Chapter 46

Employment-Based Health Benefits in the Public Sector

Introduction

Public-sector employers offer health benefits to their employees for the same reasons as private employers offer them: to provide workers and their families with access to health care and with protection from financial losses that can accompany unexpected serious illness or injury. Employers also offer health benefits in order to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers. A key difference is that while private-sector employment-based health benefits are offered on a voluntary basis, public-sector plans are offered under state or municipality law. Public-sector employees receive health benefits, unlike their ordinary wage income, on a pre-tax basis in the same manner as private sector employees.

According to EBRI estimates of data from the Current Population Survey, March 2006 Supplement, in 2005, 76.3 percent of federal government workers, 74.9 percent of state government workers and 73.9 percent of local government workers were covered by their employer's health plan. This compares with 54.0 percent of private-sector workers. The uninsured rate among government workers is low, 6.3 percent to 6.5 percent, compared with 20.1 percent among private-sector workers.

Employment-based public-sector group health plans typically provide comprehensive health benefits, including mental health and substance abuse treatment coverage—although these benefits are subject to limitations. Most public employees also receive dental care benefits (U.S. Department of Labor, 2000). One salient characteristic of public-employee group health plans is that employees usually become eligible to participate immediately on being hired. This is true at the local, state, and federal levels. In situations in which waiting periods apply, they tend to be three months or less (U.S. Department of Labor, 1996).

Starting in 2002, long-term care insurance for persons unable to care for themselves was offered to federal employees, annuitants, and their families, including but not limited to nursing home care, assisted living facility care, formal and informal care in the home, hospice care, and respite care (Dore and Helwig, 2001). In fiscal year 2004, there were more than 205,000 enroll-

ees in the federal long-term care insurance program (U.S. Office of Personnel Management, 2006). This benefit is already available to some public-sector workers, including 43 percent of employees at the state level and 21 percent of employees at the local level (U.S. Department of Labor, 2008).

Types of Insurance Program Operators

Although the Employee Retirement Income Security Act of 1974 (ERISA) does not cover public-sector employment-based group health plans, provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see chapter on COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which amended ERISA, do apply. Because ERISA does not generally apply to public-sector employment-based group health plans, states are free to regulate these plans in ways that they cannot regulate private-sector plans, which are subject to ERISA pre-emption. Therefore, states may mandate how public-sector group health plans operate (e.g., funding requirements, benefits offered, employee and dependent appeal rights, disclosure requirements, etc.).

In 2002, among state plans, Segal Company found 19 percent of workers were enrolled in an indemnity plan, 16 percent in a point-of-service (POS) plan, 33 percent in a preferred provider organization (PPO) and 32 percent in a health maintenance organization (HMO) (The Segal Company, 2003). In 1999, approximately 39 percent of federal civilian employees participating in the Federal Employees' Health Benefits Program were enrolled in plans offered by Blue Cross and Blue Shield, 22 percent were in employee organization plans (which are sponsored by employee organizations or unions and are only open to employees or annuitants who are members of the sponsoring union or organization), while the rest were in health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) arrangements and other managed care programs not sponsored by Blue Cross and Blue Shield or a union (U.S. Office of Personnel Management, 2000).

The combination of public policy favorable to HMOs and the inherent political difficulty involved in limiting the number of HMOs that can participate in the public sector has led to a strong representation of these organizations in public-sector programs. However, the number of HMOs offered by public plan sponsors varies greatly. According to a 1999 survey, the number of HMO/POS plans offered among state governments ranges from none in two states to 10 or more in 15 states (The Segal Company, 1999). According to the Office of Personnel Management's Office of Actuaries, the federal government offered approximately 167 HMOs during 2002.

Over the past few years, there has been a dramatic increase in the number of full-time state and local employees covered under PPOs. According to BLS, 35 percent of state and local employees were covered by PPOs in 1998, compared with 30 percent in 1994 and 7 percent in 1987 (U.S. Department of Labor, 1988, 1996, and 2000).

Contributions

Among full-time workers in state and local plans, it is common for the public-sector employer to pay the entire premium for the employees' coverage but to require a contribution from employees who elect coverage for their dependents. The 1998 BLS survey showed that 51 percent of participants contributed to their own coverage, whereas 75 percent made a contribution for dependents (U.S. Department of Labor, 2000). However, the incidence of noncontributory coverage for the worker may be declining as state and local jurisdictions, like all other employers, seek to manage their health care costs. For federal employees, the federal government pays 72 percent of the average premium and not more than 75 percent of the total premium of any plan.

Cost Management

During the past two decades, many employers sponsoring employee group health plans have struggled with the problem of how to manage what appear to be ever-escalating costs. In 1982, the federal employee health benefits program introduced mandatory coinsurance and deductibles in all health program offerings in an effort to curb utilization and, consequently, costs. Public employers have tried many of the same strategies that private employers have used to eliminate unnecessary service and to control costs. These strategies include utilization review, case management, disease management, larger out-of-pocket responsibilities for use of out-of-network providers, and specialty networks of physicians, hospitals, diagnostic centers, transplant services, pharmacy (including mail order), and vision and dental providers, etc. HIPAA places some restrictions on how public-sector employment-based group health plans may use a pre-existing condition limitation provision in order to curtail costs.

Health care costs have continued to rise for both private and public employers. Recently, some employers in both sectors have attempted to curb utilization and price by using managed care arrangements. For example, many public entities have adopted POS programs under which the method of service delivery is selected at the time of treatment, with the expectation that patients will respond to financial incentives to use more cost-effective

HMO or PPO arrangements. Other public-sector group health plans are encouraging employees to opt for HMOs by providing relatively greater financial support to those making this choice. Some larger entities that self-insure the cost of health coverage, and possibly self-administer by negotiating favorable arrangements directly with providers of medical care and administrative services, are also big consumers of stop loss insurance. One thing is certain: Most public-sector employment-based group health plans have ceased to offer traditional indemnity coverage altogether, relying instead exclusively on managed care arrangements.

Post-Employment Coverage

COBRA—State and local employers are subject to the continuation of coverage provisions of COBRA, as amended. While the federal government, as an employer, was not originally subject to the act, similar requirements were subsequently imposed on federal agencies by separate legislation.

Retiree Coverage—In 2006, all states provided health insurance for pre-Medicare retirees and 48 provided it to Medicare-eligibles. (Workplace Economics, 2006). Federal workers enrolled in a plan under the Federal Employees Health Benefits Program for the five years immediately preceding retirement may continue coverage during retirement with the same level of employer-paid premiums as active workers. Where postretirement coverage exists in public plans, it almost always continues for the retiree's lifetime. Depending on the specific terms of the plan, coverage may also continue for the survivor's lifetime. In most cases, the level of coverage for retirees is the same as that for active workers, although employment-based benefits are usually coordinated with Medicare for retirees age 65 and over. Government entities, like private-sector employers, must account for post-employment benefit obligations, including retiree health care costs, on their financial accounting statements.

Bibliography

Dore, Todd, and Dawn Helwig. "Long-Term Care Insurance for Federal Employees: Program Implications for Other Employers." Milliman USA. *Benefit Perspectives* (Fall 2001): 1–3.

Fronstin, Paul. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey." *EBRI Issue Brief*, no. 298 (Employee Benefit Research Institute, October 2006).

National Academy on Aging. *The Federal Employee Health Benefits Program, Managed Competition, and Considerations for Medicare*. Washington, DC: National Academy on Aging, 1995.

The Segal Company. *Summary of Findings, The Segal Company's 1999 Survey of State Employee Health Benefit Plans*. New York, NY: The Segal Company, 2000.

_____. *2003 Segal State Health Benefits Survey: Medical Benefits for Employees and Retirees.* New York, NY: The Segal Company, 2003.

U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in State and Local Governments, 1987*. Washington, DC: U.S. Government Printing Office, 1988.

_____. *Employee Benefits in State and Local Governments, 1992*. Washington, DC: U.S. Government Printing Office, 1994.

_____. *Employee Benefits in State and Local Governments, 1998*. Washington, DC: U.S. Government Printing Office, 2000.

U.S. General Accounting Office. *Comparison of Federal Health Programs* (GAO/HEHS-98-231R). Washington, DC: U.S. General Accounting Office, 1998.

_____. *Federal Employees' Health Program: Reasons Why HMOs Withdrew in 1999 and 2000* (GAO/GGD-00-100). Washington, DC: U.S. General Accounting Office, 2000.

U.S. Office of Personnel Management. *Statistical Abstracts: Federal Employee Benefit Programs—Fiscal Years 1998 and 1999*. Washington, DC: U.S. Office of Personnel Management, Retirement and Insurance Service, 2000.

Workplace Economics, Inc. 2006 *State Employee Benefits Survey*. Washington, DC: Workplace Economics, Inc., 2006.

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