Mary Katherine Stout is the director of the Center for Health Care Policy Studies at the Texas Public Policy Foundation. Contact Mary Katherine Stout at: mkstout@texaspolicy.com.

Endnotes

[1]Texas Legislative Budget Board, "Fiscal Size-Up 2006-07," 78.
[2]Ibid, 77-78.
[3]Texas Legislative Budget Board, "Fiscal Size Up: 1994-95 Biennium, Texas State Services," 7-7.
[4]Presentation by Ann Fuelberg to the Senate State Affairs Committee, 27 July 2006.
[5]Texas Employees Retirement System, "2005 Comprehensive Annual Financial Report," 101.
[6]Ibid.
[7]Ibid.
[8]Ibid.
[9]Texas Employees Retirement System, Legislative Appropriations Request for FY 04-05, 30 Aug. 2002.
[10]Texas Employees Retirement System, "2005 Comprehensive Annual Financial Report," 101.
[11]Ibid
[12]Ibid.
[13]Cost savings and detailed information on design changes can be found in the Texas Legislative Budget Board's Fiscal Size-Up 2004-05, 88; and the Senate Committee on State Affairs Interim Report to the 79th Legislature, 6-7.
[14]Texas Legislative Budget Board, Fiscal Size-Up 2006-07, 78.
[15]Texas Employees Retirement System, Legislative Appropriations Request FY 2008-09, 25 Aug. 2006, 6.
[16]Email response to TPPF from the New York Employee Benefits Division, 31 July 2006.
[17]Colorado Department of Personnel and Administration, "New Medical and Dental Rates and Plans," *Health Line* newsletter, April 2005.
[18]Arkansas State Employee Benefits Division, "Arkansas State Employees-Actives: January 1, 2006 Self-Insured Premium Rates (Adjusted for HRA and Tobacco Use)."
[19]Employees Benefits Council, Plan Year 2006 Rates (January 2006 through December 2006).
[20]Alaska Retirement and Benefits, 2006-2007 Benefit Credits, http://www.state.ak.us/drb/ghlb/benefit-credits.shtml, accessed 4 Aug. 2006.
[21]Hawaii Employer-Union Health Benefits Trust Fund, "Premium Rates for plans Effective July 1, 2006," http://www.eutf.hawaii.gov.
[22]National Conference of State Legislatures, "State Employee Health Benefits-Monthly premium costs (Family coverage), http://64.82.65.67/health/StateEmpl-healthpremiums.pdf#search=%22NCSL%20State%20Employee%20Health%20Benefits%20-%20Monthly%20premium%20costs%22, accessed 9 Aug. 2006.
[23]Ibid.
[24]Ibid.
[25]Arkansas State Employee Benefits Division, "Arkansas State Employees-Actives: January 1, 2006 Self-Insured Premium Rates (Adjusted for HRA and Tobacco Use)."
[26]Ibid.
[27]Arkansas State Employee Benefits Division newsletter "EBD Buzz", 2nd Quarter 2006, http://www.arbenefits.org/ebd_pages/forms/vol2issue1.pdf accessed 17 Aug. 2006.
[28]Ibid.
[29]Arkansas State Employee Benefits Division, "Arkansas State Employees-Actives: January 1, 2006 Self-Insured Premium Rates (Adjusted for HRA and Tobacco Use)."
[30]South Dakota Bureau of Personnel, "Benefits News Briefing: August 1, 2005," https://www.bopweb.com/NlTemplate.asp?id=1177, accessed 22 Sep. 2006.
[31]Healthy Utah, "Rebate Program Basic Information," http://www.healthyutah.org/hu_programs/rebates/rebateinfo.html accessed 9 Aug. 2006.
[32]Ibid.
[33]Kelley M. Butler, "Employer-based smoking cessation programs give smokers extra power to kick the habit," *Employee Benefit News*, Jan. 1, 2006, http://www.benefitnews.com/detail.cfm?id=8456, accessed 22 Sep. 2006.
[34]South Dakota Bureau of Personnel, "FY 2007 Enrollment Guide," 2, http://www.bopweb.c/uploadedFiles/FY2007%20Enrollment%20Guide.pdf, accessed 22 Sep. 2006.
[35]Commonwealth of Kentucky Personnel Cabinet, "Kentucky Employees Health Plan 2007 Plan Year Health Insurance Handbook," 9, http://kehp.ky.gov, accessed 22 Sep. 2006, and Alabama State Employees' Insurance Board, "State Employees' Insurance Board Tobacco User Policy," http://www.seib.state.al.us/v1.0.0/healthinsurance/sehip/pdf/tobacco_policy.pdf#search=%22Alabama%20state%20employees%20%2420%20tobacco%, accessed 9 Sep. 2006.
[36]Texas Employees Retirement System, Legislative Appropriations Request FY 2008-09, 25 Aug. 2006, 6.