Health Cost Containment and Efficiencies

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Pooling Public Employee Health Care

Cost Containment Strategy and Logic

Pooled public employee health benefit programs refer to efforts to merge or combine state employee health insurance with that of other public agencies and programs. About half the states have opened participation in their state employee health benefit plans to other public-sector employers, such as school districts or cities and counties. Two states have piloted programs to allow private sector employers to join their state employee pools.

Some public purchasers regularly try to lower overall administrative costs and negotiate lower prices from providers and insurers using their large numbers of enrollees as a bargaining tool. Health costs are controlled by using size, volume purchases and professional expertise to:

- Minimize and combine administrative and marketing costs;
- Facilitate negotiations with health insurers for more favorable premium rates and broader benefit packages; and
- Relieve individual employers of the burden of choosing plans and negotiating coverage and payment details.

In addition to cost containment and simplification, multi-agency purchasing arrangements also can give employees more choices of health benefit plans. This option often is not available if each smaller agency were to obtain coverage independently.[1]

Small public employer groups often benefit the most from purchasing pools and alliances. As Figure 1 illustrates, the larger the employer group, the lower the percentage of the health premium devoted to administrative costs versus medical care payments.

Target of Cost Containment

Small and medium-sized employers are at a decided disadvantage compared to the much larger state governments. Smaller groups that join existing state pools or join to form a purchasing alliance may be able to obtain coverage at a lower cost than if they purchased it through the open market. Proponents of public employer health purchasing pools note that small local governments and local public entities (fire districts or school districts, for example) often lack the volume and personnel expertise to obtain favorable rates.

In the past three years, for example, policy leaders in Connecticut, Michigan, New Jersey and Washington have sought to create large-scale health insurance employee pools as a major element of health cost containment.

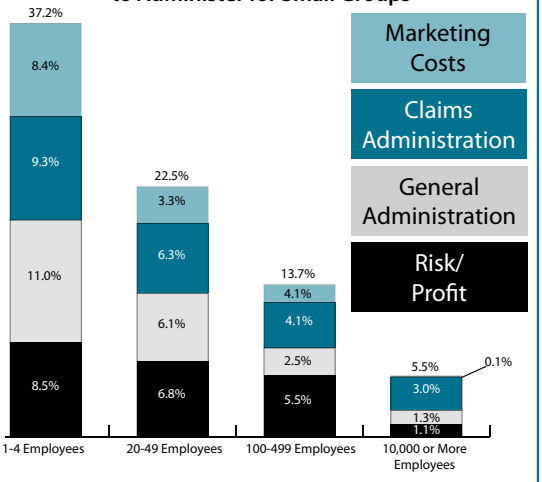
Combining small employer groups into large state employee pools can save up to 15 percent in administrative costs for small employers that join. Direct savings by states is not widely documented.

State employee health benefit programs already command a significant and relatively stable segment of the health insurance market; several benefit programs are the largest employers in their states. The programs have high-level, qualified personnel managers and negotiators and can take advantage of their size and expertise to negotiate rates and work with multiple insurers. The combined state-plus-local pooled programs can also use their large enrolled population to negotiate establishing innovative health programs such as wellness and prevention, tobacco cessation plans, electronic health records and provider incentive copayments. These prevention and modernization programs also aim to contain health costs, leading to an ideal of dual or multiple savings within the pooled programs.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 2010, includes several new federal insurance rules that take effect starting in October 2010 or later, at the start of an ex-

Figure 1. Insurance Is More Costly to Administer for Small Groups



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

isting insurance plan year. The rules include prohibiting insurers from imposing lifetime limits on benefits and restrictions on the use of annual limits. Unmarried children will be able to remain on their parents' health plan until they reach age 26. Existing public employer plans can seek "grandfathered" plan status, which locks in certain benefits and out-of-pocket charges. Creation of health exchanges by 2014 also may affect public employee health plans. Because states have special status as employers, there are legal issues that affect which federal reform provisions apply to state government. Future information and guidance will be posted online by NCSL (http://www.ncsl.org/?tabid=19932).

State Examples

At least 24 states currently authorize other public employees to combine with state employees and retirees to create a larger insurance pool (Table 1). Of these, 11 states pool all members for health status or "rating" to spread premium costs among all or most employers and employees. Local public employer participation is optional in all but two states. In practice, some municipalities or local agencies join, while others choose to find their own coverage. California, Louisiana, New Jersey, New Mexico, North Carolina, South Carolina, Utah, Washington and West Virginia have substantial combined enrollment, adding 20 percent or more of local workers to the pooled total.

Table 1. State Employee Health Plans that Include Local Governments

State	Local Government Employees Covered by State Employee Plan	R
Arkansas (since 2003)	School employees	
California (since 1967)	Municipal employees	R
Delaware	Municipal employees	R
Florida	School employees	
Georgia	Municipal; all school employees	R
Hawaii	Municipal and school employees	
Illinois	Municipal employees	
Kentucky	School employees	R
Louisiana (since 1980)	School employees	R
Maryland	Municipal employees	
Massachusetts (since 2007)	Municipal employees	R
Mississippi	School employees	
Missouri	Municipal and school employees	
Nevada	Municipal and school employees	
New Jersey (since 1964)	Municipal and school employees	
New Mexico	Municipal employees.	R
New York (since 1958)	Municipal and school employees	R
North Carolina	All school employees	R
South Carolina	Municipal and school employees	R
Tennessee	Municipal and school employees	
Utah (since 1977)	Municipal and school employees	
Washington	Municipal and school employees	R
West Virginia (since 1988)	Municipal and school employees	
Wisconsin	Municipal employees	

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

California attributes $40 million in annual premium savings for the overall plan to local participation.

- California: The California Public Employees' Retirement System (CalPERS) provides both health and retiree benefit services and manages health benefits for nearly 1.3 million members. Thirty-one percent of enrollees are state employees, 38 percent are school employees and 31 percent are local public agency employees. CalPERS reported that "local participation greatly increases the state's buying power."[2]

- New Jersey: Although local participation is optional, about 50 percent of the state plan's 780,000 enrolled members work for municipal employers.

- West Virginia: West Virginia's Public Employees Insurance Agency (PEIA), which covers both local jurisdictions and state employees,[3] has a public/private partnership with insurance companies that choose to offer the plan. Results are described below under "Evidence of Effectiveness."

State Proposals not Enacted

- In 2009-10, Michigan House leaders proposed a comprehensive multi-agency pooled plan aimed at covering all local and school public employees. The Michigan House published *An In-Depth Look at the Michigan Health Benefits Program* in September 2009 as part of an evaluation of the benefits and cost savings of pooling all public employees into a single program. The report indicated an estimated potential annual savings of $200 million due to pooling and further savings from quality initiatives.

- Connecticut's Health Partnership Act (House Bill 5536), passed in 2008 and 2009 but vetoed twice by the governor, would have allowed 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. With consent of the State Employees' Bargaining Agent Coalition, all new employees would have been pooled with state employees in the state insurance. The act would have required the agency to provide insurance for employers that seek to cover all their employees or retirees.[4] Program features would have been similar to those for Medicaid and children's health "HUSKY" enrollees.

Evidence of Effectiveness

It is not clear whether purchasing pools have slowed the growth in premium costs overall; the evidence is mixed. It appears that including small employer groups in large state employee pools may benefit the small employers that join.

A 2008 study by the Lewin Group noted, "Given that state governments are typically the largest employer group in any given state, state employee health plans (SEHPs) are responsible for a

large volume of health care purchasing. This can yield considerable influence in negotiations with participating health plans and provider groups, in terms of encouraging their participation in quality improvement, cost containment, and related initiatives. In addition, SEHPs may be in a position to combine their quality improvement activities and strategies with other large public and private sector purchasers, including Medicaid, other public programs, and private health plans and employer groups. The combined market leverage of such coalitions can enhance SEHPs' purchasing advantage and help to coordinate state-level quality promotion activities."[5]

- Some documented evidence shows modest and, in at least one case, substantial cost savings to small and medium employers by combining a large number of in-state agencies and entities into a single administrative and insurance purchasing pool covering from 100,000 to 1.6 million enrollees.

- In 42 states, the state pool is "self-insured," which can save between 5 percent and 6 percent in administrative costs, compared to benefits that are fully insured through outside companies. A better negotiating position sometimes can result in modestly better benefits (such as a lower office visit copayment), although most states have not seen lower premium costs.

- California evaluated how local government membership in the state program affects costs. California Public Employees Retirement System (CalPERS) officials indicate that adding 490,000 local government employees reduced the state plan's annual premium costs by approximately $40 million per year.

- The West Virginia Public Employee Insurance Agency (PEIA) sets its own provider reimbursement rates, which are approximately 20 percent to 25 percent lower than private market rates. The program's total administrative expenses were 5 percent for FY 2008; medical and pharmaceutical expenses represented 95 percent of total expense. A non-pooled town or district with 200 employees would expect to pay administrative costs of 12 percent to13 percent. The savings apply to 602 local and regional public agencies with a total of 52,000 employees plus other dependents.

- West Virginia also created a Small Business Plan. According to its 2010 website, "Participating insurance carriers use PEIA payment rates for doctors and other health care providers; this is the key to making Small Business Plan premium rates lower than standard rates, typically ranging between 17 percent and 22 percent less than regular small business rates;" however, they caution, "rates and discounts will depend on the profile of each small business."

- Utah's Public Employee Health Plan (PEHP) includes approximately 52 percent of eligible local governments, including service districts, counties and public schools; the fact that they joined voluntarily indicates favorable terms and savings.[6]

- Massachusetts enacted legislation in 2007 that allowed all municipalities to combine with state workers to purchase insurance. Statewide savings of $225 million were estimated by FY 2010 and of $750 million by FY 2013. As of August 2009, however, only 17 of 351 towns were participating. Savings statewide have not yet been documented.

- South Carolina law requires state employees and retirees plus public school districts and public colleges and universities to obtain coverage through the state health plan; as a result nearly 10 percent of the state's population is covered by the plan.

- North Carolina is the largest example of mandatory combined local and state participation, covering 667,000 state and local employees and retirees.

Complementary Strategies

- Several states have created a combined health care purchasing agency that includes Medicaid, state employees and other agencies. Examples include the Kansas Health Policy Authority in 2005, the Oklahoma Health Care Authority in 1993 and the Georgia Department of Community Health. Although state and local employees are not "pooled" with Medicaid, the joint administration under one management structure results in "combining the state's purchasing power."[7]

- Some state employee programs have become leaders in demanding quality and efficiency in purchasing insurance. Examples of state plan innovations include promoting provider adherence to clinical guidelines and best practices, publicly disseminating provider performance information, implementing performance-based incentives, developing coordinated care interventions, and participating in multi-payer quality coalitions.[8]

- Louisiana, South Carolina and Washington review the claims history of local entities that seek to join with state employee programs and, if the risk history is higher than the existing pool, the new local member is charged a higher rate (usually for a limited period) to cover the risk. Although this approach is a cost shift, not savings, it illustrates how states can protect against higher charges.[9]

Challenges

- Lower-than-expected participation rates by local governments were examined in a nationwide analysis in 2008. The results pointed to a number of reasons, including:
  - Local governments had other affordable coverage options;
  - State plan requirements made it difficult for some local governments to join;

- Some municipalities would rather have a less comprehensive (and less expensive) plan than that offered by the state;
- Some local governments prefer keeping local control of their health plans; and
- One state placed a moratorium on new members.[10]

- Existing state employer programs may be concerned that having local agencies as members could result in "adverse selection" that could lead to higher premiums if employees are older or sicker than original pool members.

- Traditions of local autonomy and collective bargaining can mean less willingness to change or opposition to formation of multi-employer pools.[11]

For More Information

Cauchi, Richard. *State Employee Health Benefits*. Denver: NCSL, 2010.

Commonwealth Fund. "What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States." Washington, D.C.: Commonwealth Fund, 2008; http://www.commonwealthfund.org/usr_doc/McKethan_whatpublicemployeehltplanscando_1097.pdf?section=4039.

Connecticut Office of Legislative Research. "Impact of Pooling State and Local Employee Health Insurance In Other States." Hartford: Connecticut Office of Legislative Research, Aug. 29, 2008; http://www.cga.ct.gov/2008/rpt/2008-R-0463.htm.

NCSL will post supplemental materials and 2010 updates on this topic online at http://www.ncsl.org/?tabid=19932.

Notes

1. Another type of multi-employer purchasing arrangement is the state purchasing alliances for small business employers. These are discussed in another NCSL publication: Richard Cauchi, *Purchasing Alliances and Cooperatives for State Health Insurance* (Denver: National Conference of State Legislatures, Nov. 12, 2009); http://www.ncsl.org/default.aspx?tabid=18905.

2. Connecticut Office of Legislative Research, *Impact of Pooling State and Local Employee Health Insurance in Other States* (Hartford: Connecticut Office of Legislative Research, Aug. 29, 2008); http://www.cga.ct.gov/2008/rpt/2008-R-0463.htm.

3. As of mid- June 2008, West Virginia PEIA provided health coverage to 119 state agency divisions with approximately 21,000 primary participants (not including dependents), 55 county school boards with approximately 32,000 primary participants, 524 local government entities with approximately 10,000 primary participants, and 23 college and university entities with approximately 10,000 primary participants. Approximately 88,000 dependents also participated in PEIA health plans. West Virginia Public Employee Insurance Agency, *Comprehensive Annual Financial Report 2008* (Charleston, W.V.: West Virginia Public Employee Insurance Agency, 2008); http://www.peia.wv.gov/forms-and-downloads/Documents/financial%20reports/cafr/Comprehensive_Annual_Financial_Report_2008.pdf.

4. An earlier Connecticut law (Public Act 03-149 of 2003) authorized 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 in June 2003.

5. Commonwealth Fund, *What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States* (New York: Commonwealth Fund, 2008); http://www.commonwealthfund.org/usr_doc/McKethan_whatpublicemployeehltplanscando_1097.pdf?section=4039.

6. Connecticut Office of Legislative Research, *Impact of Pooling State and Local Employee Health Insurance in Other States.*

7. State Coverage Initiatives, "Value-Based Purchasing and Consumer Engagement Strategies in State Employee Health Plans – A Purchaser Guide (Washington, D.C.: State Coverage Initiatives, May 13, 2010); http://www.statecoverage.org/node/2335.

8. Commonwealth Fund, *What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States*.

9. Ibid.

10. Ibid.

11. For example, the Michigan multi-agency pooled plan was formally opposed by local school employees and associations.

About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

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