

PRESENTED BY:

**naspe**

CHALLENGES &  
CURRENT PRACTICES  
IN STATE EMPLOYEE  
HEALTHCARE

JULY 26, 2010





## Acknowledgements

State healthcare, personnel and benefits officials who manage employee healthcare plans are responsible for some of the largest programs in state government, and today they face unprecedented challenges. This paper was written to help state officials understand the current environment, and serve as a resource to those proposing and implementing changes that will help their states and plans weather the current economic storm.

The data and insights presented in this paper would not have been possible without the contributions of several organizations and individuals, who deserve acknowledgement. I must begin by thanking University of Chicago Graduate students Betta Sherman, Colleen Schlecht and Katie Meyer as this paper is 100 percent their work product. Through direct ownership of this initiative and their tireless efforts to interview state officials and analyze key data, they have created a unique viewpoint for use by state governments. I also want to thank The University of Chicago and Laura Botwinick, Director of the University's Graduate Program in Health Administration and Policy.

Also deserving of recognition are the state officials who participated in the surveys and interviews that informed this publication. During the information-gathering process, they generously agreed to share opinions and anecdotes about successes and challenges in their states. They have contributed tremendously in an effort that will enable their peers in other states to help employees and their families lead healthier lives.

We would like to thank Jeff Schutt, the Chair of the 2006 Healthcare Taskforce for his collaboration with the graduate students and his contributions to the team.

In addition, we would like to thank the Council of State Governments and the National Association of State Personnel Executives (NASPE). Without the support of NASPE's President, Jeff Herring of Utah, and Executive Director Leslie Scott, production of this paper would not have been possible.

Like its predecessor from 2006, we hope this paper will continue to "spark more dialogue on the challenges and strategies" for the dedicated officials who manage state government employee healthcare benefits.

### Paul Campbell

Vice President, State Solutions  
Public Sector, UnitedHealthcare

WRITTEN WITH  
SUPPORT FROM:



### How to cite this paper:

Meyer K, Schlecht C, Sherman B. *Challenges and Current Practices in State Employee Healthcare*. NASPE white paper. University of Chicago, 2010

## Executive Summary

A collaboration between the University of Chicago, the National Association of State Personnel Executives (NASPE), and UnitedHealthcare, this paper functions as an update to a September 2006 white paper on challenges and best practices in state government employee healthcare benefits. For this update, state benefits administrators in 24 states were interviewed by the students between January and June 2010 with the goal of identifying topics of importance in the design and administration of state employee health plans.

### RESULTS

Of 15 healthcare topics identified in the survey, respondents ranked disease and chronic care management, plan design, and wellness and prevention as the most important issues affecting health plan administration in their respective states.

Due to fiscal pressures caused by the economic recession, many states were examining these issues as part of initiatives to reduce costs while continuing to provide effective and affordable coverage for state employees.

While the top priority for benefits agencies remains effective coverage for their populations, they face the following challenges as they undertake efforts to meet employee needs while controlling costs:

- Low rates of adoption and implementation of wellness programs.
- Barriers to plan design innovation, including a resistance to change among members and employee representatives.
- Lack of access to data to support the case for plan and program changes.
- Uncertainty regarding the impact of federal healthcare legislation.

The following summarizes survey responses with regard to the highest-ranking state healthcare priorities:

- **Disease and Chronic Care Management:** Many states cited a relatively small number of unhealthy, high-cost employees as responsible for driving rate and premium increases for entire state healthcare plans. Benefits managers recognize the need for more effective prevention programs that can thwart the high costs of treating chronic conditions. The most common conditions targeted for disease management programs were identified as heart disease, high blood pressure and diabetes.
- **Plan Design:** Many states are realizing savings through plan redesigns or drug benefit changes. A common strategy is to increase employee out-of-pocket costs. Few states have been successful at implementing changes that systematically decrease or redirect utilization, citing resistance to plan changes by members and employee collective bargaining organizations.
- **Wellness Programs:** Survey respondents most commonly cited a lack of high-quality data as a barrier to effective wellness plan implementation. While most states are committed to

wellness, benefits administrators encounter funding and implementation challenges that could be overcome by demonstrating a program's return on investment through the use of reliable data. The difficulty of engaging employees in wellness programs was also cited as a barrier to program effectiveness.

While the survey participants cited numerous barriers to change, this paper also interviewed states that feel they have successfully implemented innovative approaches, plans and programs that helped lower costs while improving employee health and wellbeing:

- **New Mexico** dispatches mammogram vans to worksites, offering free examinations to employees. As a result, breast cancer screening rates have increased significantly.
- **Oklahoma** employs wellness coaches to deliver counseling for stress and depression after identifying these conditions as drivers of obesity.
- **Ohio** provides free diabetic supplies and insulin to employees who enroll in a diabetes program that includes working with a disease management nurse.
- **Virginia** is working with behavioral health experts to identify factors associated with successful adoption of healthy behaviors.
- **West Virginia** has a comprehensive wellness and disease management initiative including weight management, diabetes, and heart disease programs. Their innovative worksite wellness program offers monetary incentives to employees based on a personal health report card.

Other issues indicated to have an impact on state employee healthcare included unfunded liabilities associated with retiree health plans, a trend toward cooperative purchasing, the need to address rural healthcare challenges, the role of unions in plan procurement and design, and uncertainty about the impact of recent federal healthcare reform.

## A WAY FORWARD FOR STATE EMPLOYEE HEALTHCARE

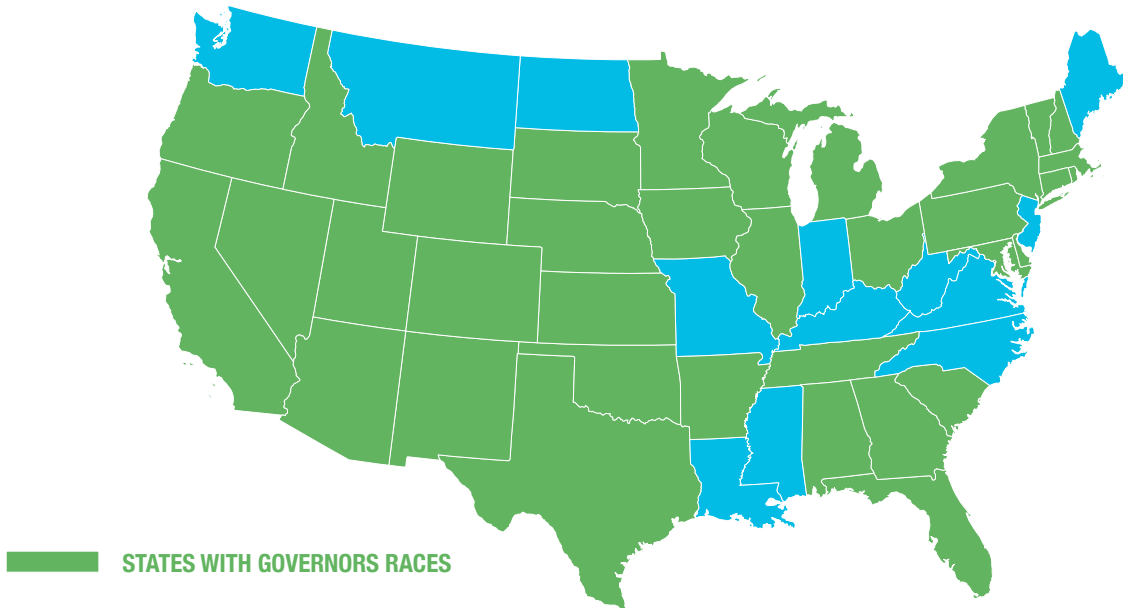
The information gathered for this paper points to several steps that agencies may consider to help overcome cost and wellness challenges. These may include:

- **Development of standardized metrics for measuring health and wellness program return on investment (ROI).** This step is essential for quantifying program impact, identifying opportunities for program improvement and reinforcing a culture of health and wellness in the workplace. With more reliable ROI estimates, benefits administrators can direct healthcare resources more effectively, present a more compelling case for program funding to legislatures, and use data to help make the case for change among resistant employees and union representatives.
- **Engage employees before and during transitions.** Although employees may be resistant to plan and program changes critical for implementation during the recession, steps can be taken to minimize disruption to members that include communication about the state's contribution to employee benefits, outlining the options that will ensure a plan's

sustainability and avoid reductions in force, and soliciting employee input on proposed design and program options.

Given the severe budgetary constraints facing state governments, now is the time to discuss their impact on state employee health plans and share strategies among states to mitigate negative effects. Additionally, with 37 gubernatorial races in November 2010, significant turnover is expected in state government leadership and administration in January 2011. This political environment, combined with the current state of the economy and recently enacted federal healthcare reform, make 2010 an opportune time to embrace the potential for change, identify what is currently working in state employee benefits administration and chart a path for the future.

### Turnover in the States:



## Introduction

### ➤ ABOUT THIS PAPER

A collaboration between the University of Chicago<sup>1</sup>, the National Association of State Personnel Executives (NASPE)<sup>2</sup>, and UnitedHealthcare<sup>3</sup>, this paper functions as an update to a September 2006 white paper on challenges and best practices in state government employee healthcare benefits. Like its 2006 predecessor, the goal of this project is to help states share best practices in state employee health plan administration and to enhance connections among state personnel executives. For this update, state benefits administrators in 24 states<sup>4</sup> were interviewed between January and June 2010 with the goal of identifying topics of importance in the design and administration health plans for employees (see appendix for interview definitions). To that end, each state was asked to rank a list of fifteen priorities for their employee healthcare benefits system in Fiscal Year 2011.<sup>5</sup> States were probed in greater depth on the three topics they rated most highly, as well as on several key trends identified in the 2006 paper. In keeping with NASPE's commitment to meaningful communication among states, this paper seeks to highlight the issues that are unique to state employee health plans and the strategies states use to address them. As NASPE members tackle the challenges ahead, the intention of this paper is to help facilitate discussion among state leaders toward healthcare administration that effectively utilizes public resources and improves employee health and well-being.

## ➤ BACKGROUND

The timing of this update is critical. Given the severe budgetary constraints facing state governments, now is the time to discuss their impact on state employee health plans and share strategies among states to mitigate negative effects. While many recognize the large proportion of state budgets dedicated to Medicaid spending (22% on average<sup>6</sup>), most are not aware of the high cost of providing state employee healthcare. In 2008, state employees were on average 45 years of age.<sup>7</sup> Providing coverage to this aging population – many of whom are slated to receive full benefits into retirement – claims a significant portion of state budgets. Additionally, with 37 gubernatorial races in November, and only 14 involving incumbents, significant turnover is expected in state government leadership and administration in January 2011. This is an opportune time to embrace the potential for change, and to identify what is currently working in state employee benefits administration. Finally, of critical importance are the short and long-term effects of the March 2010 Patient Protection and Affordable Care Act (PPACA) on state employee health plans. As states begin to adapt their plans to comply with the new federal regulations, identifying current best practices in plan administration can benefit the states.

## Fiscal Conditions and the Impact on State Employee Health Plans

Budgetary hardships and economic realities have forced states to amend healthcare priorities and evaluate employee health plans. With no indication that the financial situation will improve in the near future, states must determine how to best weather the storm. Ray Scheppach, Executive Director of the National Governors Association, described the next ten years as a “lost decade” for states. He predicted that while state revenues may begin to rebound in late 2010 and in early 2011, they will not return to pre-recession levels until 2014-2015. Even after recovery begins, states will need to focus on backfilling investments that were deferred during the downturn, replenishing contingency funds, and restoring pre-2007 resource levels to programs and funds. Consequently, it will take states nearly a decade to fully emerge from the current recession.<sup>8</sup>

In response to budget shortfalls, most states surveyed for this paper indicated that they have had to do more with less. While few states resorted to layoffs within the benefits division, other departments found staff reductions necessary. Some states have avoided layoffs by implementing other cost-saving staffing strategies, such as furlough days, and hiring and salary freezes. The upcoming Fiscal Year 2011 budget offers little relief as state governments continue to face deficits while attempting to pay down accumulating debt.



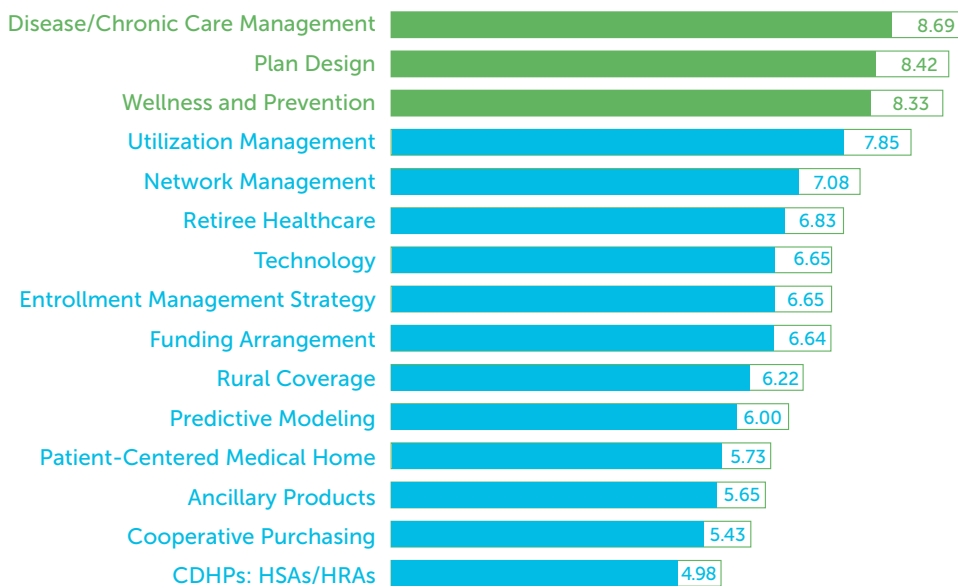
In New Jersey, Governor Christie has proposed that state workers contribute 1.5 percent into their health plans – up from zero – in addition to shouldering a salary freeze.<sup>9</sup> As expected, these types of changes are met with considerable employee resistance and often create employer/employee friction. Most states surveyed, however, said that these options were preferable to layoffs.

While most states agreed that the effects of the budget crisis have been overwhelmingly negative, a handful of states said the crisis helped facilitate needed change. In Maine, grim financial realities have made unions more amenable to changes in plan design. Frank Johnson, Executive Director of Employee Health and Benefits in Maine said: “It [the \$5.5 million in de-appropriation] has allowed us to make some changes that both parties [union and the state] have wanted and can agree to do. So, in a way, it’s helped to drive change. It hasn’t made it easy but it has helped facilitate some changes; no question.” Other states credited the recession with increasing employee awareness of the value of the benefits they receive. Ed Holland, Benefits Manager from the Department of Administrative Services in Iowa said, “If anything, [the budget crisis] has raised the status of benefits.” Anecdotal evidence supports the assertion that budget shortfalls may inspire innovation and forge productive relationships unlikely to occur in more robust economic climates.

## Vital Issues for Fiscal Year 2011

Out of 15 topics presented to interview participants, Wellness and Prevention, Disease and Chronic Care Management, and Plan Design emerged as the top priorities for the upcoming fiscal year. The states interviewed rated Wellness and Prevention, Disease and Chronic Care Management, and Plan Design as most important (see chart). Discussion of the current status, challenges, and evolution of these issues revealed significant overlap in states' treatment of Wellness and Prevention, and Disease and Chronic Care Management. This paper discusses these issues in depth.

### Importance of Various Healthcare Issues as Rated by Survey Participants\*

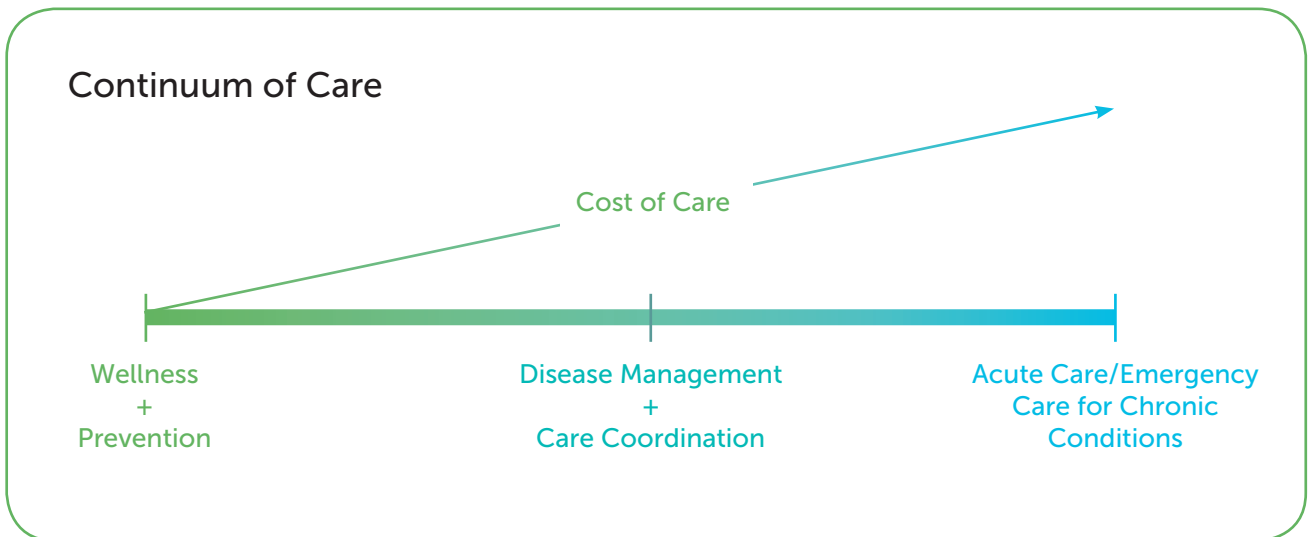


\* On a scale of 1-10, with 10 being "most important."

## ➤ WELLNESS, PREVENTION AND DISEASE MANAGEMENT

### Introduction

Rising healthcare costs and broadening fiscal constraints are forcing states to reexamine the structure of health plans and modes of service delivery. Given current utilization rates, states simply cannot sustain the level of benefits and number of options offered. Since most states



are reluctant to limit the volume of healthcare benefits provided to employees, many have turned to wellness, prevention and disease management programs as a primary strategy to reduce healthcare costs. As stated by an administrator of one Western state, "Disease management is the low-hanging fruit in cost containment." At the broadest level of care, wellness and prevention programs can be utilized by entire populations to increase health awareness and improve the health of all employees, regardless of baseline status. The next level on the care continuum is disease and chronic care management, which concerns the identification of populations suffering from chronic conditions and the implementation of effective disease management programs. The premise of these programs is that the improvement in lifestyle through better disease management will ultimately reduce the need for emergency or intensive long-term care, and will reduce the costs associated with chronic conditions. Nearly every state interviewed identified wellness and prevention and/or disease and chronic care management as a top priority for the upcoming fiscal year, and most had health and wellness programs in place.

While program specifics vary across states, the shared impetus is an overwhelming commitment to improving the health of employees and reducing utilization rates. States have focused on prevention and disease management as the primary means to meet these commitments. Many states commented that premium increases are often due to an increasingly unhealthy population with higher utilization rates. These types of high-cost claims are causing serious damage to state budgets. One state mentioned that 235 of its highest-cost employees spend as much as 15,000 other members. With the goal of slowing and eventually reversing rising costs, states have realized that many of the most cost-intensive health conditions are easily identified through simple screenings such as

blood pressure, glucose levels, BMI, and waist circumference. States also identified heart disease, high blood pressure, and diabetes as the top conditions targeted in disease management programs. If states can properly identify individuals at-risk for chronic conditions, disease rates and service utilization can be reduced. As Oscar Jackson, Cabinet Secretary and Administrator, Oklahoma Office of Personnel Management, said, "Prevention is cheaper than a cure."

Flexibility is a common theme across state wellness programs. Employees are often able to choose the most suitable program elements for their needs, and some plans customize programs for the most pressing and cost-intensive health concerns. The success of any prevention and disease management program is determined by the participation and engagement level of the target population. The onus lies on the state to offer opportunities for its employees to get healthier, and for employees to take advantage of those opportunities. "If we're going to drive wellness, we need to provide [employees] with the tools to help themselves," said Ted Cheatham with the State of West Virginia. Wellness programs are usually voluntary and are offered within most or all of the plan options provided by the state. Some states mentioned the importance of interaction with the retiree population in terms of wellness and prevention. Many states see implementing wellness programs for the existing workforce as a way to control future costs of retiree healthcare. Additionally, states are attempting to identify cost drivers in the retiree population that could be mitigated through earlier prevention efforts targeting active employees.

### Data Quality and Return on Investment

The collection of high quality data is a challenge and necessity to determine the impact of wellness, prevention, and disease management programs. Due to recent growth in wellness and prevention programming, many states have hired a vendor or third party administrator to manage the program and collect program data. Simultaneously, the low quality or inaccessibility of vendor-provided data have led a separate set of states to switch vendors or to return to in-house management of wellness programs and data collection. Data critical for program management include the number of people engaged in the program, the manner in which they are utilizing the programs, whether their behaviors and health outcomes are altered by their participation, and ultimately, financial impact. While wellness has been identified as a top priority in most states, there are different opinions regarding whether a return on investment (ROI) for these programs can be quantified.

Some states cite a decrease in claims and tangible cost savings while others have only recently mandated that wellness program vendors demonstrate ROI. For example, Oklahoma developed a contingency plan in which providers would be forced to lower premiums if the state could enroll a certain proportion of employees in wellness programs, and prove

a reduction in claims. Other states, including Indiana, South Carolina, and West Virginia questioned the reliability of ROI data. Even if costs are reduced post-implementation, many states indicated that attributing savings to wellness programs was challenging. Ted Cheatham from West Virginia encountered this difficulty during the first four years of their “Improve Your Score” program. “We could see the costs start to diminish, but measuring the return, and measuring cost avoidance still remains difficult,” he said. While many states did not trust ROI estimates, some believe in their potential. To produce reliable estimates, many said that proper measures and metrics need to be identified, and issues of data quality and database integration need to be resolved.

### Engaging Employees

When it comes to engaging employees in wellness and disease management programs, the method of outreach and the comprehensiveness of program information provided are crucial. Since the potential benefit for each individual is long term, with up-front commitment and investment required, states are finding that people are less inclined to invest in preventative behavior. As Daniel Hackler, Director of the Indiana State Personnel Department said, “culture change is needed to make disease and chronic care management programs work.” Many state employers believe that increasing employees’ involvement in their own health and disease management requires a culture shift in the organization and beyond.

Most states understand the importance of clearly and effectively communicating the benefits of any program or plan, especially one that involves lifestyle or behavior change on the part of the employee. Doug Farmer, Deputy Director of the Kansas Health Policy Authority, acknowledged that “getting people to engage in their own health, not healthcare” is both the state’s biggest challenge and priority. Additionally, most are acutely aware that lack of communication can hinder the widespread adoption of wellness and disease management programs. Educating the population on how to become informed consumers and more engaged patients is crucial to success. If the importance of good health is clearly communicated to members, and lifestyle changes can be linked to lower premiums, then states may be successful in achieving a healthier employee base and lower costs. However, some states may face difficulty in extending that communication to all members in their state. In Colorado, incomplete mailing addresses and the absence of a statewide employee email system make it difficult for administrators to communicate with all employees.

#### CHALLENGES IN STATE WELLNESS PROGRAMS:

- FUNDING
- UP-FRONT COSTS
- EMPLOYEE ENGAGEMENT

Educating the population on how to become informed consumers and more engaged patients is crucial to success.

Many states have identified the need for incentives to encourage participation in wellness and disease management programs. Some states, such as Ohio, Oklahoma, Nevada, Washington and West Virginia, offer financial incentives for successful completion of their wellness programs or health risk assessments. West Virginia's previously mentioned, "Improve Your Score" program offers free health risk assessments and provides a report card to each employee upon completion. A "green" score pays the employee \$50, a "yellow" score pays \$25, while a "red" score indicates "see a doctor." Ted Cheatham of West Virginia indicated they have seen "pay-out in hundreds of dollars in incentives each year; we have 16,000 [employees] in the program and we have had a pay-out of \$750,000 in incentives." And while this may prove success in terms of engagement, Cheatham indicated the data gathered since April 2008 have been erratic. "Scores are all over – Greens have moved to reds and reds to greens," said Cheatham. As a result they have moved to a "process-based system" – Instead of paying out money, they will offer premium discounts for score improvements. In this manner, West Virginia hopes not only to engage employees, but to inspire lifestyle changes and see trends toward consistent positive scores. In states where statutes or political reasons make financial incentives infeasible, other approaches have been employed. Nebraska, for example, covers preventive services at 100% if the employee completes a health risk assessment. As Paula Fankhauser said, "We have a statute that we cannot financially reward employees; so instead we built a wellness plan with an attractive premium and complete coverage of wellness care." Another approach involves fines for refusing to participate in wellness programs or failing to change unhealthy behavior. In 2008, Alabama mandated that all state employees complete an annual health screening.<sup>10</sup> In January 2010, employees were assessed a health premium of \$25, but were discounted \$25 upon completion of a health screening during the previous year. Additionally, state employees designated as obese were required to demonstrate progress in addressing their health challenges in order to receive the discount. Employees who failed to show progress or produce a physician's certificate documenting patient effort had to pay the \$25 assessment. State efforts to help obese employees make positive lifestyle changes include YMCA discounts and state-sponsored Weight Watchers programs. Another punitive approach that is becoming more common is to increase healthcare premiums for tobacco users. Kansas, Alabama and several other states charge tobacco users higher rates than non-tobacco users. If tobacco users participate in cessation programs, their premiums may be lowered. The use of fines may be the future of wellness and disease management programs as states strive to encourage member engagement and help members better understand the risks associated with unhealthy behaviors.

## Implementation Challenges

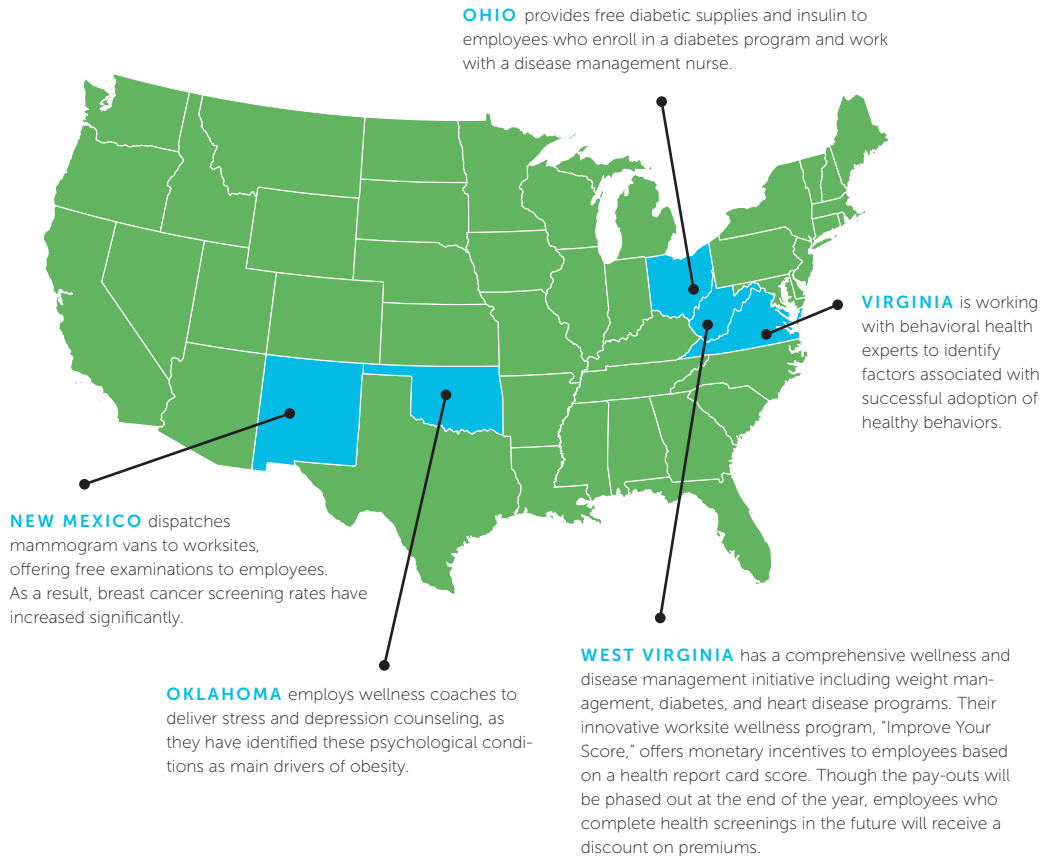
While states have recognized the importance of wellness, prevention and disease management programs, many face challenges in implementation and delivery. To start, many states encounter funding difficulties. As previously mentioned, ROI may be difficult to quantify, and returns are not immediate. Describing a common experience among states, a benefits administrator from a Western state said, "The politics of our state dictate, 'show me the money now, or I don't want to talk about it.'" Iowa's Holland indicated that the state had to drop its wellness program due to lack of funding. The initial cost of program implementation is significant and sometimes prohibitive, especially without a guaranteed ROI. Yet the primary challenge lies in engagement of the workforce.

The success of any prevention or disease management program ultimately lies in member participation, behavior, and attitudes. As Dennis Studer, Director of Employee Benefits for the Bureau of Personnel in South Dakota said, "If employees are not personally motivated to take advantage of the preventative services offered by the health plan there is very little anyone in an organization can do to motivate the employee beyond installing disincentives for employees not interested in their own personal health." Many states indicate that employees often view wellness and disease management programs as government intrusion, and are not comfortable with the state or their vendors collecting personal health data. There is a general lack of trust among employees regarding how the information may be used, and whether it could threaten their insurance coverage status, cause a reduction in benefits or an increase in premiums. Ultimately, the most influential way to combat employee fear and apprehension is through effective communication regarding the complete details of the program, how employee information will be used, and why it will ultimately save them money and improve their lives.

Many states indicate that employees often view wellness and disease management programs as government intrusion, and are not comfortable with the state or their vendors collecting personal health data.

Overall, states are much more proactive in addressing and investing in the health of their employees than they were ten years ago. There has been a strong movement to identify at-risk individuals and to intervene before incurring higher costs. Even though there are challenges and barriers to overcome in these programs, most surveyed states indicated that they are a prerequisite to controlling costs and to improving employee health and wellness. While the data and metrics are not yet in place to identify a clear return on investment for wellness and disease management programs, most states continue to move forward with their implementation and delivery. All states that identified these programs as a top priority agreed that they will remain a high priority for the next decade.

## Innovative Examples of Wellness and Disease Management Programs



### ➤ PLAN DESIGN

In addition to wellness and disease management programs, states continually examine plan design as a potential source of cost savings. While major design changes are often out of reach for states due to challenging collective bargaining environments, many have revised cost-sharing practices within existing plans, shifting a greater percentage of costs to employees. A common strategy is to increase employees' out-of-pocket contributions by introducing or increasing deductibles and/or co-pay amounts on medical benefits. While some states evaluate these increases on an ad hoc basis, others, such as Nevada, index deductibles and out-of-pocket maximums annually to keep pace with rising costs. Many states also increased the employee responsibility for in-and-out-of-network charges. South Carolina, for example, recently changed its in-network benefit from an 80/20 employer/employee split to 60/40.



Many states have realized cost-savings through redesigning or changing drug benefits. Several states, such as Nevada, and South Carolina, have added or increased drug deductibles and/or drug co-pays. In 2009, New York overhauled its pharmacy program, transitioning from a three-tier (generic, preferred, non-preferred) benefit to a flexible formulary plan. Under the guidance of a clinical committee and a value committee, the state introduced drug tiers based on value rather than brand name, and began excluding certain drugs from coverage altogether, contingent on the availability of an alternative in the same therapeutic category. The exclusion of one brand-name pharmaceutical – with many acceptable substitutes on the market – saved the state an estimated \$30 million in one year. When Kansas moved to a self-funding model, it introduced a value-based pharmacy benefit to better manage drug spending. The new program lowered co-pays for medications used to manage the top 5 highest-cost diseases. “We decided the plan needed to be set up to eke out the most value for our members. That doesn’t mean setting a benefit for a certain drug in a certain category at a certain cost, but rather recognizing that spending more money on a blood pressure medication early on saves so much money down the road,” said Doug Farmer, Executive Director of the Kansas Health Policy Authority.

A minority of the surveyed states have made more substantial changes intended to decrease or redirect utilization. While relatively few have successfully introduced Consumer Driven Health Plans (CDHPs), many states have incorporated consumer-based incentives into existing plans. Indiana, the only state interviewed with widespread CDHP enrollment said, “The focus of our plan design is to educate employees to be good consumers of healthcare.” While few states have made such dramatic changes, many echoed this sentiment. Maine provides a particularly innovative example of a consumer incentive system. Over the past few years, the state has transitioned from a traditional in- and out-of-network benefit to a three-tier preferred system for many services. In its preferred hospital benefit, for example, the Maine Health Management Coalition identifies high-performing hospitals based on clinical quality and patient safety measures, and incentivized members to choose them by waiving their deductible and co-pay. Maine has a similar system for primary care practices and is planning to extend the preferred benefit to specialty services. While dollar return on the program has yet to be quantified, the state has seen substantial migration in outpatient services and improvement on core measures for hospital and clinical performance. Value tiering requires a significant upfront investment, but has the potential to generate significant cost-savings for states and to drive improvements in overall healthcare quality. States that have successfully developed safety, cost, and quality metrics and used them to evaluate hospitals and practices have usually done so as part of an alliance with private sector employers and health plans, hospitals, and physicians.

## Barriers to Innovation

States identified two main barriers to innovation in plan design: the union environment and employee resistance to change. Benefits administrators in heavily unionized states pointed to an inability to make adjustments to plan design and utilize common cost-saving strategies because of the collective bargaining process. While several states expressed a desire to incentivize healthy behavior through plan design, namely by imposing higher cost-sharing on members who make poor lifestyle choices, most viewed this as difficult or impossible to implement in a collective bargaining environment. “Employers can’t keep underwriting fallout from noncompliant employees. Unfortunately, labor is able to undermine or defeat attempts to change the status quo,” said a Western state administrator. In extreme cases, such as in Utah, a 2006 overhaul in the structure of the retiree benefit resulted in a lawsuit brought against the state by the Employee Association. The role of unions and other employee organizations in states’ abilities to drive change is discussed in greater detail in a separate section below.

The second major barrier to innovation in plan design is state employees’ resistance to

change. According to most state benefits administrators, employees have grown accustomed to generous plan designs and are unwilling to either increase cost sharing or to reduce benefit levels. “Our people don’t pay a lot for plans and don’t pay much out of pocket. They’ve gotten used to such a rich set of benefits over the years, it’s hard to make changes,” said Brenda Lakeman, Director of Statewide Benefits in Delaware. In addition, administrators said that employees are typically unaware of the state’s level of contribution toward their healthcare. As rising healthcare costs necessitate changes to plan design, many states have introduced benefit education programs for employees. Indiana, which successfully transitioned its plans to consumer-driven designs, said the transition required upfront employee education that defined benefits as a component of salary and positioned the state as a partner in healthcare. Doug Farmer, Deputy Director of the Kansas Health Policy Authority, said: “We want employees to move beyond the idea of health insurance as just writing a check each time you see a doctor and to understand that we’re trying to build a plan that helps them as they seek to improve their health.”

“There are a lot of changes we’ve seen across the country that haven’t been made here. For example, we have not even implemented some of the most basic plan design changes because of the bargaining process.”

**Ed Holland**  
Benefits Manager  
Department of Administrative  
Services in Iowa

Texas minimized the disruptive impact of plan design changes by soliciting employee feedback in advance. When faced with increasing costs that threatened to deplete the state's fund balance, Texas decided to increase member cost-sharing. Prior to proposing changes to the Board, the Employees Retirement System of Texas surveyed employees to determine preferences regarding plan changes. Results of the survey indicated that members preferred co-payment increases over increased deductibles, as well as smaller but frequent increases to cost-sharing amounts over larger, more infrequent ones. As a result, staff recommended the Board approve small co-pay increases in virtually all benefits categories, to be implemented September 1st, 2010.<sup>11</sup>

Additionally, there has been a movement toward more technologically intensive methods of communication with health plan members. The use of online marketing and information sharing with employees is becoming increasingly common. Technology is employed to ease the process of selecting and changing plans for employees. While this has been a largely successful strategy for active employees, online communication is not as successful for the retiree population in most states. Educating retirees on changes to plan design is still a challenge for most states, one that has not been mitigated by the use of online mechanisms.

Finally, a minority of state benefits administrators expressed reluctance to increase employee cost-sharing or to make major changes to plan design in the current economic climate, since many state employees have already been asked to make sacrifices in terms of pay, staffing and work environment. "We've had furloughs and other things that have impacted employees, so we wanted to have the least amount of additional disruption for them," said Nancy Bearce with the State of New Mexico.

**"The retiree population is so influential in terms of plan expenses and demographics, that we need to identify strategies to effectively communicate and interact with them."**

**Frank Johnson**  
Maine's Executive Director  
Department of Administrative  
Employee Health & Benefits

## Other Important Factors in State Employee Health Plan Administration

In addition to Wellness, Prevention & Disease Management, and Plan Design, several other factors are integral to the administration of state employee health plans. During interviews with participating states, the following topics were either of critical current importance or of long-term significance in decisions regarding employee health benefits.

## ➤ FUNDING ARRANGEMENT

Many states described the funding decision as a trade-off between mitigating risk and exercising control over cost containment and plan design. Virtually all states interviewed self-fund at least one employee plan, which can typically save between five and six percent in administrative costs relative to fully-insured plans.<sup>12</sup> Most states self-fund PPO plans, and the majority self-fund HMO plans, citing greater cost-savings, design flexibility and data integrity. "In return for assuming risk, we get rewarded from favorable experience. Being self-funded allows us greater flexibility in terms of benefit design and collaborating with providers in partnerships," said Frank Johnson, Maine's Executive Director of Employee Health & Benefits. Additionally, self-funding has helped states implement wellness programs. Daniel Hackler, Director of the Indiana State Personnel Department said, "Being self-funded provides an incentive to implement wellness programs, since we pay the bills while someone else does the implementation and day-to-day management of the program." As many states identified, there are significant cost savings to be realized through self-funding. "You are potentially looking at hundreds of thousands, if not millions saved by going self-funded from fully insured," said Debbie Cragun, Human Resource Administrative Director, Utah Department of Human Resource Management. In Maryland, where cost trends have been below the national average, self-funding has been a major benefit. Anne Timmons, Director, Employee Benefit Division, Maryland, said, "If we were fully insured, our costs would be significantly higher."

Even though most states expressed enthusiasm for self-funding, a few were more cautious, noting that successfully managing a self-funded program requires considerable time, skill and financial resources. "States have to be realistic about whether they have the leadership and capacity to run a self-funded program successfully. The results of poor capacity, decisions or indecision can be severe," said Ralph Cobb, a Health Policy Advisor in the State of California Benefits Division. Nebraska's Employee Benefits Administrator, Paula Fankhauser, said that while the state's plan is stably self-funded, it encountered problems when it transitioned to self-funding without sufficient financial resources. "The state was literally waiting for employees to pay their premiums so the state could pay their claims," she said. After an overhaul of the state's funding practices, Nebraska now has an account balance that can cover all claims under almost any circumstance. Some states such as West Virginia and Wisconsin believe that savings associated with self-funding have been exaggerated, citing risk as the only difference between self-funded and fully insured designs. For example, Wisconsin tried self-funding plans in the past and saw a large increase in cost.

Among states that are either partially self-funded or fully insured, some are comfortable with (or contractually bound to) their current arrangement and others are looking to transition to a completely self-insured system. New York, one of the few fully-insured states interviewed, has introduced a bill that would give state health insurance the ability to self-fund. Ohio, which recently began self-funding mental health coverage, is looking to self-fund other plan areas. Wisconsin does not prefer this approach. William Kox, Wisconsin's Director of Health Benefits and Insurance Plans for the Department of Employee Trust Funds states, "We believe that if employees are provided an incentive to choose a health plan that is efficient, then regardless of its funding arrangement, the benefits will offset the costs."

Regardless of the duration of self-funding (more than a decade for some states), most states re-evaluate funding arrangements on an annual basis. "Every time we re-examine it, we come to the same conclusion: when you have the resources to manage your own pool the size of a state, it is a benefit to be self-insured," said Doug Farmer, Deputy Director of the Kansas Health Policy Authority. Among self-funded states, there is generally a high level of satisfaction with their current funding practices. While funding arrangement is not a top priority for many states in the upcoming fiscal year, it is an area of constant attention and monitoring. And while there are a few exceptions, most states agree that self-funding health plans affords them greater flexibility in terms of design and administrative cost-savings.

## ➤ RETIREE HEALTHCARE/UNFUNDED LIABILITY

One trillion dollars. According to the Pew Center on the States, that is the difference between the amount of money states pay for retiree benefits (\$2.35 trillion) and the cost of the benefits promised to retirees (\$3.35 trillion.<sup>13</sup>) In the wake of GASB 45, the 2004 financial and accounting rule requiring government employers to measure and report the liabilities associated with post-employment benefits, most states said the continued provision of retiree healthcare was an area of serious financial concern. Many states, such as Maine, described the sticker shock expressed by legislative leaders upon seeing the dollar amount tied to the liability. Others, such as Utah, felt that additional policy maker education would be necessary in order to effectively address the liability. Even after an overhaul of Utah's retiree health benefits, administrators believed the future costs would be unsustainable.

States reporting substantial unfunded liabilities tended to share certain plan design features: most provided coverage to both

### COMMON FEATURES OF STATES WITH SUBSTANTIAL LIABILITIES:

- Coverage offered to both pre- and post-medicare eligible retirees
- Heavily or fully subsidized the cost of retiree care

### COMMON FEATURES OF STATES WITH LOW OR NO UNFUNDED LIABILITY:

- Coverage offered only up to medicare eligibility
- Retirees pay all or most of the cost of care

pre- and post-Medicare eligible retirees and either heavily or fully subsidized their cost of care. The few states with low or no unfunded liability generally covered retirees up to Medicare eligibility and/or required retirees to pay all or most premium costs.

States use a variety of approaches to pay down the existing liability and to slow future growth, including creating an irrevocable trust or other funding mechanism, prospectively changing eligibility criteria for retiree healthcare enrollment, and integrating retirees into the active employee risk pool. While the majority of states established an account to pre-fund outstanding liabilities, the recent budget crisis has caused contributions to slow or stop. In Maine, the legislature allocated \$100 million in 2007-2008 to pay down the liability, and pledged another \$70 million in 2009-2010, but was unable to follow through due to budgetary constraints. "Funding makes sense, but you need money to do that. And frankly, there isn't any," said Robert DuBois, Director of New York's Employee Benefits Division. Nevada's fund was emptied when a special legislative session ordered the money in the account be returned to the state. Most states have decided that scarce resources are urgently needed for gaps in existing programs. They plan to pay off debts when resources are less constrained, thus allowing the trillion-dollar gap to grow.

Yet despite recent funding disruptions, most states believe that they have the right strategies and tools in place to address the outstanding liability, and will resume doing so once the economy rebounds. Unfortunately, this may not be for another four to five years at the earliest. In the meantime, to slow the growth of retiree healthcare costs, some states, such as South Carolina, have significantly increased the minimum duration of employment required to qualify for retiree health coverage. "It will take a while to realize savings, but in 50 years, people will be thanking the authors of that legislation," said Rob Tester, Director, South Carolina Employee Insurance Program. Others have ended the retiree health plan subsidy for new hires or have prospectively prohibited Medicare-eligible retirees from retaining state coverage. Still other states, such as Virginia and Maine, have integrated retirees into the same risk pool as active employees, which effectively subsidizes the cost of retiree healthcare. While Virginia views this as a strategy to increase affordability for the retiree population (their costs are 2.8 times higher than active employees in the state), Maine views this subsidization as an unintended consequence.

States vary in their responses to GASB 45. Some states, such as Utah and South Carolina, have implemented sweeping changes to retiree health plans, while others such as Maryland are just now assembling a committee to review the best course of action to ensure plan sustainability. "We haven't made changes to retiree benefits in quite some time, and that's statutorily driven. It's required that the retirees have the same benefits, same premiums and costs as active employees, unless they're eligible for Medicare," said Anne Timmons, Director, Employee Benefit Division, Maryland. In 2010, Maryland planned to convene a committee of

state officials, employees and citizens to consider changes. Although not identified as the top priority for 2011 for most states, unfunded retiree benefit liability is a cause for constant concern and evaluation. Many states are unlikely to address this challenge until state revenues return to pre-recession growth levels.

### ➤ CONSUMER-DRIVEN HEALTH PLANS

While approximately a third of the states interviewed have at one time offered a consumer-driven health plan (CDHP), most reported that these plans were unpopular with state employees. Benefits administrators tended to attribute the lack of traction to the rich benefits and low cost of the state’s traditional plans. “There’s no incentive for anybody to sign up for the high deductible plan at all. The current plan is so cheap and the deductible is so low,” said one administrator with the Public Employee Health System of Utah. Others attributed the lack of interest to a fear of the unknown, stating that more employee education

## States that Pool Government Employees for Health Insurance Coverage

STATE	LOCAL GOVERNMENT EMPLOYEES COVERED BY STATE EMPLOYEE PLAN	R*	STATE	LOCAL GOVERNMENT EMPLOYEES COVERED BY STATE EMPLOYEE PLAN	R*
Arkansas <i>(since 2003)</i>	School employees	R	Missouri	Municipal and school employees	
California <i>(since 1967)</i>	Municipal employees	R	Nevada	Municipal and school employees	
Delaware	Municipal employees	R	New Jersey <i>(since 1964)</i>	Municipal and school employees	
Florida	School employees		New Mexico	Municipal employees	R
Georgia	Municipal, all school employees	R	New York <i>(since 1958)</i>	Municipal and school employees	R
Hawaii	Municipal and school employees		North Carolina	All school employees	R
Illinois	Municipal employees		South Carolina	Municipal and school employees	R
Kentucky	School employees	R	Tennessee	Municipal and school employees	
Louisiana <i>(since 1980)</i>	School employees	R	Utah <i>(since 1977)</i>	Municipal and school employees	
Maryland	Municipal employees		Washington	Municipal and school employees	R
Massachusetts <i>(since 2007)</i>	Municipal employees	R	West Virginia <i>(since 1988)</i>	Municipal and school employees	
Mississippi	School employees		Wisconsin	Municipal employees	

R = State and local government employees are pooled for insurance premium rating purposes.  
Sources: Connecticut Office of Legal Research (2008); NCSL research (2007-2010).

needs to be done for the plans to attract members. “Employees don’t think about benefits every day. The more you can get in front of them face-to-face and explain things like the value of participating in an Health Reimbursement Account (HRA), the tax benefits for those things, the more they’ll value it,” said Oscar Jackson of Oklahoma. In Indiana, 70% of its 30,000 employees have chosen to transition into flexible Health Savings Accounts (HSAs), one of two Consumer Driven Health Plans which are eligible for a Health Savings Account (HSA).<sup>14</sup> The state credits education initiatives for the high level of employee enrollment and retention in its consumer-driven plans. “Those who are in it, love it. Those who are not in it, there is a trust factor. You have to educate employees to be good consumers of healthcare and to have plans in place to be able to do that,” said Daniel Hackler, Director, State Personnel Department, Indiana.

Among states that had never offered consumer-driven health plans, several had plans to introduce them over the next few years. Even some without concrete plans for implementation, such as Alaska, mentioned strong support in the state legislature for CDHPs as a way to manage costs. States that had no plans to introduce CDHPs frequently mentioned union resistance. “In the public sector, there’s strong opposition to CDHPs by organized labor. As result, we don’t see near-term prospects for introducing CDHPs in the state employee population,” said an administrator of one Western state.

**“More is better,  
when purchasing  
services or goods...  
the more people I  
have in my group,  
the more pressure  
I can bring to those  
selling services in  
the market place.”**

**Doug Farmer**  
*Deputy Director*  
Kansas Health Policy Authority

## ➤ COOPERATIVE PURCHASING

Many states have engaged in cooperative purchasing as a strategy to lower administrative costs and negotiate lower prices from providers and insurers. According to a recent report by the National Conference of State Legislatures, about half of all states have allowed other public-sector employees, such as school districts, cities and counties, to participate in state employee health benefits plans.<sup>15</sup>

States mentioned using their sizeable enrollee population as a bargaining tool to negotiate lower premiums, better benefit packages and innovative new programs. “It gives us a little more flexibility because we can go out and bid together and make our own unique plan design,” said Justin Najaka, Director of Compensation, New Mexico State Personnel Office.

However, apart from size and volume advantages, many states felt like most benefits of cooperative purchasing accrued to small public employer groups, through huge gains in



administrative savings, personnel expertise and plan choice. New Mexico, which experienced a 40% enrollment increase after encouraging local bodies to join, said the state employee health plan now has a much greater administrative burden in terms of payroll and invoicing. Others mentioned that state employees could face rising premiums if utilization rates were higher among the other public employees joining the state plan. To deal with this, some states charge local government and other non-state public employees higher rates until they are integrated into the pool and utilization has normalized.

While the majority of states opened up plan participation to local governments and school districts, a few mentioned combining with other large public purchasers, such as Medicaid or the State Retiree Authority, to leverage purchasing power and coordinate state-level quality improvements. In the state of Washington, the governor recently combined the state employee health program, Medicaid, and Basic Health, a state-subsidized health product for lower-income residents, into a single agency. In Kansas, the Health Policy Authority coordinates purchasing and network-building with Medicaid programs, enabling data and information-sharing related to service costs and providers. New Mexico's state employee health plan is involved in a consolidated purchasing agreement with three large state entities – the Public School Insurance Authority, the Retiree Health Care Authority, and the Albuquerque Public School District – to leverage buying power to insurance companies for self-funded programs. While all three states cited advantages in terms of information-sharing and market power, they also mentioned challenges in coordinating initiatives across different employee segments. One such challenge lies in understanding where initiatives can be similar state wide and where they can differ. Kansas mentioned the difficulty of crossing networks to negotiate joint rates for state employee health and Medicaid, and New Mexico cited the challenge of aligning employee and retiree interests.

## ➤ RURAL COVERAGE

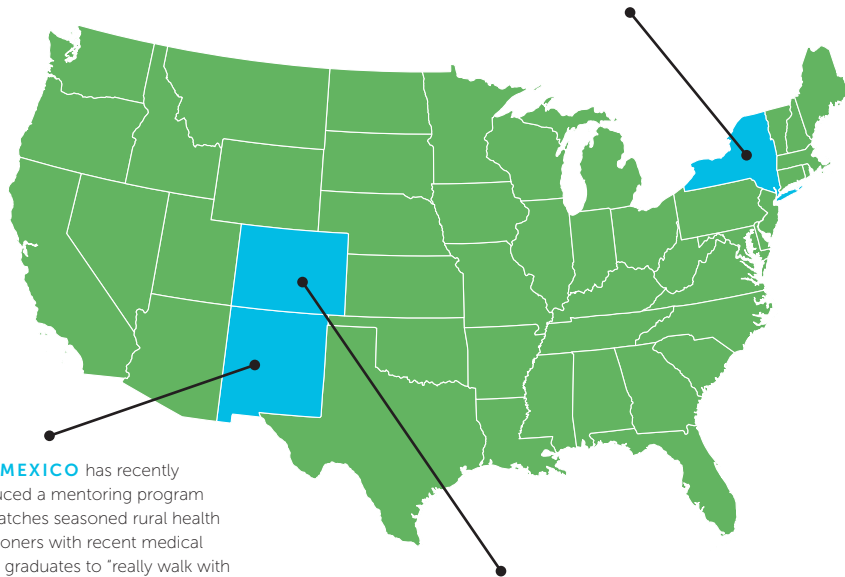
Virtually all states that discussed rural coverage mentioned the deficit of healthcare resources in rural areas and the difficulty of getting providers to practice in them. With employees located in every county, states indicated a struggle between maintaining broad coverage and controlling costs. Many mentioned the high levels of frustration among rural employees about the extra distance, time and costs associated with receiving care. "Many employees located in rural areas think it's the state's fault that the provider won't expand. They don't understand it's not our choice to make. It causes a little dissention in the workforce," said Karen Fassler, Total Compensation Manager with the State of Colorado.

"The way networks are set up dictates how physicians practice medicine," said Doug Farmer, Deputy Director of the Kansas Health Policy Authority. This statement was echoed by most

states, regardless of their rural coverage program. Nebraska and Indiana, the only rural states interviewed that felt adequately covered, credited the extensive network of their providers. “Our provider has to be able to reach out to every square foot of the state and provide benefits, and there are not too many others who can do that,” said Daniel Hackler, Director, State Personnel Department, Indiana. Among those with less extensive networks, some states, such as California, have compensated rural employees for the expense and distance necessary to travel to access healthcare, while others have implemented innovative programs to address the scarcity of providers (see map).

### Innovative Approaches to Rural Coverage:

**NEW YORK** is piloting a project in the rural Adirondacks that increases Medicaid reimbursements and provides additional monthly health management fees to providers who locate in that region. The program – a partnership between hospitals, the State Department of Health, seven private insurers and the Employee Benefits Division – was created to offset the high start-up costs associated with rural practice, strengthen the areas primary care network, and address the particular health needs of the local population. In exchange for higher reimbursement rates, providers must meet a new standard of care that is consistent with patient-centered medical home principals, which focus on preventive medicine, disease management and improved care coordination.



**NEW MEXICO** has recently introduced a mentoring program that matches seasoned rural health practitioners with recent medical school graduates to “really walk with them during the first couple of years of setting up a rural practice,” said Nancy Bearce of the State of New Mexico.

**COLORADO** started a telemedicine pilot program to address the expense and difficulty of accessing specialty physicians in rural areas. State employees located in rural regions can go into area community centers and consult with specialists located elsewhere in the state via high-definition video technology.

## ➤ ROLE OF UNIONS

Nearly one-third of all states have union membership rates at or above 15%. The role of unions in states interviewed ranged from non-existent to highly influential. Consequently, perspectives on states' relationships with unions and unions' impact on states' ability to drive change were equally varied. A handful of states interviewed, including Indiana, Nevada, South Carolina, South Dakota and Virginia, did not have a union presence. This absence can grant states additional flexibility in terms of enacting change, but can also be a hindrance. "We don't have unions, period. Therefore, we don't have to bargain over anything – we have the ability to make changes," commented Daniel Hackler, Director, State Personnel Department, Indiana. The majority of states described their relationship with unions as mutually beneficial – recognizing that more effective communication and information-sharing between the two leads to more efficient delivery of services to employees. Robert DuBois, Director of the Employee Benefits Division in New York, said "keeping an open line of communication with the unions helps us communicate with our population." In this manner, unions generate more dialogue with members, and thus more trust, increasing the likelihood that state changes to plan design will be accepted by members. Some states believe it is advantageous to have the union serve as a sounding board. Frank Johnson of Maine recognized that "unions are equal partners in the decision making process with regard to benefit design vendor selection and out-of-pocket expenses." In some states, however, union power can be challenging for states. In California, CalPERS (California Pension, Employee, and Retirement System) is highly influenced by the unions, making change to plan design very difficult. "Unions are one of the most influential constituencies with respect to CalPERS, and the CalPERS board holds control over the health program. It can be an uphill battle for employers at the state and local level to obtain desired changes in the health program because of all the parties involved," said Greg Beatty, Chief, Benefits Division from California. In New Jersey, the aforementioned 1.5% increase for public workers payment for their healthcare as proposed by the Governor is being met with staunch opposition from the state's public employee unions.<sup>16</sup>

## ➤ ORGANIZATIONAL DESIGN

As noted in the 2006 white paper, the organizational design and structure of state employee healthcare varies significantly from state to state. State employee healthcare is administered by a variety of different entities, including boards or commissions, committees, legislatures, and departments of healthcare, administration, personnel, labor, or finance. It may be housed independently or with other state functions ranging from Medicaid to human resources to shared services. The administration of state employee healthcare depends critically on the organizational design and structure of its governing agency.

A minimum of 23 first-term governors will take office in January 2011. With the advent of healthcare reform and a wide disparity among existing state plans, incoming governors may choose to re-envision the management and delivery of state healthcare benefits. While many states currently house employee health separately from other state health programs, efficiencies may be gained by uniting state health functions under a single department. Such an office would not only oversee Medicaid, employee benefits, and corrections, but could also be charged with the development and implementation of state health exchanges. Streamlining state healthcare delivery may also enable states to realize significant cost-savings through economies of scale in purchasing, administration and network management. Since this massive restructuring requires careful planning, as well as buy-in from the unions and legislature, states should look to the early adopters, such as the state of Washington, for guidance.

## ➤ FEDERAL HEALTHCARE LEGISLATION

With the Patient Protection and Affordable Care Act (PPACA<sup>17</sup>) signed into law March 23, 2010, most states have assembled teams of experts to analyze what changes must be made to existing plans to comply with the new federal legislation. While few states have determined their exact course of action, most agree that the PPACA will significantly impact the way they deliver employee healthcare in both the short and long term.

The short-term impact of reform will vary from state to state. States must immediately address mandatory coverage for dependents up to age 26, the elimination of lifetime caps on individual insurance claims, the exclusion of over-the-counter drugs from reimbursement through Health Savings Accounts (HSAs), and the elimination of coverage denial based on pre-existing conditions. States' reactions to the short-term impacts of reform have varied according to their current coverage level and the amount of change necessary to comply with the legislation. Karen Fassler in Colorado stated, "On the real tangibles, we're ahead of the game, specifically on pre-existing conditions, annual limits, and we already cover dependents up to age 25." Several other states such as Iowa, Ohio, and Utah reported that they already covered dependents up to age 25 or 26 and that they do not exclude members based on pre-existing conditions. New Mexico will make few changes in order to comply with the initial requirements of health reform. "All of our plans are ahead of the curve: we don't exclude based on pre-existing conditions, we already have unlimited lifetime benefits, and we're way ahead on prevention and wellness in terms of plan design," said Nancy Bearce of the State of New Mexico. Ohio also seemed optimistic about reform.

Although some states are prepared to comply with the short-term mandates, others anticipate that significant, costly changes will need to be made. Some states expressed concern that the additional coverage of dependents will increase premiums, which will be passed on to employees. Other concerns included the inability to make the necessary changes given current staffing levels and uncertainty surrounding the management of the new risk pool. Kansas, took a more oppositional approach by introducing legislation that would prohibit the federal reform bill from being enacted in their state. The legislature in Utah passed a bill requiring approval of the state legislature for implementation of any reform-based changes. Nevada plans to challenge the legality of the bill. In total, attorneys general in 20 states have signed onto one lawsuit against the U.S. Department of Health and Human Services.<sup>18</sup>

Regardless of a state's ability to block specific changes, all are planning for change. In order to best prepare and plan for changes, many states have put together special teams and panels to inform the legislature of the change that will be needed to meet reform requirements. While states have some understanding of the short-term implications of reform, many are unclear on what is going to happen in the long-run with the more significant changes slated for 2014. One long-term issue is the question of what it means to be a grandfathered plan and what changes are allowed before that status is jeopardized. Another long-term unknown is the role of exchanges. Some states are unsure whether they will continue to offer benefits or if it will be more cost-effective to go through an exchange, where others (Kansas) are discussing whether the state employee health plans will run the exchange. Yet another valid concern is the fines that large employers face if an employee applies for and receives a subsidy. Debbie Cragun of Utah said, "My biggest concern as an employer is if we have one employee apply for and get a subsidy then we are going to have to pay taxes (fines) on every employee. Out of 23,000 employees, the likelihood of this happening is pretty high. How are we going to pay for that? I don't know where we are going to come up with the money to pay these potential fines." In this scenario, inquiries about how debt-ridden states are to pay these fines are looming. Even though there are some questions that will not be answered until there is further clarification on definitions and until regulations are written, states are doing their best to measure the long-term effects of health reform.

**"The Governor and Legislature will need to make a number of decisions about how health reform will be implemented in Kansas. One of the discussions that will need to occur is how or whether the State Employee Health Plan participates in an exchange."**

**Doug Farmer**  
*Deputy Director*  
Kansas Health Policy Authority

However, one aspect of healthcare reform that was not discussed by many states is the expansion of Medicaid. This is because many state employee health benefits representatives interviewed do not oversee Medicaid in their state. This may also be due to the fact that many states are immediately focused on the short-term changes that are effective either six months from enactment on January 1, 2011. Wisconsin was one state that discussed the impact of reform on Medicaid reimbursements. While Wisconsin feared the state would sustain mostly negative impacts from the implementation of reform as a large employer, it also thought some of these may be mitigated by the state's low reimbursement status. Increases in Medicaid reimbursement for some providers, as well as the expansion of Medicaid, may actually benefit Wisconsin. Wisconsin currently has state-funded programs that insure low-income individuals above the poverty level; these programs will now be supplanted by federal programs using federal dollars. "Even if providers shift the costs of low Medicaid reimbursement onto us, the employer plans would not be impacted as greatly, or the situation could even improve, if the level of reimbursements actually improve," said William Kox, Wisconsin's Director of Health Benefits and Insurance Plans for the Department of Employee Trust Funds. The expansion of Medicaid will impact each state differently. It will be important and necessary for states to analyze the expansion of and changes to these public programs.

The total impact that PPACA will have on states is impossible to know this early on. The teams that some states have put together to analyze the requirements of reform are crucial when implementing changes tied to deadlines. It is going to be essential for states to implement changes that will bring them into compliance with the bill to avoid fines and taxes.

## Conclusion

Our survey of state personnel executives reveals that recent budget constraints have had a significant and widespread impact on the design and administration of employee health plans. During the economic downturn, states have focused on cost containment and utilization reduction through ongoing evaluation of plan designs and implementation of wellness, prevention and disease management programs.

While the top priority for benefits agencies remains the health and coverage of their populations, they face the following challenges as they undertake efforts to meet employee needs while controlling costs:

- Rates of adoption and implementation of wellness programs are low.
- Barriers to plan design innovation, including a resistance to change among members and employee representatives.

- Lack of access to data to support the case for plan and program changes.
- Uncertainty regarding the impact of federal healthcare legislation.

## Way Forward

The information gathered in this survey points to several steps that states may consider to overcome cost and wellness challenges. These steps include:

- Develop standardized metrics for measuring health and wellness program return on investment (ROI). This step is essential for quantifying program impact, identifying opportunities for program improvement and reinforcing a culture of health and wellness in the workplace. Standardized metrics will facilitate longitudinal as well as cross-state analysis of employee health status and program performance. With more reliable ROI estimates, benefits administrators can direct healthcare resources more effectively, present a more compelling case for program funding to legislatures, and use data to help make the case for change among resistant employees and union representatives.
- Engage employees before and during transitions. Although employees may be resistant to plan and program changes critical for implementation in response to the recession, steps can be taken to minimize disruption to members:
  - ▶ Communicate the state's current level of contribution to employee benefits, including how it compares to other employers and why it is unsustainable.
  - ▶ Present employees with the choices facing the state in terms of benefit changes, emphasizing the state's commitment to avoiding layoffs.
  - ▶ Solicit employee input in the form of a survey on proposed cost-saving strategies, such as variations of benefits reduction and increased member cost-sharing.
  - ▶ Introduce changes in plan design and/or cost-sharing that respect employees' preferences and address their concerns to the greatest extent possible.
  - ▶ Communicate with complete transparency the features of the new plan/cost-sharing arrangement months in advance of the roll-out.

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## Appendix: Interview Definitions

**Ancillary Products** – are additional products available to employees as part of a comprehensive healthcare and benefits package including and not limited to dental, vision, life insurance, long-term disability, and prescriptions.

**Consumer-Driven Health Plans** – refers to health insurance plans that allow members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay routine healthcare expenses directly.

**Cooperative Purchasing** – is the ability for small cities, towns, and municipalities within a particular state to band together to negotiate for improved health insurance coverage for employees.

**Cost Containment and Utilization** – the extent to which the members of a covered group use a program or obtain a particular service over a given period of time (ex. # of services used 100 people eligible for the service).

**Disease and Chronic Care Management** – prospective identification and evaluation of patients with chronic diseases, using intervention designed to prevent exacerbations or worsening of disease.

**Enrollment Management Strategy** – there are several different tools that can be used for employees to enroll for their healthcare benefits and to make yearly amendments to their selected benefits (ex. online enrollment).

**Funding Arrangements** – the employer option of payment for a specific health benefit plan such as fully-insured funding arrangements or self-funded arrangements.

**Network Management** – is the way in which an employer that offers health benefits manages a system of contracted physicians, hospitals and ancillary providers that provides healthcare to members.

**Patient-Centered Medical Home** – is a model that creates a healthcare setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

**Plan Design** – is the process by which states develop the best benefit plan designed for their covered population through considering plan characteristics such as plan cost, satisfaction, and financial contribution for employees.

**Predictive Modeling** – is the process by which a healthcare benefits package is created or chosen to try to best predict the probability of an outcome. Predictive modeling can be used as a tool to estimate disease risk and to evaluate the effectiveness of a healthcare intervention.

**Retiree Healthcare** – are benefits provided by employers to their retirees. These benefits are usually designed to supplement Medicare and Medicare-eligible retirees.

**Rural Coverage** – access to healthcare in rural areas is typically much lower than in a metropolitan area and employees in these regions struggle to find quality healthcare. Some states are working to strengthen rural healthcare delivery systems by maintaining a focal point for rural health.

**Technology (Health Information Exchange)** - is defined as the mobilization of healthcare information electronically across organizations within a region, community or hospital system. HIE provides the capability to electronically move clinical information among disparate healthcare information systems.

**Telemedicine** – is the transfer of medical information via telecommunication technologies for the purpose of consulting or for remote medical procedures or examinations.

**Wellness and Prevention** – creating programs that offer wellness activity assistance and prevention screenings to promote disease prevention and early detection.

## Endnotes

1. About the authors: Colleen Schlecht and Betta Sherman received their Master of Public Policy from the Irving B. Harris School of Public Policy Studies in June 2010. Katie Meyer will receive a joint Master of Public Policy from the Harris School and a Master of Arts from the School of Social Administration (SSA) in June 2011. The Harris School is one of six professional schools at the University of Chicago and seeks to enhance the University's role in shaping and understanding public life by conducting policy relevant research and preparing talented individuals to become leaders and agents of social change. All three students participate in the University's Graduate Program in Health Administration and Policy (GPHAP), a multi-disciplinary certificate program for students interested in health administration and policy that attend the Harris School, SSA, and the Chicago Booth School of Business. GPHAP students must complete a supervised practicum as part of their training, providing the opportunity to apply theoretical knowledge to real life administrative and policy challenges. This white paper project was funded in part by the GPHAP program and met the practicum requirement for all three students. Before returning to school to earn her Masters, Colleen Schlecht worked at the National Governors Association for nearly 5 years. Her primary policy interests center around family and child health and wellness, childhood obesity, healthcare systems and youth development. She received a B.A. in Public Policy from Duke University in 2001. After receiving her Master of Public Policy, Betta Sherman joined Strategic Management, LLC as a regulatory analyst, working with healthcare organizations on compliance issues. While at the University of Chicago, she contributed to a variety of policy research projects with topics ranging from health disparities and healthcare access to teenage pregnancy to mid-career job loss. She received a B.S. in Social Policy from Northwestern University in 2006. Prior to returning to school to earn her Masters, Katie Meyer worked in research at The University of Iowa, The University of Chicago, and is currently engaged in research at Children's Memorial Hospital. This summer, she will participate in an internship at the National Opinion Research Center in its Department of Public Health. Katie is primarily interested in health disparities and quality of healthcare services. She received a B.S. in Psychology from the University of Wisconsin – La Crosse.
2. The National Association of State Personnel Executives is the recognized authority on state government human resource issues, trends, practices, and policies and serves as a leader and catalyst for the development of state human resources and is dedicated to enhancing the image of state public service.
3. UnitedHealthcare supported this project with financial and logistical aid to the students. The interviews were conducted and paper written solely by the students. As a result, the statements and positions in this paper should not be construed as being the statements or positions of UnitedHealthcare.
4. Methodology: Healthcare benefits administrators from the following states were surveyed for this paper: AR, CA, CO, DE, IN, IO, KS, MD, ME, MI, MO, NW, NM, NY, OH, OK, NV, SC, SD, UT, VA, WA, WI and WV. These states are: AR, CA, DE, FL, GA, HI, IL, KY, LA, MD, MA, MI, MO, NV, NM, NY, NC, SC, TN, UT, WA, WV, WI.
5. Topics include Wellness and Prevention, Disease and Chronic Care Management, Utilization Management, Predictive Modeling, Cooperative Purchasing, Consumer Driven Health Plans, Retiree Healthcare, Plan Design, Funding arrangement, Rural Coverage, Technology, Network Management, Patient-centered Medical Home, Enrollment Management Strategy, and Ancillary products (ie. Dental, Vision, Rx, Life, LTD, etc.).
6. "The State Fiscal Direction: The Lost Decade" Scheppach, Ray. "The State Fiscal Direction: The Lost Decade". National Governors Association. January 11, 2010. Available at: <http://www.nga.org/Files/pdf/0911FISCALLOSTDECADE.PDF>
7. The National Association of State Personnel Executives, Annual survey data, 05-09 state composition
8. Scheppach, Ray. *Ibid*
9. <http://www.cnn.com/2010/OPINION/05/18/avlon.christie.fiscal/>
10. Alabama was not interviewed for this paper.
11. "Review, Discussion and Consideration of the Insurance Plans under the Texas Employees Group Benefits Program." PUBLIC AGENDA ITEM - #19c. May 25, 2010.

12. "Combined Public Employee Health Benefit Programs." Health Cost Containment and Efficiencies. National Conference of State Legislatures Brief. March 2010.
13. "The Trillion Dollar Gap: Underfunded state retirement systems and the roads to reform". Pew Center on the States. February 2010.  
Available at: [http://downloads.pewcenteronthestates.org/The\\_Trillion\\_Dollar\\_Gap\\_final.pdf](http://downloads.pewcenteronthestates.org/The_Trillion_Dollar_Gap_final.pdf)
14. Arthur B. Laffer, Stephen Moore, Jonathan Williams. *Rich States, Poor States*. American Legislative Exchange Council. 3<sup>rd</sup> Edition. 2010.
15. "Combined Public Employee Health Benefit Programs." Health Cost Containment and Efficiencies. NCSL Brief. March 2010.
16. New Jersey was not interviewed for this paper.
17. It should be noted that when interviewing for this NASPE paper began, reform had not been passed. The states interviewed prior to reform did their best to speculate how they thought reform would impact their state. For the purposes of this paper, all of the states mentioned in this section were interviewed after reform was passed.
18. [http://www.msnbc.msn.com/id/36001783/ns/politics-health\\_care\\_reform/](http://www.msnbc.msn.com/id/36001783/ns/politics-health_care_reform/)

