Introduction

Virtually all full-time state government workers are eligible to participate in employer-provided health plans and are given access to the same health plan in retirement. The rising cost of health care has rapidly increased the total expense to public sector employers of providing health insurance. These costs have also risen as a proportion of payroll and as a percentage of state budgets. Moreover, state governments are facing staggering levels of unfunded actuarially accrued liabilities associated with the provision of retiree health insurance. This issue brief provides a detailed analysis of the health plans in three large states, California, North Carolina, and Ohio. In addition to documenting the rising costs, this brief reviews recent changes in plans and policy options to help contain expenditures on health insurance.
The provision of health insurance to current and retired state employees has become a major public policy issue in many states. The combined forces of an aging public sector workforce, the increases in the ratio of retirees to active workers, and the relentless increase in the cost of medical care continue to drive up the cost of providing health insurance to active and retired state employees. Increases in the annual cost of health insurance and substantial growth in the unfunded liabilities associated with retiree health plans are forcing many states to reevaluate their current programs and make fundamental changes to reduce current costs and future liabilities of health plans.

A recent survey of state administrators and policy makers found that state leaders were aware of the importance of medical benefits to human resource goals but were very concerned about the rising cost of these plans (Daley and Coggburn, 2008). The survey found that most states had adopted or were considering adopting cost containment policies along with methods of shifting an increasing proportion of the total cost of health insurance to workers. Plans for specific changes included the adoption of wellness programs and health savings accounts, along with requiring a higher premium for individuals, greater deductibles, and increased co-payments. To further examine changes by specific states, this issue brief examines how three large states, California, North Carolina, and Ohio, have responded to rising annual costs. The increase in the cost of providing health insurance to active and retired workers is analyzed, along with any changes in health plans that have been adopted to slow the rate of growth of the cost of this employee benefit.

Cost Sharing

Virtually all full-time teachers and state employees are covered by employer-provided health insurance. Typically, employees pay a small portion of the total premium for their own coverage and a somewhat larger percent of the total cost for spousal and dependent coverage. The BLS (2009) found that, on average, state and local employees were required to pay 10 percent of the total premium; however, on average, state and local workers pay about 27 percent of the total premium for family coverage. In addition to health insurance coverage while actively employed, most of these public employees also have the ability to continue their health insurance coverage in retirement.

Nationally, the total cost of employee health premiums for state employees in 2009 averaged $474 per month, with employees paying an average of 8 percent of the total cost for individual coverage. Data from a survey by the National Conference of State Legislatures found that in 2009, the average total premium for family coverage was $1,062 per month, with employees paying an average of 18 percent of the total premium (Cauchi, 2009).

The cost of providing health insurance to public employees and retirees has been increasing rapidly as a percent of payroll and as a proportion of the state budget, thus placing pressure on state budgets. The Kaiser Family Foundation (2010) reported that average annual health insurance premiums increased from $6,438 in 2000 to $13,770 in 2010, an increase of 114 percent. As a result of cost shifting, employer contributions as a percent of the total premium fell from 75 percent to...
71 percent. Premiums for public employees were slightly higher than comparable plans for workers in other sectors of the economy. Ultimately these costs may limit the ability of states to fund other priorities.

The premiums for retiree coverage are normally based on a combined pool of workers and retirees. Thus, the cost for retiree coverage is understated by the premium. Spouse premiums are also usually calculated using a common risk pool for spouses of both active and non-Medicare eligible spouses. In these cases, risk pooling leads to significant adverse selection into the risk pool and results in claiming retirees paying a lower premium than the true cost of this coverage, since spouses and dependents of active workers tend to have lower costs.

**GASB and Unfunded Liabilities**

Until recently, the liabilities associated with extending subsidized access to the state health plan to retirees was not well understood or clearly quantified. In 2004, the Governmental Accounting Standards Board issued statements that required public employers to prepare actuarial statements that reported the actuarial accrued liabilities (AAL) of retiree health plans, assets (if any) that are invested in an irrevocable trust, unfunded actuarial accrued liabilities (UAAL) which is equal to AAL minus assets, and the annual required contribution (ARC) necessary to move the plan toward full funding, typically over a 30-year period. Data from these actuarial reports have been front page news in many states and resulted in many states taking a closer look at the cost retiree health plans and how these plans are financed.

Many states have undertaken plan design modifications or instituted wellness programs in attempts to curb the growing costs of health insurance. This issue brief considers the history and current status of health insurance plans for public employees and retirees in California, North Carolina, and Ohio. It reports the actual and projected costs of health insurance and how they have changed over time in these states. It also examines the policy implications of the annual cost of health insurance and what changes these states have made in response to rising costs. The concluding section discusses how the experiences of these states might inform the debate in other states.

**California**

In 1962, the California legislature enacted the Public Employees’ Medical and Hospital Care Act, which authorized the State Employees’ Retirement System (CalPERS) to begin providing health benefits to state employees and retirees. The state paid most of the cost of employee and retiree health insurance at that time, with an employer premium of $5 per month. Total cost of health insurance in 1961–62 was $4.8 million or 0.3 percent of General Fund spending. Beginning in 1974, the state set its contribution to be 80 percent of the premium for current and retired employees and 60 percent of the premium for dependent coverage. The state share of the premiums was increased to 100 percent for workers and retirees and to 90 percent for dependents in 1978 (California Legislative Analyst’s Office, 2007).

This state retirement plan was subsequently reorganized into the California Public Employees Retirement System (CalPERS). Participants are offered their choice of three health maintenance organization (HMO) plans, three preferred provider organization (PPO) plans, and three special PPOs for certain members of specific employee associations. More than two-thirds of the participants are enrolled in one of the HMO plans. In 2011, CalPERS manages health benefits for approximately 1.3 million active and retired state and local government employees and their dependents. The total cost of this plan is expected to exceed $6.67 billion in 2011, up from $5.83 billion in 2009.

**Health Insurance for Retired State Employees**

Currently, the state pays 100 percent of the premium for qualified retirees and 90 percent of the premium for dependent coverage for retirees who were first employed prior to 1985. Retirees must enroll in Medicare when they become eligible and the state plan then becomes secondary to Medicare coverage. The state premium is based on coverage of one of several basic plans. If the retiree selects another of the plan options, she would have to pay the difference in the premium between the basic plan and the chosen plan. Employees hired after 1985 must have been employed for a minimum of 10 years to be eligible for health coverage through the state plan, with the state paying 50 percent of the premium for those with exactly 10 years of employment. The proportion of the premium paid by the state increases by 5 percentage points for each year of service up to a maximum of 100 percent paid by the state for those with 20 or more years of service.

The cost of the retiree health plan has been rapidly increasing from around $300 million in 1998–1999 to more than $1.0 billion in 2006–07 (California Legisla-
vive Analyst’s Office, 2007). Increases can be attributed to national trends in health care costs, employer health premiums in California rising faster than the national average, and the growing number of retirees. In fiscal year 2010–2011, premiums for health insurance were $9,554 annually or $796 per month. During this same time the total cost of retiree health insurance was $1.4 billion, up from a total of only $387 million in 2000.

The actuarial evaluation reports for the California retiree health plan show the rapid increase in liabilities associated with this benefit. The 2007 actuarial statement showed that accrued liabilities (AAL) were $47.9 billion. Since the state had no assets set aside for this benefit, the UAAL was also $47.9 billion with an annual required contribution (ARC) of $3.6 billion. By 2010, the AAL had risen to $59.9 billion or an increase of 25 percent in three years. The UAAL was also $59.9 billion and the ARC in 2011 was projected to be $4.2 billion (see Table 1).

An interesting fiscal comparison is shown in the 2010 actuarial report, which includes a comparison of the 2009 values to those of 2010. The AAL increased by more than $8 billion in this one year. Based on the 2009 assumptions, the AAL was expected to increase to $54.8 billion in 2010. The additional increase in liabilities was primarily due to resetting of the health care cost trend10 ($1.3 billion) and changes in demographic assumptions due to an updating of the mortality table used to calculate future health care costs ($3.14 billion).11

### Plan Changes

On April 4, 1995, Executive Order W-119-95 was signed, based on recognition of the need for improved physical and mental well-being of the state workforce. According to this document, the desired increase in well-being could be achieved through areas such as preventive medicine, diet, exercise, stress management, smoking cessation, drug and alcohol avoidance, and accident prevention. Further, the document argued that by creating a healthier workforce the state will see higher quality work and productivity from employees, improved morale, reduced absenteeism due to illness, and lower health care costs.

The Department of Personnel Administration (DPA) coordinates health and fitness promotion and illness prevention information. Executive Order W-119-95 directed each state department to allocate resources to coordinate participation in the California WorksWell Health Promotion Program (DPA Health Promotion Program) to achieve the goals of improved employee health and well-being. California WorksWell now offers reduced membership rates at various health clubs (more than 2,200) throughout the state for state employees. It also offers discounts for weight loss programs. The program’s website lists resources for disease prevention and tips for a healthy lifestyle, including nutrition, weight management, and fitness resources.

Beginning in 2004, CalPERS initiated a series of measures in the hope of containing cost increases and improving health outcomes for members. New policies included promoting hospital performance transparency and managing hospital costs, eliminating high cost hospitals from the Blue Shield network, adjusting premiums for regional markets, encouraging the use of generic drugs, adding new lower-cost health plans, and adopting a series of wellness programs.

### North Carolina

The State Health Plan of North Carolina (SHP) provides health insurance to qualified teachers, state employees, and retirees, with no employee premium. In addition, members of the plan may purchase dependent coverage, but the individual must pay 100 percent of the premium.

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAL</td>
<td>47.88</td>
<td>48.22</td>
<td>51.82</td>
<td>59.91</td>
<td></td>
</tr>
<tr>
<td>Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>UAAL</td>
<td>47.88</td>
<td>48.22</td>
<td>51.82</td>
<td>59.91</td>
<td></td>
</tr>
<tr>
<td>UAAL/Payroll (percent)</td>
<td>267</td>
<td>270</td>
<td>281</td>
<td>341</td>
<td></td>
</tr>
<tr>
<td>ARC</td>
<td>3.59</td>
<td>3.72</td>
<td>3.91</td>
<td>4.17</td>
<td></td>
</tr>
</tbody>
</table>

* Variables are for fiscal year ending June 30.

Total plan expense in fiscal year 2010 was $2.56 billion and is projected to increase to $2.73 billion in FY 2011.\textsuperscript{12} The SHP of North Carolina was established in 1972 to provide health insurance to teachers and state employees.\textsuperscript{13} Initially, the appropriation by the legislature for health insurance was not to exceed $10 per month for each employee. In 1974, soon after the health plan was established, the state began allowing retired employees who were receiving a retirement benefit to remain in the health plan. In the early years, the retiree had to pay the full premium for health insurance coverage. In 1976, the state created a separate insurance benefit for Medicare eligible retirees and began requiring retirees to also enroll in Medicare, which becomes the primary payer, when they became eligible to do so. In 1978, the state appropriated sufficient funds to pay the full premium for retirees, thus making retiree health insurance non-contributory. In 1982, the state created the self-funded SHP and specified in statute that retiree coverage was non-contributory.

In fiscal year 2010–11, active and retired employees were given the choice of enrolling in one of two options provided by the SHP. Both options are PPOs, with the primary difference between the plans being the level of co-payments and deductibles and the cost of purchasing dependent coverage.\textsuperscript{14} During this time period the cost to the state (i.e., the premium) is $410.80 per month per participant in both plans. The cost to the state in 2009–10 was $377.22, yielding a one-year increase in the cost to the state of $33.58 per person per month, or 8.9 percent. Table 2 shows that total expenditures for the SHP were $2.6 billion in 2009. This represented 17.1 percent of annual payroll. The annual cost of the expenditures for the SHP represented 5.7 percent of the state budget.

### Table 2. Total Expenditures by the State of North Carolina for the State Health Plan: 2009*

<table>
<thead>
<tr>
<th>Cost of Health Plan (millions)</th>
<th>$2,625 (FY 2008–2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Payroll (millions)</td>
<td>$15,364 (December 2009)</td>
</tr>
<tr>
<td>State Budget (millions)*</td>
<td>$46,375 (Fiscal 2009–2010)</td>
</tr>
<tr>
<td>Health Expenditures/State Payroll</td>
<td>17.1%</td>
</tr>
<tr>
<td>Payroll/Budget</td>
<td>33.1%</td>
</tr>
<tr>
<td>Health Expenditures/State Budget</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

* The budget represents appropriations for the general fund and revenues from the highway fund, the federal government, and all other sources.

Source: Estimate for the cost of the SHP is from a presentation on the SHP website (August 12, 2010). Data on the state payroll was provided by David Vanderweide, Fiscal Analyst, North Carolina General Assembly, while state budget data is from the Office of the State Budget and Management (2009).

Health Insurance for Retired State Employees

Retired teachers and state employees are allowed to continue their participation in the North Carolina State Health Plan (SHP). Upon becoming eligible, retirees must enroll in Medicare. Medicare becomes the primary payer for these individuals, thus reducing the cost to the state of providing what becomes supplemental health insurance. Since the plan was implemented, the ratio of retirees to workers increased, health care expenditures per person rose, and life expectancy increased. As the magnitude of the cost of this benefit increased, state policy makers began to focus on the escalating costs, especially for employees who had relatively short careers with the state. Recognition of the rising cost of lifetime coverage for workers and the substantial cost of this benefit relative to their service for workers with only a few years of employment, led the legislature to adopt changes in the eligibility requirements in 2006. Workers hired after 2006, who retire with five years of service but less than 10 years of retirement service credit, are eligible to remain in the SHP if they pay the full premium for the health insurance. Retirees with 10 to 19 years of service must pay 50 percent of the individual coverage premium to remain in the state health plan, while employees with 20 or more years of service continue to have access to the health plan without paying any premium. Since the change in eligibility standards applies only to persons hired after 2006, the short-term impact of this change has only a modest effect on current cost and the accrued liabilities of the NC health plan.\textsuperscript{15}

The first GASB 45 statement in North Carolina covered the plan as of December 31, 2005. The actuarial statement indicated the AAL was $23.9 billion and that the state had assets of only $139 million in reserve. Thus, the state had unfunded actuarial accrued liabilities (UAAL) of $23.8 billion. Subsequent reports covering the years 2007, 2008, and 2009 show a substantial increase in the UAAL of the state to $32.8 billion in 2009, an increase of $9 billion (38 percent) in five years. Table 3 shows the increase in these values between 2005 and 2009.

The annual cost of providing coverage to retirees has increased rapidly over the past three decades. In 1984, premiums for retirees were $23.3 million. By
1990, state expenditures had increased to $70.8 million and, by 2000, the employer cost of premiums for retirees reached $192.0 million. Annual costs have more than tripled in the last decade and in 2010 totaled $616.0 million. The rate of increase in the annual cost of retiree health insurance has outpaced the growth of the state budget. As a result, the proportion of the state budget devoted to retiree health insurance has increased from 1.14 percent in 1995 to 2.82 percent in 2010, roughly a 147 percent increase over 14 years.

In North Carolina, retirees and active workers are part of the same plan, so that changes made to the SHP should affect the UAAL associated with retiree health insurance provision. In 2007, the state eliminated the option of an indemnity plan; however, this change also had a negligible effect on future costs. The most significant changes were adopted in 2008 (effective July 1, 2009), when substantive modifications were made to the Basic and Standard PPOs. In total, these plan changes lowered the UAAL by $1.26 billion. At the same time, the Plus PPO was eliminated, which reduced the projected UAAL by another $486 million. As discussed further below, these types of changes had a clear impact on the projected actuarially accrued liabilities associated with the provision of retiree health insurance.

**Plan Changes**

Over time, the per person cost of providing health insurance to active employees has risen rapidly and the rate of increase has exceeded the rate of growth of payroll and the state budget. In fiscal year 1997–98, the individual premium, or the employer cost of health insurance coverage, was $144.60. This had risen to $410.80 in 2010–11, an increase of 284.1 percent over 12 years. Initially, the state health plan was a traditional fee for service or indemnity plan. As the cost of providing health insurance outstripped the growth in revenues, the state modified its plan by adopting various types of managed care plans. First, HMO options were provided and then PPOs were introduced. In 2007, the state dropped the indemnity plan and in 2008 the state eliminated the most generous and expensive PPO options, a plan that had a co-insurance of only 10 percent. The primary objective of these changes was to lower the cost to the state of providing health insurance to its employees and retirees. Even as the cost of providing health care has risen over time, the SHP has not yet required employees or qualified retirees to pay any premium for health insurance coverage.

In an effort to slow the rise of the cost of the SHP, the legislature instituted a series of wellness programs to encourage and assist individuals to quit smoking, exercise, and reduce their weight. Smokers were required to enroll in the Basic Plan with higher co-insurance payments. In 2011, the governor proposed adding a premium for state employees for the Standard Plan and for shifting administration of the SHP to the Office of the State Treasurer. The General Assembly then passed legislation calling for a premium to be paid by employees for both health plans and also repealing the wellness initiatives. The governor vetoed the bill and the General Assembly was unable to override her veto. At present, the General Assembly is considering new legislation to reform the SHP.

Recent legislation in North Carolina, enacted in the 2011 session of the General Assembly, fundamentally alters the management of the SHP and authorizes it to impose employee premiums for the first time.

The legislation moves the administration of the SHP from a committee of the General Assembly to the Office of the State Treasurer. Going forward, the General Assembly will authorize a specified amount of funding for the employer contribution for health insurance for state employees and teachers and retirees. If these

**Table 3. Retiree Health Insurance Liabilities in North Carolina**

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAL (billions)</td>
<td>$23.9</td>
<td>$28.9</td>
<td>$28.3</td>
<td>$33.3</td>
</tr>
<tr>
<td>Assets (billions)</td>
<td>$0.14</td>
<td>$0.30</td>
<td>$0.44</td>
<td>$0.56</td>
</tr>
<tr>
<td>UAAL (billions)</td>
<td>$23.8</td>
<td>$28.6</td>
<td>$27.9</td>
<td>$32.8</td>
</tr>
<tr>
<td>UAAL/Payroll</td>
<td>192.4%</td>
<td>193.1%</td>
<td>182.1%</td>
<td>216.5%</td>
</tr>
<tr>
<td>Funding Ratio</td>
<td>0.6%</td>
<td>1.0%</td>
<td>1.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>ARC (billions)</td>
<td>$2.4</td>
<td>$2.7</td>
<td>$2.7</td>
<td>$3.0</td>
</tr>
<tr>
<td>ARC/Payroll</td>
<td>19.3%</td>
<td>18.0%</td>
<td>17.5%</td>
<td>19.9%</td>
</tr>
</tbody>
</table>

Source: Actuarial reports of the postemployment medical plan for retired teachers and state employees of North Carolina, prepared by Aon Hewitt.
funds are not sufficient to cover the cost of health insurance, the Board of the SHP and the State Treasurer have the authority to impose employee contributions for both the Basic and Standard health plans to fill the budgetary shortfall; the plan managers could also increase deductibles, co-payments, and co-insurance in order to moderate any premium increases. Retirees enrolling in the Standard plans could be charged a similar premium but the Basic plan will remain available to retirees at no premium.

Based on current cost projections, it is anticipated that the Basic plan will be available to employees with no premium contribution in both FY 2011–12 and FY 2012–13. However, in future years, if the General Assembly increases funds for the employer contribution at a rate less than the rate of increase in the cost of the plan, the State Treasurer and the Board of the State Health Plan will need to impose a premium on health coverage for state employees.17

Ohio18

According to 2008 Census data, the state of Ohio and local governments in the state employed a total of 750,760 people. Of those employees, 539,008 were full-time employees receiving a net total pay of $2,188,567,523 per month and 211,752 were part-time employees paid a total of $208,806,484 per month. More than 54 percent of those employees, or 409,618 employees, worked in education or higher education.

In Ohio, each state employee has a choice of five state health care providers.19 Employees have the option to select a PPO or an HMO. All of the plans have co-payments of $20 per visit and co-insurance of 20 percent of costs, and have annual deductibles of $200 for single coverage and $400 for family coverage. Full-time employees pay 15 percent of the premium as established by the state for single coverage. In 2011, the employee premium was between $63 and $73 per month, depending on the provider chosen by the employee.

Interestingly, Ohio also allows part-time employees to participate in the state health plan. The proportion of the premium that part-time employees must pay for coverage depends on the number of hours they work in a two-week period: employees who work less than 40 hours pay 100 percent of the premium; those who work 40 to 59 hours pay 50 percent of the premium; and those who work 60 to 79 hours pay 25 percent of the premium. Family coverage is also available and is partially subsidized by the state with the employee paying approximately 15 percent of the total premium (Ohio DAS).

Health Insurance for Retired State Employees

Retiree health insurance began in 1974. Individuals who worked for at least 10 years for an Ohio Public Employees Retirement System (OPERS) employer can apply for coverage under the OPERS health plan at the time of retirement.20 Retirees are offered three levels of coverage: enhanced, intermediate, and basic.21 In the enhanced plan, the deductible is $700 and in-network co-insurance is 80 percent. Deductibles are higher but co-insurance payments are lower in the other plans. Medicare eligible retirees are offered the opportunity to enroll in the Humana Medicare Advantage Plan. This plan has a $250 deductible for single retirees. In addition, OPERS partners with Express Scripts to offer Medicare eligible retirees the OPERS Medicare Part D prescription plan. Kaiser Permanente is an alternative health plan for both Medicare-eligible and non-Medicare eligible retirees.

Unlike most other states, Ohio has established a trust fund for its retiree health insurance program. Assets in this fund are greater than any other state fund for retiree medical benefits. In 2009, this retiree health fund had sufficient assets to pay health insurance benefits for 11 years (see Table 4). The AAL in 2008 for the Ohio retirement health plan was $29.6 billion dollars and the retiree health fund had assets equal to $10.7 billion, leaving an UAAL of $18.9 billion. This represented a funding ratio of 36.3 percent. Unfunded liabilities represented 147 percent of active member payroll in 2008. In 2009, the ARC was $1.7 billion and state employers contributed 43.6 percent of the ARC (Ohio CAFR 2009).

Plan Changes

Wellness programs have been introduced by the state in an effort to improve health and reduce plan costs. Ohio has a preventive care plan called “Stay Healthy, Save Money” that encourages a variety of health exams and physicals, along with immunization vaccines with no deductible, co-payment, or co-insurance. Participation in this program can earn employees and their spouses up to $100 in incentives each. Retirees who select a medical plan or dental and vision options that have a total monthly cost less than the monthly health care subsidy from OPERS can receive funds for their Retiree Medical Account (RMA). In addition, OPERS encourages retirees to engage in wellness programs. Retirees who participate in the OPERS personal health management program earn up to $100 to deposit in their Retiree Medical Account. Individuals earn $50 for each of the following activities (up to the $100 maximum):
Table 4. Retiree Health Insurance Liabilities in Ohio

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AAL (billions)</td>
<td>$29.5</td>
<td>$31.8</td>
<td>$30.7</td>
<td>$29.8</td>
<td>$29.6</td>
</tr>
<tr>
<td>Assets (billions)</td>
<td>$10.8</td>
<td>$11.1</td>
<td>$12.0</td>
<td>$12.8</td>
<td>$10.7</td>
</tr>
<tr>
<td>UAAL (billions)</td>
<td>$18.7</td>
<td>$20.7</td>
<td>$18.7</td>
<td>$17.0</td>
<td>$18.9</td>
</tr>
<tr>
<td>Assets/AAL</td>
<td>36.7%</td>
<td>34.8%</td>
<td>39.1%</td>
<td>42.9%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Solvency Years**</td>
<td>18</td>
<td>18</td>
<td>27</td>
<td>31</td>
<td>11^</td>
</tr>
</tbody>
</table>

* Revised actuarial assumptions based on experience study.
** Solvency years represent an estimate of the number of years the fund will be able to provide benefits under the immediate actuarial assumptions.
^ The OPERS 2009 CAFR, page 25, states, “The market losses of 2008 reduced the solvency years of the health care fund from 31 years as of December 31, 2007, to 11 years as of December 31, 2008.”

completing a health assessment, undergoing an annual physical exam, completing a wellness program, and successfully participating in a disease management program. Funds from the RMA can be used for qualified health expenses including medical, dental, and vision as allowed by the IRS and thus are not subject to personal income tax (OPERS, 2011).

On January 1, 2007, the first phase of the Health Care Preservation Plan (HCPP) was implemented with the objective of improving the long-term solvency of the Health Care Fund. The plan provides monthly allowances for the purchase of medical and pharmacy coverage based on the number of years of service. The allowance is set at retirement and is adjusted annually for inflation. Individuals eligible to retire on January 1, 2007, with at least 10 years of service received an allowance equal to 100 percent of the cost of the enhanced health plan. Individuals hired before January 1, 2003, and eligible to retire after January 1, 2007, were to receive allowances ranging from 50 percent to 100 percent of the cost of the enhanced plan, while persons hired after January 1, 2003, would receive an allowance equal to 25 to 100 percent of the health plan cost. The allowances for these last two groups increased with years of service, up to the maximum of 100 percent for those with 30 years of service.

Discussion and Conclusions

The cost of providing health insurance for employees and retired public workers continues to increase rapidly. In all three states considered in this issue brief, the rate of increase in health care expenditures has been in excess of the inflation rate, the rate of growth of payroll, and the rate of growth of state revenues. In most states, this fiscal pressure on state finances has occurred despite changes in the state health plans that have reduced annual costs. Except for Ohio, which has a relatively large trust fund for retiree health insurance, the unfunded liabilities associated with health insurance for retirees are also rising. In California and North Carolina, the health plans for retirees have been financed using pay-as-you-go funding so accrued liabilities grow without any corresponding increase in funds that could be used to pay for these promised benefits. Other states that have some significant degree of funding include Alaska and Arizona.22 In most states, the expectation is that the unfunded liabilities associated with the provision of retiree health insurance will continue to increase in coming years due to the lack of payment of the ARC and the assumed medical care cost trend used in the projections. Of course, if the health care cost growth does not decline as assumed in the projections then future UAALs will be much higher.

The primary determinant of the rising cost of providing health insurance to public employees is the rising cost of health care itself. This problem is not unique to any individual state and reflects the general growth in medical care spending in the United States. Many employers, both public and private, have recently begun wellness programs. These programs can take many forms and often include annual physical exams or health assessments, individual counseling, seminars, weight loss and exercise programs, and smoking cessation programs. In a recent study, Baicker et al. (2010) conclude that each dollar spent on wellness programs reduces medical costs by $3.27.23 Adopting plans, such as consumer-driven health plans, gives employees a closer look at the true cost of health and may discourage over-consumption of medical care.

Besides creating a wellness program, the main policy instrument to reduce costs available to any employer is cost shifting. Not only can an employer require that a larger share of the cost of health insurance is paid by
employees and retirees, but ideally this would lead to a reduction in individuals’ demand for health care services without resulting in a loss of health.

The states considered in this issue brief have adopted either wellness programs or cost-shifting measures in an effort to contain costs. It is difficult to quantify the effectiveness of these measures, as rising health care costs make predicting future expenses nearly impossible. Still, public sector employers are experimenting with various strategies to contain cost growth and ensure fiscal solvency going forward.

Endnotes

1 The survey focused primarily on retiree health plans offered by the states, but such changes also have implications for the health plans offered to active employees.
2 Segal (2009) reports that relatively few states required employees to pay the entire cost of spousal and dependent coverage. In 2009, states on average paid 89 percent of the total premium for health insurance coverage and only 14 states paid for 100 percent of the premium (NCSL, 2011).
3 These national data on the cost of employer-provided health insurance are based on survey data that include both public and private employers.
4 In those states that provide some subsidy for insurance coverage for retirees, accounting standards refer to this as an implicit subsidy for retirees and it must be reported as a liability to the governmental employer. Clark and Morrill (2010) provided a detailed discussion of the governmental accounting standards and explain this implicit subsidy.
5 Clark and Morrill (2010) discuss the GASB requirements and present evidence from these actuarial reports for all 50 states.
6 For a detailed discussion of the landscape of retiree health plans in the public sector, see Clark and Morrill (2010) and Kearney, et al. (2009).
7 Unless otherwise cited, the discussion in this section comes from various papers and reports on the CalPERS website, which are listed in the references at the end of this issue brief. Note that teachers in California are covered by different pension and health plans.
8 The State Employees’ Retirement System was the precursor of CalPERS.
9 HMO providers are Blue Shield of California NetValue, Blue Shield Access +, and Kaiser Permanente; the PPO providers are PERS Select, PERS Choice, and PERS Care.
10 The primary reason for this adjustment was that the health care cost did not decline as expected.
11 The new mortality tables used in the 2010 report showed lower age-specific mortality and higher life expectancy. As a result, health insurance must be provided for a longer period of time and thus projected liabilities increase.
12 In 2006, plan expenses were $2.29 billion, while current projections indicate the costs will be $3.85 billion in 2015. Estimate is from a presentation, Financial Update, on the SHP website (August 12, 2010).
13 In North Carolina, most of the funds for salaries and benefits for teachers are provided by the state. Teachers and state employees are in the same SHP and are also covered by the same pension plan. Details of the history of the SHP described in this paragraph were provided by David Vanderweide, Fiscal Analyst, North Carolina General Assembly.
14 Both plans are managed by Blue Cross/Blue Shield of North Carolina.
15 It is interesting to note that the General Assembly enacted the same change in eligibility requirements for retiree health insurance in 1995 (SL1995-507). However, before these new standards could affect any retirees, the legislature eliminated the new requirements and reestablished the old eligibility standards in 2000 (SL2000-184).
16 In the face of a large projected deficit for fiscal 2011–12, the governor has proposed that employees and retirees pay $21.50 per month for the more generous of the two PPO plans offered to teachers and state employees. Participation in the less generous plan will continue to be offered at no premium.
17 Analysis of the legislation is provided in Legislative Actuarial Note on House Bill 578 at http://www.ncleg.net/Sessions/2011/FiscalNotes/House/PDF/HAH0578v4.pdf
18 Unless otherwise cited, the material in this section is from reports and papers that were found on the Ohio Department of Administrative Services website and that of the Ohio Public Employees Retirement System, which are listed in the references section at the end of this brief.
19 Current providers are Aetna, Ohio Med, Paramount, The Health Plan, and UnitedHealthcare.
20 Retirees who complete their careers with less than 10 years of service may purchase health care coverage offered by OPERS’ health care administrators; however, this insurance is not offered by OPERS and OPERS does not subsidize the insurance provided to these retirees.
21 The OPERS health care plan for state retirees who are not eligible for Medicare is administered by Medical Mutual.
22 Coggburn and McCall (2009) report findings from a survey of state administrators that indicate that several other states are considering developing trust funds for their retiree health plans. See Perlstadt et al (2008) for a discussion concerning prefunding in Michigan.
23 Baicker et al (2010) also find significant cost savings to employers from wellness programs because of reduced absenteeism.

References


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