

POLICY BRIEF

# State Employee Health Insurance

*Assessing the Scale of State Purchasing Power*

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## Introduction

Across the nation, state governments are major purchasers of health insurance for their employees. According to the US Census Bureau, 100 percent of state governments offered health insurance benefits to their employees in 2018.<sup>1</sup> The Census Bureau further reported that state governments provided health insurance benefits to 67.6 percent of their 5.4 million employees in 2018.<sup>2</sup> This total of approximately 3.7 million employees does not include the number of dependents, retirees, or enrollees of local governments, and other public employers that also participate in states' health insurance programs. In 2012, based on a report published by Pew Charitable Trusts and MacArthur Foundation, total spending exceeded \$30 billion covering 2.7 million households.

Between employee benefits and Medicaid programs, states' spending on health insurance represents a major budgetary item. In 2018, the federal Center for Medicare and Medicaid Services (CMS) reported that health insurance spending for all state and local governments totaled \$433.6 billion and that spending has experienced an average annual increase of 3.9 percent over the past five years.<sup>3</sup> In Fiscal Year 2019-20, the state of New York itself spent \$22.1 billion on Medicaid and \$4.3 billion on employee and retiree health insurance costs.<sup>4</sup> To alleviate these escalating costs, some states have examined options to coordinate purchasing across state programs in an attempt to achieve economies of scale. Recently, California proposed policies to leverage their purchasing of prescription drugs by combining employee health insurance programs with other state programs such as Medicaid and Correctional Health.

**\$433.6B**

**HEALTH  
INSURANCE  
SPENDING FOR  
ALL STATE  
AND LOCAL  
GOVERNMENTS  
(2018)**

The purpose of this policy brief is to examine the extent to which the states in their role of purchasers drive the evolution of the healthcare delivery system. This brief examines the availability of basic financial and cost data relating to state employee insurance programs. It assesses the scale of state health insurance purchasing using existing data and presents results from a preliminary survey of states. We also review the degree to which employee purchasing decisions are coordinated with other state health policy purchasing goals such as Medicaid and the Affordable Care Act (ACA) insurance marketplaces.

## Background

Unlike state Medicaid programs and ACA insurance marketplaces governed by federal statute, all states have independently developed their own employee health insurance programs. This inherent variation can make identifying and comparing information related to such programs especially challenging.

Any exhaustive comparisons or research needs to consider the unique history and context of state employee health insurance recognizing the critical role it plays in collective bargaining and as a fringe benefit that reflects the tradeoff of benefits for cash wages. Nonetheless, in the opinion of the authors much can be learned and shared by first better understanding basic statistics on the scale and reach of state employee health insurance programs.

## Data Availability

### Availability of Basic Information

Several organizations collect and publish regular updates on state Medicaid programs.<sup>5,6</sup> It is also possible to find annual information about costs and enrollment for ACA exchange populations.<sup>7</sup> The third avenue through which states provide healthcare, as an employer, is less transparent. There is limited up-to-date and publicly available data on state employee health insurance spending and enrollment.

While most state employers provide current data on benefit design (copayments and deductibles) and premium cost sharing, there is limited information on key aggregate financial and enrollment data for state employee health insurance programs. As noted above, the US Census Bureau annually reports high-level information on health insurance benefits offered by state and local governments. However, the information reported is limited to enrollment information, per enrollee premium levels, and plan design features, such as copayment, deductible, and coinsurance amounts. While CMS also provides an aggregate spending for state and local governments on health insurance, which was \$184.8 billion in 2018, it does not report separate spending levels for the states.<sup>8</sup>

There is no regularly updated, publicly available dataset that provides information on the number of employees, retirees, and dependents covered. Nor is there reliable information about the impact of state employee health plans on state budgets. In 2014, The Pew Charitable Trusts and the MacArthur Foundation published a comprehensive

report reviewing state employee health plan spending. The 2013 data (included in the Pew-MacArthur report) is the most up-to-date information available. In 2016, The Pew Charitable Trusts published a related report on state spending for retiree health insurance costs, also known as other post-employment benefits (OPEB), which provided state-by-state OPEB expenditures as of 2013 and the liabilities associated with the funding commitments to retiree health insurance, but notably did not include spending for active employees in the scope of the report.<sup>9</sup> Other reports on this topic exist, but are typically not publicly available<sup>10</sup> or are focused on benefit design.<sup>11</sup>

In contrast to extensive journal and popular press articles covering state Medicaid programs and state purchasing objectives for the ACA marketplaces, the state employee health insurance programs are understudied. Using only available literature, it is difficult to assess the scale of the health insurance plans across the states. In addition, there is no information available on administrative policy, such as the degree to which state purchasing of health insurance is coordinated with other state health purchasing or health reform goals such as value based purchasing or delivery system reform.

## Rockefeller Institute Pilot Survey of Select States

In response to the lack of up-to-date information, the authors drafted a brief pilot survey with questions for managers of state employee health insurance programs. The survey included questions related to spending, enrollment, governance, and coordination with Medicaid programs. The goal was to collect preliminary information and to assess states' willingness to respond.

The authors selected a cross-section of states to receive the pilot study that would include variation by:

- Populous and less populous states;
- states where collective bargaining was likely to be a factor in plan design and those where it is not;
- states that run their own ACA exchanges and those that do not (to compare ACA enrollment as a crude indicator of more active state policy); and
- geographic distribution throughout the country.

To encourage participation in the pilot study, the authors limited the survey to a brief set of questions focused on enrollment, cost, and coordination with Medicaid and other health programs. The survey was sent to administrators of state employee health insurance plans. The full list of questions is shown in [Table 1](#).

TABLE 1. Survey of Administrators of State Employee Health Insurance Plans

Q1	What agency or department administers your state employee health insurance program?
Q2	Is this the same state department or agency that administers your state's Medicaid program?
Q3	If no, what state department or agency administers your state's Medicaid program?
Q4	Does your state employee health insurance program cover retirees?
Q5	If yes, are Medicare-eligible retirees and dependents in your state employee program?
Q6	If no, are they enrolled in a separate Medicare Advantage or other type of plan?
Q7	Are local governments or other public employers allowed to participate in your state employee program?
Q8	How many total covered lives does your program have?
Q9	Please include covered lives of other public employers, if applicable.
Q10	For the three most recently concluded fiscal years, how much did your state government spend on its health insurance program?
Q11	What was the total program spending? Please include any premiums paid by enrollees or other participating public employers.
Q12	Are any aspects of your health insurance program subject to collective bargaining?
Q13	Is your program self-insured?
Q14	Does your program offer multiple enrollment options?
Q15	How frequently do you competitively bid the contracts for your plan?
Q16	As you know, Medicaid typically represents the state's largest healthcare program. Can you describe the extent to which the state's employee health insurance program considers or coordinates with the Medicaid program from a policy, program, or innovation context?
Q17	Building on the above question, can you describe how the employee health insurance program coordinates or works with the state's overall health policy leaders to implement or advance state health policy goals?
Q18	Are there any other important features or details of your program that you think we ought to know?

Of the 12 states that were sent surveys, we received responses from the states listed below:

- Florida;
- Massachusetts;
- Minnesota;
- New Jersey;
- New York;
- North Carolina;
- Ohio; and
- South Carolina.

The authors also reviewed a public report from the California Public Employees Retirement System (CalPERS) regarding their health insurance program for state employees that was used to supplement the data collected from states.<sup>12</sup> As a result, we have preliminary data from nine states. These nine states employ 35.6 percent of the total state government workforce.

## Preliminary Findings

### Enrollment and Spending

For Calendar Year (CY) 2019, the total enrollment in these states' employee health insurance program was 4.2 million total covered lives, which includes all enrollees (employees and retirees) and their covered dependents. The CalPERS report for CY 2018 shows an additional 1.5 million total covered lives. [Table 2](#) shows the enrollment for each state.

TABLE 2. Enrollment and State Employment of Respondents, 2019

State	Covered Lives	State Employees
Florida	366,062	221,943
Massachusetts	432,000	114,438
Minnesota	50,927	81,848
New Jersey	789,000	129,907
New York	1,239,070	228,195
North Carolina	735,000	182,347
Ohio	111,250	132,313
South Carolina	511,521	93,414
<b>Total</b>	<b>4,225,830</b>	<b>1,184,405</b>
California*	1,456,806	476,217
<b>Grand Total</b>	<b>5,682,636</b>	<b>1,660,622</b>

\*California data taken from CalPERS 2018 Report, State Employee counts from BLS QCEW.

These states' programs covered almost 5.7 million lives, which is considerably higher than the total state employee workforce of 1.7 million. Our survey and related research finds that many state employee health insurance programs are also made available to local governments and school districts on an optional basis. For example, in the CalPERS 2018 annual report, it cites over 1,200 agencies and schools as part of its program. The New York State Health Insurance Program includes approximately 900 participating local governments, school districts, and other employers. In addition, it is common for states to provide health insurance coverage to retirees.



For the most recently completed plan year, the spending by the eight states that responded to the survey totaled \$28.7 billion. This figure represents total program spending, including contributions from state governments, participating local governments, and enrollees. The CalPERS report for CY 2018 shows an additional \$9.1 billion in annual spending for California.

States reported widely differing trends in aggregate spending over time. Our survey asked for 2017, 2018, and 2019 spending, and states reported increases ranging from a low of 2 percent to a high of 10 percent. Several factors could drive spending, including enrollment changes and case mix. Subsequent studies could explore the variability in enrollments and spending over time in more depth.

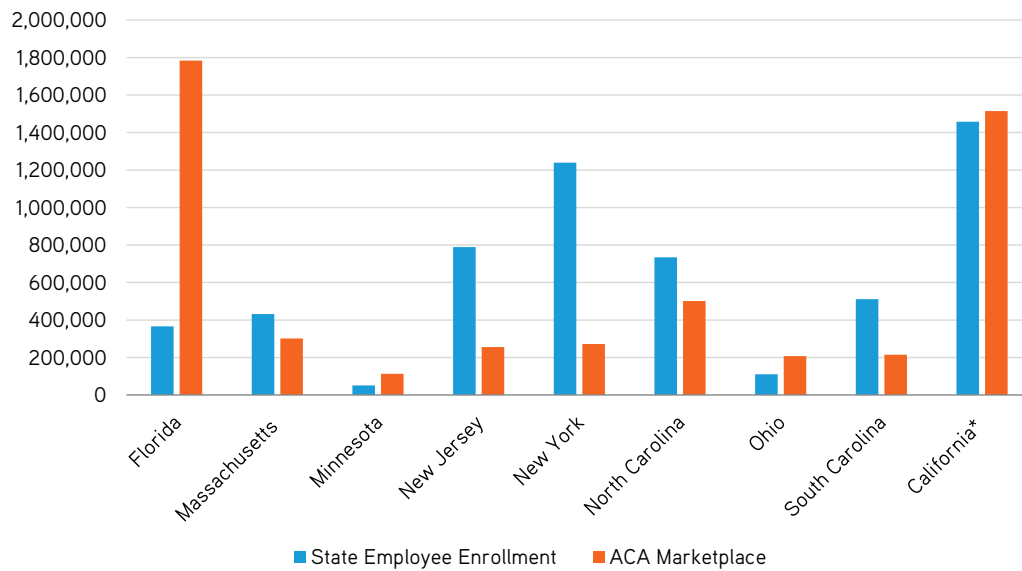
## **Comparison to ACA Insurance Marketplaces**

To create context with respect to the scale of these programs, we compare a state's employee health insurance enrollment to the state's ACA individual market exchange in the same year. The results are revealing. In six of the nine states, enrollment in the employee health insurance program is higher than enrollment in the health insurance plans offered through the state's ACA marketplace.

The combined 2019 ACA marketplace enrollment for these nine states was 5.2 million (including California), approximately 600,000 fewer covered lives than these states' health insurance programs. In some states, such as New Jersey, employee health insurance program enrollment was substantially greater than ACA marketplace enrollment. In other states such as Florida, ACA marketplace enrollment exceeded the state employee program. In evaluating the ACA exchange enrollment, it is important to consider whether that state had expanded Medicaid; where it did not, exchange enrollment will be higher. This could reflect the degree to which state employee plans permit local governments to join and the degree of participation of those local governments. While 100 percent of all state governments offered health insurance plans, only 92 percent of small local governments (defined as fewer than 250 employees) offered coverage to employees.



FIGURE 1. Enrollment in Employee Program vs. ACA Marketplace, 2019<sup>13</sup>



The comparison between state employee program and ACA marketplace enrollment is relevant to the question of the degree to which states are active purchasers. As major purchasers of health insurance in their local markets, state governments could potentially seek to drive delivery system reforms. They could use their purchasing power to demand greater emphasis on value-based payment systems and enhance delivery system integration. Indeed, some states that operate their own state-based ACA exchanges have acknowledged active purchasing goals. For example, the California Health Benefit Exchange website states that:

The Exchange will be a catalyst for change in California’s health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.<sup>14</sup>

## OTHER SURVEY FINDINGS

0 of 9 STATES

managed the state employee health insurance program in the same agency as its Medicaid program.

8 of 9 STATES

allow local governments to participate in their state employee health insurance program.

8 of 9 STATES

provide some form of health insurance coverage to retirees.

## Policy Through Purchasing

We wish to explore if states are also using their purchasing power in the state employee health insurance market to influence policy. To better understand the relationship, we asked survey recipients what state agency was responsible for the management and procurement of the state employee health insurance program. While responses varied, ranging from the human resources department to other state agencies, in all cases the program was separate from the large Medicaid programs that are typically driving the state's health policy and reform goals.

The survey also asked the respondents the degree to which they coordinate broader health policy and/or purchasing goals with the state Medicaid agency. Throughout the nation, state Medicaid programs have advanced a wide variety of health system and delivery system reforms, often through federal Section 1115 demonstration project waivers and in their procurement programs for Medicaid managed care organizations.<sup>15</sup> New York has advanced payment and delivery system reform through its Delivery System Reform Incentive Payment waiver, which seeks to transition the payment system to a value-based model with a goal of reducing avoidable hospital utilization by 25 percent over five years.<sup>16</sup> In North Carolina, the state announced its goals for Medicaid transformation in a Request for Proposals issued to managed care organizations that cited improving whole person care to include behavioral health and social determinants of health.<sup>17</sup>

In general, the survey respondents cited relatively little coordination with state Medicaid agencies, but in some cases they acknowledged a desire to increase coordination. While one state's response said that "the level of coordination is extensive," most responded that coordination was "centered on pharmacy fraud and provider compliance with the Medicaid agency." Another stated, "coordination has been limited due to differences in populations served, funding, and governance." And one state simply acknowledged that "there is no coordination."

## Examples of State Purchasing or Policy Coordination

Insights gained through quantitative data can be supplemented through case studies of individual states. Recently, some states have more actively recognized the potential advantages of coordinating state healthcare policy and combining purchasing across the state employee insurance and Medicaid programs. Despite the potential for cost savings, the implementation has proved challenging.

### California

In California, an executive order (N-01-19) was signed right after Governor Newsom took office in 2019.<sup>18</sup> The order consolidated multiple separate purchasing programs for prescription drugs, including Medicaid, employees' insurance, and optional offerings to local governments, into one state entity. The action effectively created the largest single purchaser for prescriptions in the US. Previously, under its managed care program for Medicaid, the prescription drug benefit was administered separately by more than 10 health plans.

While the California initiative originally contemplated including the state employees program administered by CalPERS, CalPERS ultimately chose not to participate. Gaining a better understanding of that decision could shed light on the challenges and barriers of greater coordination. Nonetheless, California has moved forward with a carve-out for pharmacy benefits in its Medicaid managed care program with savings cited below from excerpts of the budget:

DHCS [California's Department of Health Care Services] has continued the work, pursuant to Governor's Executive Order N-01-19 issued in January 2019, to transition the Medi-Cal pharmacy benefit to the FFS [fee-for-service] delivery system effective January 1, 2021. The Budget includes savings of \$178.3 million (\$69.5 million General Fund) specific to Medi-Cal Rx.<sup>19</sup>

### Oregon

Though Oregon was not one of the survey respondents, the state provides a good example of the practical implications of coordinating state purchasing across Medicaid and state employees. In 2017, SB 1067 passed the legislature and was signed into law by the governor in August 2017. In a direct effort to contain the state's costs for employee health insurance, the bill merged the Public Employees' and Oregon Educator Benefit Boards. The legislation also instituted a 3.4 percent cap on the rate of growth for per-member expenditures in the public employee programs.<sup>20</sup>

## Recommendations

To gain insights into the management of state employee health plan programs, we conducted a pilot survey. The goal was to gain a better understanding of the scale and scope of these benefit programs and identify how policies will impact their management in the near- and long-term. Based on survey responses from eight states, it appears that there is limited coordination between employee health programs and other large state purchasing programs.

Even though the pilot study did not identify coordination efforts, the cases of California and Oregon indicate that such policy changes are being considered and, in some cases, implemented. We believe a focus for further research would be to determine the implications, mechanics, and possible outcomes of greater collaboration across state systems. In addition to plan managers, we would need to recognize the role of other key stakeholders including budget offices, collective bargaining organizations, unions, and retiree organizations, as well as the different enrollee groups covered by these programs.

## Qualitative Research and State Case Studies

Practitioners could benefit from learning more about recent efforts to encourage collaboration across healthcare programs. The states we survey reported limited coordination across their health programs, but some respondents expressed a desire to collaborate more. We looked at initiatives underway in Oregon and California to better understand how those states arrived at their decisions to coordinate across healthcare programs.

In this regard, the Rockefeller Institute will convene a forum in early 2021 with state healthcare policy managers, groups representing state employee health insurance programs, and individual state administrators to discuss implications of these very preliminary findings, and to cover such topics as:

- The degree to which states could better coordinate their health insurance programs.
- The existing barriers to coordination and whether it is practical to harmonize programs given the important role collective bargaining plays in determining state employees benefit design, cost sharing, and trade-offs between wages and benefits.
- How coordinating across state health programs could affect provider participation given payment rate differences, benefit design variations, and coverage rules.
- The sharing and coordinating of procurement policies, such as: frequency of competitive bidding, goals to include strategies for delivery system reform, and criteria for selection of insurers.

- Since state employee insurance program managers are implementing innovations in plan design and purchasing, what mechanisms could be developed to help inform over all state policy?

## Comprehensive and Up-to-Date Statistics

Given the scale of state employee health insurance programs and the lack of complete and current publicly available data on costs and enrollment, we plan to expand on our pilot survey to integrate all 50 states. The information will allow states to better understand national cost and enrollment trends and will identify innovative policies being implemented in other regions. Using feedback from the forum, our research team will work with other interested stakeholders and possible funding partners to further consider a thorough 50 state survey.

## Conclusion

Through their state employee insurance programs—which cover millions of state employees and their families, retirees, and in many cases local jurisdictions—states represent significant purchasers of healthcare. State healthcare policy has traditionally focused on public programs. And, states have used their purchasing power to affect change in Medicaid and health insurance exchanges. Our research and pilot survey of select states suggests, however, that states may find it helpful to further explore coordinating their state employee programs with broader purchasing and policy goals. Consequently, we see a need for more research into this important topic at the intersection of healthcare and fiscal policy.

## Endnotes

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