HOUSE RESEARCH ORGANIZATION
Texas House of Representatives

focus REPORT

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State health benefit funding shortfall to be addressed

Faced with a projected $140.4 million funding shortfall for fiscal 2011 state employee group health benefits, the board of trustees of the Employees Retirement System (ERS) of Texas will meet on May 25 to address it. ERS projects the state will need an additional $880 million from all funding sources for group health benefits in fiscal 2012-13. The funding shortfall means health care benefits for state employees, retirees, and their dependents are likely to change, and some or all state employees and retirees probably will pay more for their benefits in the future.

This report outlines the history behind the projected $140.4 million shortfall in ERS group health benefits funding for fiscal 2011. It also reviews the options the Texas Legislature and the ERS board of trustees have for addressing immediate and future funding needs for state employee group health benefits.

The funding gap has emerged because actual costs for state employee group health benefits for fiscal 2010-11 exceeded the amount the Texas Legislature appropriated. The Legislature's appropriation for group health benefits in the 2009 regular session was a 6.5 percent increase for fiscal 2010 and a 6.8 percent increase for fiscal 2011 from appropriations made for the previous biennium. A contingency reserve fund balance of $283 million was to be used for additional funding needs. Because the current cost trend for state employee group health benefits actually has increased at a rate of about 9.1 percent annually, the contingency reserve fund will not be enough to pay state employee health claims, leading to the anticipated $140.4 million shortfall.

This report outlines the history behind a projected $140.4 million funding shortfall for ERS state employee group health benefits for fiscal 2011 and reviews options for addressing immediate and future funding needs.

To address the shortfall, the ERS board of trustees may vote to make benefit design changes — such as changing copayment amounts for doctor visits or adding an annual medical cost deductible. Only the Legislature may make certain other changes, such as adjusting the contribution strategy, which is the determination of how much participants must pay for the fixed monthly cost of their health

coverage. In recent weeks, ERS has solicited feedback from state employees and retirees through a survey and focus groups on the types of benefit design changes they would prefer and plans to hold public meetings throughout the state starting May 6.

State employee group health benefits

More than 527,000 state and higher education employees and retirees and their dependents are enrolled in health plans provided by the Texas Employees Group Benefits Program (GBP). The Texas A&M University and University of Texas systems operate their own group health benefits programs. The Teacher Retirement System provides health benefits to public school teachers and other public school employees and retirees.

State contribution

The state contributes all or part of the monthly cost of health benefits for Texas state employees and retirees. Texas pays the full cost of monthly coverage for full-time employees and retirees and 50 percent for their dependents. Part-time employees and retirees receive a 50 percent state contribution toward health coverage and a 25 percent contribution for their dependents.

State employees may choose to receive their health benefits through the state's self-funded HealthSelect plan or through an insurance plan of one of three health maintenance organizations (HMOs). About 94 percent of state employees have HealthSelect coverage.

HealthSelect plan

Because of the high participation rate in the HealthSelect plan and the way it is funded, HealthSelect is the major cost driver for state employee group health benefits. HealthSelect is not technically insurance because the risk that revenue will cover claims is not assumed by an insurance company but by the plan members and the state. In other words, the HealthSelect plan is "self-funded," which means that if plan costs increase, they must be paid with more state contributions or by sharing more costs with members (*see Definitions, page 9*).

HealthSelect is administered by Blue Cross Blue Shield of Texas, which establishes the plan's network of health care providers, negotiates providers' rates, processes claims, and performs other operational duties.

The HealthSelect plan provides coverage for health services from both network and non-network providers, although participants pay more for non-network services. State employees who enroll in the state's HMO plans receive health care coverage from a regionally based network of providers and must pay the full cost of services received from non-network providers.

Funding group benefits

HealthSelect plan costs are funded from several sources, including plan participants, state appropriations, and a contingency reserve fund.

Sources of funding

Plan participants. Plan participants share the cost of their health coverage when they pay copayments, coinsurance, and deductibles on pharmacy purchases. Part-time employees pay 50 percent of their monthly plan contribution. Participants also pay a share of the monthly plan contribution costs for their dependents.

State appropriations. The state makes a biennial appropriation for GBP health benefits that anticipates the number of participants who will be receiving health coverage and how much the plan must contribute for each participant monthly to cover health claims costs. The current monthly contribution required for member-only coverage is $385, and the state pays 100 percent of this cost for full-time state employees and retirees and 50 percent of this cost for part-time state employees.

Reserve fund. The other major funding source is HealthSelect's contingency reserve fund. The ERS board of trustees is required by Insurance Code, sec. 1551.211 to request legislative appropriations to maintain a 60-day reserve to pay for HealthSelect benefits. Historically, this fund has not contained a 60-day reserve, and the Legislature has directed ERS to use whatever amount of the reserve fund is necessary to cover annual health plan cost increases. Over time, this policy has created a structural deficit in the way the plan is funded. For example, for fiscal 2008 and fiscal 2009 the Legislature did not appropriate funding for cost increases but instead directed ERS to spend down the contingency reserve

Current group benefits program costs for participants

Benefits	HMOs	HealthSelect network	HealthSelect non-network
Primary care office visit	$30 copay	$20 copay	40% coinsurance*
Specialist office visit	$40 copay	$30 copay	40% coinsurance*
Diagnostic x-rays, lab tests	No charge	20% coinsurance	40% coinsurance*
Emergency care	$100 copay	$100 copay + 20% coinsurance	40% coinsurance*
Inpatient hospital	$100/day copay ($500 copay max per stay)	$100/day copay + 20% coinsurance ($500 copay max per stay)	$100/day copay + 40% coinsurance* ($500 copay max per stay)
Max calendar year out-of-pocket coinsurance	None	$1,000 per person	$3,000 per person

* *after payment of $500 deductible for non-network services*

fund to cover any plan cost increases (*see graph, page 4*). This appropriations decision marked the turning point at which the contingency reserve fund balance began to decline after several years of increases.

History of funding

Before the 78th Legislature in 2003, the state already was confronting increasing health care funding demands and insufficient revenue streams. In 2003, the last major set of benefit design changes shifted $621.3 million in costs to participants to curb rising state contribution costs. Among other changes, copayments were increased for primary care visits, specialist visits, emergency care, and prescription drugs. A daily inpatient hospital copayment was added. A $50 deductible for drug purchases was implemented, along with a 90-day waiting period before newly hired employees could receive health coverage.

The 2003 benefit changes led to growth in the reserve fund balance and a brief decline in the "health benefit cost trend." The health benefit cost trend is the annual rate at which the average per capita health benefit cost paid by the state increases or decreases. The health benefit cost trend changes due to several factors, such as use of health care services and supplies, price increases, and more use of advanced medical technologies. While the health benefit cost trend generally shows an increase, per capita costs borne by the state declined in 2004. This was because the 2003 benefit design changes shifted more costs to state employees.

In recent years, the health benefit cost trend has been increasing steadily, resulting in a growing cost burden on the state to fund employee and retiree health benefits. Fiscal 2008 was the turning point at which the effect of legislative appropriations that were less than necessary to cover the increasing health benefit cost trend caused the contingency fund balance to begin declining sharply (*see graph, page 4*).

Funding gap

The projected fiscal 2011 funding gap of $140.4 million is the result of actual costs for state employee group health benefits for fiscal 2010-11 exceeding the amount the Texas Legislature appropriated.

Legislative appropriations request

In deciding how much to appropriate for group health benefits in a biennium, the Legislature reviews the ERS legislative appropriations request (LAR). The LAR for fiscal 2010-11 contained a baseline request of $2.1 billion, reflecting fiscal 2008-09 funding levels, as well as two exceptional item requests.

$170 million of the reserve fund balance will be used in 2010. This would leave only $112 million available for fiscal 2011. After applying this fund balance to the projected $253 million in health claims that would not be covered by the 6.8 percent cost increase appropriated for fiscal 2011, ERS estimates that $140.4 million would remain in state employee health benefit claims that would not be funded in fiscal 2011 without intervention.

Budget reduction request

In addition to addressing the GBP funding gap, ERS was among the agencies that received a request from the governor, lieutenant governor, and House speaker to identify ways to reduce the agency's general revenue spending by 5 percent for certain programs. ERS proposed that no action need be taken by the agency to reduce group health benefits by an additional 5 percent because this reduction should be achieved through attrition as other state agencies implement hiring freezes and other staffing strategies to reduce their budgets. Fewer state employees drawing health benefits would lower the state's contribution for health care benefits.

Major program cost drivers

Many factors contribute to the current cost trend projection of a 9.1 percent annual increase. With current annual expenditures of about $2.5 billion, each percent increase in group health benefits costs requires about $25 million in additional funding annually.

ERS has implemented a variety of cost containment measures that have kept the cost trend for state employee group health benefits lower than many similar programs nationally. These include negotiating discounted reimbursement rates with providers, reviewing claims for ineligible charges, and instituting utilization management for participants with higher health costs. Despite these measures, the health benefit cost trend still is increasing.

Hospital costs

The main driver for higher HealthSelect costs is hospital costs, which account for 46 percent of total plan cost increases. Hospital cost increases are driven by inflation in hospital contracting and by participants receiving increasingly advanced or complex treatments.

Several factors have contributed to the higher cost of hospital contracting. Hospitals say that reimbursements from Medicare and Medicaid often are inadequate to cover costs and that they also must provide services to uninsured and underinsured patients who cannot pay the full cost of their treatment. Hospitals also must recover their costs for expanding and upgrading facilities. In addition, patients are being diagnosed and treated with more costly medical technologies. For example, a doctor may use a CAT scan rather than an X-ray to make a diagnosis. These costs are passed to private payers, including HealthSelect.

ERS also faces challenges in bargaining power with hospitals as many hospitals are consolidating and reducing competition, and many rural areas are served only by a single hospital. HealthSelect's third-party administrator, Blue Cross Blue Shield of Texas, sometimes must negotiate higher rates with a hospital to maintain access for all HealthSelect participants. When accounting for increases in utilization, cost per health service, and other factors, the annual rate of increase for hospital-related costs to the GBP health plans is 10.5 percent.

Age of plan participants

Other cost increases for group health benefits are caused by the rising average age of state employees. The average age of a health plan participant is 41. When dependents are excluded, the average age of active state employees and retirees is 52. Older patients often have greater and more expensive health care needs.

Member cost sharing

Another component of increasing costs to the state is that the contributions made by plan members make up a decreasing share of total plan costs. After major benefit design changes were implemented in 2003, plan participants paid 23 percent of total plan costs. That figure since has declined to 17 percent.

When the cost of a service goes up for which the member is responsible only for a flat copayment, the plan absorbs the full amount of the cost increase. A 10 percent increase for a service can result in a more than 10 percent increase in costs borne by the health plan. The plan member faces no increase in out-of-pocket costs.

The first exceptional item request of $312.4 million was the amount ERS projected would address an 8.4 percent annual increase in costs from the previous biennium. The LAR stated that this funding level, when combined with spending down the reserve fund to a $50 million balance, was expected to be sufficient to cover state employee health benefits in fiscal 2010-11.

The second exceptional item request of $212.3 million was intended to reflect the amount necessary, when combined with additional funding sources, to make the contingency reserve fund balance sufficient to provide 60 days of HealthSelect health benefits. The LAR projected that 60 days of reserves for fiscal 2010-11 would equal $433.1 million.

General appropriations act

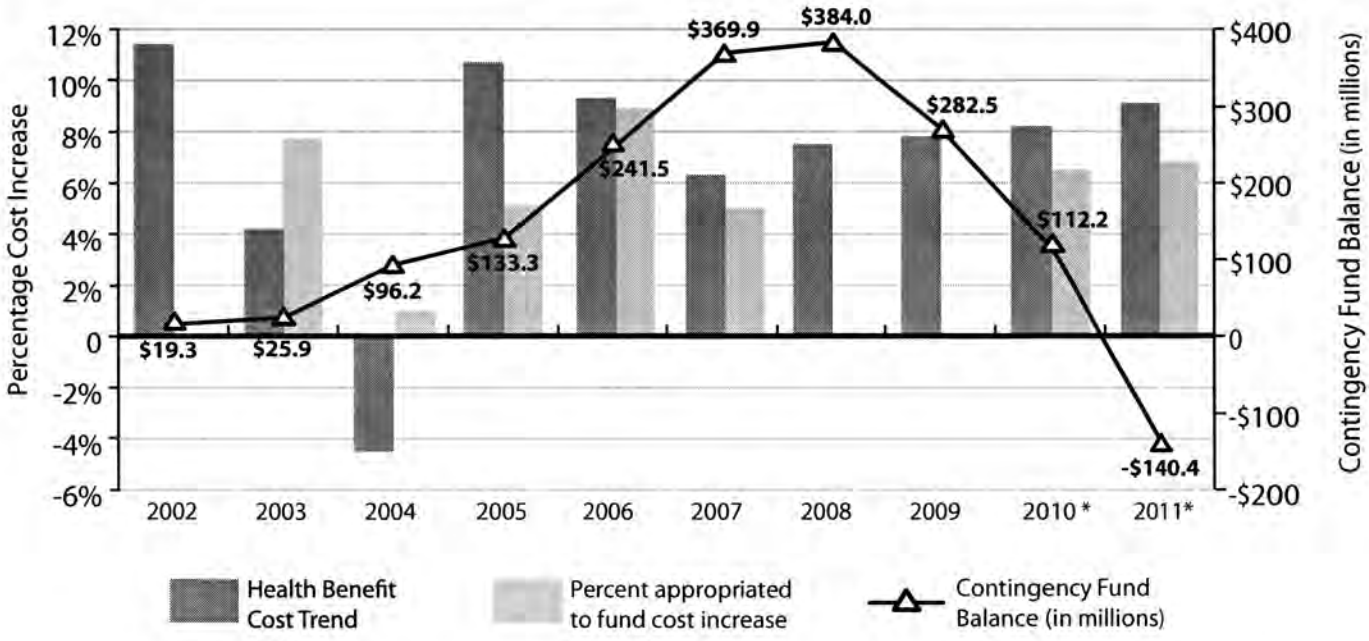
Instead of adopting the funding levels recommended by ERS, SB 1 by Ogden, the general appropriations act for fiscal 2010-11, increased funding for group health benefits by 6.5 percent in 2010 and 6.8 percent in 2011. The appropriation was based on an assumption that these increases would cover state employee health care benefits if the contingency fund, which had a balance of $283 million to begin the biennium, was spent down to $0. This strategy would have funded a 7.5 percent annual cost increase in each year of the biennium.

Program costs

The actual rate at which GBP health benefits costs are increasing is estimated at 9.1 percent annually, higher than was appropriated for by the Legislature and higher than the amount of need projected by ERS.

At the beginning of fiscal 2010, the contingency reserve fund contained about $283 million. Because the 6.5 percent appropriation increase for fiscal 2010 will not be enough to cover plan costs, ERS estimates that

Texas Employee Group Benefits Program — Funding history and projections
fiscal years 2002 - 2011



Health benefit cost trend *- annual rate at which average per capita health benefit cost paid by the state increases or decreases subject to various factors, including use of services and supplies, price increases, and use of advanced medical technologies.*

Percent appropriated to fund cost increase *- increase in the per capita state contribution rate.*

** Note: Figures for 2010 and 2011 are projections.*

Data Source: Employees Retirement System of Texas

Options to fill funding gap

Funding shortfalls in the Texas Employees Group Benefits Program (GBP) could be addressed by the ERS board of trustees or by the Legislature. The ERS board may vote to make benefit design changes — such as changing copayment and coinsurance amounts or adding an annual medical cost deductible for network services — that would require state employees and retirees to absorb a larger portion of GBP health coverage costs. During the upcoming legislative session, the Legislature could make supplemental appropriations to cover all or part of the fiscal 2011 shortfall and could consider changes to the state's health benefits contribution strategy, such as requiring full-time employees and retirees to pay a percentage of the monthly state contribution for their health benefits.

Benefit changes ERS board could make

The ERS board will meet on May 25 to decide on benefit design changes for GBP health benefits. The board will consider ERS staff recommendations that would shift an estimated 5.4 percent in plan costs to participants. Each percent shifted saves the state about $25 million in plan costs. If benefit design changes are adopted, they would take effect September 1, 2010. Even if such changes are made, ERS projects, GBP health benefits will require an additional $880 million from all funding sources for fiscal 2012-13 to maintain the new benefit levels.

One consideration in changing benefit design is whether to make many changes that have a smaller individual impact or whether to make a few changes with a more major impact on the shortfall. Another question is whether the changes should distribute costs among all participants or if participants with higher medical costs should bear most of the cost burden. The board also could prioritize strategies that encouraged participants to use health care services more efficiently.

Increasing copayments. Copayments are required for most HealthSelect network services. Network hospital care, emergency care, and outpatient surgery require a $100 copayment and 20 percent coinsurance. Primary care visits require a $20 copayment and specialist visits a $30 copayment. The ERS board could increase copayments in various ways.

Copayments could be increased by small amounts across the board, including for hospital and emergency care and for all types of doctor visits. This would more evenly spread the costs of care, with less impact on individual budgets. Alternatively, copayments for primary care visits could remain $20 and specialist copayments could increase more. This would keep copayments affordable for routine care and would require those who use more expensive, specialized medical services to pay more.

Implementing or increasing deductibles. Currently, there is no deductible for network medical services, but there is a $50 annual deductible for the Prescription Drug Program (PDP) before the plan starts paying for drug benefits. The ERS board could increase, for example, the PDP deductible to $100, establish a $100 medical deductible for network services, and increase the $500 deductible for non-network services to $750.

Some prefer increased copayments to implementing or increasing deductibles because the cost of copayments is spread out more through the year. Increasing copayments rather than deductibles may help people with tight budgets pay for medical expenses. Also, some people might forego routine care, such as physicals, or fail to see a doctor in the early stages of an illness if they see the higher up-front costs of a deductible as a barrier to obtaining appropriate care. This could lead to higher long-term treatment costs if illnesses become more advanced or go undiagnosed. These consequences could be mitigated by excluding preventive care from the deductible.

Coinsurance. Coinsurance is the percentage share of the cost of certain health services that must be paid by plan participants. The ERS board could increase the coinsurance percentage for certain services or replace some copayments with coinsurance. Applying coinsurance to more services would require participants to more proportionally share the burden of future medical cost trend increases.

The fact that so many services currently are paid for with copayments rather than coinsurance accelerates the rate at which the health benefit cost trend increases for the state. With copayments that do not increase over time, only the state shoulders the burden of health cost increases. People who prefer copayments say they make the cost of receiving health care services predictable.

ERS also could increase the coinsurance stop-loss amount, which is the cap on the amount plan participants annually must pay for coinsurance. Each calendar year, HealthSelect participants must pay no more than $1,000 coinsurance for network services and $3,000 coinsurance for non-network services. Some say that increasing annual coinsurance maximums would be fair because people who use more health services would contribute more to overall cost increases.

Use of medical technology. Medical technology, particularly imaging technologies such as MRIs and CAT scans, is being used more often. Some suggest that many diagnoses made with costly advanced technologies could be made just as accurately with less costly imaging services, such as X-rays. ERS could establish a low copayment for X-rays so that participants were encouraged to use such lower-cost diagnosis options if they were medically suitable. More advanced technologies could have a significantly higher copayment. Some express concern that often X-rays are not a suitable diagnostic alternative to higher-priced technologies like CAT scans and that if a copayment were too high it might prevent some people from using these diagnostic tools for critical purposes.

Wellness programs and disease management. ERS could establish incentives for members to receive wellness check-ups or participate in prevention and wellness programs, such as the Special Beginnings prenatal education program. Like several other wellness programs, Special Beginnings encourages healthy behaviors designed to ensure the best health outcomes for mothers and their babies. The difficulty with such financial incentive programs is that the state will incur up-front costs to encourage participation before realizing long-term savings from better health outcomes. The state instead could institute financial penalties for people who do not enroll in wellness programs for which they are eligible. For example, the plan could implement a $200 delivery copayment for pregnant women who do not participate in Special Beginnings.

Prescription Drug Program. HealthSelect currently requires a $50 annual deductible before the plan starts paying for drug benefits. Drug costs are tiered so that the copayment for generic drugs is lowest, brand-name drugs are more, and the most costly tier is reserved for "non-preferred" drugs, those which have less costly yet medically adequate alternatives.

ERS could increase the drug benefit deductible and raise copayments for prescriptions in all three drug tiers. Alternately, the copayment for generic drugs could be left at the current cost to encourage their use, while only the brand name and non-preferred

Participant feedback

ERS surveyed active and retired members on the contribution strategy and benefit design changes they would prefer. More than 45,000 responses were received by the March 26 survey deadline, a 26 percent response rate. Four focus groups also were conducted, with a total of 41 participants, in order to gather feedback elaborating on the survey results. In addition, ERS staff will hold nine "member feedback sessions" in eight cities across the state over a three-week period, starting May 6. Employees and retirees may voice their concerns about potential plan design changes at those sessions.

According to ERS, survey responses indicated that plan participants would prefer to pay only a little more for many different services than to pay a lot more for certain services, such as hospitalization and emergency room visits. About 60 percent of respondents would prefer to have higher copayments than to pay a medical deductible of any kind. When asked what approach they would prefer if changes were made to the cost of radiology services, about 71 percent of survey respondents preferred adding a copayment only for high-tech radiology services like CAT scans and MRIs to increasing copayments for both high-tech radiology and X-rays or requiring pre-authorization for high-tech radiology. If contribution strategies were modified, respondents would prefer paying some of the monthly contribution for their health benefits to paying more than 50 percent for their dependents.

drug copayments were increased. The ERS board also could reduce the copayment for maintenance drugs for chronic conditions. Some people forego the appropriate drug regimen for chronic conditions because of high drug costs. In many cases, the participant can achieve better health outcomes and the state can realize long-term savings if the participant takes a costly drug that prevents the future development of conditions that cost even more to treat.

Provider rate negotiations. Many argue that state employees and retirees should not bear the full cost of benefit design changes when it is not the rate of participant use of services that is driving up the cost of group health benefits as much as it is the rates charged by providers for services. Providers argue that they must negotiate higher rates to remain in business because factors such as high medical inflation for new technologies, labor costs such as nursing shortages at hospitals, and uncompensated care costs annually drive up their operating expenses.

ERS could encourage HealthSelect's third party administrator, Blue Cross Blue Shield of Texas, to more aggressively negotiate with network providers to fund smaller reimbursement rate increases for doctors and hospitals. Such battles must be weighed carefully in light of the risk that providers unhappy with reimbursement rates could leave the network and diminish access to care for HealthSelect participants. Loss of network hospitals in rural areas could be particularly problematic given that some rural hospitals are the only hospitals within a multiple-county area. Some also question the extent to which lower rates could be negotiated given that Blue Cross Blue Shield of Texas already reimburses at a lower rate than any other insurer in Texas, in part because it carries the total bargaining power of 4.5 million Texas participants, including the half-million HealthSelect participants.

Alternate payment systems. HB 4586 by Pitts, the supplemental appropriations bill enacted by the 81st Legislature in 2009, included a requirement that ERS implement pilot programs to study alternate payment systems. One system might involve encouraging health care providers to achieve cost savings for HealthSelect by giving them a share of the savings they achieve. For example, ERS could negotiate performance targets for a provider to reduce high-tech radiology costs by substituting X-rays for CAT scans when medically adequate. If the provider met the performance target and realized a cost savings to HealthSelect, the state could share a portion of this cost savings with the provider. Other alternate payment systems that are not fee-for-service also could be considered.

Provider tiering based on efficiency. ERS could place providers in tiers based on the "efficiency of care" they provide. To determine a health provider's efficiency level, the health plan would review the cost to the plan for all the health services a provider renders to treat a specific injury or illness over a period of time. Providers with a lower total cost of care for various diagnoses would be placed in tier 1. Plan participants would pay a lower copayment if they used a tier 1 provider.

Opponents of such an approach fear providers might find ways to reduce costs to qualify as tier 1 providers that would adversely affect the quality of care they provided. The tiering of providers also could unfairly bias plan participants to think that the providers were tiered according to direct measures of the quality of care they provided, not just their efficiency of care.

ERS staff proposal

As of the end of April, the proposal that ERS staff intend to bring to the ERS board for their May 25 meeting includes several recommendations for cost changes to GBP health benefits intended to shift about 5.4 percent in costs to plan participants. ERS anticipates that these recommendations, when combined with participant behavior changes in response to certain cost increases, should come close to covering the funding shortfall currently projected at $140.4 million. The proposed changes are not expected to leave any balance in the contingency reserve fund.

The proposal focuses primarily on copayments but also includes other potential changes. HealthSelect copayments would increase from $20 to $25 to visit a primary care physician and from $30 to $40 to visit a specialist. The cost to stay in a hospital would increase by $50 per day, to $150 per day with a $750 per stay cap. The $100 per day copayment for out-patient procedures would not increase. Out-patient procedures generally are less costly than in-patient procedures because they limit facility use and staffing needs.

The copayment for an emergency room visit would increase from $100 to $150. The copayment for an urgent care clinic visit, which currently is the same cost as an emergency room visit, would drop to $50. Urgent care clinics generally are less costly service providers than hospital emergency rooms, so a lower copayment for urgent care is intended to encourage participants to use the less costly option when possible.

The cost for each prescription would increase by $5 for generic drugs, by $10 for name-brand drugs, and by $20 for non-preferred drugs. Also, for many years participants have been able to buy their drugs for less if they bought a 90-day supply by mail order. The ERS proposal would allow members to purchase more than a 30-day supply of medication at participating retail pharmacies without paying an additional retail maintenance fee.

The ERS staff proposal would add a $100 copayment for high-tech radiology services, such as CAT scans and MRIs. This copayment would be in addition to the existing 20 percent coinsurance for these services. There would remain no copayment for X-rays only.

The maximum amount of coinsurance a HealthSelect participant could pay annually would increase from $1,000 to $2,000 for network services, from $3,000 to $7,000 for non-network services, and from $1,000 to $3,000 for out-of-area services. Out-of-area services include those services provided to members who are out of state.

The recommended changes also would limit the number of annual visits to a chiropractor to 30 visits and would allow charges of no more than $75 per visit.

Potential legislative changes

The Legislature makes biennial appropriations for much of state employee and retiree health benefit costs and also decides the share of plan contributions paid for by members. The state historically has paid 100 percent of the monthly contribution for full-time state employees, which is $385 per month for fiscal 2010. The state pays 50 percent of the cost for dependents. Part-time state employees pay a monthly $193 contribution toward their health coverage, 50 percent of the monthly cost. The state pays for 25 percent of the monthly

Definitions

Self-funded health plan — a health plan in which the risks of the plan are assumed by the employer, not an insurance company. The employer may contract with an insurer to administer plan benefits. HealthSelect is a self-funded health plan for which the state assumes the risk of participant health claims and contracts with Blue Cross Blue Shield of Texas as the plan administrator.

Contribution — the fixed monthly amount necessary to pay for a member's participation in the HealthSelect self-funded health plan. A contribution is similar to a premium in an insured health plan.

Coinsurance — a member's share of the cost of a health service that is calculated as a percentage of the total amount the health plan allows to be charged for that health service. For example, HealthSelect participants pay 20 percent of the cost of an X-ray.

Copayment — a set dollar amount that a health plan participant must pay for a particular health service. For example, HealthSelect participants currently pay a $20 copayment for a visit to their primary care physician.

Deductible — a defined amount of money that a health plan participant must pay for health services before the health plan begins sharing the cost of health claims. For example, a HealthSelect participant must pay a $50 prescription drug deductible each plan year before HealthSelect will begin sharing the cost of prescription drugs.

Opponents of the Legislature addressing all funding needs for group health benefits through direct appropriations say that given the current budget environment it would be impossible to continue funding current state employee health care benefits without taking money away from other critical programs during a tight budget cycle. They say that Texas is treating its employees more fairly than other states because the state has not had to make large rounds of layoffs or institute furloughs. Only about one third of large private sector firms even offer retiree health benefits. They also point out that because the costs of health coverage increase each year, employees actually have been receiving increased benefits each year during which their health coverage has gone unchanged, even if this benefit is not reflected directly in their paychecks.

Because the fiscal 2011 funding gap is imminent, opponents say, the ERS board would be acting irresponsibly if they did not make benefit design changes now, gambling that the 82nd Legislature would pass an adequate supplemental appropriations bill to address the shortfall. A supplemental appropriations bill likely could not take effect until June 2011. If such a bill did not pass, there would be limited time to implement any significant changes to address the shortfall, which would risk state employee health claims going unpaid at the end of fiscal 2011.

Contribution strategy. The Legislature could change the amount the state pays for certain plan participants' health coverage. Most simply, the state could begin requiring full-time state employees and retirees to pay a share of the monthly contribution to cover their health care costs. For example, plan participants could be asked to contribute a specific amount, such as $25 per month, to the cost of their health care benefits. They also could be asked to pay a fixed percentage, such as 10 percent, of the monthly contribution. Employees and retirees also could be required to pay a greater share of their dependents' health care costs.

Requiring participants to pay a percentage of the monthly cost of their health benefits would provide a funding stream from participants that, unlike flat copayments, grew proportionally with increases in the overall health benefit cost trend. Supporters of such an approach say that a small monthly contribution could be easier for many participants to budget for than would other cost-saving proposals because these added costs would be spread throughout the year. Opponents say once the state crosses the line of expecting employees and retirees to pay part of their monthly plan contribution that it would be easier for subsequent legislatures to increase the percentage of plan contributions paid by participants rather than considering other cost savings measures. Some also say that requiring all participants to pay an equal share of their plan contribution would distribute increasing plan costs evenly to everyone when it would be more fair for those who use more health services or more costly services to pay more into the plan.

Other contribution strategy changes could require different contribution levels from members with different characteristics. For example, participants could pay a greater contribution for their dependents' benefits if they exceeded a certain number of dependents on their health plans.

The state could make larger contributions for retiree health care costs based on the years of service time that the employee had before retiring. For example, retirees with 20 years of service could receive a 100 percent contribution while those with only 10 years of service received a 50 percent contribution. Similarly, newly hired employees could receive a lower contribution from the state than those who had worked for the state for several years. This would provide an incentive for employees to remain in state service.

The Legislature could tier contribution levels based on lifestyle choices. Those who smoked or who were obese could receive a smaller contribution for their health plan than other state workers. Supporters of tiering contributions based on lifestyle choices say it is logical that people who engage in risky behaviors should pay more when their behaviors contribute more to the increasing health benefit cost trend. Opponents of such an approach say it would unfairly discriminate against smokers, the obese, and other groups that could be identified. Some people may be obese due to underlying health conditions and should not be penalized. Also, other groups engage in unhealthy behaviors, so smokers and the obese should not be discriminated against simply because they are the easiest to identify.

The Legislature also could require the state to pay for a minimum level of coverage under HealthSelect and allow participants to "buy up" to a higher level of

coverage. This would allow participants to receive basic coverage and then have control in determining if the added benefits they could receive were worth added out-of-pocket costs. Some express concerns that the pool of people who chose to buy up to a higher benefit level could contain a disproportionately high level of people with greater health risks. If this phenomenon occurred, costs for the "buy up" plan could become prohibitively expensive because that segment of the population likely would have greater health care claims.

Offering more plan types. The Legislature could establish multiple plan options from which participants could choose based on the benefits that best suited their needs. For example, those who anticipated using less health care services might want a plan that recovered costs with higher copayments, while those who anticipated using more health services might prefer a plan with a deductible and lower copayments.

Another example of a different plan offering could be allowing employees and retirees to have the state contribute to a health savings account (HSA) rather than a traditional health plan. HSAs are arrangements in which an employer may make deposits on behalf of employees into a savings account that is not subject to federal income taxes, as long as the employee also has a high deductible health plan. The employee may use funds from the HSA to pay health expenses. Any balance in an HSA that goes unspent during a year is available to the individual for health care spending the following year.

Advocates of providing an HSA option for state employees and retirees say that HSAs encourage efficient use of medical services because participants directly see the full cost of the health services they use, encouraging them to avoid unnecessary or overly costly services. They say that many other states that have implemented an HSA option have high participation rates and have realized health plan cost savings. Opponents of an HSA option express concern that only younger, healthier people will select this option, shifting costs to the traditional health plans, which will have a higher proportion of high-risk participants. They also say people who opt for HSAs may not pursue certain more costly yet critical health services because they will exhaust their savings account balances. Many people do not have funds to pay the out-of-pocket expenses for high-cost health conditions after their savings account has been exhausted but the high deductible on their health plan has not yet been met.

— by Carisa Magee

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cost for the dependents of part-time employees. The following section discusses changes the Legislature could consider to cover the cost of health benefits.

Legislative appropriations to meet cost increases. The Legislature could address all funding needs for group health benefits with state appropriations rather than by requiring members to increase cost sharing.

Supporters of this approach say that many retirees are living on a fixed income and many active state employees already are living from paycheck to paycheck without having the added burden of increased out-of-pocket health costs. Most state employees did not receive a raise during fiscal 2010-11, which perpetuates the trend of consumer inflation outpacing Texas state employee wage increases.

Supporters of the state absorbing health benefit costs say that requiring state employees and retirees to pay a larger share of state health benefits would amount to a salary cut and undermine one of the advantages of state employment, eventually resulting in a loss of qualified employees. State jobs already pay less than similar jobs in the private sector. Despite troubled economic times, the turnover rate at many state agencies remains more than 20 percent. The state loses significant amounts of money having to train new workers in fields with high turnover rates, not to mention that the experienced workers Texas does retain often have higher productivity rates than new hires. Increasing health care costs would hit state retirees even harder because their pensions have not increased since January 2002 and are not expected to rise any time in the foreseeable future.

ERS staff recommendations for HealthSelect benefit changes

Benefit recommendation	Current cost*	ERS recommended cost*
Primary care physician visit increase copay by **$5**	**$20** copay	**$25** copay
Specialist visit increase copay by **$10**	**$30** copay	**$40** copay
In-patient hospital stay increase copay by **$50** per day and increase maximum per stay by **$250**	**$100/day** copay (**$500** max copay per stay) + 20% coinsurance	**$150/day** copay (**$750** max copay per stay) + 20% coinsurance
Emergency room visit increase copay by **$50**	**$100** copay + 20% coinsurance	**$150** copay + 20% coinsurance
Urgent care facility visit reduce copay by **$50**	**$100** copay + 20% coinsurance	**$50** copay + 20% coinsurance
High-tech radiology add **$100** copay	**$0** copay + 20% coinsurance	**$100** copay + 20% coinsurance
Prescription drug cost** increase copay by **$5** for *generic drugs* increase copay by **$10** for *name brand drugs* increase copay by **$20** for *non-preferred drugs*	 **$10** copay **$25** copay **$40** copay	 **$15** copay **$35** copay **$60** copay
Annual maximum coinsurance increase by **$1,000** for *network services* increase by **$4,000** for *non-network services* increase by **$2,000** for *out-of-area services*	 **$1,000** annual max **$3,000** annual max **$1,000** annual max	 **$2,000** annual max **$7,000** annual max **$3,000** annual max

* *For HealthSelect network services, unless otherwise specified.*

** *Reflects the cost of a non-maintenance drug prescription.*

Source for data: Employees Retirement System of Texas