NACo TRENDS ANALYSIS PAPER SERIES • ISSUE 2 • 2014

County Health Benefits 2014

Lead Authors:

Emilia Istrate
NACo Director of Research

Kirk Heffelmire
NACo Research Associate

Molly Longstreth
Public Service Assistant
Carl Vinson Institute of Government
The University of Georgia

COUNTIES FUTURES LAB NACo

AUTHORS

CARL VINSON INSTITUTE OF GOVERNMENT

THE UNIVERSITY OF GEORGIA

Molly Longstreth, Ph.D.
Public Service Assistant

Minsoo Kim, M.S.
Graduate Research Assistant

Theresa A. Wright, Ph.D.
Director, Survey Research and Evaluation

Cavan J. Gray, M.S.
Graduate Research Assistant

Courtney R. Yarbrough, M.P.A.
Graduate Research Assistant

NATIONAL ASSOCIATION OF COUNTIES

Dr. Emilia Istrate
Director of Research

Kirk Heffelmire
Research Associate

ACKNOWLEDGMENTS

The authors are grateful to the support given by the Carl Vinson Institute of Government, particularly Ted Baggett and Theresa Wright. The authors would also like to thank Quincy Quinlan, Marcia Chadbourne and Janice Mazone for their helpful feedback on the draft of this report. This effort would not be possible without the previous work in 2009 to develop and field the original survey by Jacqueline Byers, Angela R. Fertig, Kelly Foster and Tamar Gabunia. We are also indebted to the county government officials and staff who gave their time and attention to answering the survey. Within the National Association of Counties, we would like to thank Matt Chase, Paul Beddoe, Maeghan Gilmore, Mary Bell and Tom Goodman for their thoughtful comments throughout the writing of this report. We also thank Alice Zhai for research assistance, Jack Hernandez for graphic design and Matthew Fellows for designing the accompanying Web page.

FOR MORE INFORMATION, CONTACT:

Emilia Istrate
Director of Research
National Association of Counties
research@naco.org

Kirk Heffelmire
Research Associate
National Association of Counties
research@naco.org

Executive Summary

County governments not only provide vital health services to residents, but also serve as major public employers, offering health benefits to their employees, dependents and retirees. Two surveys in April 2009 and March 2014 of the same sample of counties provide valuable insights and data on county employee health benefits coverage, changes and current challenges. An analysis of these survey results reveals:

1 – County health benefit eligibility for employees and dependents and county spending on health insurance increased significantly over the last five years. In 2014, an estimated 2.5 million county employees — out of 3.5 million full-time and part-time county workers — and nearly 2.4 million of their dependents are enrolled in health plans offered by county governments. For health insurance premiums alone, counties spend an estimated $20 billion to $24 billion annually. Between 2009 and 2014, average monthly premiums for county health plans increased by 20 percent. Full-time employees are eligible for county health benefits in almost all counties and 80 percent of counties offer health coverage for all employee dependents. Between 2009 and 2014, the share of responding counties offering health coverage to all of their part-time employees doubled (from 8 to 16 percent).

Counties provide extensive health coverage to their employees, dependents and retirees, and continue to balance expanding coverage eligibility with rising costs.

2 – Counties are making plan changes and reducing costs. One third of counties reported shopping for a new plan in 2013. Cutting costs was the most common reason cited by counties that changed their offerings (31 percent). Counties are also working with their employees to contain health care costs, by continuing to share premium costs or increasing the deductible amounts, copayments and/or out-of-pocket limits. Between 2009 and 2014, the shares of employee contributions to health insurance premiums stayed relatively the same across plan types and coverage levels. The average deductible across all plans increased by 49 percent for single coverage and 67 percent for family coverage. Over the past five years, the average out-of-pocket maximums increased by an average of 59 percent across all plan types and coverage levels, but are still below the maximum amounts allowed by the Affordable Care Act (ACA).

3 – Counties are still grappling with the effects of the Affordable Care Act (ACA) on the health benefits offered to their employees. While 34 percent of responding counties mentioned increased costs because of ACA implementation, 35 percent reported no ACA effects and 7 percent were not aware of any impact on their county, as of March 2014. The complexity of the ACA statute and compliance requirements was the most commonly cited barrier to the implementation of federal health care reform, as reported by 42 percent of responding counties.

4 – Most counties offer some type of wellness program, at a higher rate than in 2009. A majority of counties (59 percent) offered one or more wellness programs in 2009. By 2014, the share of counties offering at least one wellness program rose to more than 80 percent. The most common wellness program among responding counties in 2014 was smoking cessation (60 percent), followed by weight loss programs (52 percent). Between 2009 and 2014, the share of counties offering any rewards to their employees for participation increased from 26 percent to 35 percent.

5 – Counties are more likely to offer retiree health benefits than other employers. Sixty-eight (68) percent of counties offered health benefits to their retirees in 2014, more than the 2013 national average for employers with more than 200 employees (28 percent). Counties offer retiree health benefits at a higher rate than employers with more than 200 employees for both early retirement (97 percent compared with 90 percent) and after the age of 65 (72 percent compared with 67 percent). In 2014, 93 percent of responding counties offered their current employees health benefits upon retirement.

Counties provide extensive health coverage to their employees, dependents and retirees, and continue to balance expanding coverage eligibility with rising costs. While the ACA imposed significant changes on the health insurance market, counties have reacted differently to the impact of the ACA's early provisions. Employee wellness programs offered by counties expanded over the past five years, and counties provide health benefits to their retirees at a higher rate than other employers.

This report is a snapshot of how counties are responding to rapidly changing regulatory and market environments. The variations in the data illustrate the tensions that are inherent to the county government's role in the health system. Rooted in counties' traditional function as health care safety net providers, there is evidence of strong support for maintaining and even expanding employee eligibility for health insurance coverage. At the same time, the survey respondents register resistance to complicated regulations and federal preemption of local control. Overall, county governments play a critical role in the planning, management and implementation of health benefits coverage to their employees, retirees and their dependents.

Introduction

Collectively, county governments are one of the largest employers in the United States and represent a major source of health care coverage for Americans. Counties employ more than 3.5 million full-time and part-time workers, 2.7 percent of the U.S. workforce, according to the U.S. Census of Governments 2012 data.[1] This study estimates that 2.5 million county full-time, part-time, temporary and seasonal employees and nearly 2.4 million of their dependents are enrolled in health plans offered by county governments in 2014, and counties spend an estimated $20 billion to $24 billion annually on their health insurance premiums. The implementation of the Patient Protection and Affordable Care Act — commonly referred to as the Affordable Care Act (ACA) — offers an opportunity for counties to assess their current health benefits, changes over the last five years and potential effects of, and barriers to, ACA implementation.

The regulatory changes mandated by the ACA affect private and public employers alike. According to the U.S. Department of Health and Human Services, the ACA has a number of goals — to increase access to health care and make it more affordable, to enhance patient protections in the insurance market and to improve health care quality.[2] A number of ACA provisions that represent substantial changes to employment-based health plans affect counties, including but not limited to the elimination of preexisting condition limits, the removal of annual and lifetime benefit caps, extended coverage for dependent children up to age 26, classification of employees as full-time when working 30 hours per week or more and to define the benefit level required as essential coverage (For a detailed discussion of the ACA provisions affecting counties as employers, see the NACo Counties as Employers Health Reform Toolkit at *www.naco.org/healthreformimplement*).[3]

The implementation of the Patient Protection and Affordable Care Act offers an opportunity for counties to assess their current health benefits.

This study creates a baseline for understanding county health benefits for their employees, dependents and retirees, before all changes resulting from ACA implementation take place. The National Association of Counties (NACo) developed this research in partnership with the Carl Vinson Institute of Government (CVIOG) at the University of Georgia. This report uses the results of two surveys of county governments from April 2009 and March 2014, both done together with CVIOG. The 2009 survey used a stratified random sampling method to select about 1,000 counties representing all four U.S. Census regions as well as counties of different population sizes.[4] The 2014 survey (henceforth, "the 2014 NACo/CVIOG survey") was distributed to the same sample used in the previous survey. In addition, it included many of the questions posed in the previous survey for determining trends. All the change estimates between 2009 and 2014 reported as statistically significant were tested at a 95 percent confidence level, unless noted otherwise. Due to the low number of responses from counties in certain population or regional groups, this study reports only aggregate results.

This report examines current county benefit packages offered to employees and their dependents, changes since 2009 and county spending on health insurance premiums. It also analyzes reasons behind health plan changes and trends in the employee share of premiums, deductibles, copayments and out-of-pocket limits. It captures county reaction to effects of, and barriers to, ACA implementation. This study also identifies trends in county offerings of wellness and incentive programs. Finally, this research examines the health benefits offered to county retirees and changes in retiree health eligibility for current county employees.

KEY TERMS USED IN THIS REPORT

Coinsurance: The percentage of the costs of a covered health care service the enrollee pays at the time of service. For example, if the coinsurance is 20 percent, the amount for an office visit is $100 and the enrollee has met his or her deductible, the coinsurance payment would be $20. The health insurance or plan pays the rest of the allowed amount.[5]

Conventional Indemnity Plan: This health insurance plan reimburses the patient and/or provider as expenses are incurred. A conventional indemnity allows the participant to choose any provider without effect on reimbursement.[6]

Copayment: A fixed amount (for example, $15) the health insurance enrollee pays for a covered health care service, usually when the service is rendered. The amount can vary by the type of covered health care service.[7]

Deductible: The amount the enrollee owes for covered health care services before the health insurance or plan begins to pay. For example, if the deductible is $1,000, the health plan will not pay anything until the enrollee meets the $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.[8]

Dependents: A child or other individual for whom a parent, relative or other person may claim a personal exemption tax deduction.[9]

Exclusive Provider Organization (EPO) Plan: A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).[10]

Full-Time Employees: Employees as classified as full-time by their employer. According to the Affordable Care Act, individuals who work 30 hours or more per week.[11]

Fully Insured or Underwritten Plan: A type of plan where the employer purchases coverage from an insurance company and the insurer assumes all financial responsibility for claims and administrative costs.[12]

Grandfathered Health Plan: A group health plan that was created on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers.[13]

Health Maintenance Organization (HMO) Plan: In this plan, participants receive treatment only from an HMO physician in order for the treatment expenses to be covered under insurance. This type of health care system assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee.[14]

High-Deductible (HD) Plan: A type of plan that features higher deductibles than traditional insurance plans. High-deductible plans can be combined with a health savings account or a health reimbursement arrangement to allow the enrollee to pay for qualified out-of-pocket medical expenses on a pre-tax basis.[15] According to IRS rules, deductibles in a plan tied to a health savings account must be at least $1,250 annually for single coverage and at least $2,500 for family coverage in 2014.[16]

Maximum Out-of-Pocket Expense: The highest amount the enrollee pays during a policy period (usually one year) before the health insurance or plan starts to pay 100 percent for covered essential health benefits. This limit must include deductibles, coinsurance, copayments or similar charges and any other expenditure required of an individual, which is a qualified medical expense for the essential health benefits.[17]

Part-Time Employees: Employees as classified as part-time by their employer. According to the Affordable Care Act, individuals who work less than 30 hours per week.[18]

Point of Service (POS) Plan: A type of plan that requires the enrollee to get a referral from a primary care doctor in order to see a specialist. The enrollee pays less when using doctors, hospitals and other health care providers that belong to the plan's network.[19]

Preferred Provider Organization (PPO) Plan: A type of plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. The enrollee pays less when using providers in the plan's network, but can use doctors, hospitals and other providers outside of the network for an additional cost.[20]

Premium: The amount paid for enrollment in a health insurance or plan. The enrollee and/or the employer usually pay it monthly, quarterly or yearly.[21]

Self-Insured Plan: A type of plan where the employer assumes all financial responsibility of paying employees' and dependents' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan.[22] All types of plans (Conventional Indemnity, PPO, EPO, HMO and POS) can be financed on a self-insured basis.[23]

Temporary/Seasonal Employees: Employees as classified as temporary or seasonal by their employer. Generally, a worker who performs labor or services for only a certain period of time.[24]

Findings

1. County health benefit eligibility for employees and dependents and county spending on health insurance increased significantly over the last five years.

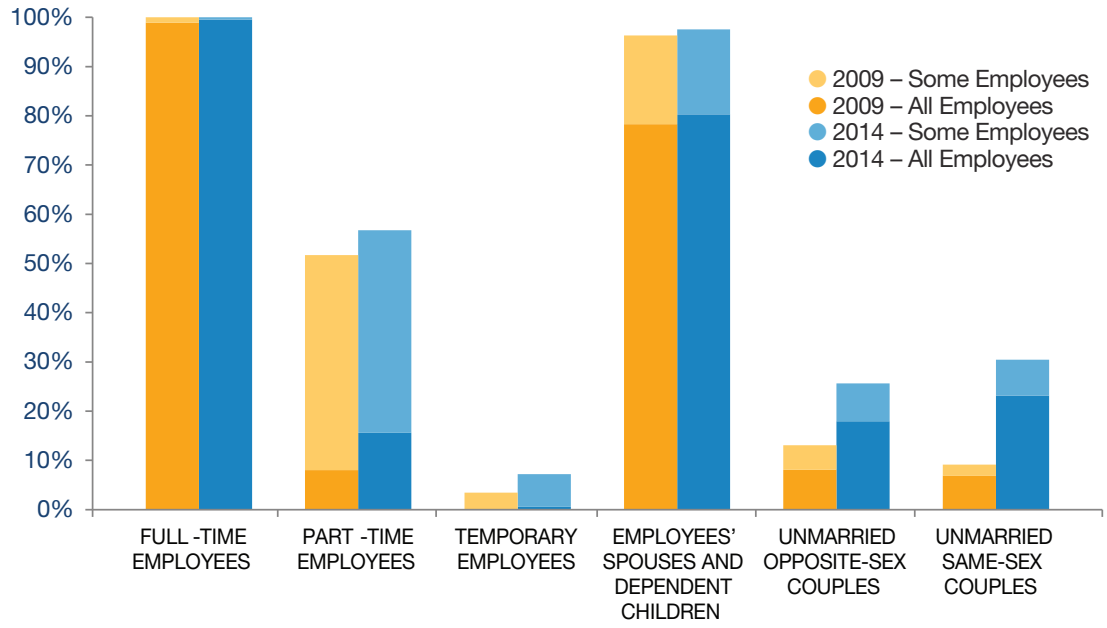
County governments are one of the largest employers in the United States and represent a major source of health care coverage for Americans. Counties employ more than 3.5 million full-time and part-time workers, 2.7 percent of the U.S. workforce, according to the U.S. Census of Governments 2012 data.[25] Counties offer health benefits not only to their employees and dependents, but also to their retirees. Based on the 2014 NACo/CVIOG survey, virtually all the responding counties (more than 99 percent) offer health benefits to their employees and 86 percent of eligible county employees use the health insurance offered by counties. This translates to an estimated 2.5 million county full-time, part-time, temporary and seasonal employees and nearly 2.4 million of their dependents covered by county health plans across the 3,069 counties in 2014.

Most counties do not rely on their states for health insurance. In 2014, only 11 percent of responding counties participated in their state's health insurance program, down from 16 percent of the responding counties in 2009.[26] Among counties offering health insurance coverage, about half of the plans are fully insured (with the county contracting with a health insurer for coverage) and half are self-insured plans, in which the county bears responsibility for their employees' and dependents' medical claims.

Expansion of health coverage eligibility for employees and dependents. County governments expanded their health benefits eligibility over the last five years.[27] Counties offer health benefit coverage not only to full-time employees, but also to their dependents and some part-time employees as well. Full-time employees are eligible for benefits in practically all of the responding counties (See Figure 1).[28] The coverage eligibility expansion occurred for other types of employees: part-time and temporary. The share of responding counties offering coverage to all of their part-time employees doubled between 2009 and 2014, reaching 16 percent. In addition, more than half of responding counties offer health benefits to at least some of their part-time employees. While still limited, the proportion of counties offering coverage to at least some temporary employees doubled between 2009 and 2014, up to 7 percent.

County health coverage eligibility also became more inclusive. Coverage eligibility for domestic partners witnessed a significant expansion. A quarter of responding counties offered benefits to some or all unmarried opposite-sex domestic partners in 2014, a significant increase from 13 percent in 2009 (See Figure 1). Between 2009 and 2014, the share of responding counties offering benefits to some or all unmarried same-sex partners more than tripled, with 30 percent of responding counties extending such benefits. Eighty (80) percent of counties offer benefits to all employee spouses and dependent children, which was essentially unchanged between 2009 and 2014, given the high level of coverage already in place in 2009.

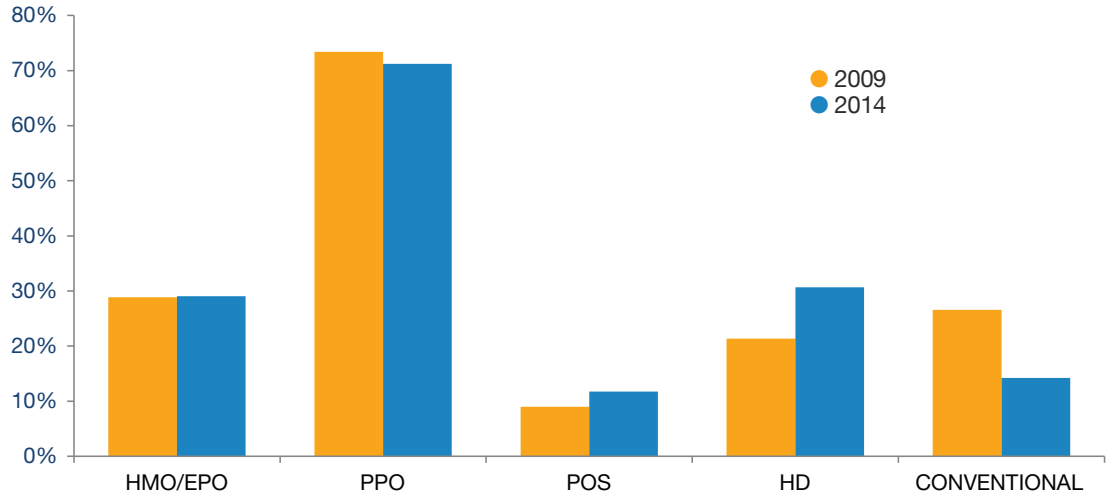
FIGURE 1. County Health Insurance Coverage for Employees and their Dependents, Shares of Responding Counties, 2009 and 2014



Note: Both 2009 and 2014 surveys used the same sample of counties. All estimates of change are significant at the 95 percent level, except for full-time employees and employees' spouses and dependent children. The response rate for these items ranged from 84 percent to 89 percent in the 2009 survey and from 72 percent to 99 percent in the 2014 survey.

Sources: NACo/CVIOG surveys, 2009 and 2014

FIGURE 2. County Health Insurance Plans Offered to Employees and their Dependents, Shares of Responding Counties, 2009 and 2014



Note: Both 2009 and 2014 surveys used the same sample of counties. Shares add up to more than 100 percent since more than 40 percent of responding counties offer multiple plans. Only the estimates of change for conventional and HD plans are significant at the 95 percent level. The response rate for these items was 87 percent in the 2009 survey and ranged from 78 percent to 91 percent in the 2014 survey.

Sources: NACo/CVIOG surveys, 2009 and 2014

PPO plans are the most popular. While many counties offer a range of health plans, Preferred Provider Organization (PPO) plans are the most popular. Forty-one (41) percent of responding counties offered two or more insurance plan options in 2014, similar to the selection available in 2009. Preferred Provider Organization (PPO) plans are the most prevalent among counties, independent of the number of plans offered by the county; more than 70 percent of responding counties (See Figure 2) and 63 percent of counties with a single insurance plan offer a PPO plan. Among responding counties, nearly 30 percent offered Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) plans. The High-Deductible (HD) plans witnessed the highest increase in popularity, from 21 percent to 31 percent of counties between 2009 and 2014. In contrast, the conventional indemnity insurance plans saw the largest change in plan offerings between 2009 and 2014, as their prevalence fell by nearly half, from 27 percent to 14 percent of responding counties. The Point of Service (POS) plans are the least common among responding counties; only 12 percent of responding counties provided these plans in 2014.

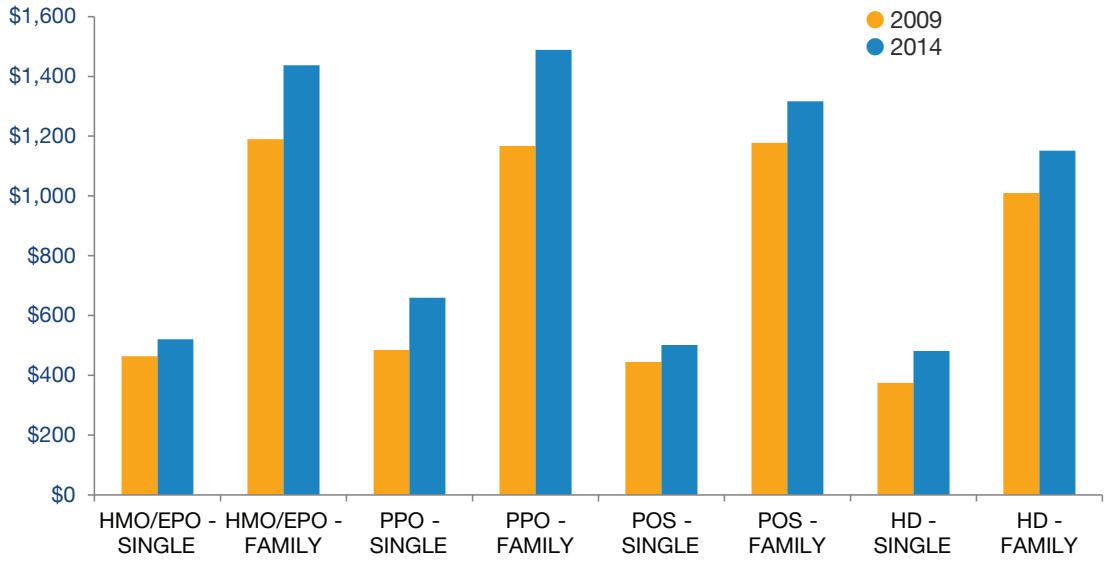
Counties offer health benefits beyond health insurance. Counties are active in offering dental, vision and prescription drug coverage. Nearly two thirds of responding counties reported offering stand-alone dental insurance and half of the responding counties provide separate vision insurance to their employees in 2009 and 2014.[29] Both dental and vision coverage are popular with county employees as nearly 79 and 75 percent of enrollees in county plans opt for them, respectively. Most health insurance plans offered by counties include prescription drug coverage. For example, more than 90 percent of HMO, EPO and PPO plans include prescription drug coverage for both single and family coverage. Slightly fewer of the HD (86 percent) and POS plans (88 percent) offered by responding

counties include prescription drug coverage. While the share of county health insurance plans with prescription drug benefits remained stable between 2009 and 2014, the share of PPO plans offering prescription drug benefits decreased slightly from 95 percent to 92 percent.

County spending on health insurance premiums. Health insurance premiums represent a major cost for counties. For health insurance premiums alone, counties spend an estimated $20 billion to $24 billion annually (See Methodology Appendix for more detail on the estimation method). This estimate does not include county health spending on the coverage of retirees and their dependents; premiums for other health benefits such as stand-alone prescription drug, dental or vision benefits; contributions to health reimbursement accounts; flexible or health savings accounts or for wellness and disease management programs.

Counties' health spending increased significantly over the last five years. Between 2009 and 2014, the price of county health coverage (the average total monthly premium) rose by approximately 20 percent.[30] This rise in costs is more than the 16 percent growth rate of medical price inflation.[31] Preferred Provider Organization (PPO) plans witnessed the highest growth in average total monthly premium cost, by nearly 36 percent for single coverage and over 27 percent for family coverage between 2009 and 2014 (See Figure 3).

FIGURE 3. Average Total Monthly Premiums of Health Insurance Offered by Counties, by Plan and Coverage Level, 2009 and 2014



Note: The total monthly premiums include the employer and employee contributions. Both 2009 and 2014 surveys used the same sample of counties. All estimates of change are significant at 95 percent level, except for HD plans under family coverage and POS plans under both single and family coverage. The response rate for these items ranged from 54 percent to 81 percent in the 2009 survey and from 80 percent to 89 percent in the 2014 survey. The survey does not distinguish between grandfathered and non-grandfathered plans.

Sources: NACo/CVIOG surveys, 2009 and 2014

County governments pay the majority of the health insurance premium costs for their employees and their dependents. In 2014, employees contributed between 5 and 33 percent of the total monthly premium cost, depending on the plan they were enrolled in and whether they had single or family coverage (See Table 1). For single-coverage plans, employees contributed the least to HD plans (5 percent) and the most to POS plans (13 percent). For family coverage, the average employee share ranges from 26 percent for HD plans to 33 percent for PPO and POS plans.

TABLE 1. Average Employee Shares of Contribution to Premium Cost, by Plan and Coverage Level, 2014

Plan	Coverage	Average Employee Share
HMO/EPO	Single	12%
	Family	27%
PPO	Single	11%
	Family	33%
POS	Single	13%
	Family	33%
HD	Single	5%
	Family	26%

Note: HMO/EPO = Health Maintenance Organization/Exclusive Provider Organization plan; PPO = Preferred Provider Organization plan; POS = Point of Service plan; HD = High-Deductible plan. The 2009 and 2014 surveys used the same sample of counties. The response rate for these items ranged from 54 percent to 81 percent in the 2009 survey and from 76 percent to 89 percent in the 2014 survey.

Source: NACo/CVIOG survey, March 2014

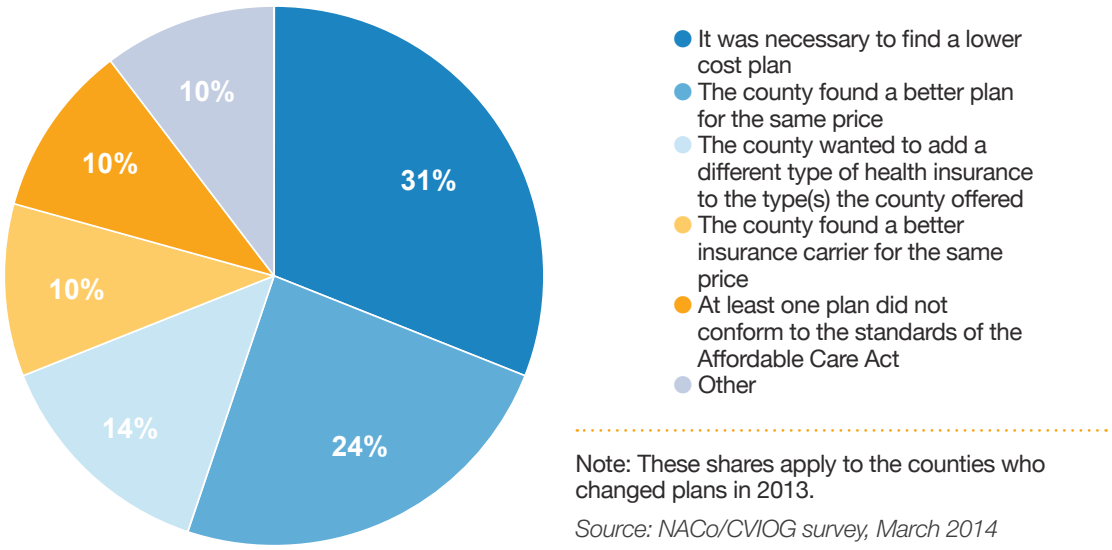
Counties as employers offer health insurance to meet the needs of their workers and their dependents. Offering health coverage does not stop at full-time employees, and has rapidly increased for part-time employees, temporary employees, dependents and domestic partners over the last five years. They also offer health benefits beyond health insurance, including dental, vision and prescription drug benefits. More than 70 percent of counties offer a PPO plan, making it the most prevalent plan offered. This plan witnessed the highest average monthly premium increases between 2009 and 2014. County spending on health insurance premiums for employees and their dependents reached $20 billion to $24 billion annually for 2014.

2. Counties are making plan changes and reducing costs.

As counties face budget pressures and rising expenses, they are seeking ways to contain their health insurance costs. Counties can pursue several strategies to reduce their health costs. Shopping for new plans allows for selecting insurance plans that offer greater value. Counties can also ask their employees to share expenses by splitting premium costs, selecting higher copays, coinsurance and deductibles.

Reducing costs is the main driver for health plan changes. Reducing costs is the main reason counties change the health plans offered to their employees. One third of responding counties reported shopping for a new plan in 2013.[32] Out of the counties who considered different health plans than their offerings in 2013, 15 percent changed their plan, 9 percent changed their health insurance company and 13 percent changed both their plan and carrier. Cutting costs was the most common reason cited by counties for making changes to their offerings (31 percent) followed closely by finding better benefits for the same price (24 percent) (See Figure 4).

FIGURE 4. Reasons for Changing Current Health Plan(s), Among Counties that Changed Plan(s) for 2014

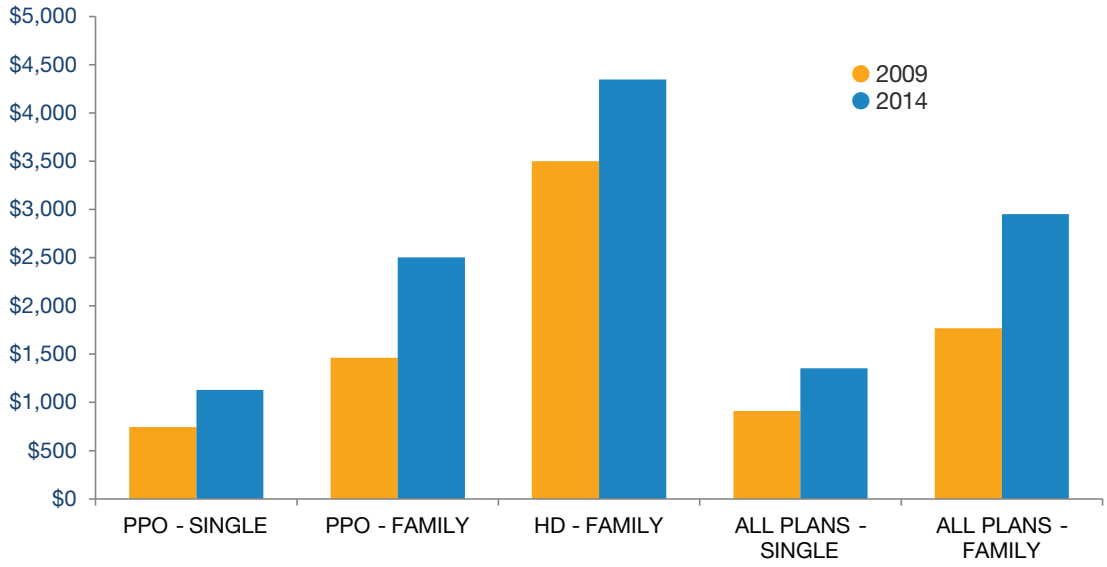


Note: These shares apply to the counties who changed plans in 2013.

Source: NACo/CVIOG survey, March 2014

Counties are asking their employees to help contain health cost increases. Counties are also working with their employees to contain health care costs, through sharing premium costs, or increasing the deductible amounts, copayments and out-of-pocket limits. Fifty-three (53) percent of responding counties in 2014 said they were very likely to split future increases in premiums between the county and employees. Between 2009 and 2014, the employee contribution shares to health premiums stayed relatively the same across plan types and coverage level.[33]

FIGURE 5. Average Deductibles for Plans with Significant Change, by Plan and Coverage Level, 2009 and 2014



Note: Both 2009 and 2014 surveys used the same sample of counties. These are the plan deductibles that experienced statistically significant change at the 95 percent level. The response rate for these items ranged from 25 percent to 67 percent in the 2009 survey and from 43 percent to 89 percent in the 2014 survey.

Sources: NACo/CVIOG surveys, 2009 and 2014

Deductibles rose rapidly. The amount that county employees spend out of pocket before insurance reimburses their expenses changed dramatically between 2009 and 2014. The average deductible increased by 49 percent for single coverage and 67 percent for family coverage (See Figure 5). The greatest increase occurred in family coverage under PPO plans, with 71 percent. Deductibles are lower for single coverage than family coverage across all plan types. As defined by the health plan, the HD plans had the highest average deductibles in 2014, at $2,166 and $4,346 for single and family coverage, respectively. Forty-seven (47) percent of responding counties reported in 2014 that they were very likely or somewhat likely to increase the deductible amount in 2015, the same share as in 2009.

Employee copayments increased between 2009 and 2014, but at different rates across health plans. Copayment amounts for physician office visits increased for both HMO/EPO and PPO plans by 19 and 13 percent, respectively. The average copayment for hospital admission was $317 dollars for HMO/EPO plans and over $642 for PPO plans in 2014. The growth in the hospital admission copayment for PPO plans between 2009 and 2014 was significant, at over 150 percent.[34] Thirty-eight (38) percent of responding counties said they were very likely or somewhat likely to increase the amount employees pay for office visit copayments and coinsurance in 2015, similar with the response rate in 2009.

The out-of-pocket limits rose faster than the average county health premiums. Over the past five years, the average out-of-pocket maximums increased by an average of 59 percent across all plan types and levels of coverage (See Table 2). The HMO/EPO plans witnessed the fastest rise, with the out-of-pocket maximums more than doubling for both single and family coverage. The growth in out-of-pocket maximums for PPO plans was 38 percent for single coverage and 44 percent for family coverage. However, the average out-of-pocket maximums in 2014 are all still below the maximum allowed amounts under the ACA of $6,350 for single coverage and $12,700 for family coverage.[35]

TABLE 2. Average Out-of-Pocket Maximums, by Plan and Coverage Level, 2009 and 2014

Plan	Coverage	Average Out-of-Pocket Maximum	
		2009	2014
HMO/EPO	Single	$1,135	$2,410
	Family	$2,426	$5,125
PPO	Single	$1,946	$2,687
	Family	$4,008	$5,776
POS	Single	$1,846	$2,487
	Family	$2,833	$5,573
HD	Single	$2,965	$3,366
	Family	$5,506	$6,832

Note: HMO/EPO = Health Maintenance Organization/Exclusive Provider Organization plan; PPO = Preferred Provider Organization plan; POS = Point of Service plan; HD = High-deductible plan. The 2009 and 2014 surveys used the same sample of counties. The out-of-pocket amounts are in nominal 2009 and 2014 dollars. The response rates ranged from 50 percent to 78 percent in the 2009 survey and from 67 percent to 81 percent in the 2014 survey. All estimates of changes are significant at the 95 percent level, except for POS under single coverage and HD plans under single coverage.

Sources: NACo/CVIOG surveys, 2009 and 2014

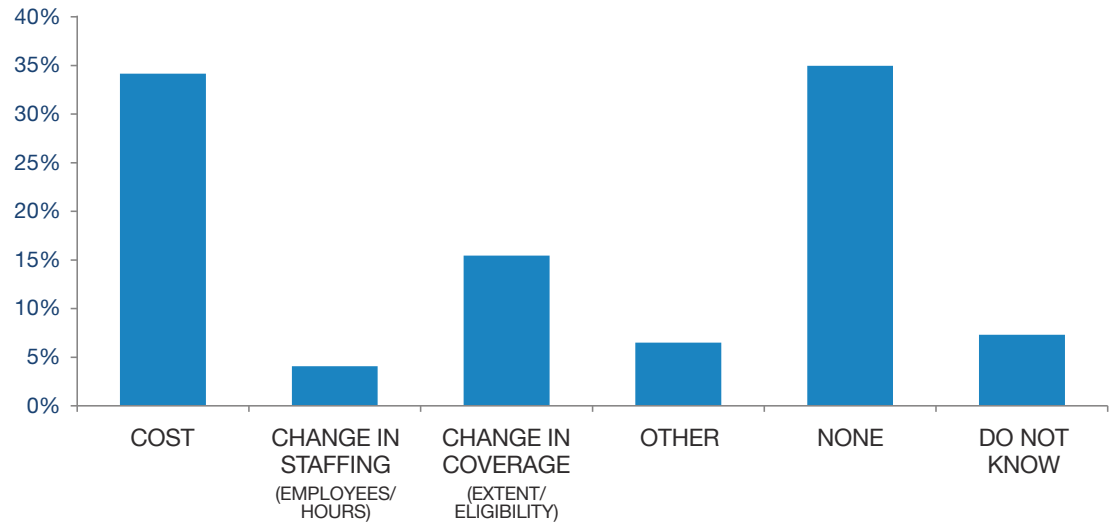
In response to rising costs, counties are active in the health insurance market, shopping for new plans and exploring strategies to share expenses with their employees. One third of responding counties shopped for a new plan in 2013 and cutting costs was the most common reason cited for those making a change. Counties also expanded their cost sharing with employees through increased out-of-pocket maximums, copayment amounts and deductibles. Preferred Provider Organization (PPO) plans, the most common across counties, experienced all of these changes over the last five years.

3. Counties are still grappling with the effects of the Affordable Care Act (ACA) on the health benefits offered to their employees.

The Affordable Care Act (ACA) introduced a host of changes to health insurance that affected the health benefits offered by county governments to their employees. The 2014 NACo/CVIOG survey asked respondents to offer their opinions about the ACA effects on their health benefits and barriers they encountered in implementing ACA provisions.[36] More than 62 percent of respondents gave an answer to at least one of these questions.

A significant share of counties report no ACA effects yet. The implementation of the ACA is still being rolled out, with a few provisions and regulations coming into effect in the years to come.[37] Thirty-five (35) percent of counties considered that the statute has not affected them yet, and 7 percent are not aware of any current effects to their health insurance offerings (See Figure 6).

FIGURE 6. ACA Effect on the Health Benefits Offered by Counties, Shares of Responding Counties, March 2014



Note: This is based on a 59 percent item response rate. Shares add up to more than 100 percent since a few respondents mentioned multiple effects.

Source: NACo/CVIOG survey, March 2014

Rising costs with ACA implementation. Many of the new ACA rules have a direct impact on employers, such as counties.[38] Thirty-four (34) percent of the responding counties indicated that complying with the law has already increased their health benefit spending or will in the future (See Figure 6).[39] Some of the increase in county spending on employee health insurance may be attributed to the implementation of some ACA provisions that took effect in 2011 for non-grandfathered plans and 2014 for grandfathered plans, such as the required coverage for dependent children up to age 26, the removal of lifetime caps on essential health benefits and the elimination

of insurer's ability to deny coverage to minors for preexisting conditions.[40] Some counties cited cost increases resulting from the elimination of preexisting condition limits, the removal of annual or lifetime benefit caps and the increase in benefits required as essential coverage. In 2014 alone, one of the responding counties implemented an employee premium of $40 per month due to rising costs of approximately $300,000 associated with ACA. Another county with approximately 1,000 employees estimated that implementing all the ACA provisions would cost the county over $700,000 by the end of 2015. In addition, one of the responding counties indicated that their costs increased dramatically due to the ACA, so they are considering not offering health insurance as a benefit any longer.

Counties are preparing for other ACA provisions with later implementation timelines. For example, in 2018 insurers or employers will pay a 40 percent excise tax on the value of health insurance plans that exceed an annual value of $10,200 for individual coverage or $27,500 for family coverage.[41] If this excise tax were implemented in 2014, it would apply to at least 6 percent of the health plans offered by responding counties. Sonoma County, Calif. estimates that the impact of the excise tax as currently interpreted, could cost the county, its employees and retirees an estimated $4.1 million in increased premium rates annually.[42] Some counties responded they are acutely aware of this provision and are very concerned about the penalty.[43] They are looking to make changes in benefits to reduce premiums in advance of 2018 and thus avoid the excise tax.

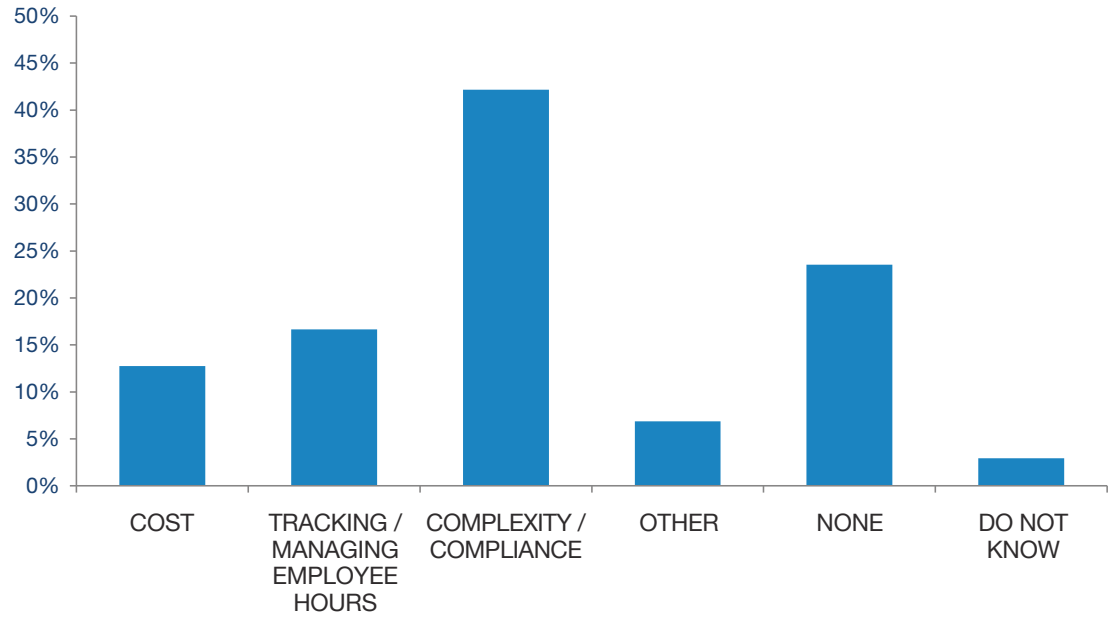
Change in staffing. Other ACA provisions prompted counties to reconsider their human resources policies and the level of coverage provided for their employees. Four percent of counties that provided answers to the open-ended question regarding ACA effects have already changed or are considering changes to their staffing policies, regarding the number of hours worked or the distribution of employees between temporary, part-time and full time status (See Figure 6). This may be the result of preparing for 2015 when counties with more than 50 employees may face a penalty if they do not offer affordable health coverage to 95 percent of their employees and if at least one of their full-time employees purchases coverage from the health insurance marketplace and receives a subsidy.[44]

Changes in health coverage. Counties are also considering changes to the extent and eligibility of health benefits. Fifteen (15) percent of counties mentioned changes in employee coverage, whether already implemented or planned in the near future (See Figure 6). For example, a responding county eliminated family or spousal coverage, and another removed dental care from its medical coverage and may remove vision coverage in 2015.

Counties' ACA implementation challenges. The difficulty of understanding the statute, associated regulations and compliance rules was the most prevalent obstacle cited by responding counties in ACA implementation (See Figure 7). Forty-two (42) percent of the responding counties reported complexity as a problem. For example, some counties explained that keeping up with information regarding the ACA and its provisions was a significant burden and they were frustrated by changing deadlines and definitions.

Difficulty in tracking/managing employee hours. The complexity of complying with the ACA can affect different aspects of county management. For example, 17 percent of responding counties considered it difficult to track/manage employee hours, necessary for compliance with the ACA. The ACA defines part-time employees as those working fewer than 30 hours per week on average.[45] Counties expressed concern about the difficulty of tracking employee hours and classification in their existing payroll systems, particularly for seasonal or temporary employees. One county mentioned that it would be difficult to track the employee share of health insurance premiums over the course of the year as wage and premium levels may change within the year.

FIGURE 7. Barriers Encountered in Implementing ACA Provisions, Shares of Responding Counties, March 2014



Note: This is based on a 49 percent item response rate. Shares add up to more than 100 percent since a few respondents mentioned multiple barriers.

Source: NACo/CVIOG survey, March 2014

The increased costs associated with complying with the ACA may also prove to be a barrier to compliance. Thirteen (13) percent of the responding counties mentioned costs as an obstacle to implementation. Some counties were concerned that rising premiums will make coverage more expensive and no longer qualify as affordable under the ACA. Other counties noted the increase in costs resulting from offering coverage to previously part-time employees working more than 30 hours per week, who are now defined as full-time employees.

Overall, the ACA has brought changes to the health insurance market, and counties as employers are adapting to the new environment. Several ACA provisions have the potential to raise costs for employers, such as required coverage for dependent children up to age 26, removal of lifetime caps on essential health benefits and the elimination of insurer's ability to deny coverage to minors for preexisting conditions, which represent a concern for some county governments. While 34 percent of responding counties mentioned an increase in costs because of ACA implementation, 42 of counties report no ACA effects or are not aware of any effects yet, as of March 2014. The complexity of the ACA itself and of the federal regulations issued to implement it were the most commonly cited barriers to the implementation of the ACA.

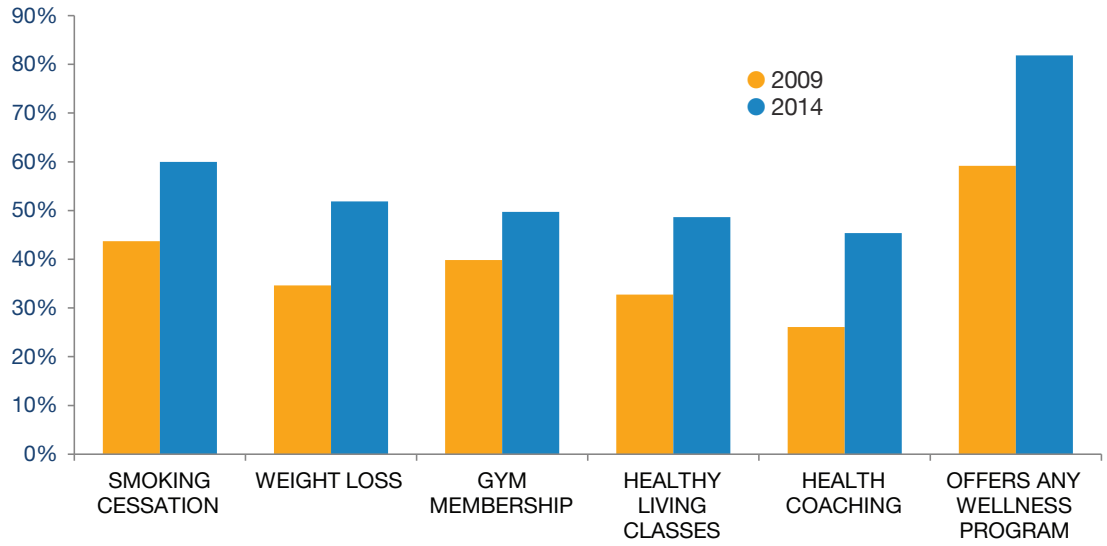
4. Most counties offer some type of wellness program, at a higher rate than in 2009.

In an effort to improve the health and well-being of employees and reduce insurance costs, counties offer various wellness programs.[46] These programs vary from help to quit smoking, weight loss programs to personal health coaching. To encourage participation in these programs, some counties reward employees for their cooperation or penalize those who smoke or do not take advantage of wellness offerings.

Current wellness programs. Counties offer a variety of wellness programs to their employees. In 2014, the most common wellness program among responding counties was a smoking-cessation program (60 percent) (See Figure 8). Over half of responding counties offer weight-loss programs, gym memberships or exercise facilities in 2014. Some responding counties offer health assessments and biometric screening as well as personal meetings with a health coach to help their employees. One responding county described assisting their employees through the public health department, which offers help to quit smoking and presentations of wellness tips and classes.

Expansion of county-offered wellness programs. Counties are expanding wellness program offerings to their employees. The majority of responding counties (59 percent) had wellness programs in 2009, before passage of the ACA. By 2014, the share of responding counties offering at least one wellness program rose to more than 80 percent. Personal health coaching registered a dramatic increase, with 74 percent growth in the share of responding counties between 2009 and 2014 (See Figure 8). The prevalence of smoking cessation programs across responding counties grew as well, with a 37 percent increase in the share of respondents over the past five years.

FIGURE 8. Wellness Programs Offered, Shares of Responding Counties, 2009 and 2014



Note: This is the percent of counties that provided answers to the questions regarding wellness programs. The response rate for these items ranged from 74 percent to 75 percent in the 2009 survey and from 88 percent to 92 percent in the 2014 survey. All estimates of change are significant at the 95 percent level.

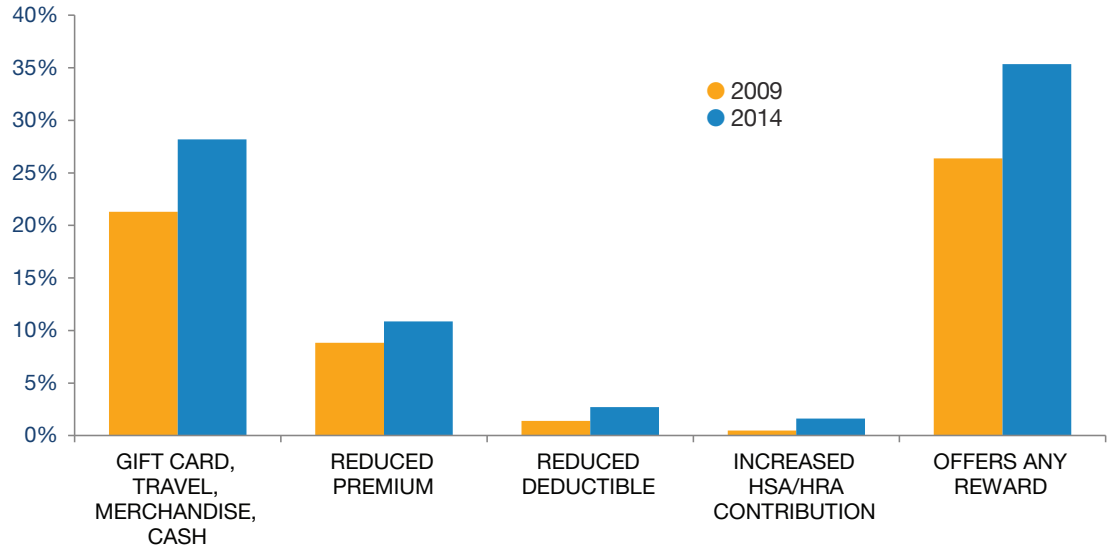
Sources: NACo/CVIOG surveys, 2009 and 2014

Rewards for employees. Starting in January 2014, the ACA increased the incentive limits employers may reward employees for participating in wellness programs.[47] The statute allows employers such as counties to expand their spending on health-contingent reward programs up to 30 percent of the cost of health coverage, an increase from the previous 20 percent limit.[48] Rewards to employees participating in smoking cessation programs can reach a maximum of 50 percent of the cost of health care coverage.[49] Some wellness program rewards may depend on employees meeting certain health-related goals. These goals can be flexible in order for all employees to participate in health improvement activities regardless of current health condition.[50]

Some counties offer rewards to employees who participate in wellness programs and a small minority penalize for not participating or completing the program. Between 2009 and 2014, the share of responding counties offering any rewards to their employees for participation increased from 26 percent to 35 percent (See Figure 9). In contrast, only 7 percent of responding counties in 2014 penalize employees who do not complete the requirements of wellness programs. Also in 2014, 5 percent of responding counties levied a penalty on tobacco users. In both surveyed years, the most common rewards offered by counties were incentives such as gift cards, travel, merchandise or cash. Only about 10 percent of responding counties offered employees lower insurance premiums for their participation in wellness programs in both 2009 and 2014. For example, one of the surveyed counties explained that county-insured employees and their dependents do not pay a deductible or copayment to visit the county clinic. The same county is implementing a disease management program for diabetes, hypertension and high cholesterol and it will not require a copayment or a deductible for generic drugs, will offer a discount for brand name drugs and have free or discounted nutritional counseling for county-insured employees and their dependents.

County wellness programs have become more prevalent since 2009. More than 80 percent of responding counties offered at least one wellness program in 2014, a higher rate than in 2009. These offerings aim to help employees quit smoking, lose weight or achieve other health goals that will ultimately lower the cost of providing health insurance. To encourage participation, counties are offering rewards to employees who participate or complete wellness programs. In 2014, 35 percent of responding counties reported offering some type of reward to their employees, with gift cards, travel, merchandise or cash being the most common rewards.

FIGURE 9. Rewards Offered for Wellness Program Participation, Shares of Responding Counties, 2009 and 2014



Note: This is the percent of counties that provided answers to these questions regarding rewards for wellness program participation. The response rate for these items ranged from 69 percent to 70 percent in the 2009 survey and from 87 percent to 88 percent in the 2014 survey. Only the estimates of change for increased HAS/HRA contribution and offers any reward are significant at the 95 percent level. HSA = Health Savings Account; HRA = Health Reimbursement Account.

Sources: NACo/CVIOG surveys, 2009 and 2014

5. Counties are more likely to offer retiree health benefits than other employers.

County governments, like many state and local governments, continue to provide health benefits to their employees after retirement. According to the 2013 Kaiser Family Foundation and the Health Research & Educational Trust (Kaiser/HRET) Employer Health Benefits Survey, the share of employers offering retiree health insurance benefits declined steadily in recent decades.[51] The proportion of large employers (with 200 employees or more) offering retiree health benefits has dropped by more than half since 1988, reaching 28 percent by 2013. Among large employers, state and local governments are the most likely to offer health benefits to their employees; 78 percent of large state and local governments (with 200 employees or more) offered health coverage to their retirees in 2013.

Counties are more likely to offer retiree health benefits than other employers. Sixty-eight (68) percent of responding counties offered health benefits for their retirees in 2014, more than the national average for large employers in 2013 (See Table 3). Most responding counties offering retiree health benefits provided them to early retirees who are not yet Medicare eligible (97 percent). Counties cover Medicare-age retirees to a lesser degree; 72 percent of responding counties offer health benefits for retirees over age 65. For both categories of retirees, counties offer health benefits at a higher rate than large employers. This is a high level of coverage, taking into account that 44 percent of all U.S. counties are not large employers (have less than 200 employees) and only 5 percent of all employers nationwide with less than 200 workers offered this benefit to their retirees in 2013.[52]

County employee eligibility for retiree health benefits. Employees are eligible for retiree health benefits in the majority of responding counties. In 2014, 93 percent of responding counties offered their current employees health benefits upon retirement. Most often, the health benefits are for early retirement; 90 percent of responding counties mentioned that at least some of the current employees are eligible for county health benefits as retirees, if they retire before age 65. Two thirds of counties offer at least some of their current employees health benefits if they retire at age 65 or older. Eligibility for retiree benefits typically depends on the number of years of county employment and sometimes on the hire date, if eligibility rules changed previously. In some cases, retiree eligibility for health benefits is limited to only 18 months of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage.

TABLE 3. Retiree Health Coverage, Large Employers 2013 and Responding Counties 2014

Share of Responding Counties Offering Health Benefits	2013 Kaiser/HRET Estimates for Large Employers	2014 NACo/CVIOG Estimates for Counties
To retirees	28%	68%
To early retirees	90%	97%
To Medicare-age retirees	67%	72%

Note: The 2013 Kaiser Family Foundation and the Health Research & Educational Trust (Kaiser/HRET) Employer Health Benefits Survey considers organizations with 200 or more workers as large employers. The 2014 NACo/CVIOG results are based on 58 percent to 59 percent item response rate.

Sources: 2013 Kaiser/HRET Employer Health Benefits Survey; NACo/CVIOG survey, March 2014

Eligibility for county retiree health benefits remained unchanged between 2009 and 2014. Counties did not take significant steps to limit eligibility between 2009 and 2014 for both the recently hired and other employees. In 2014, 70 percent of responding counties mentioned that at least some of their employees hired in the preceding year would be eligible for benefits once they retire, if they stay employed by the county until retirement. This is not significantly different from the level reported in 2009, when 68 percent of responding counties extended retiree health benefits to their new employees. Further, the eligibility rates for all active county employees (beyond just the newly hired) also stayed the same between 2009 and 2014 among responding counties.

Cost sharing with current and future county retirees. Counties deal with cost sharing for their retiree health coverage in different ways. In some cases, counties continue to share the health benefit costs with their former employee in either a fixed share or set amount of the cost. One responding county indicated that the employee would only receive county-paid benefits until reaching age 70. Other counties choose (1) to pay either the entire cost of retiree health benefits, as long as the retiree meets the county eligibility requirements or (2) to extend health coverage to eligible retirees, who then bear the full cost. State retirement systems may determine the rules about eligibility and cost sharing, as indicated by several responding counties.

Overall, counties are more likely to offer health benefits to their retired employees than large employers nationally. Eligibility for retiree health benefits is widespread for current county employees and has not appreciably changed since 2009. Between 2009 and 2014, counties did not limit the eligibility for retiree benefits for the new hires. Many counties share their costs for coverage with their retirees, but rules vary considerably and they can be regulated by the state retirement system.

Conclusion

This analysis of the health benefits counties offer their employees, dependents and retirees shows that counties are responsible employers who provide health insurance for their workers and their dependents. Counties provide broad coverage to their employees — particularly full-time and a growing share of part-time workers — as well as their dependents. Over the last five years, county health benefit eligibility has become more inclusive, with an increasing share of counties offering health benefits to part-time employees, dependents and domestic partners. Concurrently, county health premium expenses increased rapidly over the same period, due to the rise in the average monthly premiums for popular plans, such as PPO plans.

Counties are active in containing costs, looking for plan alternatives that would provide the same benefits at a lower cost. In addition, they are looking to their employees to share some of the cost increases. They also expanded wellness programs and provided different types of incentives for employees to enroll in such programs. Counties offer health benefits to their retirees at a higher rate than other employers, and they have not substantially changed the eligibility for retiree health care for their current employees since 2009. While the ACA has introduced many changes to the health insurance market, county governments have responded in different ways in the five years since the law was enacted. The top ACA-related concern for counties is the complexity of the law itself and its implementing regulations.

The top ACA-related concern for counties is the complexity of the law itself and its implementing regulations.

This report is a snapshot of how counties are responding to rapidly changing regulatory and market environments. The variations in the data illustrate the tensions that are inherent to the county government role in the health system. Rooted in counties' traditional function as health care safety net providers, there is evidence of strong support for maintaining and even expanding employee eligibility for health insurance coverage. At the same time, the survey respondents register resistance to complicated regulations and federal preemption of local control. Overall, county governments play a critical role in the planning, management and implementation of health benefits coverage to their employees, retirees and their dependents.

METHODOLOGY APPENDIX

The National Association of Counties (NACo) developed this research in partnership with the Carl Vinson Institute of Government (CVIOG) at the University of Georgia. This report uses the results of two surveys of county governments from April 2009 and March 2014, both done together with CVIOG. The 2014 survey (henceforth, "the 2014 NACo/CVIOG survey") is an updated version of the survey of county governments conducted in 2009 by NACo and CVIOG. In order to make broader comparisons across other public and private employers, the research partners developed the 2009 survey to allow for comparable results to the Employer Health Benefits annual survey conducted by the Kaiser Family Foundation. Due to the passage of the ACA and deficiencies found in the 2009 survey, the 2014 survey questions were revised and expanded.

In late 2013 and early 2014, the survey was reviewed internally and then sent for beta testing to 10 county administrators, human resource directors and state associations of counties with health insurance expertise. The feedback from beta testing helped clarify the survey questions.

The 2014 survey was sent to the same sample of 978 counties as the 2009 survey for comparability of survey results. The original sample was selected using a stratified random sampling method. The sample is representative across the four U.S. Census regions as well as across county population categories. The survey was open from March 10, 2014 to April 4, 2014 to the human resource director (or equivalent) in each of the counties surveyed. The survey was conducted as a Web-based questionnaire. After the original invitation to participate in the survey, non-respondents were sent three reminders to encourage participation. Overall, 209 counties responded to the survey (21.4 percent response rate). Item non-response adjustment was applied to the survey responses, based on individual county responses to a number of control questions.

The size of the county government in terms of the number of employees is an important consideration for provisions of the ACA and in making comparisons between this survey and the Kaiser/HRET Employer Health Benefits Survey. The distribution of survey respondents corresponded quite well with all counties in the U.S. A slightly higher share with 50 to 199 full-time and part-time employees responded to the survey compared to the share of all counties with similar employment. The share of responding county governments with more than 200 full-time and part-time employees was lower compared with all U.S. counties.

The distribution of survey respondents corresponded relatively well with the population distribution of the counties included in the sample (see Figure A1). The share of all responses from mid-sized counties was greater than the sample proportion (32 percent compared with 28 percent in the sample). The response share for large counties was just slightly below the sample proportion (3.3 percent compared with 3.7 percent). Small counties were not as well represented, with a share of 65 percent of all responding counties compared with 69 percent in the sample.

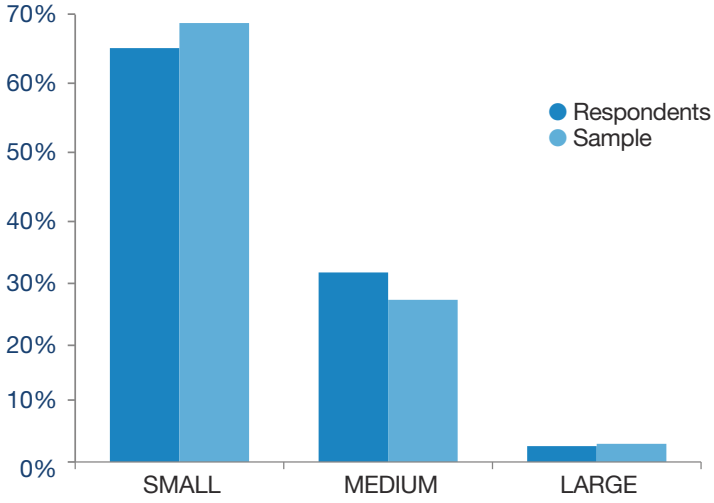
TABLE A1. Distribution of Responding Counties Compared with All U.S. Counties across Total Full-time and Part-time Employees

Full-time and Part-time Employees	Responding Counties	All 3,069 Counties
1 to 49	7%	7%
50 to 199	41%	37%
200 or more	52%	56%

Note: The differences between the distribution of responding counties and all 3,069 counties is not statistically significant.

Sources: NACo/CVIOG survey, March 2014; U.S. Census Bureau, 2012 Census of Governments

FIGURE A1. Distribution of Responding Counties Compared with the Sample across Population Size



Note: Small counties have fewer than 50,000 residents. Medium-sized counties have between 50,000 and 500,000 residents. Large counties have more than 500,000 residents. The differences between the distribution of responding counties and the sample is not statistically significant.

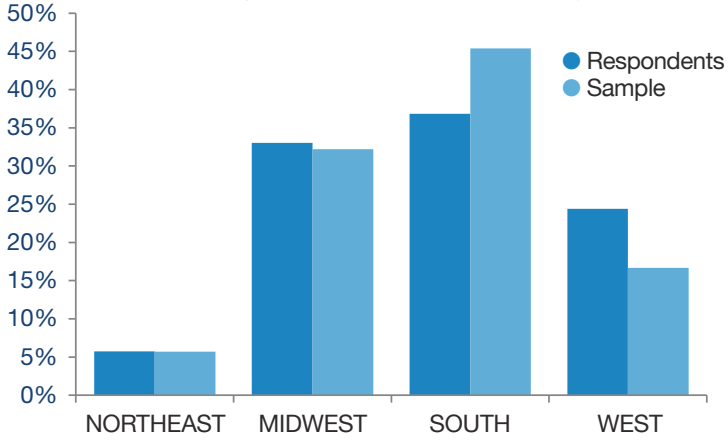
Source: NACo/CVIOG survey, March 2014

The distribution of responding counties across the four U.S. Census regions was representative for the Northeast and Midwest regions (see Figure A2). However, the share of responding counties in the Western region was much greater than the sample proportion (24 percent compared with 17 percent). Counties in the Southern region were underrepresented among respondents compared with the sample (37 percent compared with 45 percent).

Due to the low absolute number of responses from counties in certain population or regional groups, this study reports only aggregate results. All the estimates of changes between 2009 and 2014 reported as statistically significant were tested at a 95 percent confidence level, unless noted otherwise.

In order to estimate the annual health insurance premium spending of county governments, the survey data were used to estimate an average monthly premium cost per covered employee and by coverage level, then multiplied by the estimated number of employees selecting different coverage levels. The average monthly premium cost was calculated from the survey results separately for 2009 and 2014 and for each coverage

FIGURE A2. Distribution of Responding Counties Compared with the Sample across U.S. Census Regions



Note: The differences between the distribution of responding counties and the sample is statistically significant.

Source: NACo/CVIOG survey, March 2014

level. The distribution of health plans and coverage levels was estimated from the survey data separately for 2009 and 2014 as well. The average monthly premium costs were then weighted by the distribution of plan types to get a single average for monthly premium cost for each coverage level. Beginning with the total number of full-time and part-time county employees from the 2007 and 2012 Census of Governments the number of employees eligible for health benefit coverage and then those who have coverage was estimated based on the survey results. From the average premium cost per employee by coverage level and the distribution of employees across coverage level, the total expenditure was calculated.

To estimate the growth in health insurance price (i.e. the total monthly premium) the average premium was calculated separately for each plan and coverage level in both 2009 and 2014. Growth rates were then calculated for each plan and coverage level, then these individual growth rates were averaged to calculate the aggregate growth in health insurance price. This method weights all plans equally and is thus more representative of a price change as opposed to an average weighted by the distribution of plans, which would put greater weight on the more common plans and thus better represent a growth in expenditure. The aggregate figure for premium growth should be interpreted with caution, since it does not account for the differences in premium growth rates between plans.

ENDNOTES

1. U.S. Census Bureau, "2012 Census of Governments;" U.S. Bureau of Labor Statistics, "Current Employment Statistics" Total Nonfarm Employment, March 2012.
2. U.S. Department of Health & Human Services. "Key Features of the Affordable Care Act by Year" (2013), available at http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html (March 28, 2014).
3. Emmanuelle St. Jean, "Counties as Employers Health Reform Toolkit: Making Sense of Complex Issues" (Washington, D.C.: National Association of Counties, 2013).
4. Jacqueline Byers et al., "County Health Benefits Study" (Washington, D.C.: National Association of Counties, 2009).
5. U.S. Centers for Medicare & Medicaid Services, "Glossary: Co-insurance" (n.d.), available at https://www.healthcare.gov/glossary/co-insurance/ (June 2, 2014).
6. U.S. Bureau of Labor Statistics, "Definitions of Health Insurance Terms" (2002), available at http://www.bls.gov/ncs/ebs/sp/healthterms.pdf (June 2, 2014).
7. U.S. Centers for Medicare & Medicaid Services, "Glossary: Co-payment" (n.d.), available at https://www.healthcare.gov/glossary/co-payment/ (June 2, 2014).
8. U.S. Centers for Medicare & Medicaid Services, "Glossary: Deductible" (n.d.), available at https://www.healthcare.gov/glossary/deductible/ (June 2, 2014).
9. U.S. Centers for Medicare & Medicaid Services, "Glossary: Dependent" (n.d.), available at https://www.healthcare.gov/glossary/dependent/ (June 2, 2014).
10. U.S. Centers for Medicare & Medicaid Services, "Glossary: Exclusive Provider Organization (EPO) Plan" (n.d.), available at https://www.healthcare.gov/glossary/exclusive-provider-organization-EPO-plan/ (June 2, 2014).
11. St. Jean, "Counties as Employers Health Reform Toolkit."
12. U.S. Bureau of Labor Statistics, "Definitions of Health Insurance Terms."
13. U.S. Centers for Medicare & Medicaid Services, "Glossary: Grandfathered Health Plan" (n.d.), available at https://www.healthcare.gov/glossary/grandfathered-health-plan/ (June 2, 2014).
14. U.S. Bureau of Labor Statistics, "Definitions of Health Insurance Terms."
15. U.S. Centers for Medicare & Medicaid Services, "Glossary: High Deductible Health Plan" (n.d.), available at https://www.healthcare.gov/glossary/high-deductible-health-plan/ (June 2, 2014).
16. U.S. Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans" (2014).
17. U.S. Centers for Medicare & Medicaid Services, "Glossary: Out of Pocket Maximum Limit" (n.d.), available at https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/ (June 2, 2014).
18. St. Jean, "Counties as Employers Health Reform Toolkit."
19. U.S. Centers for Medicare & Medicaid Services, "Glossary: Point of Service Plan (POS) plan" (n.d.), available at https://www.healthcare.gov/glossary/point-of-service-plan-POS-plan/ (June 2, 2014).
20. U.S. Centers for Medicare & Medicaid Services, "Glossary: Preferred Provider Organization (PPO)" (n.d.), available at https://www.healthcare.gov/glossary/preferred-provider-organization-PPO/ (June 2, 2014).
21. U.S. Centers for Medicare & Medicaid Services, "Glossary: Premium" (n.d.), available at https://www.healthcare.gov/glossary/premium/ (June 2, 2014).

22. The Henry J. Kaiser Family Foundation, "Health Reform Glossary" (n.d.), available at http://kff.org/glossary/health-reform-glossary/#glossary-s (June 2, 2014).
23. U.S. Bureau of Labor Statistics, "Definitions of Health Insurance Terms."
24. U.S. Internal Revenue Service, "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act" (May 13, 2014), available at http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act (June 2, 2014).
25. U.S. Census Bureau, "2012 Census of Governments;" U.S. Bureau of Labor Statistics, "Current Employment Statistics" Total Nonfarm Employment, March 2012.
26. This change is significant at a 94 percent level.
27. The survey did not ask respondents to explain why coverage eligibility expanded. It is possible that the provisions of the ACA that penalize certain employers not offering affordable coverage to their employees are driving the expansion. However, the survey data cannot confirm or refute this explanation.
28. Only one out of the 207 responding counties does not offer health benefits coverage to all of their full time employees.
29. The ACA includes dental and vision coverage for children under 18 in essential health benefits. Refer to Compilation of Patient Protection and Affordable Care Act, Sec. 1302 (b)(1)(J), 111th Congress, 2d Session (Office of the Legislative Counsel, May 2010), available at http://housedocs.house.gov/energycommerce/ppacacon.pdf (June 2, 2014).
30. This growth in price does not account for any change in the quality (i.e. benefits available) of the underlying insurance. Under the ACA grandfathered health plans are exempt from provisions that may raise costs, so the increase in costs among non-grandfathered plans is likely higher.
31. U.S. Bureau of Labor Statistics, "Consumer Price Index" U.S. Medical Care sub index, March 2009 and March 2014.
32. The survey did not ask if county health plans had grandfathered status or not, so it is not possible to determine if shopping for a plan varied across grandfathered status.
33. None of the estimates of change is significant at the 95 percent level.
34. Low response rates limited the number of significant changes identified for copayments between 2009 and 2014.
35. U.S. Centers for Medicare & Medicaid Services, "Glossary: Out of Pocket Maximum Limit" (n.d.), available at https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/ (June 2, 2014).
36. The two survey questions were, "How, if at all, has or will the Affordable Care Act (ACA) affected your county's health benefits?" and "What are the most important barriers/obstacles you have encountered in your efforts to implement provisions of the Affordable Care Act?"
37. St. Jean, "Counties as Employers Health Reform Toolkit."
38. Ibid.
39. The survey did not ask if county health plans had grandfathered status or not, so it is not possible to determine if respondents citing cost increases varied over the grandfathered status of their health plan(s).
40. St. Jean, "Counties as Employers Health Reform Toolkit."
41. The value of the plan includes both employer and employee contributions as well as any funds in a health savings account or flexible savings account. The thresholds are higher for high-risk professions (such as law enforcement, firefighters, etc.) and pursuant to age and gender. Refer to, St. Jean, "Counties as Employers Health Reform Toolkit."
42. Sonoma County Board of Supervisors, "Sonoma County Expands Services and Partnerships for Health Care Reform," (September 12, 2013), available at http://sonomacounty.ca.gov/Board-of-Supervisors/Press-Releases/2013/Sonoma-County-Expands-Services-and-Partnerships-for-Health-Care-Reform-Implementation/ (June 2, 2014).
43. County governments offering self-insured health plans may have greater awareness of the cost of the excise tax, since they would pay the tax directly instead of counties offering fully insured plans where the insurer pays the tax. Refer to, St. Jean, "Counties as Employers Health Reform Toolkit."
44. St. Jean, "Counties as Employers Health Reform Toolkit."
45. Ibid.
46. U.S. Department of Labor, "Fact Sheet: The Affordable Care Act and Wellness Programs" (n.d.), available at http://www.dol.gov/ebsa/newsroom/fswellnessprogram.html (June 2, 2014).
47. U.S. Department of Labor, "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans" (June 3, 2013), available at http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=26880&AgencyId=8&DocumentType=2 (June 2, 2014)
48. St. Jean, "Counties as Employers Health Reform Toolkit."
49. Ibid.
50. United States Department of Labor, "Fact Sheet: The Affordable Care Act and Wellness Programs."
51. This citation applies to the entire remainder of the paragraph. Refer to, The Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits Survey: 2013 Annual Survey" Section 11, (2013).
52. The 2013 Kaiser/HRET Employer Health Benefits Survey does not report a national average for retiree health coverage, but separate averages for large and small employers. The share of counties with less than 200 employees is based on the total of full-time and part-time employees per county reported in the 2012 Census of Governments. Refer to, U.S. Census Bureau, "2012 Census of Governments."

NACo TRENDS ANALYSIS PAPER SERIES • ISSUE 2 • 2014

County Health Benefits 2014

ABOUT NACo

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo assists America's 3,069 counties in pursuing excellence in public service to produce healthy, vibrant, safe and resilient counties. NACo promotes sound public policies, fosters county solutions and innovation, promotes intergovernmental and public-private collaboration and provides value-added services to save counties and taxpayers money. For more information about NACo, visit www.naco.org.

COUNTIES FUTURES LAB NACo

660 NORTH CAPITOL STREET, NW | SUITE 400 | WASHINGTON, DC 20001
202.393.6226 | FAX 202.393.2630 | *www.naco.org*

fb.com/NACoDC
twitter.com/NACoTweets
youtube.com/NACoVideo
linkedin.com/in/NACoDC