



How have health benefits changed in state and local governments from 1998 to 2011?

Health insurance coverage for state and local government employees has undergone significant changes over the past decade. Although state and local governments still provide comprehensive coverage to most employees, the total percentage of employees who are covered by insurance has declined. In addition, a higher proportion of health care costs have shifted to employees, and a larger percentage of employees are now enrolled in contributory plans that require employees to pay premiums. Coverage for benefits has also changed; more employees have restricted health plans or plans with limited coverage, requiring them to pay deductibles or coinsurance.

This issue of *Beyond the Numbers* looks at changes in health care plan participant provisions for state and local government employees in 1998 and 2011. Detailed provisions on state and local government benefits are collected periodically in the National Compensation Survey (NCS).¹ Data for 2011 are now available in the NCS; this is the first detailed study of government benefits since 1998.² Estimates of 2011 state and local government benefit provisions in this issue are from “National

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Compensation Survey: Health Plan Provisions in State and Local Government in the United States, 2011," available online at <http://www.bls.gov/ebs/detailedprovisions/2011/ebbl0049.pdf>. Estimates of 1998 state and local government benefit provisions in this issue are from "Employee Benefits in State and Local Governments, 1998," available online at <http://www.bls.gov/ncs/ebs/sp/ebbl0018.pdf>. Estimates of 2011 benefit provisions in this issue are from "National Compensation Survey: Employee Benefits in the United States, March 2011," available online at <http://www.bls.gov/ebs/benefits/2011/ebbl0048.pdf>. See the Glossary beginning on page 5 for definitions of the terms used in this issue.

Coverage of employer-provided health insurance

In 2011, 82 percent of full-time employees in state and local government participated in a medical plan, compared with 86 percent of such employees in 1998. From 1998 to 2011, full-time employee participation declined for dental care, vision care, and outpatient prescription drug coverage plans. Sharper declines occurred for part-time employees participating in medical care coverage plans, with only 18 percent of part-time employees obtaining coverage in 2011, compared with 37 percent in 1998. Declines were also recorded for dental care, vision care, and outpatient prescription drug coverage. (See table 1.)

Table 1

Participation in health care coverage for state and local government employees, in percent, National Compensation Survey, 1998, 2011

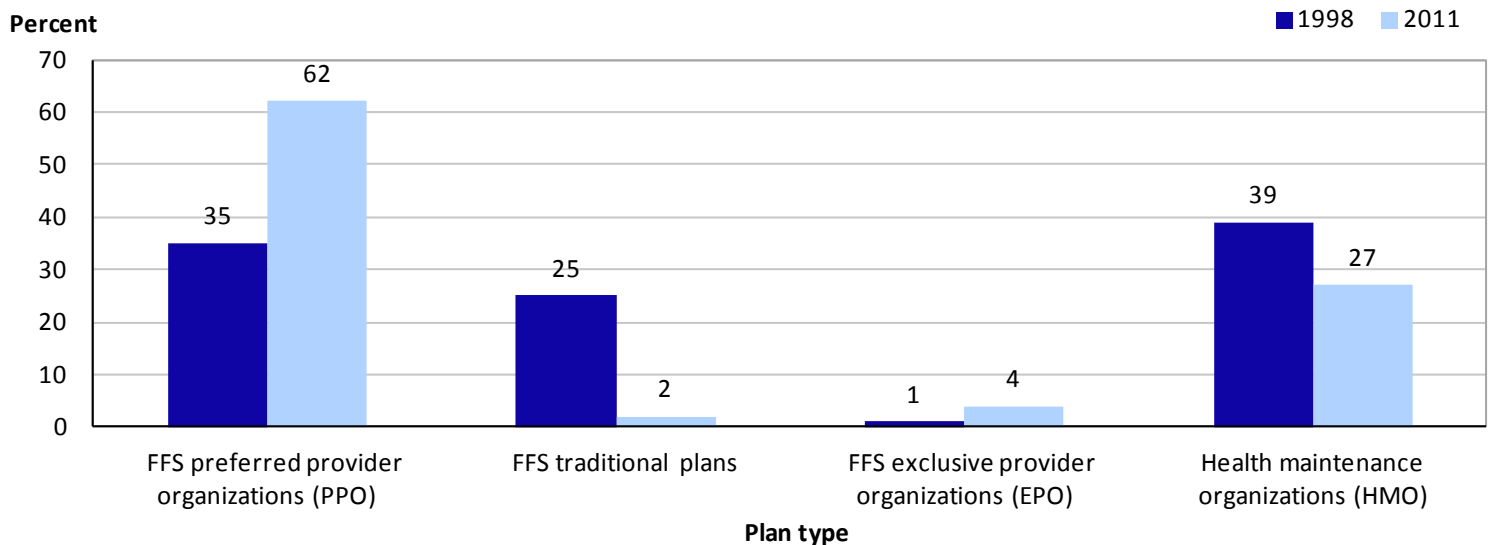
Benefit	Full-time employees		Part-time employees	
	1998	2011	1998	2011
Medical care	86	82	37	18
Dental care	60	54	31	13
Vision care	43	35	17	9
Outpatient prescription drug coverage	84	81	33	18

NOTE: All workers = 100 percent.
SOURCE: U.S. Bureau of Labor Statistics.

New types of health plans were established between 1998 and 2011.³ In the 1990s, many employers adopted "managed care" plans, which established administrative control of health care service as a means to control costs. Traditional fee-for-service plans, which allowed access to any provider without affecting reimbursement, had been the dominant health plan. In 1998, a quarter of employees were still enrolled in traditional fee-for-service plans. In 2011, traditional fee-service plans had nearly disappeared, accounting for only 2 percent of enrollees. (See chart 1.)

Chart 1

Participation by selected health plan type, full-time state and local government employees, National Compensation Survey, 1998, 2011



NOTE: FFS = Fee-for-service.
SOURCE: U.S. Bureau of Labor Statistics.

Table 2

Type of coverage and monthly amount of employee contribution for medical care benefits, full-time state and local government employees, National Compensation Survey, 1998, 2011

Type and amount of contribution	Single coverage		Family coverage	
	1998	2011	1998	2011
Noncontributory coverage (in percent)	49	34	25	12
Contributory coverage (in percent)	51	66	75	88
Employee contribution (flat monthly amount)	\$31.94	\$90.90	\$152.46	\$397.32

SOURCE: U.S. Bureau of Labor Statistics.

Preferred provider plans (PPO) and exclusive provider organizations (EPO) obligate enrollees to use only the plan's providers; use of services outside the network may be available at higher costs. In 1998, 36 percent of health care plan participants were enrolled in PPO or EPO plans. By 2011, PPO and EPO plans had grown sharply, accounting for nearly two-thirds of plan participants.

Health maintenance organizations (HMO), which provide comprehensive medical services in return for a fixed, prepaid fee from members, accounted for 39 percent of health care plan participants in 1998. HMO plans declined to 27 percent of participants in 2011. In addition, point-of-service plans, a hybrid combining features of PPO and HMO plans, had 5 percent of enrollees in 2011.

Employee contributions to health insurance

Employee costs of health insurance underwent sharp increases from 1998 to 2011. The proportion of full-time employees in noncontributory plans, those in which the employer pays the entire premium, declined from 49 to 34 percent for single coverage and from 25 percent to 12 percent for family coverage plans. Employee contributions also rose for health premiums. In 1998, monthly premiums for single coverage plans averaged \$31.94 and family plans averaged \$152.46. In 2011, single coverage premiums had increased nearly three times to \$90.90, and family coverage increased 2½ times to \$397.32. (See table 2.)

Other health insurance costs rose too. Individual deductibles, which are the annual amounts that employees pay before the insurer begins coverage, increased from a median of \$200 in 1998 to \$500 in 2011. Family deductibles had a similar increase from 1998 to 2011, from a median of \$400 to \$1,000.

Maximum out-of-pocket expense is the amount the employee must pay during the year before the insurer pays the remaining covered expenses. Individual out-of-pocket limits in plans with flat dollar amounts rose to a median of \$1,750 in 2011 from a range of between \$501 and \$999 in 1998.⁴ Family out-of-pocket expenses rose to a median of \$3,250 in 2011 from \$2,000 in 1998. (See table 3.)

Table 3

Deductibles and out-of-pocket expense maximum (individual and family) for full-time state and local government employees, fee-for-service plans with flat dollar amounts, National Compensation Survey, 1998, 2011

Benefit provision	Median annual amount	
	1998	2011
Individual deductible	\$200	\$500
Family deductible ¹	400	1,000
Individual out-of-pocket expense maximum	501-999	1,750
Family out-of-pocket expense maximum	2,000	3,250

1. The median family deductible was not published as a dollar amount in 1998, but was specified as a number of individual deductibles that must be met to satisfy a family deductible, or as a multiple of the individual deductible. For plans which specified a multiple of an individual deductible, the majority of family deductibles were twice that of individual deductibles.

SOURCE: U.S. Bureau of Labor Statistics.

Table 4

Coverage for selected benefits in plans for full-time state and local government employees, in percent, National Compensation Survey, 1998, 2011

Benefit provision	Fee-for-service plans ¹						Health maintenance organizations					
	Full coverage		Coverage with limits		No coverage		Full coverage		Coverage with limits		No coverage	
	1998	2011	1998	2011	1998	2011	1998	2011	1998	2011	1998	2011
Hospital room and board	10	13	90	86	—	—	76	39	24	61	—	—
Inpatient surgery	25	13	75	86	—	—	93	48	7	50	—	—
Outpatient surgery	20	9	80	90	—	—	88	27	12	71	—	—
Physician office visits	3	—	97	99	—	—	13	5	87	95	—	—
Inpatient mental health care ²	5	6	94	92	1	—	9	29	90	70	1	—

1. Includes non-health maintenance organizations in 1998.

2. Estimates for 1998 are not comparable with previously published values. The estimates for “full coverage,” “coverage with limits,” and “no coverage” were recomputed to be based on all workers participating in a fee-for-service plan or a health maintenance organization plan.

NOTE: All workers participating in fee-for-service plans and health maintenance organizations = 100 percent. Totals may not equal 100 due to rounding and a small number of plans where provisions were not determinable. Dash indicates no workers in this category or data did not meet publication criteria.

SOURCE: U.S. Bureau of Labor Statistics.

The decline in access to employer-provided plans and increases in contributory health plans and employee costs for monthly premiums may help explain the decline in coverage, particularly among part-time employees.

Changes in coverage for selected benefits

The coverage for hospital room and board, inpatient and outpatient surgery, physicians’ office visits, and inpatient mental health care remained nearly universal from 1998 to 2011. However, among workers participating in fee-for-service plans, full coverage for inpatient and outpatient surgery dropped nearly in half, while full coverage for other benefits, such as hospital room and board and inpatient mental health care, were fairly stable. Full coverage means that employees have no required deductibles, coinsurances, or other limits imposed by the health insurance plan. (See table 4.)

Full coverage for various health benefits in HMO plans declined sharply—hospital room and board dropped from 76 percent to 39 percent, inpatient surgery from 93 to 48 percent, and outpatient surgery from 88

percent to 27 percent. The exception for HMO plans was inpatient mental health care, where full coverage rose to 29 percent in 2011 from only 9 percent in 1998. (See table 4.) This is largely because of the passage of the Mental Health Parity and Addiction Equity Act of 2008, which requires group health insurance plans that offer coverage for mental illness to provide those benefits in a way which is no more restrictive than other medical and surgical procedures covered by the plan.

State and local government employees, while still enjoying broad health care coverage, have seen major changes in plan provisions costs in years. Although recent data show that health insurance is still available to the majority of employees, the level of participation and extent of coverage has declined from 1998 to 2011, while the costs to employees have increased over this period. ■

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Glossary

Deductible. The deductible is a dollar amount that an insured person pays during the benefit period—usually a year—before the insurer starts to make payments for covered medical services. Plans may have both individual and family deductibles. Some plans have separate deductibles for specific services.

Dental care. Plans that provide services or payments for restorative care and related dental services.

Exclusive provider organization (EPO). This type of plan obligates employees to use only the plan’s providers in order to receive coverage, in contrast to PPO benefit plans, which merely offer a financial incentive for enrollees to use the preferred provider. An EPO is a specific type of PPO plan that can be either self-insured or insured through an insurance company.

Health Maintenance Organizations (HMOs). This type of plan assumes both the financial risks associated with providing comprehensive medical services and the responsibility for delivering health care in a particular geographic area, usually in return for a fixed, prepaid fee from members. HMOs emphasize preventive care and cover most types of care in full or subject to a copayment.

Maximum out-of-pocket expense. This feature limits the dollar amount a group member is required to pay out of pocket during a year. Until it is met, the plan and the member share in the cost of covered expenses. After the maximum is reached, the insurer pays all covered expenses, often up to a lifetime maximum.

Medical care. Plans that provide payments or services rendered in the hospital or by a qualified medical care provider.

Outpatient prescription drug coverage. Plans that provide coverage for prescription drugs during out-of-hospital stays.

Point-of-service (POS) plan. This type of plan combines features of PPOs and traditional HMOs. POS enrollees receive more generous benefits for services within the network and for specialist care authorized by their primary care physicians. Benefits are less generous for care received outside the network and for self-referrals.

Preferred provider organization (PPO). This type of plan provides coverage through a network of participating health care providers. Enrollees may receive services outside the network, but at higher costs. The additional costs may be in the form of higher deductibles, higher coinsurance rates, or both, or in the form of nondiscounted charges from providers.

Traditional fee-for-service plan. This type of plan finances, but does not deliver, health care services; the plan allows participants the choice of any provider, without affecting reimbursement. Employers pay premiums to a private insurance carrier to provide a specific package of health benefits. Some employers may choose to self-fund a fee-for-service plan, in which case the employer, as opposed to an insurance company, assumes responsibility for payment of all eligible benefits.

Vision care. Plans that provide coverage for the nonsurgical improvement of eyesight, including eye glasses and contact lenses. Coverage typically is limited and is subject to applicable copayments or scheduled cash allowances.

Notes

1. National Compensation Survey produces annual data on the percentage of state and local government workers with access to and participation in employee benefit plans.
2. Statistical comparison statements cannot be validated between 1998 and 2011 data because standard error estimates were unavailable for 1998.
3. The “fee-for-service” terminology changed between the 1998 bulletin and the 2011 bulletin; the usage here is consistent with the terminology from 2011. In 1998, fee-for-service plans were titled “non-HMO plans” and included traditional fee-for-service, preferred provider organizations, and exclusive provider organizations.
4. Median annual amounts were not published in 1998, but were determined from a distribution of values. The median value for the individual out-of-pocket expense maximum was within the category \$501–\$999.

