



NCSL

NATIONAL CONFERENCE OF STATE LEGISLATURES

State & Public Employee Health Benefits: Trends Across the States

**Presentation by Richard Cauchi
Director, Health Program**

**to the Michigan Legislature
Public Employee Health Care Reform Committee**

September 17, 2009

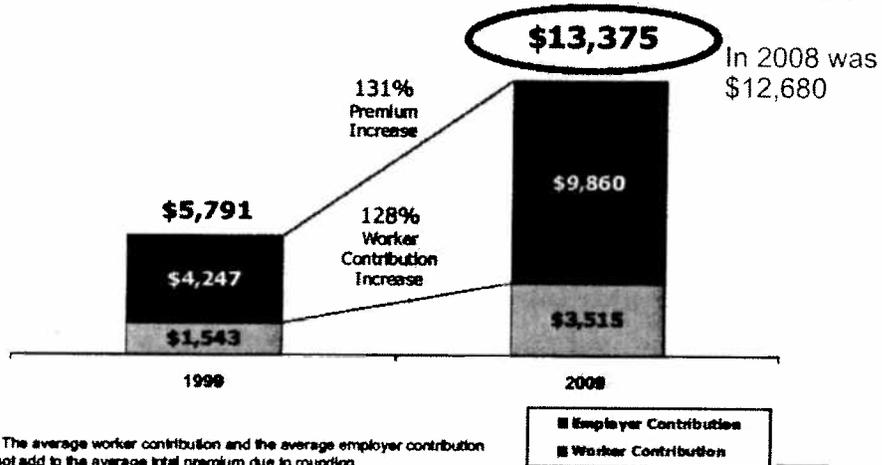
Rev 9/15/09-b

State governments: A major health purchaser

- **All 50 states provide health insurance and coverage to most of their employees, and most of their retirees**
- **About 3.4 million current/former workers**
- **The state programs include at least 7 million covered lives**
- **Nationwide, 8% of state health budgets are for state employee health**
 - 72% is for Medicaid; 2% for CHIP
 - 1% Higher education; 1% Corrections
 - 5% Community-based Services
 - 5% Population/Public health services

Health Insurance Cost Concerns Sept. 15, 2009 Update

Figure 1
Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2009



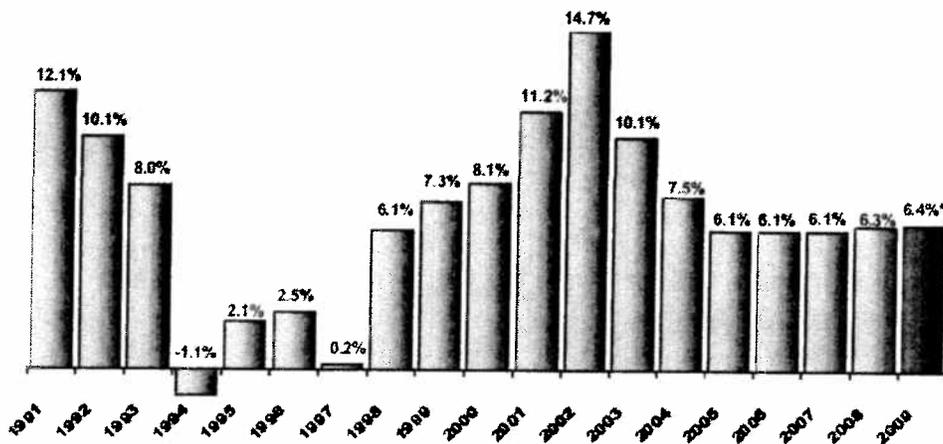
Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008.



The commercial health insurance market

Cost growth remains flat
Annual change in total health benefit cost from 1991-2009



Note: Results for 1991-1998 are based on cost for active and retired employees combined. The change in cost from 1999-2008 is based on cost for active employees only.

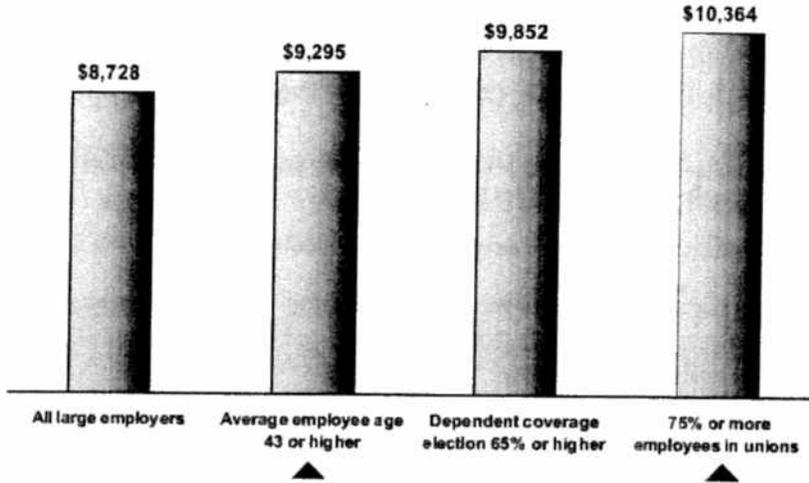
* Average increase projected for 2009 after changes to plan design.

Mercer

Source: Mercer Employer Health briefing, Denver, February 2009

The commercial health insurance market

Factors that affect average cost per employee
Employer/employee demographics—large employers

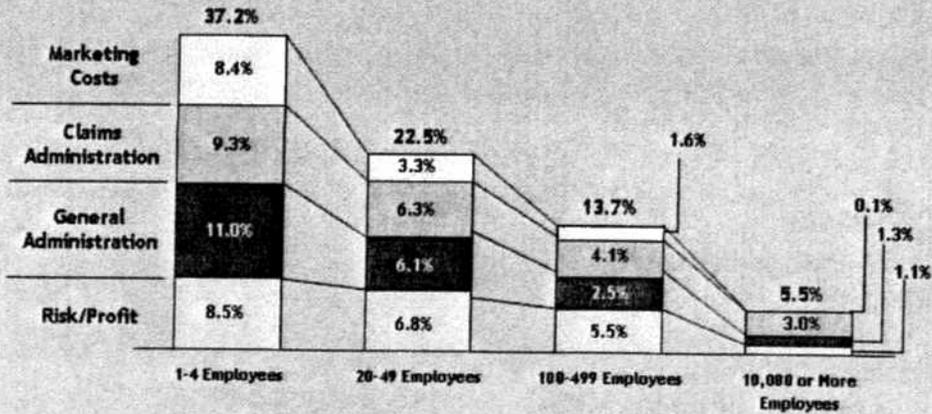


Mercer

33

Source: Mercer Employer Health briefing, Denver, February 2009

Insurance is More Costly to Administer for Small Groups



Source: Lewin presentation on "Cost and Coverage Impacts" to Colorado Commission, August 23, 2007

THE LEWIN GROUP

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State Employee Health Premiums - NCSL 2009 survey

- Costs increasing for both state and workers.
- Very wide variation among the 50 states on cost-sharing:
 - AK, DE, IA, ND, OK, OR: **state pays 100% of lower-cost full family policies**
 - AR, KS, KY, LA, ME, MS, NE, NC, TX: **employees pay over \$300/month for lower-cost full family coverage**
- **50-state typical lower-cost widely-available policy option:**

2009 Monthly	State share	Employee share	Total Monthly
Individual	\$437	\$38 (8%)	\$474
Family	\$870	\$188 (18%)	1,062

Choices (HMO, PPO, HAS/HDHP), packages, tiers, vary up to 50+%

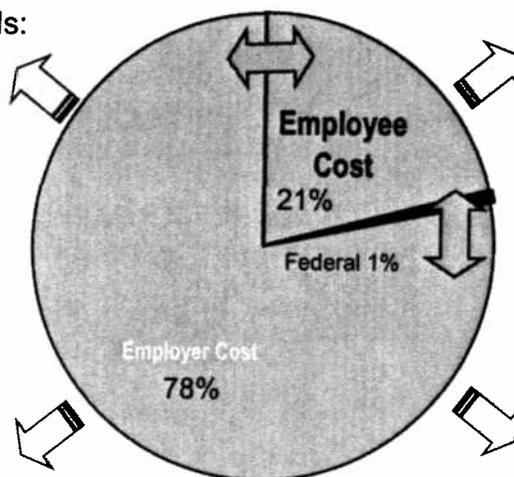
Public Employee Health Benefit Funding

- Only two sources of funds:

- Employer subsidy
- Employee premiums and out-of-pocket costs
- Rarely: CHIP & Medicaid

- Cost levers

- Hold down overall cost of the plan
 - *Size of the pie*
- Shift cost to the members
 - *Size of the pie slices*



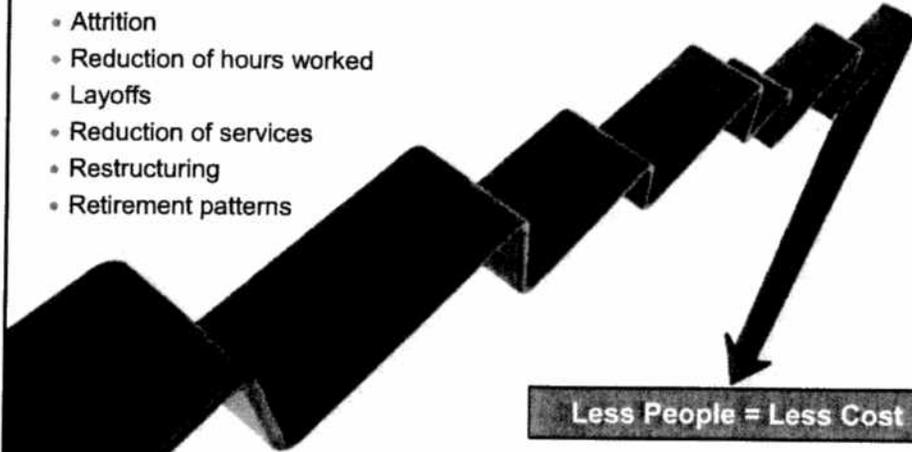
Adopted from Segal presentation by Richard Johnson to NCSL, 7/21/2009

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Impact of Falling State & Local Budgets

➤ Falling budget revenue ultimately translates into staff reduction through:

- Attrition
- Reduction of hours worked
- Layoffs
- Reduction of services
- Restructuring
- Retirement patterns



➤ But a reduced workforce could also mean higher costs...

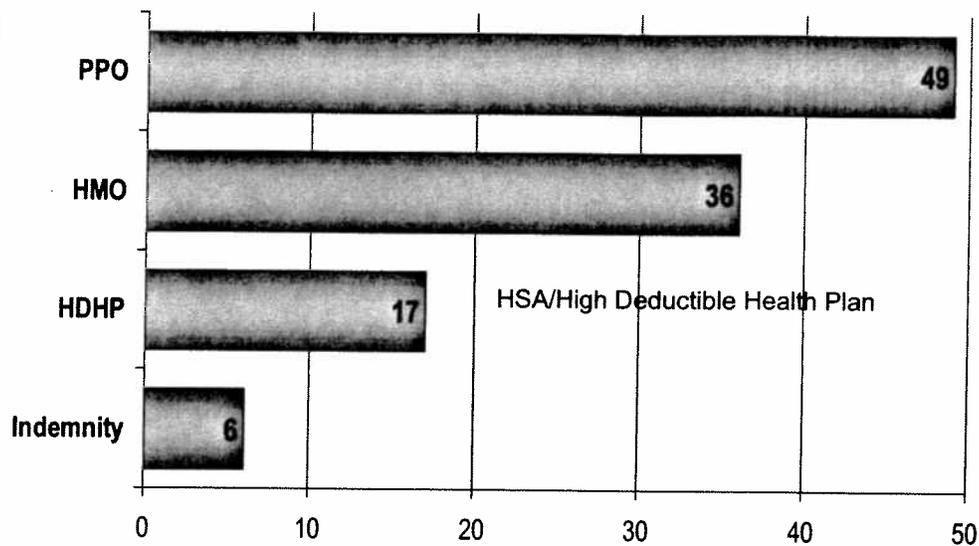
Actions State Health Plans Are Taking

Redesign Health Benefit Plans

- Adverse times externally are a good time to make plan changes internally
- Identify benefit features that can be reduced or restructured without eliminating key coverage areas
- Does the plan design promote and encourage preventive care and discourage unneeded care?
- Can a lower-cost plan option help?



Number of States Offering Medical Plan Types



Source: Segal State Survey 2009.

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Actions Health Plans Are Taking *continued*

Review Cost-Sharing Strategy

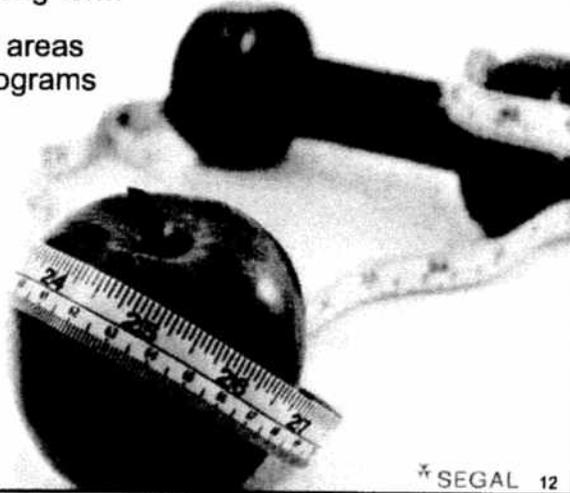
- Trade fixed copayments for coinsurance so employees share in increasing costs automatically
- Where possible, share premium cost increases proportionally
- Be aware of limits on employees' ability to absorb radical cost increases in years without pay increases
- Balance cost shifting with need to provide a reasonable benefit level
- Incentive for participants to cover spouse and dependents elsewhere



Actions Health Plans Are Taking *continued*

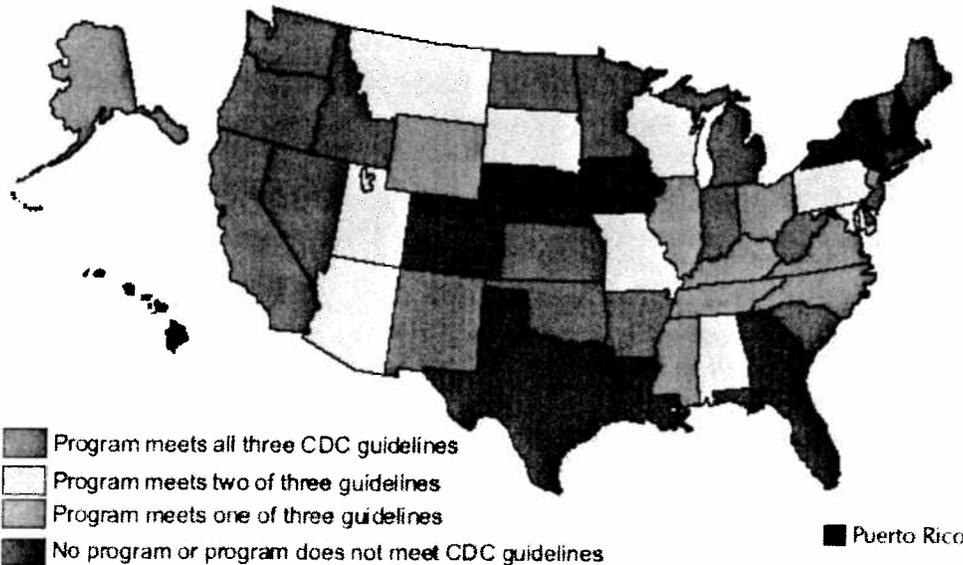
Enhance Wellness Programs

- Even if they cost a bit more now, wellness programs can help hold plan costs down in the long-term
- Target specific "high results" areas rather than broad general programs
- Avoid the ROI argument, if possible, in favor of importance of keeping remaining work force healthy



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State Employee Tobacco Cessation Coverage



NCSL & CDC
data 9/2008

Guidelines include:

1. Coverage for at least four counseling sessions of at least 30 minutes;
2. Access to smoking cessation agents, including prescriptions and nicotine replacement;
3. Counseling and medication coverage for at least two quit attempts annually.

No information was available for the District of Columbia.

Actions Health Plans Are Taking *continued*

Improve Case Management and Health Coaching Services

- Help participants stay on appropriate therapies now that will help them avoid future health complications with greater plan costs
- Target specific diseases and procedures with greatest potential for demonstrable effect
- Where possible, use existing carriers as a contract add-on to avoid need for full procurements

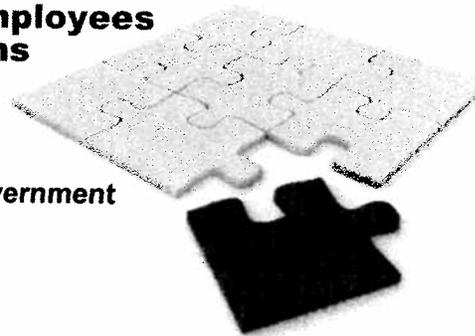


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Actions State Health Plans Are Taking

Combine or Pool State Employees with political subdivisions and education

- **More than 30 states use some combinations of state and local government**
- **Cities, towns, counties**
permitted in at least 22 states
includes: CA, NY, NJ, MO, IL, MA
- **K-12 schools**
permitted in at least 15 states
includes 11 southern states; NJ, NY, MA, WA
- **Higher Education**
Required or permitted in about 30 states
- Some participation rates are small % of program.



24 States	Local Government Employees Covered by State Employee Plan
Arkansas	School employees. (since 2003)
California	Municipal and school employees. (since 1967)
Delaware	Municipal employees.
Florida	School employees.
Georgia	Municipal and school employees
Hawaii	Municipal and school employees.
Illinois	Municipal employees.
Kentucky	School employees.
Louisiana	School employees. (since 1990)
Maryland	Municipal employees.
Massachusetts	Municipal employees. (since summer 2007)
Mississippi	School employees.
Missouri	Municipal and school employees.
Nevada	Municipal and school employees.
New Jersey	Municipal and school employees. (since 1964)
New Mexico	Municipal employees.
New York	Municipal and school employees. (since 1958)
North Carolina	School employees.
South Carolina	Municipal and school employees.
Tennessee	Municipal and school employees.
Utah	Municipal and school employees. (since 1977)
Washington	Municipal and school employees.
West Virginia	Municipal and school employees. (since 1988)
Wisconsin	Municipal employees.

Major state pool programs, as compiled by CT Legislature

State Examples: California's CalPERS

- The nation's largest pooled public employee program
- 1.6 million members.
 - 30% of their enrollees are state employees*,
 - 38% are school employees and
 - 32% are local public agency employees.

State evaluates network providers for quality and drops low-performers; enrollees using such providers pay higher share.

- * Includes state higher education

Massachusetts pooling law

- Municipal Partnership Act passed 2007, allows city and town unit employees to join the state employee program.
- A state fiscal study claimed municipalities could save \$225 mil. by FY 2010, \$750 million in FY 2013, and \$2.5 billion in FY 2018.
- State has implemented strategies "not available to cities and towns":**
 - Clinical Performance Improvement Initiative
 - prescription step therapy program
 - Generics Preferred Program
 - Health claims database that allows it to track spending & trends
- **City & town expansion is voluntary so far.**
- **17 cities & towns have signed on** (as of August 2009)

– MA Law: [Chapter 67 of 2007](#).

Connecticut's Pool Plan, H 6582 of '09 (*almost-law*)

- The State employee "Partnership" health insurance pool would become self-insured and be expanded to include:
 - Municipalities
 - Medicaid and HUSKY (*kids*) enrollees
 - + would be available to uninsured individuals,
 - not-for-profit groups,
 - small employers.
- The program would automatically enroll members unless they opt out.
 - The 2009 pool bill passed, was vetoed; the House voted to override but the Senate sustained the veto by 1 vote in July 2009.
 - **H 6600 of 2009 - now law**, creates framework for public + private "SustiNet"
 - **2003 law** - Authorizes the agency "To allow small employers and all nonprofit corporations to obtain coverage under the state employee health plan. (PA 149)

Connecticut Healthcare Partnership (2008-09)

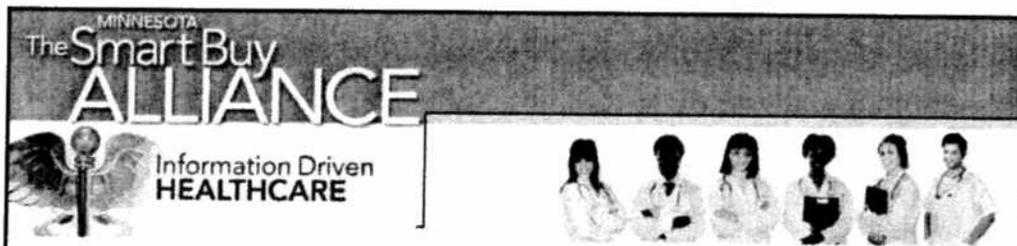
Rep. Donovan and Sec. of the State Susan Bysiewicz urge Governor Reil to sign the Connecticut Healthcare Partnership.

Connecticut Health Care Partnership	
CITY AND TOWN ESTIMATED 2008-09 TOTAL	
Danbury -	\$2,844,988
East Hartford -	\$1,135,789
Groton -	\$1,165,261
Meriden -	\$1,930,455
New Britain -	\$896,758
New Haven -	\$8,664,337
New London -	\$689,045
Sprague -	\$157,118
Tolland -	\$50,551
Wethersfield -	\$597,145
Windham -	\$849,024
Windsor -	\$721,859

Pennsylvania: HB 1881 to extend state employee plan to K-12 employees.

- 2009 bill would provide for a Statewide health benefits program for public school employees.
 - Gov Rendell: "Control school employee health benefit costs by spreading the risk more widely, managing benefits better and lowering administrative costs..."
 - Legislative study: districts could save up to \$585 million a year (2004)
 - Local school boards resisted
 - Did not pass in 2007-08.
- Other operational innovative features
 - State withholds payment for "never events".
 - Enrollees who complete a 2009 Health Assessment will save ½ of the employee contribution (1-time, up to \$460/ family)

- CommonHealth, statewide employee wellness program; 1st one; created 1987
 - Health education, health screenings, flu shots, smoking cessation, Weight Watchers
 - Adult wellness and preventive services paid at 100%
 - Lower operating costs
 - Increased participation in strategic wellness and disease management efforts
 - More efficient use of health care system
- K-12 employees included

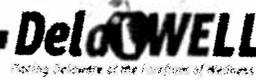
The logo for The Smart Buy Alliance in Minnesota features the text "MINNESOTA The Smart Buy ALLIANCE" in a large, bold font. Below the text is a graphic of a winged figure holding a scale, and the tagline "Information Driven HEALTHCARE". To the right of the logo is a photograph of six healthcare professionals in white coats.

➤ The Smart Buy Alliance: a group of public and private health care purchasers in Minnesota, including the state agencies Medicaid and public employee health benefits (Department of Employee Relations, DOER).

➤ Also included are coalitions of businesses and labor unions who collectively represent almost 60 percent of state residents.

➤ Developed purchasing strategies such as P4P, public reporting, and centers of excellence to promote and reward higher value. Strategies are shared with the other members for potential implementation.

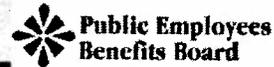
**Delaware:
Delawell wellness program**



- **A comprehensive wellness program for state employees, launched 2007.**
 - available free to full-time state employees, school district, charter and higher education employees and pre-65 retirees .
 - Expanded benefits include health risk assessment, biometric health screenings, which measure vital signs such as blood pressure, cholesterol and glucose levels + Weight Watchers.
 - \$100 paycheck bonus to employees who complete the biometric screening and health risk assessment
 - Savings = "held the line on health-care premiums [for its employees] for the past three years" (2007-09) -*Dir. Wells*"
- <http://www.delawell.delaware.gov/>

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**State Examples:
Washington State PEBB**



- The state employee program (PEBB) permits both "political subdivisions and K-12 to join.
- 2009: Serve 335,700 members including dependents and retirees.
- 80% are state; 7% are city/town/county; 13% are K-12
- Popular for K-12 retirees; more members than state retirees!
- A 25-year history of discussion, reform, negotiation.
- Major discussion in 2008 to require participation.
-
- **Northwest Prescription Drug Consortium (WA + OR)** uses evidence-based Preferred Drug List (PDL) and joint purchasing with other states. Not yet linked to public employees.

In summary...

- Many state employee health programs have "modernized" and adopted practices to:
 - 1) save state money = "Bend the cost curve"
 - 2) try to keep employee and family \$ shares affordable
 - 3) emphasize wellness and prevention
 - smoking cessation
 - obesity education and management
 - health club fees paid
 - incentive rewards for positive steps
 - 4) Combine and pool state + local governments
 - Widespread (30+ states) mostly as an option; not automatic.
 - Required participation is much less widespread
 - Pooled savings are documented

NCSL Information and Resources

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Publications

State Employee Health Benefits
2009 State Employee Premiums
State Employee Health In the News: 2009

Online:

<http://www.ncsl.org/?tabid=14345>



Special thanks to these sources:

- Richard Johnson, Senior Network V-P, Segal Company
(slides 8-13; supplemental 29-34)
- Christopher Watts, Mercer Co, Denver office (graphic slides 3, 4 5)
- John Sheils, Lewin Group (graphic slide #6)
- CalPERS - California Public Employees Retirement System
- Massachusetts Group Insurance Commission
- Sam Tyler, Boston Municipal Research Bureau
- Washington Public Employee Benefits Board
- Mary Habel, Virginia Dept. of Human Resource Management

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Issues & Research > Health > State Employee Health Benefits, 2009 Edition, NCSL

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State Employee Health Benefits

Updated: September 4, 2009

All 50 states provide health insurance coverage for their state employees. Most have done so for decades. However, the amount of coverage, who is eligible to enroll, and the portions paid by the state employer and by the individual worker always have varied from state to state.

In the past five years these state benefit plans have attracted much more attention among legislators, governors and policymakers. Often, this is because:

1. Rapidly rising commercial premiums are impacting state budgets;
2. State fiscal pressures are leading to more proposals to increase employee share of costs;
3. Co-payments and deductibles are on the rise in many places, separate from the established premiums.

A few general facts about state employee health plans, based on two national surveys: 1

- * States provided coverage for about 3.4 million state government employees and retirees. When their covered dependents and family members are included, the total is about seven million people.
- * State and local employee health plans cover about 10 percent of the total U.S. workforce and hold more than 20 percent of the nation's total pension assets. (Center for Retirement Research at Boston College, 11/13/07.)
- * Nearly all full-time state workers were eligible for coverage (97%), and take-up was high across most plans, averaging 91%.
- * 74% of part-time state employees had the option of electing health benefits (compared to 48% nationally.)
- * For 2009 the average cost of an individual policy is \$502.43; with the state paying an average of \$447.79 (89%) and the employee is responsible for the remainder, which is an average of \$56.52. (based on 48 states)
- * In 2009, 12 states paid for 100 percent of the monthly premium costs for a basic or "standard" health plan for some or all individual state employees (AL, AK, DE, IA, KY, ME, MN, ND, OK, OR, SD & TX) Six states paid for 100 percent of the "defined standard" monthly premium costs for families of state employees. (Alaska, Delaware, Iowa, North Dakota, Oklahoma and Oregon).
- * In state employee plans, 37% of workers were in HMOs, 42% in PPOs, 16% in POS plans and 5% were in conventional indemnity coverage. However, Indemnity plans enrolled a majority of *retirees* in the Midwest, Northeast and South. 2
- * Elected state legislators naturally are state employees; however within state personnel definitions, some are considered part-time employees. The following states offer health insurance to legislators but describe it as "optional at legislator's expense" -- Nebraska, Nevada, New Hampshire, Vermont and West Virginia. In addition, New Mexico, South Dakota and Wyoming do not offer health benefits to legislators, but do cover legislative staff. (data as of 2005.)3
- * As of July 2009, more than 45 states face revenue shortfalls of about \$40 billion as a result of problems associated with the economic recession. This reality places pressure on health benefit programs to seek fiscal savings. (Source: Arturo Perez, fiscal expert with NCSL)

At times states have used their employee benefit plans as a demonstration for a policy or idea - for example several states have a mental health coverage mandate specific to the state plan. At least half the states provide for selected non-state employees to be covered under the same, or parallel, health benefit plans. Most commonly, states include: city, town and/or county workers; public school teachers or employees, or public higher education employees. A few states have experimented with including segments of the general population in their state plan - see the examples from Connecticut and West Virginia, below. In the past three years there also are some trends or innovations listed and linked below, including:

LINKS TO RECENT BENEFIT PROGRAM TRENDS

- | | | |
|--------------------------------|--------------------------------|--|
| Health Savings Accounts | Self-funded state programs | Wellness Programs for Employees |
| Retiree Benefit cutbacks | Premium Surcharges for smoking | State Contractors to Provide Health Ins. |
| State + local enrollees pooled | Domestic Partner Benefits | |

This web-based report seeks to pull together diverse resources on this growing area of health and personnel policy.

<p>NCSL Charts & Other Documents</p> <p>Charts of State Employee Health Premiums:</p> <ul style="list-style-type: none"> * 2009 State Employee Health Premiums: Family coverage (includes comparison with 2006 premiums) <small>NEW</small> * 2009 Individual Coverage (includes comparison with 2006 premiums) <small>NEW</small> <p>"2008 State Legislator Compensation- Health, Dental and Optical Benefits" - compiled and researched by NCSL Legislative Management Program. Request your copy by email 4/08</p> <p>Chart of State Employee Health Premiums - 1999-2006. compares cost of family coverage. Compiled by NCSL. Updated May 2006. 3 (Xcel in PDF format for download.</p> <p>Innovations in Health: State Employee Programs:</p> <ul style="list-style-type: none"> * Presentation by Richard Johnson, Segal Company at NCSL Legislative Summit, 7/21/09. <small>NEW</small> 	<p>In The News...</p> <p>The following reports and news articles are examples of the policy discussions in individual states. NCSL is not responsible for the content or opinions expressed in these outside linked articles.</p> <ul style="list-style-type: none"> * State Employee Health In the News: 2009 Proposals; Changes - New NCSL Report with links to state articles. July 2009. <small>NEW</small> * 2009 Study of State Employee Health Benefits, SEGAL. - up-to-date comparison of state health insurance plans. <small>NEW</small> * ESCHEWING THE CARROT FOR THE STICK: ALABAMA GETS TOUGH While many states have adopted wellness programs that reward public employees for healthy behaviors, the Yellowhammer State is looking to punish those who continue their unhealthy ways. State Health Notes, 10/14/08. * The new Commonwealth Fund report What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States is designed to help state public employee health plans and other large purchasers make strategic decisions about developing or coordinating quality improvement initiatives. NCSL provided advice to this survey. 2/4/08. * Retiree Health Plans: A National Assessment Published by the Center for State and Local Government Excellence, 9/08. [32 pages PDF] * Retiree Health Care: News and Reports The CA Legislative Analyst's Office (LAO) has a new Web site, designed to be an information resource addressing issues concerning public sector retiree health benefits and the associated unfunded liabilities. * AL: 2009 Bill would increase health insurance cost for many Alabama teachers, public employees - Many teachers and other public employees in Alabama would pay more for health insurance. State agency employees who don't smoke now pay nothing in premiums for single coverage and \$180 per month for family coverage. Those monthly premiums would rise to \$25 for single coverage and remain at \$180 per month for family coverage starting Oct. 1, 2009. (Birmingham News, 3/3/09) * NC: Blue Cross state plan questioned - With state lawmakers about to embark on premium increases and benefit cuts to the health plan that serves 667,000 state employees and retirees, some critics have asked why legislative leaders are not looking into the amount paid to Blue Cross and Blue Shield of North Carolina to process claims (Charlotte Observer, 3/2/09) * The Connecticut Healthcare Partnership (HB 6582), sponsored by Speaker Christopher Donovan, will self-insure the state employee health insurance pool and open it up to small businesses, non-profits and municipalities; it passed the House in May, was vetoed by Gov. Rell but the House overrode the veto on July 20, 2009. * An In-Depth Look At The Michigan Health Benefits Program was published by the Michigan House on September 9, 2009 as part of an evaluation of pooling all public employees into a single program. The 25-page report estimates a potential \$700-\$900 million in annual savings. <small>NEW</small> 																
<p>Huge bills loom for retiree health care</p> <p>Cities and states are facing enormous shortfalls for the cost of providing health care and other benefits to their retirees.</p> <p>Unfunded health care and other nonpension benefits Preliminary estimates for selected states</p> <table border="1"> <tr> <td>Calif.</td> <td>\$70 billion</td> </tr> <tr> <td>N.Y.</td> <td>\$64</td> </tr> <tr> <td>Md.</td> <td>\$29</td> </tr> <tr> <td>Ala.</td> <td>\$19.8</td> </tr> <tr> <td>Mass.</td> <td>\$13.2</td> </tr> <tr> <td>Alaska</td> <td>\$7.8</td> </tr> <tr> <td>Nev.</td> <td>\$4.1</td> </tr> <tr> <td>Utah</td> <td>\$328 million</td> </tr> </table> <p><small>Source: State financial and actuarial reports AP</small></p> <p>Source: Post Gazette, 9/26/06</p>	Calif.	\$70 billion	N.Y.	\$64	Md.	\$29	Ala.	\$19.8	Mass.	\$13.2	Alaska	\$7.8	Nev.	\$4.1	Utah	\$328 million	
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List of State Employee Health Plan Agencies with Links

Each of the states has evolved a distinct structure for administering state employee health benefits. Many states offer a relatively complex matrix of plans and premiums, varied by family size, type of plan (HMO, PPO, Indemnity). A majority of states have some type of employee unions or collective bargaining units that may play a substantial role in defining benefits and costs. The table below provides some examples from the agencies that run these state programs.

STATE	Agency Administering State Employee Health also see 50-state Personnel Departments (NASPE link)	Examples of premiums & benefits (state web links*)
Alabama	Alabama State Employees Insurance Board (37,527 employees, 7/08); Public Education Employees' Health Insurance Plan .	2008-09 <small>NEW</small>
Alaska	Alaska Benefits Section, Department of Administration	2007-08 2008-09 <small>NEW</small>
Arizona	Arizona Benefit Options (AzBO), Dept. of Administration	2006-07 2007-08 2008-09
Arkansas	Arkansas Employee Benefits Division	2007 2008 2009
California	CalPERS - California Public Employees Retirement System	2007 2008 2009 <small>NEW</small>
Colorado	Colorado Dept. of Personnel & Administration, Division of Human Resources	2008-09 <small>NEW</small>
Connecticut	CT Retirement and Benefits Services Division, State Controller	2006-07 2007-08 2008-09
Delaware	Delaware Statewide Benefits Office, Office of Management and Budget	
Florida	Florida Div. of State Group Insurance	2008-09
Georgia	Public Employee Health Benefit Plan (SHBP) Division, Dept. of Community Health (690,440 people, 6/08)	2007 2008 2009
Hawai'i	Hawaii Employer-Union Health Benefits Trust Fund (EUTF)	FY 2007 2008-09
Idaho	Dept. of Administration: Employee Group Insurance Benefits	FY 2007 FY2009 <small>NEW</small>
Illinois	Bureau of Benefits, Dept. of Central Management Services	FY 2007 FY 2008 FY 2009
Indiana	State Personnel Dept.: Benefit Information	2007 2008 2009
Iowa	Department of Administrative Services, Human Resources Enterprise	2007 2008 2009
Kansas	Kansas Health Policy Authority	2007 Benefits 2008 2009
Kentucky	Dept. for Employee Insurance, Kentucky Personnel Cabinet (245,000 people covered 11/07)	2007 2008 2009
Louisiana	Department of State Civil Service	2006 -07 2007-08 2008-09
Maine	Maine Div. of Employee Health and Benefits	2007-08
Maryland	Maryland Department of Budget & Management	2007-08 2008-09
Massachusetts	Massachusetts Group Insurance Commission (GIC) (286,000 enrollees w/ local)	2007-08 Full cost 2008-09
Michigan	Michigan Employee Benefits Division	2006-07 2008-09 (HMO) 2008-09 (PPO)
Minnesota	Dept. of Employee Relations, Benefits Division	2009
Missouri	MO Consolidated Health Care Plan	2006 2007 2009
Mississippi	State Insurance Admin., Department of Finance and Administration	2008
Montana	Employee Benefits Bureau, Health Care and Benefits Division	2009
Nebraska	NE Administrative Services-Employee Benefits; Office of Risk Management	2008 2009
Nevada	Public Employees Benefit Program	2009
New Hampshire	Human Resources, Department of Administrative Services Health Benefits	2009 <small>NEW</small>
New Jersey	Health Benefits Bureau, Div. of Pensions and Benefits	2006 2009
New Mexico	General Services Division	2008-09
New York	Employee Benefits Division, Dept. of Civil Service Governor's Employee Rel.	2009
North Carolina	NC State Health Plan (667,000 state employees and retirees)	2006-07 2007-09
North Dakota	North Dakota Public Employee Retirement System: Group Health Insurance Plan	2007-09 benefits

Ohio	Ohio Benefits Administration Services <i>[updated 3/08]</i>	2006-07 2008-09
Oklahoma	OK Employee Benefits Council	2007 2009
Oregon	Public Employees Benefit Board (PEBB), Oregon Educator's Benefit Board (OEBB) (120,000 state individuals covered; Educators include 150,000 enrolled in 2009))	2007 2009 2010 <small>NEW</small>
Pennsylvania	PA Employees Benefit Trust Fund (PEBTF) (144,000 state employees, retirees, dependents)	
Rhode Island	Department of Administration	
South Carolina	Employee Insurance Program, SC Budget and Control Board. (244,000 employees; 400,000 lives covered)	2006 2007 2008 2009
South Dakota	Bureau of Personnel	2008-09
Tennessee	Insurance Administration, Dept. of Finance & Administration	2007 2009
Texas	Texas Employees Group Benefits Program (GBP), Employees Retirement System (ERS)	2006-07 2007-08 2008-09 (to 9/30)
Utah	Public Employees Health Program	
Vermont	Department of Human Resources, State Employee Center	2006 2007 2008 2009
Virginia	Benefits, Department of Human Resource Management	2007-08 2008-09 2009-10
Washington	Public Employees Benefit Board (PEBB) (335,309 covered members; 229,000 active employees in 2009)	2007 2008 2009
West Virginia	West Virginia PEIA	2005-06 2007-08 2008-09
Wisconsin	Division of Insurance, Dept. of Employee Trust Funds	2008 2009 <small>NEW</small>
Wyoming	Department of Administration and Information, Human Resources Division	2008 2009
State	Agency Administering State Employee Health	

Notes: Plan benefits vary widely from state to state. Numerous states offer a range of plans from basic HMO, to comprehensive HMO, plus PPO and an Indemnity plan. Some have regional pricing as well. Family size almost always affects premiums. For example Louisiana has scaled prices for 1) Single, 2) Single with spouse, 3) Single with children, and 4) Family. Retirees often have separate premiums and benefits. Premium rate links (above) connect to state agencies' pages that may change or be deleted without notice.

Health Care Reimbursement Accounts (HRA) - The pre-tax flexible spending accounts that many employees use to cover expenses not covered by insurance, as allowed by IRS Section 125.

Voluntary Employee Beneficiary Association (VEBA) - The federal government allows entities to receive favorable tax treatment on contributions to a trust set up under section 501(c)(9), IRC. Contributions to this trust may be made on a pre-tax basis, assets in the trust may be invested and earnings are tax-exempt, and certain qualified benefits may be paid out on a tax-exempt basis. States also may allow favorable tax treatment for a VEBA trust. See Montana's example and explanation: <http://www.montanaveba.org/>

States That Self-Insure and Self-fund Their State Employee Health Program

Forty-two (84%) of the fifty states now self-insure and/or self-fund at least one of their employee health care plans. At least 19 states (38%) self-fund all of their health plan offerings, indicated below as [♦].

As of 2009 the self-funding states are:

Alabama ♦	Indiana	Nevada	Tennessee ♦
Alaska ♦	Kansas	New Hampshire ♦	Texas
Arizona ^a	Kentucky ♦	New Jersey	Utah
Arkansas ♦	Louisiana	New Mexico ♦	Vermont ♦
California	Maryland	North Carolina ♦	Virginia
Colorado ^b	Massachusetts	Ohio	Washington
Connecticut ^c	Michigan	Oklahoma ♦	West Virginia ♦
Delaware ♦	Minnesota ♦	Oregon (2010)	Wisconsin
Florida	Mississippi ♦	Pennsylvania ♦	Wyoming♦
Georgia	Missouri	Rhode Island ♦	
Hawaii ^d	Montana ♦	South Carolina	

Illinois

South Dakota ♦

a -AZ self-funds PPO and EPO policies as of 2004, also has fully insured HMOs.

b -CO self-funds 3 PPOs, 1 HSA, also fully insures 2 HMOs.

c -CT passed

c -HI self-funds PPOs and HDHP as of 2007, also has fully insured HMO.

Of the eight states that do not self-fund, Oregon will switch in 2010 and Nebraska was considering implementing a self-funded program in the future.

All states with self-funded plans contract with outside vendors to provide some type of administrative service. Services include claims payment, utilization review, disease management and pharmacy benefit management. The state of Louisiana was the first state reporting that claims administration and payment is handled in-house. Pennsylvania pays a limited number of claims internally for their supplemental medical plan.

Examples of 2003-2009 Plan Features and Changes

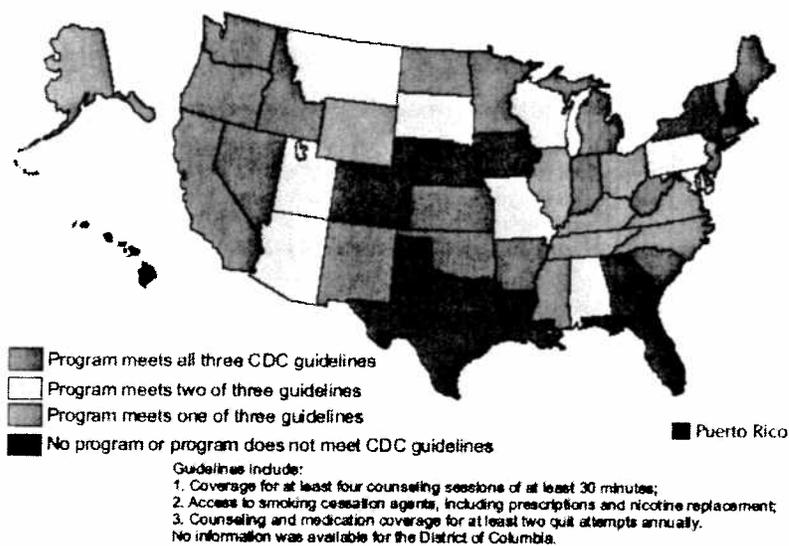
PREMIUM SURCHARGE FOR SMOKERS. At least nine states now charge or authorize lower premiums to non-smoker state employees and higher premiums to smokers.

- **West Virginia** first included such a feature in part several years ago. [view employee affidavit form]
- **Kentucky** in late 2004, (in H1a) created a smoker surcharge of \$15/month for individuals and \$30/month for family coverage.
- **Alabama** In December 2004 (in HB 2) authorized smoker rates during special legislative sessions. For 2007 the smoker surcharge increased from \$20 to \$22 per month. In August 2008, Alabama added a premium for obesity [see description below]
- **Georgia** initiated a smoker surcharge. GA: State employees who smoke pay extra for insurance. Beginning July 2005, more than 54,000 people covered by the insurance plan for state employees are paying an extra \$40 per month because they smoke or use tobacco. **Tobacco Q & A.**
- **Indiana** added a non-smoker rate incentive in 2006. For 2007, enrollees save up to \$500 /year on annual deductibles when the Tobacco Incentive is applied.
- **Kansas** has a smoker surcharge authorized in 2008.
- **Missouri** law generally provides that public and private employers may provide health insurance at a reduced premium rate and reduced deductible level for employees who do not smoke or use tobacco products.
- **South Carolina's** Budget and Control Board voted in August 2008 to impose a \$25 monthly surcharge for state public employees and their family members who smoke or chew tobacco, effective 2010. According to the *Augusta Chronicle*, an estimated 58,600 people, or roughly 20 percent of the state's more than 400,000 insurance participants, will pay the surcharge. NEW
- **South Dakota** has a smoker surcharge authorized in 2008.

SMOKING CESSATION PROGRAMS -

A growing number of states have launched tobacco cessation programs and policies, primarily using positive incentives, high visibility marketing and some assessment requirements to meet reduced tobacco use goals. The following are just a few examples.

State Employee Tobacco Cessation Coverage



- **Tobacco Cessation: State and Federal Efforts to Help** - NCSL report features 50-state map, laws and program information.
- **Alabama's** Tobacco Cessation Program is now provided by the SEIB for its covered members; for 2009 the state will reimburse each member 80% of the cost of the program, with no deductible. There is a lifetime maximum benefit of \$150. Tobacco cessation seminars and all forms of nicotine replacement are covered services. Prescription medications for tobacco cessation are covered and are not subject to the \$150 lifetime maximum benefit. [2/09]
- **Idaho's** Wellness Program: **First Phase -Tobacco Cessation**. For 2008 there will be a \$10 co-payment for every thirty-day supply of quit aids. Pharmacists will require a state Blue Cross of Idaho identification card to dispense the quit aids.
- **North Carolina**, "37 percent of all preventable deaths are attributed to tobacco. Each smoker represents approximately \$1, 623 in excess medical expenditures. By making nicotine replacement therapy patches free with counseling, the State Health Plan anticipates improved member health and significant long-term savings for the plan and for taxpayers". - **NC State Employee Smoking Cessation Plan, 2008**.
- **North Dakota's** Public Employees Retirement System recently received a grant to help state employees and their dependents age 18 and older quit smoking or chewing tobacco. The grant will help pay for participating in one of more than 20 approved smoking cessation programs. Most of these programs are available through public health departments across the state of North Dakota. This project is administered by Blue Cross Blue Shield of North Dakota. The program will pay 100 percent of your out-of-pocket expenses for your office visit and prescription and over-the-counter medication up to \$500, for a total benefit of \$700. The program will end April 30, 2009. **Program description**.

WELLNESS PROGRAMS for state employees becoming more widespread.

U.S. Dept. of Labor ISSUES CHECKLIST FOR WELLNESS PROGRAMS. Wellness programs must be carefully reviewed to assure that they fit within a variety of legal boundaries. Particularly important for 2008 and beyond are the nondiscrimination rules under HIPAA. The Department of Labor (DOL) has issued helpful guidance in Field Assistance Bulletin 2008-02 (FAB 2008-02), including a useful checklist. This guidance can be reviewed by any policymaker or plan sponsor implementing a wellness program or considering one. ["CheckUp" by Sibson, 3/10/08]

- **Alabama** will be the first state to charge overweight state workers who don't work on slimming down. The State Employees' Insurance Board in August 2008 approved a plan to charge state workers starting in January 2010 if they don't have free health screenings. If the screenings turn up serious problems with blood pressure, cholesterol, glucose or obesity, employees will have a year to see a doctor at no cost, enroll in a wellness program, or take steps on their own to improve their health. If they show progress in a follow-up screening, they won't be charged. But if they don't, they must pay starting in January 2011. The State Employees' Insurance Board implementation plan also includes a discount for participation in Wellness Screenings, with a \$25 per month wellness premium discount off the single coverage provided the employee has submitted baseline readings for the

following health risk factors: Blood pressure, Cholesterol, Glucose and Body mass index.

Articles: Government Employee Relations - Alabama Program for State Employees Seeks to Raise Awareness of Risk Factors. 8/8/08.

"Extra pounds mean insurance fees for Ala. workers" by AP, 8/22/08.

- **Arkansas** has an expanded Healthy Lifestyle program, whereby state employees can earn up to three days per year for participating in a voluntary program that focuses on increasing physical activity, increasing consumption of fruits and vegetables and decreasing or eliminating the use of tobacco products. See savings examples in the 2008 premium rate chart.
- **Delaware** officially launched DelaWELL on April 1, 2007, as a comprehensive wellness program for state employees. This statewide initiative is available free to all full-time State employees, school district, charter school and higher education employees and pre-65 retirees currently enrolled in group health insurance programs. The program assesses employee health risks and provide confidential, personalized feedback, and coaching interventional strategies that target lifestyle topics such as back care, blood pressure management, exercise, nutrition, and stress management through various modes of communication and health-related events.
- **Kansas**, in September 2007, launched a program so that state workers will be able to volunteer for personal health-risk assessments.
- **Minnesota** highlights various health improvement services offered through the Minnesota Advantage Health Plan for insurance-eligible state employees and their covered family members. An online wellness chart provides details for 2008. [2/08]
- **Missouri** has incentive rates for employees, saving up to \$25 /mo, who take the PHA and participate in *Lifestyle Ladder* or *Smart Steps*® to be eligible for the incentive rate.
- **Montana** announced Wellness Programs including new for 2007 all State employees and their adult dependents have access to free health coaching, intended to "help individuals make permanent changes in their lives." The wellness program also offers options such as health screenings, spring fitness, and lunch and learn programs, which are designed to maintain and promote healthy lifestyles for members.
- **New Hampshire's** wellness program includes a risk assessment, run by Anthem. (2008)
- **North Dakota** wellness services are included in the state BC/BS managed plan.
- **Ohio:** The Healthy Ohioans initiative, which includes wellness activities and resources, is sponsored by the State Employee Health and Fitness Taskforce. The taskforce was charged with: (1) developing guidelines for state agency health and fitness programs; (2) identifying tools to annually measure the effectiveness of such programs; (3) identifying models for on-site wellness programs; and (4) identifying community partnerships or resources that might be utilized to further wellness programming for state employees. For 2008, "Take Charge! Live Well! Road Show Events" can earn employees a \$25-\$200 incentive payment.
- **Oklahoma** in 2006 launched "OK Health wellness program," providing "All active state employees the opportunity to participate in the state's wellness mentoring program offered by the Employees Benefits Council State Wellness Program. The goal of OK Health is to give you the right tools to help you feel better and improve your health." Enrollment in the OK Health Program, involves completing an online health risk assessment (HRA). An OK Health representative will call and arrange an initial visit with your Primary Care Physician for some basic measurements and labs. They say, "As a program participant, the initial cost to visit your physician and receive lab work (specific to OK Health) will be waived by your health care provider. Following your initial PCP visit, you will receive your first orientation call from a professional health mentor."
- **Virginia:** (2007-08): Routine wellness care is covered for children through age 6 and for children and adults age 7 and over. There is no deductible, copayment or coinsurance for the member to pay before the plan pays for routine wellness coverage. Routine well child care through age 6 covers at no cost office visits at specified intervals, immunizations, routine lab tests and x-rays at facilities and doctors' offices. Routine well adult care age 7 and older includes a routine annual wellness check-up at no cost, as well as routine lab tests, immunizations and x-rays at facilities and doctors' offices. Preventive care benefits include for specified ages at no cost an annual gynecological exam or prostate exam, and the following services once per calendar year: a Pap test, mammography screening, prostate specific antigen (PSA) test and colorectal cancer screening.
- **Washington:** Wellness Initiative, 2006: King County, which comprises the greater Seattle area and is the 12th largest county in the nation, is projecting a reduction in rising healthcare costs by as much as \$40 million over the 2007-2009 period due to wellness initiatives. (10/17/06)
- **West Virginia** also created the Pathways to Wellness program by law (W. Va. Code § 5-16-8). It requires the Public Employee Insurance Plan to provide wellness programs and activities which include benefit plan incentives to discourage tobacco, alcohol and chemical abuse and an educational program to encourage proper diet and exercise.
- **HEALTH SAVINGS ACCOUNTS: Examples of states offering HSA's to their state**

employees:

- **Arkansas:** (2004) For teachers, open enrollment in 2004 results were reported as "disappointing."
- **Florida:** (2005) The state will contribute \$500 for an individual, \$1,000 for a family account and pair that with a \$1,250 (individual) \$2,500 (family) deductible plan.
- **Georgia** offers a health reimbursement account (HRA) plan and a high deductible health plan (HDHP) that are very similar in design to the PPO with higher employee costs through deductibles, co-pays, and co-insurance. Public employees hired after January 1, 2009 in Georgia are only given the option of enrolling in the HRA/HDHP plans. NEW
- **Indiana:** (2007) The state offers two HDHP/HSA choices. Plan 1 has a \$2,000 individual/\$5,000 family deductible; the state's annual contribution includes up to \$1,375 for single or \$2,750 annually for family to the HSA for active employees; the out-of-pocket annual maximum is \$8,000. Plan 2 has a \$3,400 family deductible.
- **Kansas:** (2006) is adding an HSA/HDHP choice with a \$1,500/\$3,000 deductible if network providers are used and a \$2,000/\$4,000 deductible if non network providers are used. [KS HSA plan]
- **Nebraska:** (2007) offers a PPO Consumer Driven Health Plan. The CDHP has a \$1,000 per calendar year deductible for in-network expenses with a \$2,000 per calendar year maximum out of pocket. In addition, the new CDHP implements a four-tier formulary prescription plan with higher co-pays and/or co-insurance.
- **Pennsylvania:** (2006) Offers a UnitedHealthCare CDHP option. In 2009 it features 100 percent coverage for preventive care services (PEBTF members have up to \$500 maximum for single members/\$1,000 for family per year).
- **South Carolina:** (2004) The plan conducts state employee open enrollment at the end of October.
- **South Dakota** offers a \$2000 deductible HSA-compatible plan for 2007; employees selecting this options receive \$300 per plan year in Flex Credits in a Medical Expense Spending Account. An offered \$1000 deductible plan is not HSA compatible.
- **Utah:** (2006) HB 76 requires a High Deductible Health Plan and HSA option for Public Employees Benefit and Insurance Program (PEHP).
- **Virginia:** For benefit years 2007-10, the state pays 100 percent of the premium cost for a high-deductible health plan (individual or family), with other plans requiring modest employee contribution (HDHP is \$40/mo less expensive than the full HMO option for an individual, as of 7/09.)
- **Wyoming:** (2006) implemented a federally-qualified high deductible health plan. Employees may select a state HSA vendor or their own. HSA contributions are 100% from employees.

PROMISING PRACTICES

- The idea of "value driven purchasing" through pooled negotiation, common contracts and purchases is often discussed but less commonly implemented. Four states have initiated or joined such efforts, and now have handy reports written and published through the Commonwealth Fund in 2006 and 2007.
- In **California**, **CalPERS** offers lower health premiums in 2009 if members enroll in one of the "newer plan options – Blue Shield of California NetValue (HMO) and PERS Select (PPO). These "high performance network" plans provide the same level of benefits and quality of care as Blue Shield Access+ HMO and PERS Choice, respectively. The difference is that enrollees pay a lower premium in exchange for choosing from a smaller panel of physicians. A CA example" "To illustrate the value of a high performance network plan, let's use the example of a State member who currently has health coverage for herself and her family (husband, 4-year old child, and a baby on the way) through Blue Shield. If this member transfers from the standard Blue Shield Access+ HMO family plan to Blue Shield NetValue, she would save more than \$1,800 in premiums in 2009. She could use this savings to pay for additional health care services for her family, such as co-payments for 20 office visits for non-preventive care, 20 retail generic drug prescriptions, 20 retail brand prescriptions, 4 mail-order brand prescriptions, 4 mail-order nonformulary prescriptions, 12 urgent care visits, and 4 emergency room visits (without being admitted) – and still keep an extra \$348 in her pocket. [2009 plan booklet] NEW
- The Massachusetts Group Insurance Commission (GIC), a state entity that provides and administers health insurance and other benefits to the commonwealth's employees, retirees, and their dependents and survivors, is trying to improve provider performance through "tiering." GIC assigns its health plan members to a particular tier, based on quality and efficiency, and requires these plans to offer their members different levels of cost sharing,

depending on which tier their chosen hospital or provider is designated. 8/07.

- The Minnesota Smart Buy Alliance is a group of public and private health care purchasers, including the state agencies overseeing Medicaid and public employee health benefits, along with coalitions of businesses and labor unions. The alliance is developing common value-driven principles, and its members are sharing VBP strategies. 8/07
- **Washington State's** Puget Sound Health Alliance, a broad group of public and private health care purchasers, providers, payers (health plans), and consumers, is working to develop public performance reports on health care providers and evidence-based clinical guidelines.
- The Wisconsin Department of Employee Trust Funds (ETF), the state agency that administers health benefits for state and local government employees, is pursuing value through a variety of purchasing strategies. ETF is also becoming involved in public-private collaboratives such as a statewide health data repository. ETF is the largest employer purchaser in the state, covering more than 250,000 active state and local employees and 115,000 retirees and their dependents.** The state also has a "high performance tiered" network structure - see description under Wisconsin, below.

▸ **STATE EMPLOYEES POOLED WITH SCHOOL AND LOCAL GOVERNMENT**

More than half the states allow, and in a few cases require, state employee health plans to combine with other government employee participants. These include:

- **Cities, towns and counties.** Permitted in AL, CA, HI, IL, LA, ME, MD, MA, MO, NJ, ND, NM, NY, OK, SC, TN, UT, VA, WA, WV, WI.
 - * California's CalPERS agency provides the largest combined health program, serving 1.6 million members; as of June 2009, 30% of their enrollees were state employees, 38% were school employees and 32% were local public agency employees. [CA report.]
 - * Massachusetts in 2008 expanded eligibility to all cities and towns.
 - * New Jersey includes 31% public school employees, 18% cities and towns and 15% universities and colleges.
 - * In North Carolina, the program has 58% public school employees and 11% universities and colleges.
 - * Washington has 40% universities and colleges, 2% public schools and 3% cities and towns.
- **Universities and colleges.** Permitted in CA, HI, IL, LA, MA, NV, NJ, NC, ND, OK, OR TX, WV, MO, UT and WA. 13 other states classify state college employees as state employees and do not list them separately.
- **Public Schools.** Permitted to be included in AR, GA, KY, LA, MA, MS, NJ, NY, NC, OK, SC, TN, VA, WV.
- **Other districts or units.**

▸ **DOMESTIC PARTNER BENEFITS AND TREATMENT**

At least 16 states (plus DC) that have "a law, policy, court decision or union contract that provide state employees with domestic partner benefits": **Alaska, Arizona, California, Connecticut, D.C., Hawaii, Illinois, Iowa, Maine, Massachusetts, Montana, New Jersey, New Mexico, New York, Oregon, Pennsylvania** (effective July 2009), **Rhode Island, Vermont** and **Washington**. Normally health care is covered by the term "benefits."

There are an additional eight states that prohibit discrimination against public employees based on sexual orientation/gender identity. These states do not necessarily cover health care costs for a same-sex partner. These states are: Indiana, Pennsylvania, Alaska, Arizona, Colorado, Louisiana, Michigan, Virginia.

- **State Retiree benefit programs** now extend retirement benefits to domestic partners in about a dozen states, with descriptions of policies and debates in other states. See **Domestic Partner Retirement Benefits: NCSL Survey of legislative staff** (03/06)
- Example of **Hawaii online resources** for domestic partners. (2007)
- **Expedited Partner Therapy (EPT) - State Information** - Legal status and barriers by state to providing medications to persons infected with certain STDs to be administered to their sexual partners. 15 states permit EPT; 24 states are classified as "potentially allowable" and 11 states prohibit EPT. The information applies generally, not just to public employees. (compiled by CDC, updated April 2009)

▸ **STATE CONTRACTORS REQUIRED TO PROVIDE HEALTH BENEFITS**

A few states require their private contractors to compensate their personnel using prevailing wage and benefit standards similar to public employees.

- **Illinois** - Contractor employees must be paid prevailing wages and benefits and work under "conditions prevalent in the location where the work is to be performed." This applies to contracting in the areas of public works, printing, janitorial services, window washing and security guard services. 44 Ill. Adm. Code 1.2560.
- **Massachusetts** - Contractors are required to provide their employees wages and benefits comparable to those paid to state employees performing similar services. The wages and benefits must be included in the bid and must be reported to the contracting agency on a quarterly basis. M.G.L.A. Ch. 7 Sec. 54.
- **California, Rhode Island and Washington** require prevailing rates or wages for state contractors, but do not specify health coverage in statute. The **District of Columbia, Maryland** and San Francisco, CA require paying a living wage.
- **2007 RETIREE Program cutbacks:**

The retirement of baby boomers — 79 million born from 1946 to 1964 — will make it hard for state and local governments to keep up with the cost of medical benefits for retirees. What governments are doing now:

- **Results of the Segal Medicare Part D Survey of Public Sector Plans.** A summer 2006 survey shows that 79% of public employee plans that responded took the federal 28% subsidy, but that more would reevaluate for 2007.
- **West Virginia** The state pension board is to vote Wednesday on shifting prescription drug coverage for retirees to Medicare, a federal program. The change, along with making retirees pay more, would slash the state's \$8 billion unfunded liability to \$5 billion. "By tackling this early, we hope to save money in the long run," says Ted Cheatham, director of West Virginia's Public Employees Insurance Agency.
- **North Carolina** Civil servants hired after Oct. 1 will have to work 20 years before qualifying for 100% state-paid medical coverage. Previously, workers had to wait only five years.
- **Oklahoma's** employee and teacher retirement system has become a federally qualified PDP (Medicare Prescription Drug Plan) in order to coordinate Rx services to its members while obtaining federal reimbursement for virtually all transactions. **Pennsylvania's** teachers retirement plan has taken as similar PDP direction, as an alternative to simply providing equivalent benefits and getting a 28 percent federal payment.
- **South Carolina** Republican Gov. Mark Sanford's next budget will propose putting \$245 million in a new trust fund dedicated to retiree medical benefits. Georgia, Vermont, Virginia and New York City also have started trust funds or plan to create them.

State by State Actions, Discussions and Legislation

Alabama: Alabama will be the first state to charge overweight state workers who don't work on slimming down, while a handful of other states reward employees who adopt healthy behaviors. The State Employees' Insurance Board in August 2008 approved a plan to charge state workers starting in January 2010 if they don't have free health screenings. If the screenings turn up serious problems with blood pressure, cholesterol, glucose or obesity, employees will have a year to see a doctor at no cost, enroll in a wellness program, or take steps on their own to improve their health. If they show progress in a follow-up screening, they won't be charged. But if they don't, they must pay starting in January 2011. Article: "Extra pounds mean insurance fees for Ala. workers" by AP, 8/22/08.

- **AL:** Bill would increase health insurance cost for many Alabama teachers, public employees - **Many teachers and other public employees in Alabama would pay more for health insurance under a bill filed by a state lawmaker, though their premiums still would be less than national averages.** State agency employees who don't smoke now pay nothing in premiums for single coverage and \$180 per month for family coverage. Those monthly premiums would rise to \$25 for single coverage and remain at \$180 per month for family coverage starting Oct. 1, 2009.
- The 2005 plan, adopted in a special session in House Bill 2 in November 2004, provides for: "Section 36-29-19.3. **Surcharge on smokers;** changes in contributions. A surcharge on smokers and users of tobacco products shall be added to the employee and retiree contribution by the Board to be effective October 1, 2005."
- **Alabama:** For 2009, plans require a \$50 annual per member prescription drug deductible. The plan also requires a 3-tier prescription co-payment of \$10 for Generic Drugs, \$20-\$35 for "Preferred Brand Name Drugs", and \$35-\$100 for "Non-Preferred" Drugs.
- **Alaska:** A 2005 law (SB 141) signed in July 2005 reforms public employees' retirement systems, creating defined contribution and health reimbursement plans for members who are first hired after July 1, 2006. Employees may select among four medical plans, three dental and three vision plans, life insurance, disability and flex spending accounts.

Arkansas: State Unveils Health Program for Workers. In November 2007, Gov. Mike Beebe announced that the state will extend a pilot program offering time off for lifestyle changes to all state employees. Since its 2004 inception, 2,500 people have registered for the program and almost 950 have earned days off for making lifestyle changes that improve their health.

California: CalPERS offers lower health premiums in 2009 if members enroll in one of the "newer plan options – Blue Shield of California NetValue (HMO) and PERS Select (PPO). These "high performance network" plans provide the same level of benefits and quality of care as Blue Shield Access+ HMO and PERS Choice, respectively. The difference is that enrollees pay a lower premium in exchange for choosing from a smaller panel of physicians. A CA example" "To illustrate the value of a high performance network plan, let's use the example of a State member who currently has health coverage for herself and her family (husband, 4-year old child, and a baby on the way) through Blue Shield. If this member transfers from the standard Blue Shield Access+ HMO family plan to Blue Shield NetValue, she would save more than \$1,800 in premiums in 2009. She could use this savings to pay for additional health care services for her family, such as co-payments for 20 office visits for non-preventive care, 20 retail generic drug prescriptions, 20 retail brand prescriptions, 4 mail-order brand prescriptions, 4 mail-order nonformulary prescriptions, 12 urgent care visits, and 4 emergency room visits (without being admitted) – and still keep an extra \$348 in her pocket. [2009 plan booklet] NEW

* Benefits in the Balance: The Uncertain Future of Public Retiree Health Coverage - released by CA Health Care Foundation, 9/06.

Connecticut:

* The new Connecticut Health Partnership (sHB 5536) allows municipalities, certain municipal service contractors, nonprofit organizations, and small businesses to provide coverage for their employees and retirees by joining the state employee health insurance plan. All new employees will be pooled with state employees in the state insurance plan if the State Employees' Bargaining Agent Coalition consents. The act requires the comptroller to provide insurance for employers that seek to cover all their employees or all their retirees. The law was effective September 1, 2008, except the definitions, the provision creating the advisory committees, and the SEBAC approval are effective upon passage, and the report and the authority for municipalities jointly to purchase health insurance are effective January 1, 2009.

* Public Act 03-149 of 2003 - Authorizes the agency "To allow small employers and all nonprofit corporations to obtain coverage under the state employee health plan and to provide that such coverage be exempt from the state insurance premium tax." S 353 was signed into law June 2003.

* Connecticut (effective 2008) provides for a reduced monthly employee contribution when both spouses are employed by the state. For example, for family coverage a regular employee pays \$122.85 per month, while a two-state employee household pays \$50.57, a reduction of \$72 for their household.

* **Delaware:** The State Employee Benefits Committee (SEBC) has awarded Blue Cross Blue Shield of Delaware and Aetna the contracts to administer the state group health insurance program, while dropping Coventry Health, effective July 1, 2007.

* **Florida:** To state workers: get fit or lose your job? "The state's new secretary of Corrections, Mr. McDonough has proposed mandatory fitness levels for 19,000 of his employees – some of whom have desk jobs. It's meeting resistance from a union representing prison and probation officers and making experts wonder whether requiring workers to become physically fit, or risk losing their jobs, is the best way to tackle the country's growing obesity crisis. - news article, 1/31/07.

* **Florida:** In May 2004 Governor Bush signed HB 1837, which established the state employees' prescription drug program. The new program "shall create a preferred drug list" and shall be subject to new copayments (effective 1/1/04) as follows: For generic drug with card....\$10. For preferred brand name drug with card....\$25. For nonpreferred brand name drug with card....\$40. For generic mail order drug....\$20. For preferred brand name mail order drug....\$50. For nonpreferred brand name drug....\$80.

* **Georgia:** for 2005 provides 12 plan choices including one indemnity, two PPOs, nine HMOs and a Medicare+Choice. It was one of the first states to establish a multi-agency preferred drug list, aimed at reducing costs. The same list is applied to Medicaid recipients. The five-page "PDL list" is available to all members online. The State Health Benefit Plan covered 664,703 people as of January 1, 2007. Teachers and school personnel represent almost 77% of the covered lives.

* The state requires a \$30 monthly "Spousal Surcharge" be applied to members whose spouse is eligible for coverage through his/her (non-state) employer but elects not to take the coverage. (2008)

* A \$40 Tobacco Surcharge applies to any member and/or one of his/her dependents who use(s) tobacco products. This surcharge is designed to encourage tobacco users to a healthier lifestyle. Smoking cessation classes are offered to members and dependents who want to stop using tobacco products. (2008)

* **Hawai'i** Press Release: Rate Reductions and New Benefit Plan Options for Public Employees to Save \$8 Million [2/13/07]

* A 2001 law, Chapter 87A of the Hawaii Revised Statutes, established the Hawaii Employer-Union Health Benefits Trust Fund. The Trust Fund "is to provide eligible state and county employees, retirees, and their

- * **New Jersey:** Health care drives state costs. "New Jersey, like many employers, pays a large portion of the costs of health insurance for its employees. There are several state health plans, but the most popular one is entirely free to state workers and their families...." - news article, 3/13/05
- * **New Jersey:** State aims to cut public employees' medical plan. Thousands of teachers, government workers and their families would face higher costs for prescription drugs and medical services under a state cost-cutting plan unveiled yesterday, the same day lawmakers began to debate ways to rein in public employee benefits. The Star-Ledger (Newark) 8/9/06.
- * **New Jersey:** Officials seek bargaining power on state health benefits. Local officials, school boards and county colleges are urging Gov. Jon Corzine to help them gain the power to negotiate health benefits with their 215,000 active and retired employees, an action they say would save \$34 million the first year. Currently, 55 percent of municipal and county governments, 18 of the 19 county colleges and a large number of school districts participate in the State Health Benefits Plan. The Star-Ledger (Newark) 1/3/07.
- * **New Jersey** covered 100% of family coverage until 2007. Starting that July State employees contribute 1.5 percent of annual base salary regardless of the medical plan or level of coverage that is selected. If an employee makes \$50,000 per year, this translates into an employee share of about \$63.00 per month. [NJ Benefits -07-08]
- * **New Mexico:** ACLU sues over New Mexico domestic partner retiree health insurance. New Mexican 2/5/07.
- * **North Carolina:** State Health Plan members now have access to two online tools that empower users to monitor and compare average costs for physician office visits, diagnostic procedures and screenings, disease treatments, and prescription drugs. The updated tools are: Blue Cross Blue Shield of North Carolina's (BCBSNC) Health Cost Estimator and Medco's "My Rx Choices[®]," listing prescriptions from a Preferred Drug List.
- * **North Dakota** has a member Rx rebate program, in which a portion of manufacturer rebates will be passed directly to the member to offset their prescription drug out-of-pocket expense. Effective July 2005, member's out-of-pocket expense will automatically be reduced by the amount available in their MRA at the time of purchase at the pharmacy. Members will not receive rebate checks in the mail. [Updated 2008]
- * **North Dakota** BC/BS has 90 percent of the state employee market; it has negotiated a 5.2% administrative fee for FY 2008.
- * **Oklahoma:** The Oklahoma employee and teacher retirement system has become a federally qualified PDP (Medicare Prescription Drug Plan) in order to coordinate Rx services to its members while obtaining federal reimbursement for virtually all transactions. **Pennsylvania's** teachers retirement plan has taken as similar PDP direction, as an alternative to simply providing equivalent benefits and getting a 28 percent federal payment.
- * In 2006 launched "OK Health wellness program," providing "All active state employees the opportunity to participate in the state's wellness mentoring program offered by the Employees Benefits Council State Wellness Program. The goal of OK Health is to give you the right tools to help you feel better and improve your health." Enrollment in the OK Health Program, involves completing an online health risk assessment (HRA). An OK Health representative will call and arrange an initial visit with your Primary Care Physician for some basic measurements and labs. They say, "As a program participant, the initial cost to visit your physician and receive lab work (specific to OK Health) will be waived by your health care provider. Following your initial PCP visit, you will receive your first Orientation call from a professional health mentor."
- * **Oregon:** For 2010 the entire Oregon plan will become self-insured. More than 95 percent of all providers used by PEBB members are already in the network. [Bulletin -August 2009 | Self-Insured decision]
- * For 2009-2010 Oregon members in designated rural counties will get a "rural subsidy" and be responsible only for in-network coinsurance rates when they see providers who are not in the network. Several special categories of residents are eligible for state membership in PEBB, including Blind Business Enterprise agents, State-certified foster parents, Oregon Liquor Control Commission agents and Oregon State University and University of Oregon post doctorates and J1 Visa recipients.
- * **Pennsylvania:** As of July 1, 2009, all enrollees and covered spouses that complete the 2009 Health Assessment will save ½ of the employee contribution or one percent of the gross base salary contribution. Based on an average salary of \$46,000, an employee would see savings of \$460 a year.
- * **Pennsylvania** proposal seeks health insurance savings. Hoping to save money for his state on health-care costs—and to hold down local property-tax rates used to pay for benefits—Pennsylvania Gov. Edward G. Rendell is proposing to bring all school employees under one insurance plan. *Education Week* 9/27/07. article.

- Pennsylvania:** has posted a detailed pharmaceutical Preferred Drug List for 2007 for all active state employees. The system has been administered by ExpressScripts since 2004. The program maintains a separate Prior Authorization list that allows use of some non-preferred drugs.
- Pennsylvania** in 2007 announced plans for the Pennsylvania Employees Benefit Trust Fund (PEBTF) to withhold payment for "never events". The PETBF, anticipates that this action will stimulate performance improvements that can reduce the number of unnecessary infections and other complications

Rhode Island:

- A 2008 bill (H. 8330) proposed to provide a standard \$7,000 per year stipend to elected state legislators, to cover purchase of health insurance. The legislator would have been permitted to keep any amount not needed or used for health insurance, or it may be "banked" in an HSA account if eligible. The plan was rejected in the 2008 session; it received some criticism from think-tanks, which noted that costs of individual coverage was "around \$5,500."
- RI: "More members of General Assembly paying part of health cost -- voluntarily" - The public spotlight placed on their free health-care benefits has prompted several more state lawmakers to offer to pay 10 percent of the cost of the premiums costing up to \$16,233 a year for family coverage. The number of \$13,508-a-year lawmakers paying a portion of their health insurance premiums now stands at 26 of 113. Others either get it for free, or they get a \$2,002 waiver payment for giving it up. (Providence Journal, 5/5/08.)
- RI: Judge's ruling stymies Carcieri plan on health costs - A Superior Court judge has thrown a proverbial monkey wrench in the Carcieri administration's mid-contract attempt to raise by as much as seven-fold the copays that members of the largest state employees union pay for certain medical expenses, such as emergency room visits from \$25 to \$150, for urgent care visits from \$10 to \$75, for visits to specialists from \$10 to \$25 and for prescription drugs from the current \$5/\$12/\$30 range to \$7/\$25/\$40. (ProJo news, 11/6/07)
- Rhode Island:** The state spent about \$4 million in 2004 on health-care benefits for 372 part-time state employees, an analysis of state payroll data shows.
- South Carolina:** Smokers face monthly surcharge; Tobacco users would start paying \$25 in 2010. Roughly 400,000 people are covered by the state plans, including 244,000 employees and their family members. The plans are available to teachers, state workers and local government employees, among others.
- South Dakota:** The state has a carved-out Prescription Drug Plan, emphasizing mail order and administered by Prescription Solutions. A mandatory generics policy took effect on July 1, 2004. If enrollees choose a name brand drug, and could use a generic, they will pay the generic copayment plus the difference in cost between the generic drug and the cost of the name brand drug.
- Texas:** Texas law passed in 2005 allows for a Health Insurance Opt-Out Credit, which enables employees and retirees in the Texas Employees Group Benefits Program (GBP) to get money toward optional coverage if they give up their state-provided health insurance.

Utah: the Public Employee Health Plans (PEHP) has published a price transparency online Treatment Cost Estimator Home and a separate PEHP Average Costs list for infant deliveries, effective 2008.

- The Public Employees Health Program launched a "Utah Timely Topics" program, which promotes information on topics like Avian Flu, Prostate Cancer and Influenza. They also publish a separate "Provider Bulletin."
- Virginia:** VA has a high deductible health plan for which the state pays the entire premium for the employee (all categories: individual, individual + one family member, & individual + two or more family members).
- Washington:** Wellness Initiative, 2006: Washington state's King County, which comprises the greater Seattle area and is the 12th largest county in the nation, is projecting a reduction in rising healthcare costs by as much as \$40 million over the 2007-2009 period due to wellness initiatives. (10/17/06)
- West Virginia:** In March 2004, West Virginia passed legislation (SB 143) intended to help uninsured small businesses provide coverage for their employees. The new law creates a private/public partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies that choose to offer the plan. West Virginia's plan will allow carriers to access PEIA's reimbursement rates and drug purchasing plan, enabling the new small business coverage cost to be 20-25 percent below the usual market rate. This will expand the pool of insured working West Virginians.

- * West Virginia Preferred Drug List administered by the PBM Express Scripts - effective 1/1/07.
- * **West Virginia:** also created the Pathways to Wellness program by law (W. Va. Code § 5-16-8). It requires the Public Employee Insurance Plan to provide wellness programs and activities which include benefit plan incentives to discourage tobacco, alcohol and chemical abuse and an educational program to encourage proper diet and exercise. The cost of the exercise program shall be paid by county boards of education, the public employees insurance agency, or participating employees, their spouses or dependents. All exercise programs shall be made available to all employees, their spouses or dependents and shall not be limited to employees of county boards of education.
- * **West Virginia:** Surgery abroad an option for 2007? West Virginia, Republican legislator Ray Canterbury has proposed allowing state employees to go overseas for health care if they want, as long as the cost, including travel and accommodations, is less than the expense in the United States. The bill is in a special study committee that will take it up next year. Mr. Canterbury hopes that the state legislature will at least approve a pilot program testing overseas care. (Post-Gazette, 9/10/06)
- * **West Virginia: Financial Report for FY 2008** - detailing projected increases July 1, 2007-June 30 2008 by categories
- * "PEIA chief brewing another firestorm" article describes proposals to drop future coverage for retirees and require "personal responsibility" actions by employees to avoid a premium surcharge. (Charleston Gazette, 6/7/09) NEW

Wisconsin: The agency covers 550,000 people for 2009, including state and local government employees.

- * The recently-enacted 2009 Wisconsin Act 28 (state budget) contains a number of new health insurance coverage requirements that will affect the State Group Health Insurance Program next year, including: Available coverage for domestic partners, and generally speaking, expanded coverage for: Dependents less than 27 years of age, Autism, Mental Health, Cochlear implants and hearing aids for children under age 18. [Updated 7/09] NEW
- * The WI Department of Employee Trust Funds (DETF) uses the 3-Tiered approach to health insurance purchasing. The 3-Tier model was designed in 2004 to address cost escalation problems "while maintaining high-quality, low-cost health care coverage. While still maintaining a uniform medical insurance benefits package, each plan has now been assigned to one of three tiers based on the relative efficiency with which a plan is able to provide the benefits and the quality of care required by the Board. Plans were given extra credit in the tier assignment process if they scored well on measures of quality, such as clinical measures and member experience. This approach has created significant incentives for health plans to hold down the costs they charge the state while guaranteeing that all employees in the state have access to a Tier 1 plan in their area. In addition, monthly premium contributions for the Standard Plan have been capped." For January 2009 through December 2009, the least expensive, Tier 1 (with 21 plan choices among geographic areas) individuals contribute \$31.00/month; families contribute \$78.00. Tier 2 (with one plan choice, BCBC Northwest) individuals contribute \$69.00; families contribute \$173.00. Tier 3 (with one plan, "Standard Plan") individuals contribute \$164.00; families contribute \$412.00. [2009 Benefits description]
- * In 2004, Wisconsin announced that required employee contribution rates for health coverage will increase for all employee groups beginning January 2005. Rates for both the general/teacher (from 9.8% to 10.2%) and executive/elected (from 10.8% to 11.2%) categories of employees increased by .4%. Wisconsin also authorized the Department of Employee Trust Funds (DETF) to contract with a Pharmacy Benefits Manager (PBM) to provide pharmacy benefits services to all State of Wisconsin group health insurance participants. Effective January 1, 2004, all participants receive their pharmacy benefits from the PBM, Navitus Health Solutions.
- * **Wyoming:** In March 2003 the legislature enacted (in H. 43) the following terms: \$23,025,240 for the purpose of paying the state's contribution to the state health insurance plans under W.S. 9-3-210 for each qualifying executive, judicial and legislative branch employee including employees of the University of Wyoming and the community colleges in the following amounts for the specified time periods: (A) For the period beginning March 1, 2003 and ending November 30, 2003: (I) \$335.37 per month for any employee electing single coverage; (II) \$652.95 per month for an employee electing employee plus one dependent coverage; and (III) \$744.75 per month for an employee electing family coverage. (B) For the period beginning December 1, 2003 an amount to be determined by the employees group health insurance section of the department of administration and information but not to exceed: (I) \$384.14 per month for an employee electing single coverage; (II) \$751.15 per month for an employee electing employee plus one (1) dependent coverage; and (III) \$857.40 per month for an employee electing family coverage.

Additional Professional Resources

- * **NCSL Legislative Summit 2009**, Philadelphia Pa. Panel on "Innovations in Health Insurance: State Employee Programs" Presenters: Mary Habel, Director - Office of Health Benefits VA Dept. of Human Resource Management; Richard Johnson, Senior Vice President, Public Sector Health Practice Leader, Segal, Washington D.C.
- * At a Crossroads: The Financing and Future of Health Benefits for State and Local Government Retirees, [Center for State &](#)

Local Government Excellence. (July 2009)

- White Paper: State Government Employee Healthcare Benefits by National Association of State Personnel Executives (NASPE). 9/06.
NASPE State Government Employee White Paper Addendum covering:
 - Disease Management and Wellness Programs
 - Cost Containment
 - Enrollment Management Strategies
 - Procurement Practice Initiatives
 - Consumer Driven Health Plans
- **"The Other Benefits Mess"** - A new regulation forces government retirement plans to reveal the cost of their health-benefit promises for the first time. (Kiplinger Benefits Magazine, 9/07)
- Coping with the Costs of Retiree Health Benefits - by Ron Snell, NCSL 8/07. [*member password required*]
- **High Noon In The Accounting Department: States Confront GASB 45-** NCSL State Health Notes, 9/17/07
- **Public Employee Health Benefits Have Survived Threats - So Far** - Health Affairs web exclusive 4/18/06
- **"America's Second Civil War: The Public Employment Complex vs. Taxpayers,"** - Lewis M. Andrews, Yankee Institute, 4/06 [24 pages]
- **Public Fund Survey (Retirees): Summary of findings for FY05** - National Association of State Retirement Administrators, 9/06 [PDF, 15 pp]
- **State Employee Health Benefits Overview.** - NCSL PowerPoint presentation from 9/03 by Richard Cauchi.
- **Rising insurance costs for public workers puts states in a bind** - Associated Press (10/13/03).
- **National Association of State Personnel Executives (NASPE)**, a non-profit organization, was established in 1977 to enhance communication and the exchange of information among personnel executives. NASPE is an affiliate organization of The Council of State Governments.
- **National Association of State Retirement Administrators (NASRA)** - online resources.
- **Health Care Purchasing Among State Employers** by National Health Care Purchasing Institute. In this report, James Maxwell at JSI Research Inc. chronicles major challenges for state employers, such as premium, drug, and retiree costs, and describe strategies for keeping down costs.
- **"State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards"** - AARP Public Policy Institute reports state and local governments will have to follow new accounting standards for their retiree health benefits. Compiled by Workplace Economics, 07/04. [29 pages]
Appendix: 50-state charts 2003 plan data [42 pages]
- **NASRA White Paper: Myths and Misperceptions of Defined Benefit and Defined Contribution Plans** -
- **Defined Benefit / Defined Contribution Fact Sheet**, an overview of pension plan types and their use among public employees. NASRA
- **Plan Design: A Review of Current Public Pension Issues**, report by the Kansas Public Employees Retirement System
- * **2000-2001 State Health Care Expenditure Report: State Employees' Health Benefits** - Co-Published by the Milbank Memorial Fund, the National Assoc. of State Budget Officers (NASBO) , and the Reforming States Group, 04/03.

Footnotes

- **1- Kaiser/HRET Survey: 2002 State Employee Health Plans** - Kaiser Family Foundation, July 2003.
State employee health plans provided coverage for 3.4 million state government employees in 2002. The Survey finds that premiums for state employee health plans increased 12.8% in 2002, similar to national averages. It also finds that state employee plan premiums are slightly more expensive than the national average and that state workers' contributions are less expensive than the average U.S. firm. The Survey is a supplement to the larger Kaiser/HRET Employer Health Benefits Survey. [PDF 12 pages].
- **2-2003 Segal State Health Benefits Survey** - a comprehensive look at premiums, enrollment and related structure, updated in 2003.
 - Abstract of 2004 Survey Report: **"Highlights of Segal Survey Conducted at the 2004 Benefits Management Forum & Expo"**
 - Abstract of 2004 Survey Report, **"Results of the Segal Survey of Massachusetts Jurisdictions' Benefits for Same-Gender Spouses of Employees"**

- Abstract of 2004 Survey Report, **2003 Segal State Health Benefits Survey: Drilling Down on Dental Plan Coverage for Employees**
- Abstract of 2004 Survey Report, **2003 Segal State Health Benefits Survey: Medical Plan Design for Employees and Retirees**
- Abstract of 2004 Survey Report, **"Results of Segal's Survey of Top HR and Benefits Issues for Higher Education Institutions"**
- Abstract of Winter 2004 Survey Report, **2003 Segal State Health Benefits Survey: Prescription Drug Coverage for Employees and Retirees**
- **3- Workplace Economics** "2006 State Employee Benefits Survey" published 4/24/06. This comprehensive annual survey of state features and premiums provides an excellent statistical baseline for 14 categories of benefits including health, dental and vision, life, travel and retirement. *[WorkPlace Economics no longer lists items for sale; their web site is no longer operational as of 3/08].*
- **4 - "Table 8A: Health, Dental and Optical Insurance Benefits for State Legislators, 2005"**, a survey of the 50 states.
- **States struggle to cover retirees - USA Today, 12/18/2006**

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Report compiled by Richard Cauchi. NCSL Health Program, Denver.

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State Employee Health Benefits - Monthly premium costs (Individual only coverage)

Compiled by the NCSL Health Program - Updated: August 19, 2009

Year			2006			2009		
			Individual only coverage			Individual only coverage		
State cost			\$ 406.44	(49 states)		\$ 437.25	(47 state avg)	
Employee			\$ 38.60	(46 states)		\$ 38.45	(47 state avg)	
Ave. Total			\$ 441.91	(46 states)	Premium	\$ 473.89	(48 state avg)	
	FT #	Benefit yr	State	Employee	Total	State	Employee	Total
AL		10/1-9/30	\$ 650.00	\$ 0.00	\$ 650.00	\$ 775.00	\$ 0.00	\$ 775.00
AK		7/1 - 6/30	\$ 763.00	n/a	n/a	\$ 895.95	\$ 0.00	\$ 895.95
AZ		10/1-9/30	\$ 355.68	\$ 25.00	\$ 380.68	\$ 446.00	\$ 30.00	\$ 476.00
AR	1	1/1 - 12/31	\$ 243.96	\$ 83.98	\$ 327.94	\$ 299.58	\$ 105.04	\$ 450.64
CA		1/1 - 12/31	\$ 321.00	\$ 43.93	\$ 364.93	\$ 382.00	\$ 90.00	\$ 472.00
CO		7/1-6/30	\$ 190.20	n/a	n/a	\$ 340.26	\$ 6.50	\$ 346.76
CT		7/1-6/30	\$ 407.40	\$ 26.47	\$ 433.87	\$ 377.80	\$ 7.43	\$ 385.23
DE		7/1-6/30	\$ 410.56	n/a	n/a	\$ 472.10	\$ 0.00	\$ 472.12
FL		7/1-6/30	\$ 346.16	\$ 50.00	\$ 396.16	\$ 399.26	\$ 15.00	\$ 414.26
GA	2	1/1 - 12/31	\$ 368.70	\$ 71.14	\$ 439.84	\$ 301.36	\$ 91.10	\$ 392.46
HI		7/1-6/30	\$ 164.06	\$ 107.14	\$ 271.20	\$ 169.22	\$ 91.88	\$ 261.10
ID	3	7/1-6/30	\$ 576.68	\$ 23.00	\$ 599.68	\$ 705.08	\$ 28.00	\$ 733.08
IL	4	7/1-6/30	\$ 554.32	\$ 53.50	\$ 607.82	\$ 412.13	\$ 45.71	\$ 457.84
IN		1/1 - 12/31	\$ 333.67	\$ 97.50	\$ 431.17	\$ 349.68	\$ 66.06	\$ 415.74
IA		1/1 - 12/31	\$ 517.87	\$ 0.00	\$ 517.87	\$ 398.49	\$ 0.00	\$ 398.49
KS	5	7/1-6/30	\$ 326.18	\$ 17.18	\$ 343.36	\$ 401.06	\$ 57.82	\$ 458.88
KY	6	1/1 - 12/31	\$ 488.95	\$ 0.00	\$ 488.95	\$ 446.24	\$ 0.00	\$ 446.24
LA		7/1-6/30	\$ 373.10	\$ 124.38	\$ 497.48	\$ 390.54	\$ 130.18	\$ 520.72
ME		7/1-6/30	\$ 585.20	\$ 0.00	\$ 585.20	\$ 648.10	\$ 0.00	\$ 648.10
MD		7/1-6/30	\$ 283.94	\$ 63.40	\$ 347.34	\$ 298.26	\$ 52.63	\$ 350.86
MA	7	7/1-6/30	\$ 513.28	\$ 90.58	\$ 603.86	\$ 329.00	\$ 82.25	\$ 411.25
MI*		10/1-9/30	\$ 430.17	\$ 22.64	\$ 452.81	428.56*	47.62*	476.18*
MN		1/1-12/31	\$ 368.68	\$ 0.00	\$ 368.68	\$ 447.28	\$ 0.00	\$ 447.28
MS	8	7/1-6/30	\$ 305.00	\$ 0.00	\$ 305.00	\$ 343.00	\$ 18.00	\$ 361.00
MO	9	1/1-12/31	\$ 381.00	\$ 30.00	\$ 411.00	\$ 445.00	\$ 31.00	\$ 476.00
MT		1/1-12/31	\$ 506.00	\$ 0.00	\$ 506.00	\$ 590.00	\$ 0.00	\$ 590.00
NE		7/1-6/30	\$ 321.60	\$ 85.48	\$ 407.08	\$ 414.20	\$ 110.10	\$ 524.30
NV	10	1/1-12/31	\$ 395.36	\$ 20.81	\$ 416.17	\$ 325.63	\$ 17.14	\$ 342.77
NH		1/1-12/31	\$ 592.73	\$ 0.00	\$ 592.73	\$ 534.55	\$ 30.00	\$ 564.55
NJ	11	1/1-12/31	\$ 322.15	\$ 0.00	\$ 322.15	Remain \$	1.5% of Sal	\$ 432.24
NM	12	7/1-6/30	\$ 200.96	\$ 86.13	\$ 287.09	\$ 273.38	\$ 68.34	\$ 341.72
NY	13	1/1-12/31	\$ 411.97	\$ 45.77	\$ 457.74	\$ 343.41	\$ 38.12	\$ 381.53
NC		7/1-6/30	\$ 321.14	\$ 0.00	\$ 321.14	\$ 346.38	\$ 43.98	\$ 390.36
ND	14	1/1-12/31	\$ 553.94	\$ 0.00	\$ 553.94	\$ 664.66	\$ 0.00	\$ 664.66
OH		7/1-6/30	\$ 311.03	\$ 47.17	\$ 358.20	\$ 277.46	\$ 49.38	\$ 326.84
OK		1/1-12/31	n/a	n/a	n/a	\$ 574.37	\$ 0.00	\$ 484.72
OR	15	1/1-12/31	\$ 728.14	\$ 0.00	\$ 728.14	\$ 756.46	\$ 0.00	\$ 756.46
PA		1/1-12/31	\$ 595.83	\$ 64.56	\$ 660.39	n/a	n/a	n/a
RI		7/1-6/30	\$ 391.68	\$ 24.00	\$ 415.68	n/a	n/a	n/a
SC		1/1-12/31	\$ 231.84	\$ 93.46	\$ 325.30	\$ 260.90	\$ 93.46	\$ 354.36
SD		7/1-6/30	\$ 415.36	\$ 0.00	\$ 415.36	\$ 481.08	\$ 0.00	\$ 481.08
TN		1/1-12/31	\$ 354.71	\$ 88.68	\$ 443.39	\$ 406.11	\$ 71.92	\$ 478.03

TX		9/1-8/31	\$ 343.48	\$ 0.00	\$ 343.48	\$ 360.54	\$ 0.00	\$ 360.54
UT		7/1-6/30	\$ 320.69	\$ 24.14	\$ 344.83	\$ 332.56	\$ 17.50	\$ 350.06
VT		1/1-12/31	\$ 436.58	\$ 109.14	\$ 545.72	\$ 408.68	\$ 102.16	\$ 510.84
VA	16	7/1-6/30	\$ 340.00	\$ 36.00	\$ 376.00	\$ 395.00	\$ 42.00	\$ 437.00
WA	17	1/1-12/31	\$ 350.00	\$ 14.00	\$ 364.00	\$ 561.00	\$ 25.00	\$ 586.00
WV	18	7/1-6/30	\$ 339.00	\$ 19.00	\$ 358.00	\$ 365.00	\$ 25.00	\$ 390.00
WI		1/1-12/31	\$ 484.17	\$ 22.00	\$ 506.17	\$ 477.50	\$ 31.00	\$ 508.50
WY		1/1-12/31	\$ 388.59	\$ 65.58	\$ 454.17	\$ 501.09	\$ 45.95	\$ 547.04

*MI: MI's data have been changed (8/20/09) from HMO rates to PPO rates. Previously the data cited HMO rates of total cost of \$290.28; employee share of \$ 14.52 and state contribution of \$275.78. The 2006 figures are PPO figures and the 2009 figures are also PPO after the change.

Footnotes

- 1: AR: State contribution + employee contribution does not equal total cost as there is small contribution made by the ASE trust fund.
- 2: GA: For 2009, state contributes 75% and employee contributes 25%.
- 3: ID in 2009 also had a HD plan.
- 4: IL: The most recent data available for IL are FY 08 (Jul '07-Jun'08). FY 08 data represents weighted average for all salary levels.
- 5: KS: For 2009, sal rge: \$27,000-\$47,000; KS uses both a fiscal year and calendar year framework to administer its plan. The employee contribution is assessed on a calendar year basis; the state's contribution to the premium per employee changes on a fiscal year basis.
- 6: KY: For 2009, rates are for non-smokers.
- 7: MA: 2009 rates are for employees hired after 6/30/03.
- 8:MS: for 2009 also has a HD plan.
- 9: MO: For 2009, rates are for Central & East Region.
- 10: NV: For 2009, rates are for "Southern HMO".
- 11: NJ: For 2009, employees pay 1.5% of their pay as premium and state covers the rest.
- 12:NM: For 2006 rates, the sal rge= \$30K-\$30K; (2009) sal rge: below \$50K.
- 13: NY: For 2009 rates, the rate is based on a sample county.
- 14: ND: 2009 rate is based on not participating in state's wellness program.
- 15: OR: 2009 rate is based on state paying entire premium for fulltime employees and prorated for part-time employees.
- 16:VA: also has HD plan in 2009.
- 17: WA: 2009 rates are for sample county.
- 18: WV: 2009 rates are for salary range between \$30K and \$36K.

State Employee Health Benefits - Monthly premium costs (Family coverage)

Compiled by the NCSL Health Program - Updated: August 19, 2009

Year			2006			2009		
			Family coverage			Family coverage		
State cost			\$ 818.74	50 state avg		\$ 869.71	(47 state avg)	
Employee			\$ 193.93	as above		\$ 188.42	(47 state avg)	
Ave. Total			\$ 1,012.67	as above		\$ 1,061.65	(48 state avg)	
	FT #	period	State	Employee	Total	State	Employee	Total
AL		10/1-9/30	\$ 650.00	\$ 164.00	\$ 814.00	\$ 775.00	\$ 180.00	\$ 955.00
AK	1	7/1-6/30	\$ 763.00	\$ 270.00	\$ 1,033.00	\$ 895.95	\$ 0.00	\$ 895.95
AZ		10/1-9/30	\$ 818.52	\$ 125.00	\$ 943.52	\$ 1,158.00	\$ 150.00	\$ 1,308.00
AR	2	1/1-12/31	\$ 522.84	\$ 346.90	\$ 869.74	\$ 621.99	\$ 443.70	\$ 1,097.48
CA		1/1-12/31	\$ 807.00	\$ 141.82	\$ 948.82	\$ 994.00	\$ 233.00	\$ 1,227.00
CO		7/1-6/30	\$ 460.26	\$ 362.46	\$ 822.72	\$ 782.92	\$ 257.36	\$ 1,040.28
CT		7/1-6/30	\$ 995.38	\$ 176.07	\$ 1,171.45	\$ 942.57	\$ 97.57	\$ 1,040.13
DE		7/1-6/30	\$ 1,053.52	\$ 57.84	\$ 1,111.36	\$ 1,221.10	\$ 0.00	\$ 1,221.10
FL		7/1-6/30	\$ 715.92	\$ 180.00	\$ 895.92	\$ 835.98	\$ 64.30	\$ 900.28
GA	3	1/1-12/31	\$ 587.22	\$ 217.16	\$ 804.38	\$ 875.78	\$ 223.10	\$ 1,098.88
HI	4	7/1-6/30	\$ 487.38	\$ 322.34	\$ 809.72	\$ 523.72	\$ 284.20	\$ 807.92
ID		7/1-6/30	\$ 576.68	\$ 80.00	\$ 656.68	\$ 705.08	\$ 103.00	\$ 808.08
IL	5	7/1-6/30	\$ 1,096.52	\$ 245.50	\$ 1,342.02	\$ 715.71	\$ 127.99	\$ 843.70
IN		1/1-12/31	\$ 917.58	\$ 291.66	\$ 1,209.24	\$ 961.56	\$ 182.94	\$ 1,239.87
IA		1/1-12/31	\$ 989.75	\$ 222.08	\$ 1,211.83	\$ 932.47	\$ 0.00	\$ 932.47
KS	6	7/1-6/30	\$ 604.30	\$ 357.08	\$ 961.38	\$ 586.66	\$ 351.74	\$ 938.40
KY	7	1/1-12/31	\$ 703.37	\$ 320.14	\$ 1,023.51	\$ 785.44	\$ 376.72	\$ 1,162.16
LA		7/1-6/30	\$ 645.90	\$ 397.18	\$ 1,043.08	\$ 713.36	\$ 453.00	\$ 1,166.36
ME		7/1-6/30	\$ 1,117.44	\$ 337.34	\$ 1,454.78	\$ 1,238.26	\$ 373.84	\$ 1,612.10
MD		7/1-6/30	\$ 694.49	\$ 151.72	\$ 846.21	\$ 741.93	\$ 130.93	\$ 872.86
MA	8	7/1-6/30	\$ 1,160.14	\$ 204.73	\$ 1,364.87	\$ 781.92	\$ 195.48	\$ 977.40
MI*		10/1-9/30	\$ 1,187.27	\$ 62.49	\$ 1,249.76	1182.84*	131.42*	\$ 1,314.28
MN		1/1-12/31	\$ 976.84	\$ 107.32	\$ 1,084.16	\$ 1,185.14	\$ 130.20	\$ 1,315.34
MS	9	7/1-6/30	\$ 305.00	\$ 477.00	\$ 782.00	\$ 343.00	\$ 581.00	\$ 924.00
MO	10	1/1-12/31	\$ 977.00	\$ 258.00	\$ 1,235.00	\$ 1,219.00	\$ 277.00	\$ 1,496.00
MT		1/1-12/31	\$ 506.00	\$ 187.00	\$ 693.00	\$ 626.00	\$ 204.00	\$ 830.00
NE		7/1-6/30	\$ 1,141.64	\$ 303.46	\$ 1,445.10	\$ 1,470.28	\$ 390.84	\$ 1,861.12
NV	11	1/1-12/31	\$ 676.57	\$ 114.54	\$ 791.11	\$ 726.75	\$ 150.84	\$ 877.59
NH		1/1-12/31	\$ 1,886.21	\$ 0.00	\$ 1,886.21	\$ 1,710.47	\$ 30.00	\$ 1,740.47
NJ	12	1/1-12/31	\$ 835.77	\$ 0.00	\$ 835.77	Remain \$	1.5% of Sal	\$ 1,080.60
NM	13	7/1-6/30	\$ 550.87	\$ 236.09	\$ 786.96	\$ 806.42	\$ 201.62	\$ 1,008.04
NY	14	1/1-12/31	\$ 830.25	\$ 185.20	\$ 1,015.45	\$ 771.26	\$ 180.78	\$ 952.04
NC		7/1-6/30	\$ 321.14	\$ 521.32	\$ 842.46	\$ 346.38	\$ 413.46	\$ 759.84
ND	15	1/1-12/31	\$ 553.94	\$ 0.00	\$ 553.94	\$ 664.66	\$ 0.00	\$ 664.66
OH		7/1-6/30	\$ 853.23	\$ 128.50	\$ 981.73	\$ 762.04	\$ 134.88	\$ 896.92
OK		1/1-12/31	\$ 1,098.18	\$ 0.00	\$ 1,098.18	\$ 1,427.08	\$ 0.00	\$ 1,427.08
OR	16	1/1-12/31	\$ 1,002.97	\$ 0.00	\$ 1,002.97	\$ 1,036.36	\$ 0.00	\$ 1,036.36

PA		1/1-12/31	\$ 595.83	\$ 108.50	\$ 704.33	n/a	n/a	n/a
RI		7/1-6/30	\$ 1,098.01	\$ 43.92	\$ 1,141.93	n/a	n/a	n/a
SC		1/1-12/31	\$ 529.00	\$ 294.58	\$ 823.58	\$ 602.56	\$ 294.58	\$ 897.14
SD	17	7/1-6/30	\$ 415.36	\$ 297.68	\$ 713.04	\$ 481.08	\$ 155.00	\$ 636.08
TN		1/1-12/31	\$ 885.60	\$ 221.40	\$ 1,107.00	\$ 1,013.92	\$ 182.85	\$ 1,196.77
TX		9/1-8/31	\$ 671.08	\$ 327.60	\$ 998.68	\$ 637.84	\$ 311.31	\$ 949.15
UT		7/1-6/30	\$ 882.70	\$ 66.43	\$ 949.13	\$ 915.42	\$ 48.18	\$ 963.60
VT		1/1-12/31	\$ 1,200.55	\$ 300.15	\$ 1,500.70	\$ 1,123.82	\$ 280.96	\$ 1,404.78
VA	18	7/1-6/30	\$ 889.00	\$ 127.00	\$ 1,016.00	\$ 1,035.00	\$ 147.00	\$ 1,201.00
WA	19	1/1-12/31	\$ 953.00	\$ 49.00	\$ 1,002.00	\$ 561.00	\$ 79.00	\$ 640.00
WV	20	7/1-6/30	\$ 649.00	\$ 95.00	\$ 744.00	\$ 748.00	\$ 118.00	\$ 866.00
WI	21	1/1-12/31	\$ 1,200.45	\$ 55.00	\$ 1,255.45	\$ 1,189.60	\$ 78.00	\$ 1,267.60
WY	22	1/1-12/31	\$ 897.11	\$ 158.31	\$ 1,055.42	\$ 501.09	\$ 106.39	\$ 607.48

Data based on family coverage "standard benefit package", using lowest cost full-service HMO as example. Most states offer multiple plans and options, so certain employees often pay a different rate.

Supplemented with state research and NCSL telephone interviews with state agencies, 2001-2008.

* = MI's figures have been changed (8/20/09). The current figures are PPO figures. Previously HMO figures for the state's lowest cost plan was cited. Those figures (HMO) cited total cost as \$ 783.78; cost to state as \$744.60 and employee cost as \$ 39.18. The current PPO data was substituted for the HMO figures to allow for a even comparison between the 2006 figures which are PPO data as well.

v = \$ varies

[1] AK: Includes dental & vision.

[2] AR: Total cost includes contribution made by the ASE trust fund.

[3] GA: figure is the average of 10 different managed care plans; lowest cost basic is \$117.33 in '03.

[4] HI varies by union bargaining unit. State contribution varies from \$419 to \$465 in '03.

[5] IL: The most recent figures are for FY 2008 (Jul '07-Jun '08). FY'08 data represents weighted average for all salary levels.

[6] KS: For 2009, salary range: \$27,000-\$47,000; KS uses both a fiscal year and calendar year framework to administer its plan.

The employee contribution is assessed on a calendar year basis; the state's contribution to the premium per employee changes on a fiscal year basis.

[7] KY varies by county, up to \$397 for state share; rates for 2009 are for non-smoker plan.

[8] MA has ten plan offerings, including 5 HMOs, which average \$62.55; 2009 rates are for employees hired after 6/30/03.

[9] MS for 2009 rates are for employees hired after 12/31/05; MS had HD plan in 2009.

[10] MO 2009 rates are for Central and East Region.

[11] NV 2009 rate is for "Southern HMO".

[12] NJ: Employee pays 1.5% of salary as premium and states pays remainder of premium.

[13] NM - the 2009 rates are for salary range below \$50K.

[14] NY: for 2009 rates example county; most emp. pay 1.5% of their pay for ins.

[15] ND: 2009 figures based on w/o participation in wellness prog.

[16] OR: For 2009, state pays 100% for full time emp; prorated for part-time.

[17] SD: Rates for 2009 are for non-smokers with spouse age 40-44 and 2 + children.

[18] VA: separate HD plan available in 2009.

[19] WA: 2009 rates are for sample county.

[20] WV employee share varies by income- example is for \$30-\$36k annual income for both 2006 and 2009 rates.

[21] WI varies by county.

[22] WY: \$750 deductible plan.

Study of State Employee Health Benefits

Almost all states are struggling to cope with recession-related budget shortfalls.¹ As part of the process of examining their expenditures, many states are exploring possible savings in the cost of employee health coverage. Understanding the competitive environment is crucial to balancing the need for fiscal savings with the ability to attract and retain talent.

For more than 30 years, The Segal Company has periodically gathered data about state employee health benefits plans into a comparative analysis of benefits, costs, premiums, plan designs and related issues as a resource for government leaders. This report summarizes the results of the latest study, which is based on Segal's review of information available on state Web sites, augmented by additional information provided by state benefits administrators. *The Study of State Employee Health Benefits*, which covers all states and the District of Columbia,² reflects benefits offered to active, full-time employees in 2009.

Key Findings

The *Study of State Employee Health Benefits* found that:

- A large majority of states offer medical coverage through managed care plan designs.
- The dominant design nationwide and in regions is a managed medical plan that allows employees to seek care from out-of-network providers at higher cost.
- States with the smallest populations offer the greatest choice of medical plan types.
- Multiple tiers for medical coverage are common.
- For all medical plan types, cost sharing is greater for family coverage than for employee-only coverage.
- There are regional differences in cost sharing.
- Annual per-person deductibles of under \$1,000 are common.
- Lifetime maximums for medical coverage are uncommon.
- For prescription drug coverage copayments are much more common than coinsurance.
- Most states that provide dental coverage offer a managed dental plan.



This report provides details about these findings.

MEDICAL PLAN TYPES OFFERED

The vast majority of states (96 percent) offer medical coverage through a preferred provider organization (PPO).³ Almost three-quarters of states (71 percent)

offer a health maintenance organization (HMO), a more highly managed plan with greater discounts.⁴ Far fewer states (33 percent) offer a high-deductible health plan (HDHP).⁵ Only six states⁶

¹ According to May 2009 data from the Center on Budget and Policy Priorities (<http://www.cbpp.org/files/9-8-08.sp.pdf>), "At least 47 states faced or are facing shortfalls in their budgets for this and/or the next year or two."

² For simplicity, the text in this report only refers to states.

³ The two states that do *not* offer a PPO are Alaska and Minnesota. This study uses "PPOs" to represent all preferred provider plans, including point-of-enrollment (POE) and point-of-service (POS) plans. All PPOs consist of networks of providers who agree to accept a negotiated discount payment for their services. POE plans limit coverage to the network providers. POS plans give employees more choice to seek care from out-of-network providers for a higher out-of-pocket cost.

⁴ This study uses "HMOs" to also represent exclusive-provider organizations (EPOs). Like HMOs, EPOs rely on primary care physicians (PCPs) to act as gatekeepers, directing their patients' care from other network providers and coordinating that care. HMOs and EPOs differ in how they compensate PCPs: HMOs pay on a per-person basis and EPOs pay according to services performed.

⁵ An HDHP may be part of a Health Savings Account (HSA) plan, which requires an annual deductible of \$1,150 or more in 2009, or may be a stand-alone option without the HSA component.

⁶ Those states are Alaska, Idaho, Iowa, Massachusetts, Montana and Vermont.

offer indemnity plans. Graph 1 presents this information.

The regional breakdown of medical plan offerings is similar to the national breakdown shown in Graph 1. Some notable differences follow: the percentage of Northeast states offering HDHPs is lower than the nationwide percentage (22 percent vs. 33 percent); the percentage of Midwest states offering HMOs is slightly higher than the nationwide percentage (75 percent vs. 71 percent); and no state in the South offers an indemnity plan. See Table 1.

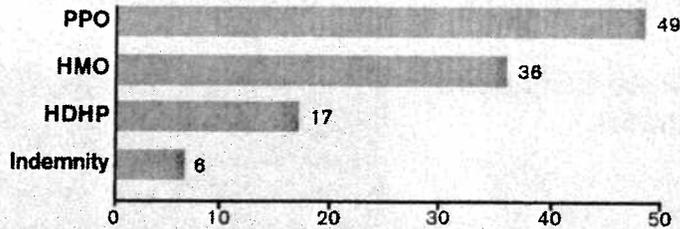
“The regional breakdown of medical plan offerings is similar to the national breakdown.”

To investigate whether population size might be a factor in the plan types offered, Segal categorized the states into four size groups, as shown in Table 2. The breakdown shows that the midsize and smallest state groups offer a greater variety of plan types than the two larger size groups. Most of the states in the large and largest size groups offer PPOs and HMOs. A large number of states in the midsize group offer HDHPs, a plan type that is less common among the other size groups.

MEDICAL COVERAGE TIERS OFFERED

All states offer employee-only and family medical coverage. As shown in Graph 2 at the top left of page 3, more than half of states also offer the following other coverage tiers: employee+spouse and employee+child(ren). Almost half

Graph 1: Number of States* Offering Medical Plan Types



* The total exceeds the number of states because most states offer multiple plan options.

Table 1: Number of States Offering Medical Plan Types by Region*

	Northeast (9 States)	South (16 states plus the District of Columbia)	Midwest (12 States)	West (13 States)	Total
PPO	9	17	11	12	49
HMO	6	12	9	9	36
HDHP	2	6	4	5	17
Indemnity	2	0	1	3	6

* The total for each region exceeds the number of states in the region because many states offer more than one option. The regional breakdown of the data follows the regional breakdown used by the U.S. Census Bureau: Northeast = CT, MA, ME, NH, NJ, NY, PA, RI and VT; South = AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA and WV; Midwest = IL, IN, IA, KS, MI, MN, MO, ND, NE, ND, OH, and WI; and West = AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA and WY.

Table 2: Number of States Offering Medical Plan Types by Population Size*

	Largest States** (8 States)	Large States*** (13 States)	Midsize States**** (22 States)	Smallest States***** (8 States)	Total
PPO	8	12	22	7	49
HMO	8	12	14	2	36
HDHP	1	3	10	3	17
Indemnity	0	1	2	3	6

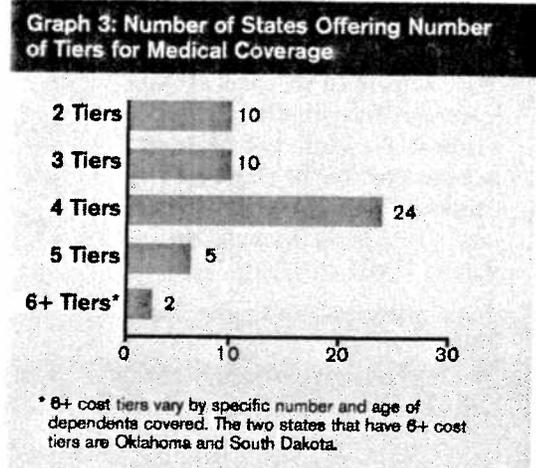
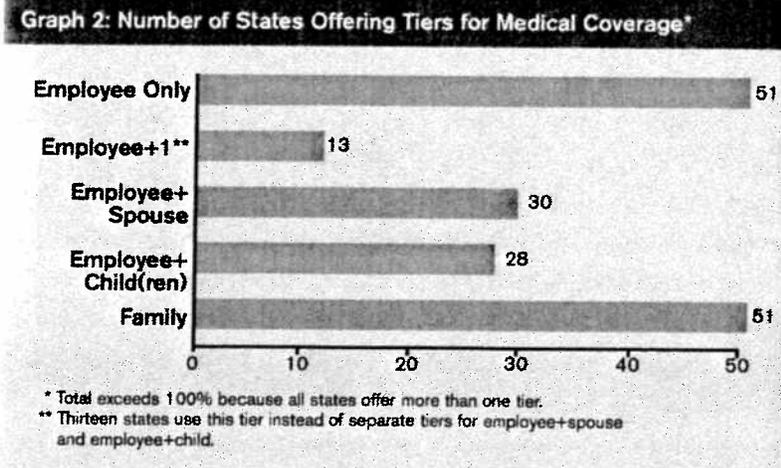
* The total for this size group exceeds the number of states in the group because many states offer more than one option.

** This group includes states with populations of 10 million or more: CA, TX, NY, FL, IL, PA, OH & MI.

*** This group includes states with populations of more than 5 million, but less than 10 million: AZ, GA, IN, MA, MN, NC, NJ, MD, MO, TN, VA, WA & WI.

**** This group includes states with populations of more than 1 million, but less than 5 million: AL, AR, CO, CT, HI, IA, ID, KS, KY, LA, NE, NH, NM, NV, ME, MS, OK, OR, RI, SC, UT & WV.

***** This group includes states (including the District of Columbia) with populations under 1 million: AK, DC, DE, MT, ND, SD, VT & WY.



of the states (47 percent) offer four coverage tiers, as noted in Graph 3.

COST SHARING

As has been the case in previous Segal state studies, the study found that for all plan types, cost sharing is greater for family coverage than for employee-only coverage. For both coverage options, cost sharing of 20 percent or more is characteristic of indemnity plans, although cost sharing at that level is also used by many PPOs for family coverage. Graph 4

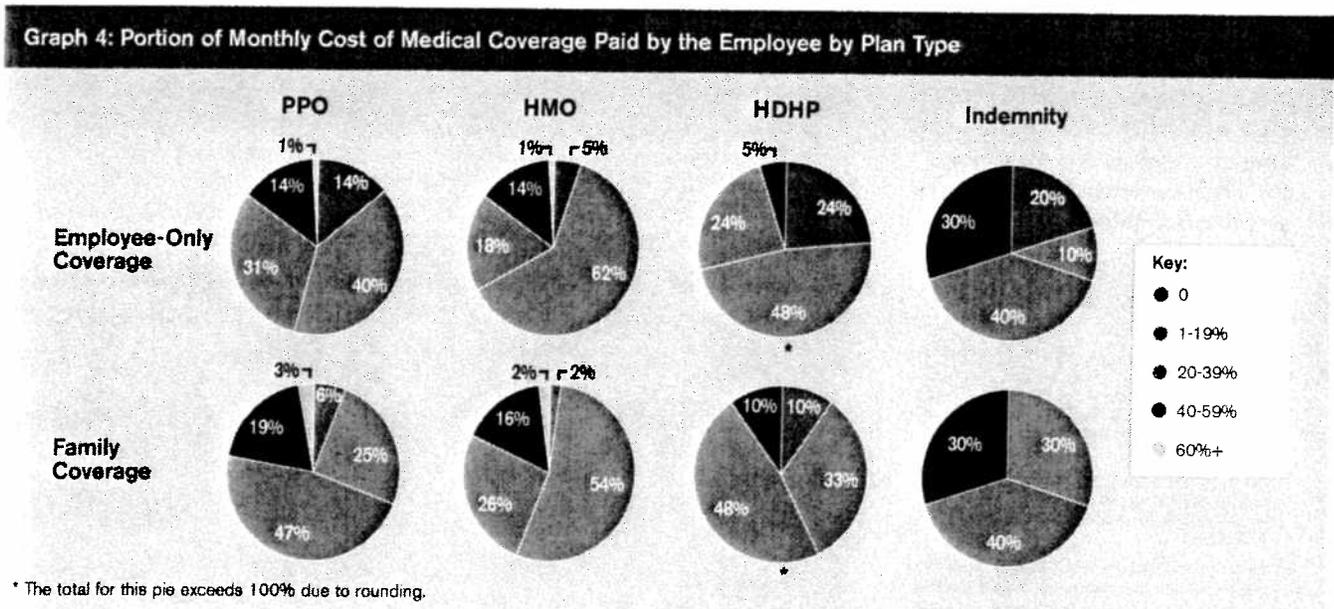
provides a detailed breakdown of cost-sharing ranges by plan type.

As a group, states in the Northeast require less cost sharing for both employee-only and family PPO coverage than states in other regions. Almost half of states in the West region require cost sharing of at least 40 percent for employee-only or family PPO coverage. One-quarter of plans in the South region pay for the entire cost of employee-only coverage, as do 21 percent of plans in the Midwest region. Smaller proportions (10 percent or

less) of plans in those regions offer all-employer-paid family coverage.⁷

Cost sharing for HMO coverage by region was also examined. Unlike most plans in the Midwest and West regions, plans in the Northeast and South regions tended to require more cost sharing for family coverage than for employee-only coverage. More

⁷ For more information about the regional breakdown for cost sharing for PPO coverage, see Table A, which is available on the Segal Web site as an online supplement to this report: <http://www.segalco.com/publications/surveysandstudies/2009statestudy.supp.pdf>



than half of states in the South region require cost sharing of at least 40 percent for family HMO coverage. As with PPOs, a few states in the South and Midwest regions pay for the entire cost of employee-only HMO coverage, and a couple do the same for family HMO coverage.⁸

Segal analyzed cost sharing for PPO coverage and HMO coverage by the four population-size groups noted in Table 2 on page 2. As a group, the largest states are more likely than states in the other three size groupings to require less cost sharing for PPO employee-only or family coverage. States in the Midwest region tend to require more cost sharing for family coverage than for employee-only coverage.⁹ The overwhelming majority of both the largest states and the large states require cost sharing of between 1 and 19 percent for HMO coverage, either employee-only or family.¹⁰

As shown in Table 3, most PPOs, HMOs and indemnity plans have annual per-person deductibles of under \$1,000.

OUT-OF-POCKET MAXIMUMS AND LIFETIME MAXIMUMS

A large portion of all plan types except for HDHPs have unlimited annual out-of-pocket maximums for single coverage for in-network services. See Table 4.

A majority of all plan types have no lifetime maximums. See Graph 5.

Table 3: Annual Per-Person Deductibles by Plan Type* and Number of Plans

	PPO**	HMO***	Indemnity****
0	48	90	2
\$1-\$499	37	14	6
\$500-\$999	15	3	2
\$1,000+	6	1	0

* HDHPs are not included in this table because, by definition, when part of an HSA, they have deductibles over \$1,000.

** For PPOs, these deductibles are for in-network services. (Data on annual deductibles for out-of-network services was available for 94 of the PPOs. Of those plans, five have no deductible; 38 have a deductible in the \$1-\$499 range; 37 have a deductible in the \$500-\$999 range; eight have a deductible in the \$1,000-\$1,400 range; two have a deductible in the \$1,500-\$1,999 range; one has a deductible in the \$2,000-\$2,499 range; one has a deductible in the \$2,500-\$2,999 range; and two have a deductible of \$3,000+).

*** For HMOs, these deductibles are for in-network services. (HMOs do not have annual deductibles for out-of-network services because those services are not covered.)

**** Indemnity plans do not have in-network and out-of-network services.

Table 4: Annual Out-of-Pocket Maximums for Single Coverage for In-Network Services* by Plan Type and Number of Plans

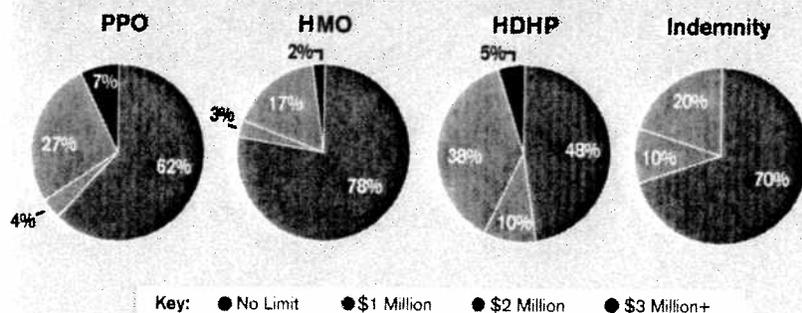
	PPO	HMO**	HDHP	Indemnity***
Unlimited	27	53	1	2
\$1-\$999	10	6	1	4
\$1,000-\$1,999	28	25	1	1
\$2,000-\$2,999	29	16	5	2
\$3,000-\$4,999	10	5	10	1
\$5,000+	3	0	3	0

* Data on annual out-of-pocket maximums for out-of-network services was available for 90 of the PPOs. Of those plans, four have maximums in the \$1-\$999 range; nine have maximums in the \$1,000-\$1,999 range; 25 have maximums in the \$2,000-\$2,999 range; 37 have maximums in the \$3,000-\$4,999 range; 10 have maximums of \$5,000+; and five have no maximums/unlimited annual out-of-pocket expenses. Annual out-of-pocket maximums for out-of-network services for HDHP plans are not reported because not enough data was available.

** For HMOs, these out-of-pocket maximums are for in-network services. (HMOs do not have out-of-pocket maximums for out-of-network services because those services are not covered.)

*** Indemnity plans do not have in-network and out-of-network services.

Graph 5: Lifetime Maximums by Plan Type and Percentage of Plans



⁸ For more information about the regional breakdown for cost sharing for HMO coverage, see Table B in the online supplement mentioned in footnote 7.

⁹ For more information about the population-size breakdown for cost sharing for PPO coverage, see Table C in the online supplement mentioned in footnote 7.

¹⁰ For more information about the population-size breakdown for cost sharing for HMO coverage, see Table D in the online supplement mentioned in footnote 7.

PRESCRIPTION DRUG COVERAGE

The study found that for state prescription drug coverage, copayments are much more common than coinsurance. Just over half of states (51 percent) have a prescription drug copayment in the \$10-19 range for retail purchases. The most common copayment for purchases via mail order, which typically cover a 90-day supply, is in the \$20-29 range, used by 32 percent of states. See Graph 6.

Most state plans require a retail copayment in the \$10-19 range for both generic and formulary prescription drugs, but there is more variation in mail order copayments, as shown in Graph 7. Copayments for retail and mail-order brand-name, non-formulary prescription drugs are higher. See Graph 8.

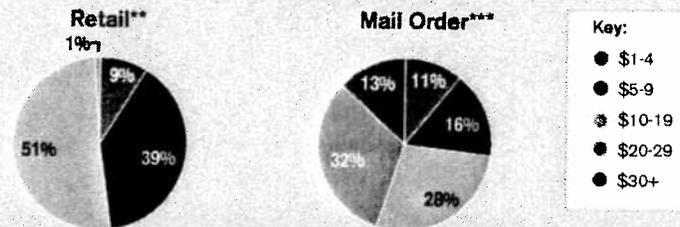
“For state prescription drug coverage, copayments are much more common than coinsurance.”

DENTAL COVERAGE

The *Study of State Employee Health Benefits* found that most states (47) offer a dental plan.¹¹ Dental provider organizations (DPOs) are the most common plan type, offered by 54 percent of states that provide dental coverage. See Graph 9 on the last page. In a majority of state dental plans (70 percent), the state pays a portion of the cost of coverage.

¹¹ The four states that do not provide dental coverage are all in the South: Kentucky, Louisiana, Mississippi and West Virginia.

Graph 6: Copayments* for Retail and Mail-Order Generic Prescription Drugs by Percentage of Plans

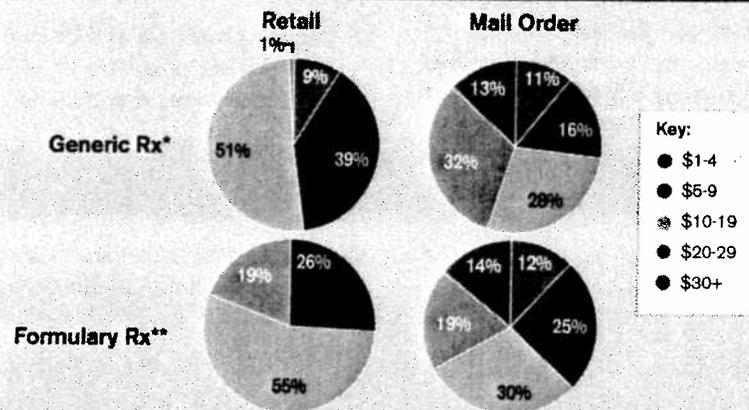


* Copayments are much more common than coinsurance. Nevertheless, 19 plans use coinsurance for retail generic prescription drugs, broken down as follows: The coinsurance for five plans is in the 1-19% range. The coinsurance for nine plans is in the 20-39% range. The coinsurance for three plans is in the 40-59% range. The coinsurance for two plans is 60% or more, and 10 plans use coinsurance for mail order generic prescription drugs, broken down as follows: The coinsurance for two plans is in the 1-19% range. The coinsurance for four plans is in the 20-39% range. The coinsurance for two plans is in the 40-59% range. Two plans have zero coinsurance for mail order generic prescription drugs.

** The retail percentages are based on 179 plans.

*** The mail order percentages are based on 121 plans.

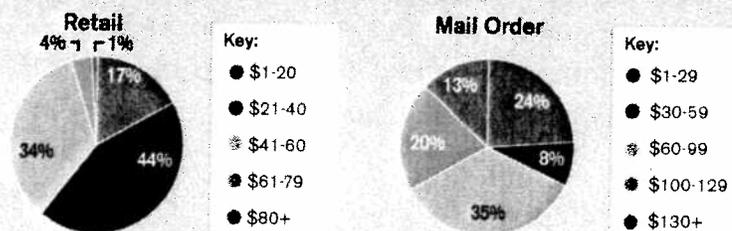
Graph 7: Copayments for Retail and Mail-Order Prescription Drugs by Drug Category (Generic and Formulary) and Percentage of Plans



* The retail percentages for generic prescription drugs are based on 179 plans. The mail order percentages for generic prescription drugs are based on 118 plans.

** The retail percentages for formulary prescription drugs are based on 151 plans. The mail order percentages for formulary prescription drugs are based on 102 plans.

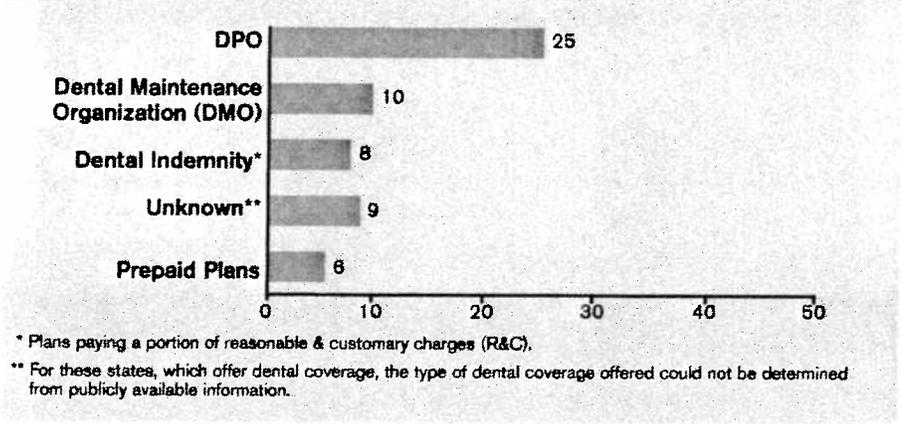
Graph 8: Copayments for Retail and Mail-Order Brand-Name, Non-Formulary Prescription Drugs*



* The retail percentages for brand-name, non-formulary prescription drugs are based on 168 plans. The mail order percentages for brand-name, non-formulary prescription drugs are based on 116 plans.

Survey

Graph 9: Number of States Offering Dental Coverage by Plan Type



including comparisons of coverage costs among plan types, regions and/or population size. For more information about Segal's state database or the design of health benefit plans for state employees, contact one of the following experts:

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 (health benefit data)
 202.833.6444
hkazemi@segalco.com

➤ **Rick Johnson**
 (health benefit consulting)
 202.833.6470
rjohnson@segalco.com

CONCLUSION

State governments face a daunting task of balancing the commitment to provide comprehensive health benefits to employees with the pressure of keeping expenses within increasingly strained state budgets. States are working with a variety of initiatives to hold health care costs in line, including:

- Maximizing federal program subsidies, particularly for Medicare-eligible retirees,
- Making program design changes to balance premium increases and participant out-of-pocket costs,
- Renegotiating and bidding vendor contracts to obtain the most up-to-date market pricing and discounts,

- Auditing plan administrators for self-insured programs to identify processing and overpayment issues,
- Targeting wellness and disease management programs to address the primary cost drivers, and
- Planning communications to educate participants in making wise and healthy choices.

Examining what other states are offering can be helpful in making tough decisions about potential changes.



This Study of State Employee Health Benefits reports just some of the information in Segal's extensive state database. Segal can be retained to provide custom data reports,

"State governments face a daunting task of balancing the commitment to provide comprehensive health benefits to employees with the pressure of keeping expenses within increasingly strained state budgets."

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Houston	713.664.4654
Los Angeles	818.956.6700
Minneapolis	952.857.2480
Montreal	514.989.3735
New Orleans	504.483.0744
New York	212.251.5000
Philadelphia	215.854.4017
Phoenix	602.381.4000
Princeton	609.520.2700
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San Francisco	415.263.8200
Toronto	416.969.3960
Washington	202.833.6400

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NCSL SUPPLEMENTAL MATERIALS

(Provided to the Michigan Legislature)

Factors That Can Increase Health Plan Costs

Adopted from Richard Johnson, Segal Co.; presentation to NCSL July 21, 2009

Factors That Can Increase Health Plan Costs




Increased enrollment of dependents

- As spouses with other coverage lose jobs and benefit coverage
- Attempted enrollment of non-qualified "Dependents"

Increased COBRA coverage elections

- As laid-off workers fail to find other work with health benefits
- To take advantage of the new COBRA federal subsidy payments

Factors That Can Increase Health Plan Costs




Delayed retirement

- As those eligible for retirement reconsider their ability to pay for health coverage after they retire

Increased likelihood of stress-related disorders

- Fear of job loss can trigger stress-related diseases and increased mental health claims
- Can cascade into increased overall sickness of the group
- Increased number of disabilities will negatively impact the disability program experience (both pre and post RIF)

Factors That Can Increase Health Plan Costs





Acceleration of claims for covered discretionary procedures

- Might have been delayed in normal times (elective surgery or major dental work)
- Pushed up now for fear of job and benefit coverage loss

Postponement of preventive services

- Preventive services help keep down long-term costs
- Out-of-pocket costs for some preventive services discourage utilization among employees worried about their jobs, who believe they can hold off until later

Claims against Medical Spending Accounts before they are fully funded

- Employer is "at risk"
- Employees intend to use the full deferred amount prior to departure, whether funded or not

Data Mining - Cost Drivers

Status	# of CEPEs	Percent of Total	Total Dollars Paid	Percent of Paid	Projected PMPY
Healthy	1,162	49.2%	\$366,903	4.5%	\$338
One or More Significant Acute Diseases	63	2.5%	\$215,111	2.5%	\$3,414
One Minor Chronic Disease	333	13.5%	\$516,322	6.1%	\$1,550
Multiple Minor Chronic Diseases	140	5.7%	\$468,616	5.4%	\$3,347
One Significant Chronic Disease	445	18.0%	\$1,715,530	19.9%	\$3,855
Two Significant Chronic Diseases	306	12.5%	\$2,772,618	32.2%	\$9,973
Three or more Significant Chronic Diseases	20	0.8%	\$245,149	2.8%	\$12,257
Complicated Malignancies	12	0.5%	\$1,965,300	22.8%	\$163,775
Catastrophic Condition	6	0.20%	\$331,685	3.8%	\$55,280
Total	2,471	100%	\$8,917,482	100%	\$3,487

CEP = Continuously Enrolled Participant

Identify Diseases That Are Driving Cost

Disease	Patients	Percent of Total	Total Cost	Percent of Cost	PMPY
Hypertension	318	9.05	726,934	9.06	2,286
CAD (coronary artery disease)	83	2.36	37,171	5.47	5,267
CHF (congestive heart failure)	20	0.57	186,979	2.34	9,349
Asthma	64	1.82	173,295	2.11	2,708
ESRD (end stage renal)	4	0.11	165,445	2.07	41,361
COPD (coronary, obstructive pulmonary disease)	39	1.11	153,314	1.92	3,931
Depression	84	2.39	131,262	1.59	1,562
Breast Cancer	17	0.48	128,774	1.59	7,467
CVA (Cerebrovascular accident)	7	0.20	78,204	0.98	11,172

(Massachusetts) Cities, towns urged to join health plan Statewide pool may save \$100m

By April Simpson, Globe Staff | August 21, 2007

Massachusetts cities and towns could save \$100 million on the rapidly spiraling cost of health insurance in the fiscal year 2009 alone if they took advantage of a new law allowing them to join the state's health insurance program, according to a report released yesterday. But, according to the report, one thing may stand in their way: labor unions.

In a controversial recommendation that has angered some union leaders, the report by the Boston Municipal Research Bureau and the Massachusetts Taxpayers Foundation said cities and towns should be allowed to bypass any negotiations with unions in order to join the state plan.

"I understand the political difficulty of that suggestion, but there are no easy answers to the local healthcare dilemma of escalating costs, and while this is a good first step, we're concerned that it doesn't go far enough and that not very many communities will take advantage of it," said Michael Widmer, president of the Massachusetts Taxpayers Foundation

Governor Deval Patrick signed a law last month giving cities and towns permission to join the state's Group Insurance Commission to take advantage of its negotiating power for better rates and flexibility.

But the law also requires that cities and towns get permission from local coalitions of labor unions, many of which have been wary of the move. The authors of yesterday's report said unions could prevent some cities or towns from meeting an Oct. 1 deadline for notifying the state it intends to join. But several union officials said yesterday they should not be eliminated from the process.

"They think that they can do a report and that report will turn into legislation," said Bob McCarthy, president of the Professional Firefighters of Massachusetts, which has 12,000 members and 193 local unions across the state. "They don't want to manage; they just want to mandate."

The insurance measure is part of Patrick's Municipal Partnership Act, which attempts to help communities cut residential property taxes by saving money on pensions and healthcare and giving them new sources of local revenue.

"Allowing cities and towns to join the Group Insurance Commission for healthcare needs is an important part of the governor's Municipal Partnership Act, and we agree that there are opportunities for serious cost savings throughout the state," Kyle Sullivan, Patrick's press secretary, said in a statement. "However, this is just one of the tools communities need to decrease costs and help ease the tax burden on property owners."

Widmer and Sam Tyler -- president of the Boston Municipal Research Bureau, a business-funded watchdog group - cautioned that cities and towns should evaluate their positions before deciding whether to sign up, although doing so would be a cost-saving measure for 90 percent of municipalities. The Group Insurance Commission purchases health insurance for state employees and teachers at a lower cost than most municipalities pay.

According to the report, healthcare costs for municipal employees jumped 63 percent between fiscal year 2001 and 2005, while municipal budgets increased 15 percent.

Mayor Claire Higgins of Northampton said that in fiscal 2001, health insurance consumed 9 percent of Northampton's \$57,791,000 budget, while in 2005, it required 12 percent of the \$61,405,000 base budget, a 43 percent increase. She said the city is evaluating its options, but won't be able to sign up by Oct. 1. Health insurance is "still a growing portion of our budget, growing faster than we'd like," Higgins said.

Dolores L. Mitchell, executive director of the Group Insurance Commission, said she understood that deciding to join would be tough for localities that are struggling financially, but are not prepared to let the state take care of health coverage.

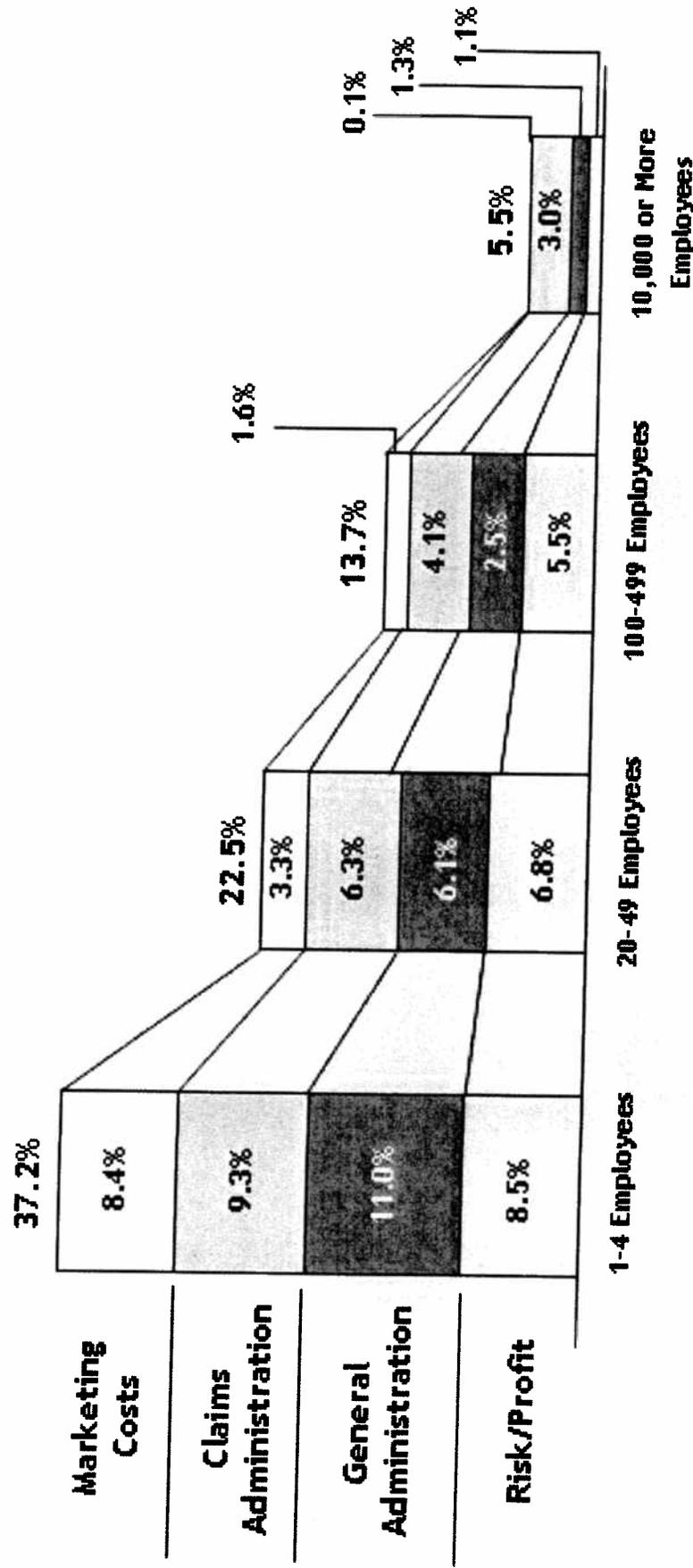
"I hope enough communities will join so they can set an example for other towns," Mitchell said. "On the other hand, if some want to wait and see, I respect that as well."

April Simpson can be reached at asimpson@globe.com ■

Table 1
Estimated Savings for Municipalities by Joining the GIC
Based on a Comparison of Municipal and GIC Rates of Growth
(Figures in Millions)

Fiscal Year	A		B		C		D		E		F		G		H	
	Municipalities do not join the GIC - 13% annual increase	Municipalities join the GIC - 8.1% annual increase	Annual Savings	Percentage Savings	Municipalities do not join the GIC - 11% annual increase	Municipalities join the GIC - 8.1% annual increase	Annual Savings	Percentage Savings								
2008	\$2,086.8	\$2,086.8	-	-	\$2,086.8	\$2,086.8	-	-	\$2,086.8	\$2,086.8	-	-	\$2,086.8	\$2,086.8	-	-
2009	2,358.1	2,255.8	\$102.3	4.3%	2,316.4	2,255.8	\$60.5	2.6%	2,316.4	2,255.8	\$60.5	2.6%	2,316.4	2,255.8	\$60.5	2.6%
2010	2,664.6	2,438.6	226.1	8.5%	2,571.2	2,438.6	132.6	5.2%	2,571.2	2,438.6	132.6	5.2%	2,571.2	2,438.6	132.6	5.2%
2011	3,011.0	2,636.1	375.0	12.5%	2,854.0	2,636.1	217.9	7.6%	2,854.0	2,636.1	217.9	7.6%	2,854.0	2,636.1	217.9	7.6%
2012	3,402.5	2,849.6	552.9	16.2%	3,167.9	2,849.6	318.3	10.0%	3,167.9	2,849.6	318.3	10.0%	3,167.9	2,849.6	318.3	10.0%
2013	3,844.8	3,080.4	764.4	19.9%	3,516.4	3,080.4	436.0	12.4%	3,516.4	3,080.4	436.0	12.4%	3,516.4	3,080.4	436.0	12.4%
2014	4,344.6	3,329.9	1,014.7	23.4%	3,903.2	3,329.9	573.3	14.7%	3,903.2	3,329.9	573.3	14.7%	3,903.2	3,329.9	573.3	14.7%
2015	4,909.4	3,599.7	1,309.8	26.7%	4,332.5	3,599.7	732.9	16.9%	4,332.5	3,599.7	732.9	16.9%	4,332.5	3,599.7	732.9	16.9%
2016	5,547.7	3,891.2	1,656.4	29.9%	4,809.1	3,891.2	917.9	19.1%	4,809.1	3,891.2	917.9	19.1%	4,809.1	3,891.2	917.9	19.1%
2017	6,268.9	4,206.4	2,062.4	32.9%	5,338.1	4,206.4	1,131.7	21.2%	5,338.1	4,206.4	1,131.7	21.2%	5,338.1	4,206.4	1,131.7	21.2%
2018	7,083.8	4,547.1	2,536.7	35.8%	5,925.3	4,547.1	1,378.2	23.3%	5,925.3	4,547.1	1,378.2	23.3%	5,925.3	4,547.1	1,378.2	23.3%

Insurance is More Costly to Administer for Small Groups



Source: Lewin presentation on "Cost and Coverage Impacts" to Colorado Commission, August 23, 2007



Pooling and Rating in the Michigan Health Insurance Market

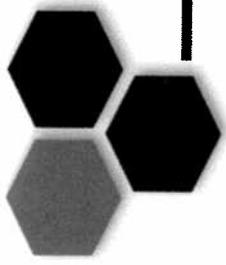
Presentation to Michigan
House Public Employee Health
Care Reform Committee

Brian T. Morris, FSA, MAAA

September 17, 2009

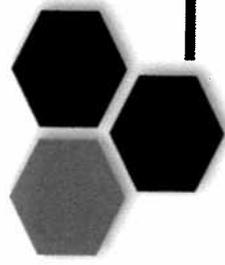
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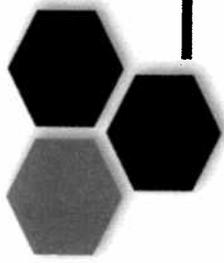
Agenda

- ◆ Insurance Rate Regulation
- ◆ Health Insurance Rating Pools
- ◆ Components of Health Insurance Rates
- ◆ Questions and Answers

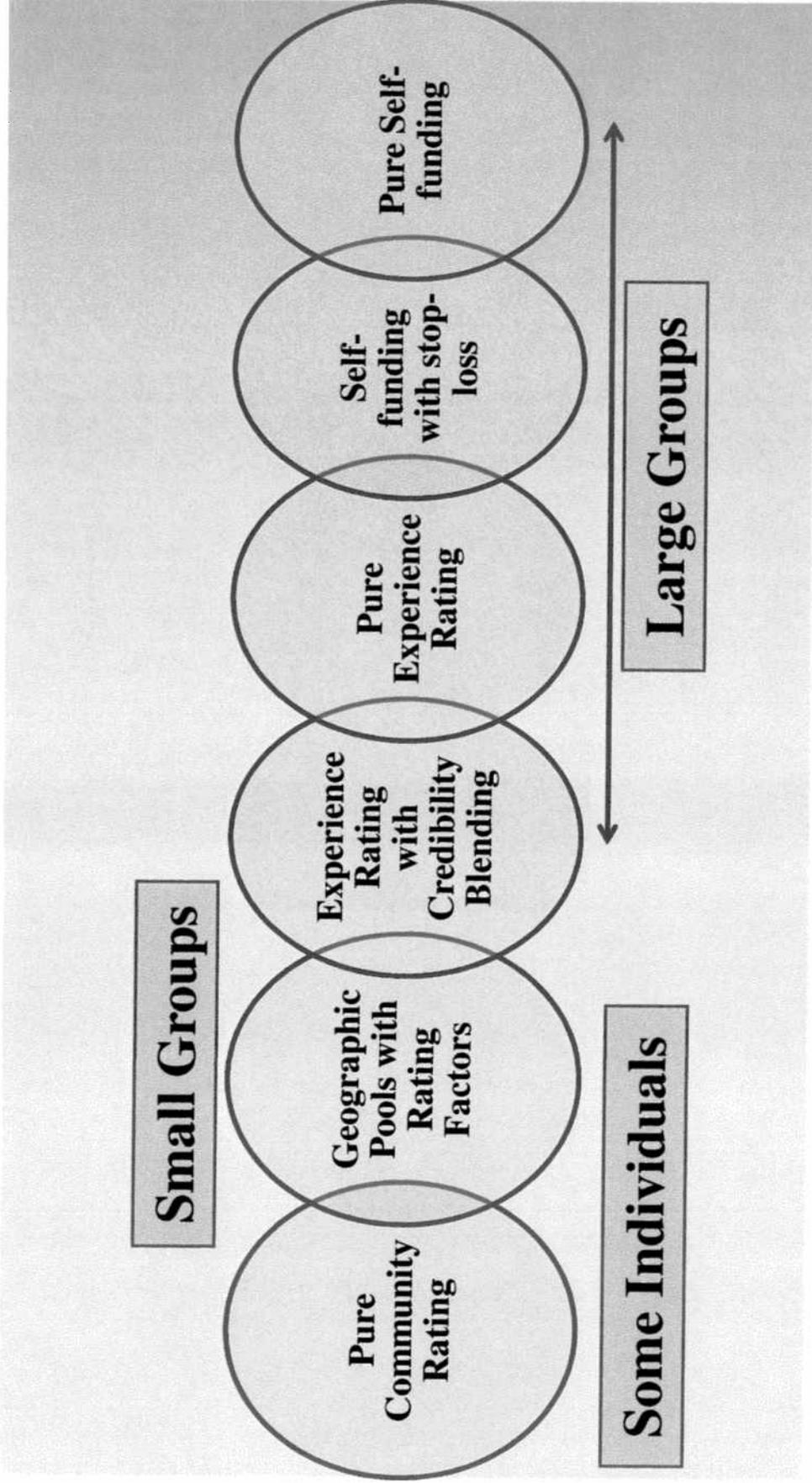


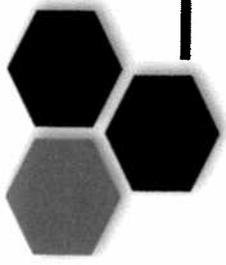
Insurance Rate Regulation

- ◆ Rate regulation depends on insurer
 - ▶ Commercial carrier
 - ▶ HMO
 - ▶ BCBSM
- ◆ Size of insured
 - ▶ Individual
 - ▶ Small group
 - ▶ Large group
- ◆ Funding
 - ▶ Insured
 - ▶ Self-funded



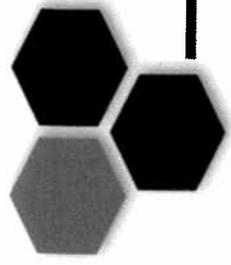
Health Insurance Rating Pools





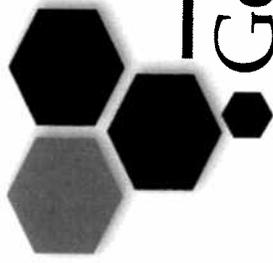
Health Insurance Rating Pools

- ◆ Pure community rating
 - ▶ Rates based on average experience of everyone in pool.
 - ▶ Rates do not vary by geography, age, gender, health status, etc.
- ◆ Few examples
 - ▶ BCBSM's individual products that existed prior to laws enacted in 2003.



Health Insurance Rating Pools

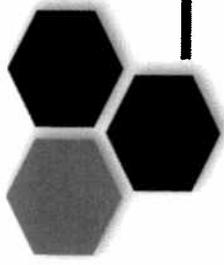
- ◆ Geographic pools with rating factors
 - ▶ Rates based on everyone in a geographic area and adjusted for known predictors of health experience (e.g., age, gender, health status).
 - ▶ Generally applied to small groups (under 50 employees).



Health Insurance Rating Pools

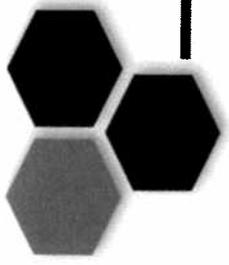
Geographic pools with rating factors

- ▶ Small group rating in Michigan
 - Applies to rating of groups with 50 or fewer employees.
 - Insurers allowed up to 10 geographic pools.
 - Commercial carriers allowed rating factors for age, industry, group size, and health status.
 - HMOs allowed rating factors for age, industry, and group size.
 - BCBSM allowed rating factors for age and industry.
 - Limitations placed on magnitude of rating factors.



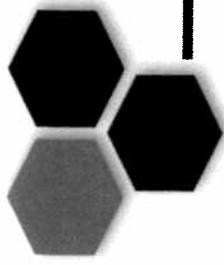
Health Insurance Rating Pools

- ◆ Experience rating with credibility pooling
 - ▶ Group's rate is based, to a degree, on their own historical claims experience.
 - ▶ Blended with the experience of other groups in the pool.
 - ▶ Generally applied by commercial carriers and BCBSM starting with group sizes over 50 employees.



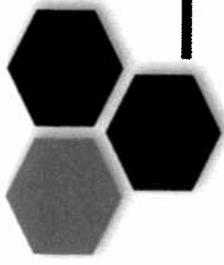
Health Insurance Rating Pools

- ◆ Pure experience rating
 - ▶ Group's rate based entirely on their own historical claims experience.
 - ▶ Insurance carriers' practices vary, but generally start at group sizes of about 500.



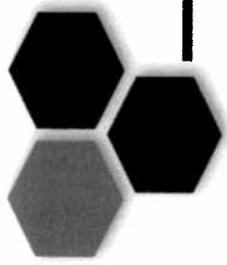
Health Insurance Rating Pools

- ◆ Self-funding with stop-loss insurance
 - ▶ Group responsible for most of its actual claims experience.
 - ▶ Group pays administrative fee to third-party administrator.
 - TPA may be a commercial carrier, HMO, or BCBSM.
 - ▶ Group purchases stop-loss insurance to limit exposure.
 - Limit claims per individual or in aggregate for group.
 - Rates generally based on pool of stop-loss customers.
 - ▶ Available to groups of more than 50 employees.

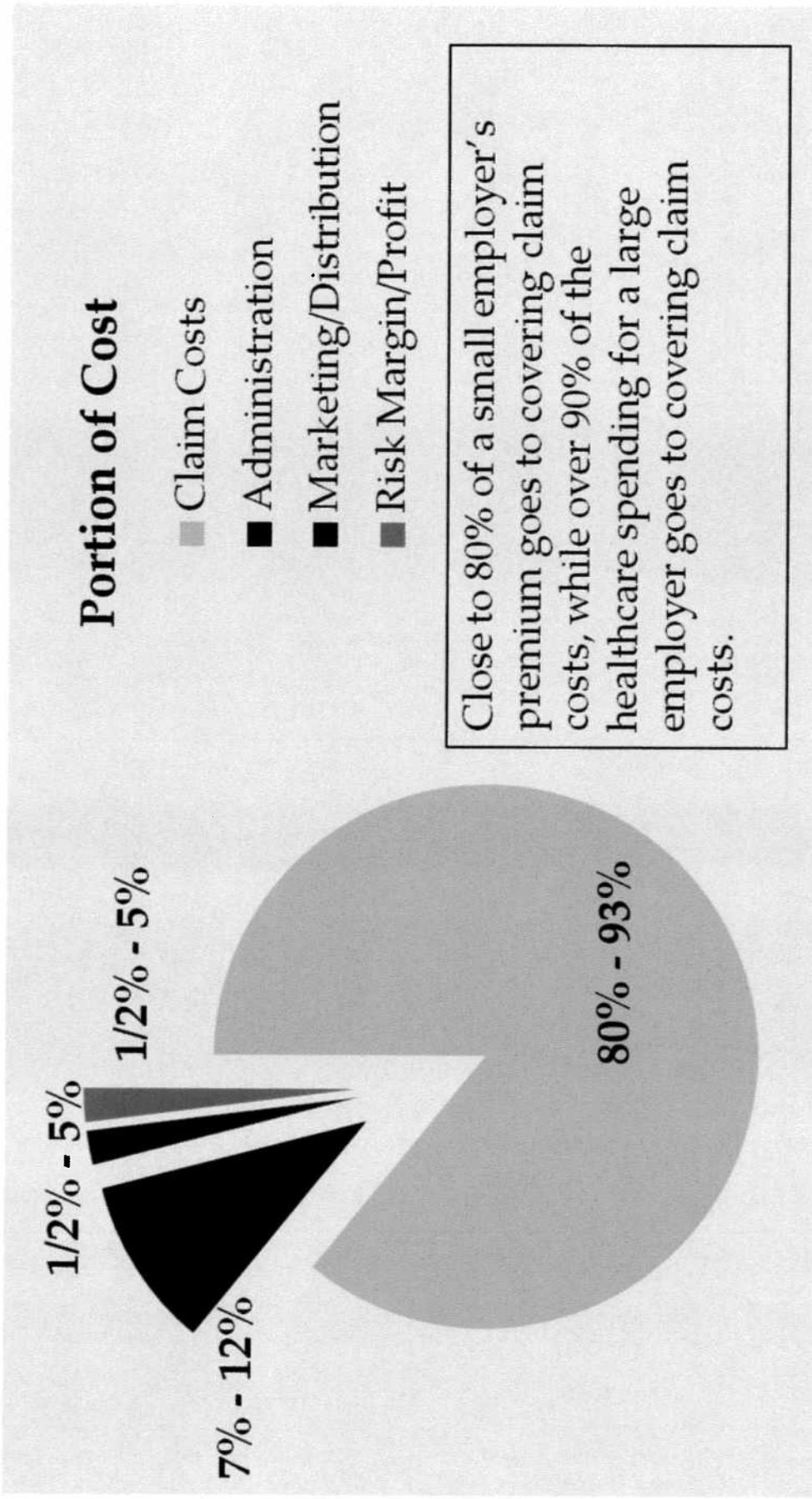


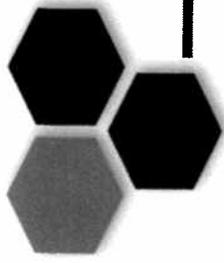
Health Insurance Rating Pools

- ◆ Pure self-funding
 - ▶ Group responsible for all of its claims experience.
 - ▶ Full risk is usually accepted only by employers with thousands of employees.



Components of Health Insurance Rates





Questions and Answers

- ◆ This presentation expresses the views of the author and does not necessarily express the views of Gabriel, Roeder, Smith & Company.

Help Preserve Cost-Effective Locally Run Health Care

Almost two decades ago, the MSU unions recognized the impact health care costs were having on the University. While other employers focused on shifting health care costs to employees, we bargained a formal partnership with the University to decrease the overall amount MSU spends on health care. In the absence of much needed broader structural reform, we began a process of reforming our internal processes and all other aspects of health care procurement, delivery and administrative practices we are able to influence from our position as employer/purchaser and employee/consumer, and we continue that important work today.

Our partnership approach has driven cost down. MSU spends \$50 Million less on health care today as a direct result of this partnership and MSU employees have avoided a great deal of the major cost shifts many other workers have experienced. By taking “ownership” of the problem and investing into a process by setting our own priorities, when sacrifice has been unavoidable we’ve determined how and what to sacrifice, and we have been able to maintain a health care benefit that provides access to quality, affordable health care to the benefit of the employees and the institution.

This wasn’t done without sacrifice. MSU employees have contributed a fair share toward paying the health care cost in the process. We have accepted direct cost shifting when doing so would steer people to using more cost effective products and services. We’ve implemented benefit design changes to lower the overall spend without causing people to forego necessary care, and we’ve recognized the economic relationship between health care and employee compensation in direct, tangible and measurable ways.

A mandatory state government-run health plan would take the ability to continue achieving these results away from MSU’s control and in all likelihood increase pressures to raise taxes and tuition to pay for an unnecessary bureaucracy.

We understand why this proposal can sound good. However, it really is not a good idea for a variety of reasons including but not limited to:

- Medical services in the State are very regionalized. What works in Lansing, may not work in Detroit or in the UP and vice versa. Choice of insurance companies, plans, networks, hospitals, etc. can make a big difference on costs by region.
- If we become part of a mega health plan across the State, we will lose the cost containment and control programs that MSU employs.
- It may end up costing MSU more money. This proposal of mandatory state regulated health benefits does not address the increasing cost of health care. It only shifts the payer of the cost and what is paid for.

We work every day to contain and bring health care cost down. We have years of experience evaluating health care cost containment and control strategies and proposals. After careful examination, we have to conclude the unfortunate truth is that this proposal cannot deliver its projected savings.

We can all agree on the need for reform. The real question is: Will how you approach this problem do anything to address the issues, or will spending time and money on making revisions – which will not produce needed relief – make things worse in the long term? This proposal will do just that – make a bad situation worse in the long term.



Background

AFSCME LOCAL 999
 AFSCME LOCAL 1585
 APA, MEA/NEA
 APSA
 CTU OF MSU
 FOP LODGE 141-Sergeants
 FOP LODGE 141-Officers
 GEU/AFT
 IATSE 274
 IUOE LOCAL 324

Structure

The Coalition Labor Organizations at MSU formally consists of the authorized representatives of each of the ten unions recognized by Michigan State University. Originally formed in the early 1980s to address health care, its primary focus remains on that issue. Each participant union holds an equal voice in the Coalition and none of the participants yield or cede their individual rights or obligations in representing their constituency.

In 1997, Michigan State University recognized the Coalition as the official representative of nine participating MSU unions for the purpose of bargaining health care. The nine unions, representing about 5,400 MSU employees are: Administrative Professional Association, MEA/NEA; Administrative Professional Supervisors Association; Clerical-Technical Union of MSU; Fraternal Order of Police–Officers; Fraternal Order of Police–Sergeants; International Association of Theatrical Stage Employees Local 274; International Union of Operating Engineers Local 324; American Federation of State, County and Municipal Employees (AFSCME) Local 999; AFSCME Local 1585. A tenth MSU union, the Graduate Employees Association negotiates a separate health care agreement.

The Coalition serves as a conduit by which the individual participants may coordinate efforts with the other unions, and participation is entirely voluntary. The Coalition has no binding authority over the individual participants. The Coalition serves the participants in two major ways: as a network for sharing information and resources in any and all matters and as a vehicle for consolidating the influence of all MSU employees in matters of common interest.

Mission Statement

The Mission of the Coalition of Labor Organizations at MSU is:

- to promote and protect the benefits and security of all MSU employees by applying the combined information, resources and influence of each member union in areas of common concern and
- to maintain the good and welfare of organized labor at MSU by providing a forum for mutual aid and support.

Vision Statement

All employees, being stakeholders in the future of Michigan State University recognize the link between their personal prosperity and the success of the institution. We believe that to our mutual benefit, labor united can further that success by participating in the process of developing long-term solutions to the difficult problems we share in common with University Administration.