Rockefeller Institute of Government

State Employee Health Insurance Programs: Assessing Scale of Purchasing and Implications

John J Kaelin
Jim DeWan
Visiting Fellows

Presentation to Public Sector Roundtable
November 2020

Disclaimer and Context

- The findings presented in this presentation and the accompanying working paper are the authors and do not represent the organizations for which they are employed
- The working paper in under peer review and comments and insights from this group would be appreciated
- The plan is to publish the paper later this year and convene a forum in early 2021
- The authors wish to thank Jacklynn Blanchard, graduate assistant at Rockefeller Institute for administering and analyzing the survey as well as other analysis

Purpose

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

Public Data

- Very limited up to date information on key aspects of state employees health insurance programs
- Comprehensive Pew Report dated 2013 is the most recent that breaks down cost and enrollment
- Some more current US Census data is available but not easily broken down for state employees insurance spending
- Good information on benefit design via surveys

Comparing to Other State Health Programs

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

Rockefeller Institute Survey

- In response to the lack of up to date information, the authors drafted a brief pilot survey with questions for managers of state employee health insurance programs.
- The survey included questions related to spending, enrollment, governance, and coordination with Medicaid programs. The goal was to collect preliminary information and to assess states' willingness to respond.
- The authors selected a cross-section of states to receive the pilot study that would include variation by:
  - Populous and less populous states;
  - States where collective bargaining was likely to be a factor in plan design and those where it is not;
  - States that run their own ACA exchanges and those that do not (to compare ACA enrollment and a crude indicator of more active state policy); and
  - Geographic distribution throughout the country.

Key Survey Results

- Across a variety of domains the 8 states which responded provided insights into key questions (see respondents on next slide)
- We combined our survey with CALPERS annual report on certain data elements as noted in the following

Covered Lives by the State Employees Program

(includes retirees and participating local jurisdictions, data from 2019)

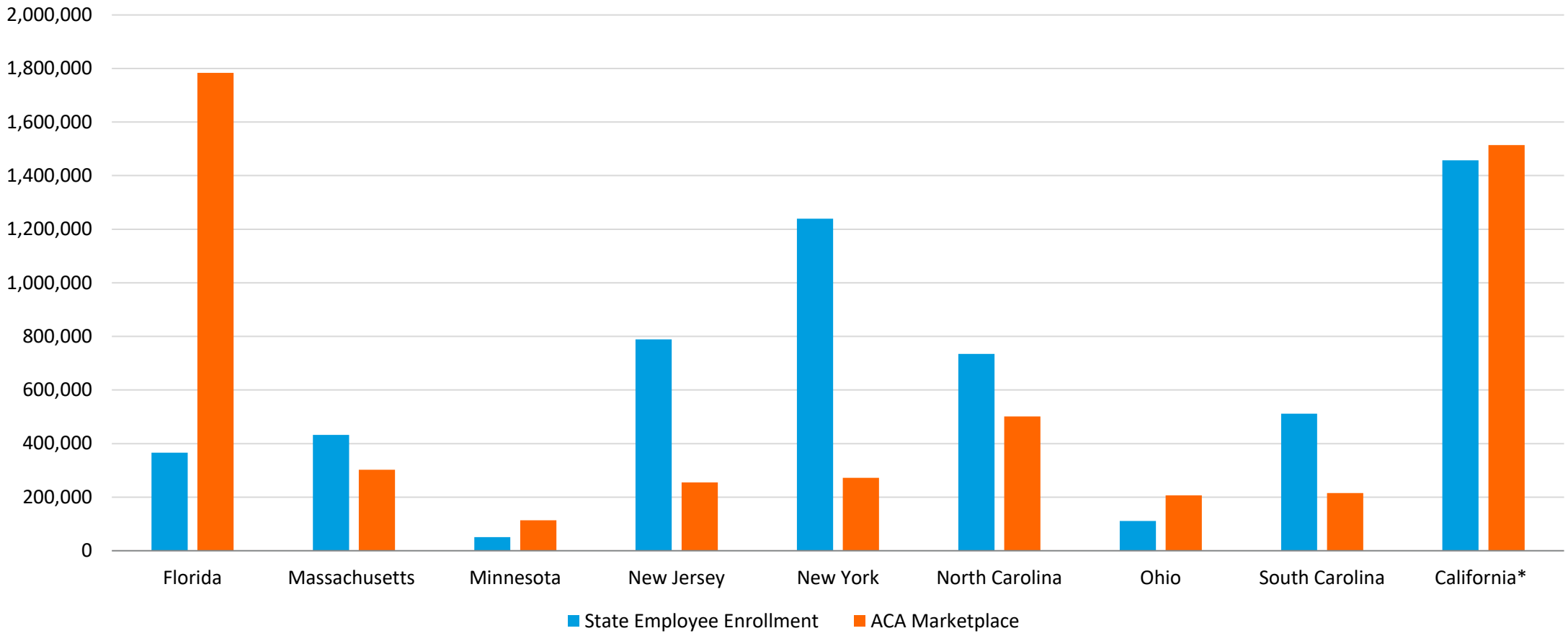
State	Covered Lives	State Employees
Florida	366,062	221,943
Massachusetts	432,000	114,438
Minnesota	50,927	81,848
New Jersey	789,000	129,907
New York	1,239,070	228,195
North Carolina	735,000	182,347
Ohio	111,250	132,313
South Carolina	511,521	93,414
Total	**4,225,830**	**1,184,405**
California*	1,456,806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

* Information taken from 2018 CALPERS report

Total Spending

- For the 8 states responding, total spending in 2019 was $28.7 billion
- CALPERS public report identifies $9.1 billion in 2018
- Thus these 9 states represent almost $38 billion in total spending (*important to note these amounts include local jurisdictions that purchase through the state programs*)
- States reported widely differing trends in aggregate spending over time. Our survey asked for 2017, 2018, and 2019 spending, and states' reported increases ranging from a low of 2 percent to a high of 10 percent. Several factors could drive spending, including enrollment changes and case mix. Subsequent studies could explore the variability in enrollments and spending overtime in more.

Comparing Scale to ACA Marketplaces



Agency Managing the State Employees Program

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

Coordinating with Overall State Health Policy

(Via Medicaid)

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

Survey Respondents on Extent of Coordination

- In general, the survey respondents cited relatively little coordination with state Medicaid agencies, but in some cases they acknowledged a desire to increase coordination
- One state responded that coordination was “centered on pharmacy fraud and provider compliance with the Medicaid agency.”
- Another stated, “coordination has been limited due to differences in populations served, funding and governance”

One Example of Coordination

- In California, an executive order (N-01-19) was signed right after Governor Newsom took office in 2019. The order consolidated multiple separate purchasing programs for prescription drugs including Medicaid, employees' insurance, and optional offerings to local governments into one state entity.
- The action effectively created the largest single purchaser for prescriptions in the US. Previously, under its managed care program for Medicaid, the prescription drug benefit was administered separately by the more than 10 health plans.
- While the California initiative originally contemplated including the state employees program administered by CALPERS, CALPERS ultimately chose not to participate.
- Gaining a better understanding of that decision could shed light on the challenges and barriers of greater coordination.
- Nonetheless, California has moved forward with a carve-out for pharmacy benefits in its Medicaid managed care program with savings built into the budget

Further Research: Convene Forum of Experts to Discuss Key Questions and Inform Further Research

- The Rockefeller Institute will convene a forum in early 2021 with state healthcare policy managers, groups representing state employee health insurance programs, and individual state administrators to discuss implications of these very preliminary findings, and to cover such topics as:
- The degree to which states could better coordinate their health insurance programs.
- The existing barriers to coordination, and whether it is practical to harmonize programs given the important role collective bargaining plays in determining state employees benefit design, cost sharing, and trade-offs between wages and benefits.
- How coordinating across state health programs could affect provider participation given payment rate differences, benefit design variations and coverage rules.
- The sharing and coordinating of procurement policies, such as: frequency of competitive bidding, goals to include strategies for delivery system reform, and criteria for selection of insurers.
- Since state employee insurance program managers are implementing innovations in plan design and purchasing what mechanisms could be developed to help inform over all state policy

Contact and Follow Up

- The authors welcome your insights and suggestions on both this preliminary analysis as well as areas for future research
- We hope many of you can attend the forum and some can participate on the panel
- Authors' Contact Information
- John J. Kaelin John.Kaelin@rock.suny.edu
- Jim DeWan jimdewan@gmail.com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