SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 1006

SPONSOR: Appropriations Committee and Governmental Oversight and Productivity Committee

SUBJECT: State Employee Health Insurance

DATE: April 23, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Wilson	GO	Fav/CS
2.			AGG	Withdrawn
3.	McVaney	Coburn	AP	Fav/CS
4.			RC	
5.				
6.				

I. Summary:

The bill makes changes to the statutory provisions governing health insurance and prescription drug products, premiums, and coverage provided employees and dependents of State of Florida agencies. It partially implements recommendations made in several legislative and consultant reports.

This bill substantially amends ss. 110.123, 110.161, and 1001.74, Florida Statutes.

II. Present Situation:

Chapter 110, F.S., provides the statutory authority for the implementation of health insurance and prescription drug coverage for officers, employees and their dependents of State of Florida agencies. Employees and retirees may choose between a self-insured indemnity plan, called a preferred provider organization (PPO), and one of several approved health maintenance organizations. Sections 110.123 and 110.12315, F.S., describe the coverage available and specify the minimum complement of benefits each approved provider must offer.

For FY 2003-04, the PPO plan is expected to average 110,416 subscribers while the HMO plans combined are expected to serve a total of 58,534 subscribers. The program is administered by the Division of State Group Insurance in the Department of Management Services. The PPO Plan provides universal access to employees in all Florida counties. Provider contracts with health maintenance organizations are negotiated separately and are available in only thirty-eight counties. While the program pays different premiums under those HMO contracts, the premiums paid on behalf of the subscribers into the State Employees' Group Health Self-Insurance Trust Fund do not vary based on participation in the PPO or HMO plans.

The health insurance plan uses a two tier coverage structure – individual and family coverage. The individual coverage allows only the employee to claim medical and pharmaceutical coverage under the program. Under family coverage, the employee, the spouse and any dependent children are provided insurance coverage by the program. The total premium due for individual coverage is $290.82 per month while the total premium for family coverage is $659.86 per month. For Career Service employees, the employing state agency pays $248.86 of the monthly premium for individual coverage and $508.88of the monthly premium for family coverage. The employees are responsible for $41.96 of the monthly premium for individual coverage and $150.98 for family coverage. This means that the agency pays 85.6% of the premium for individual coverage and 77.1% for family coverage.

For employees in the Selected Exempt Service and the Senior Management Service, employees of the Department of the Lottery and the Executive Office of the Governor, and other employees exempt from the Career Service, the employing agency pays 100% of the premium, regardless of the type of coverage (individual or family). The program provides 100% premium payments for Career Service employees married to each other.

COBRA participants and retirees not eligible for Medicare must pay 100% of the active member premium. Currently, the monthly premiums paid by the COBRA participants and these retirees are $290.82 for individual coverage and $659.86 for family coverage. Retirees eligible for Medicare pay a reduced premium since the state health insurance program provides secondary coverage. The applicable premiums are $154.67 if only the retiree is Medicare eligible, $445.55 if one is eligible and the spouse is not eligible; and $309.35 if both the retiree and the spouse are Medicare eligible.

Chapter 216, F.S., contains a procedure for the periodic estimation of revenues and expenses for state employee health insurance. The health insurance estimating conference reviews the income and claims experience of the self-insurance fund in an attempt to forecast the utilization demands and the legislative funding requirements for the succeeding coverage period.[1] The Consensus Estimating Conference has estimated operating deficits in the Health Insurance Trust Fund in FY 2003-04 and FY 2004-05 of $158.5 million and $324.1 million, respectively. To put some perspective on the magnitude of these operating deficits, a 16% premium increase would be necessary beginning July 1, 2003, with another 16% premium increase beginning July 1, 2004, if such deficits were addressed only through premium increases.

Over the past few years, several legislative and consultant reports[2] have documented the precarious state of the finances of the indemnity plan. Among the common findings reported among all of the studies have been:

[1] The plan is funded on a July through June fiscal year basis with open enrollment in September. The contract cycle, however, is on a calendar year basis.

[2] Buck Consultants, *Actuarial Report on Plan and Funding Design Alternatives*, January 29, 2002; Florida Senate, *Improved Choices for and Long-Term Financial Security of State Employee Health Insurance*, Interim Project Report 2003-129, January 2003; Office of Program Policy Analysis and Government Accountability, *Special Review: Options to Redesign State Employee Health Insurance Benefits Presented*, Report No. 01-021, March 2001; Mercer Human Resource Consulting, *State of Florida Employees' Group Health Insurance Program, Report on Program and Funding Design Alternatives*, March 2003.

1. A benefit structure more generous than that provided peer government or large private employers;
2. Co-payment and deductible provisions well below market levels;
3. Significant price subsidies for retirees, dually employed spouses, and families with many children;
4. Employer-pay-all provisions for exempt and managerial personnel;
5. The depletion of indemnity plan reserves as a consequence of a failed management experience with a prior third-party administrator;[3]
6. Cost sharing arrangements based upon a percentage of the subsidized price and not the full cost of the product; and
7. The relative absence of broadly-based wellness or preventive care measures.

These plan attributes co-exist in an employment marketplace also characterized by the following significant changes:

1. A leveling in hiring by state government agencies resulting in the attrition of profit centers of new, younger hires who do not make claims;
2. A progressive increase in retiree-claimants due to the departure into retirement of the "baby-boomer" generation;
3. The greater use of contract vendors in lieu of direct government provision of service;
4. The continued government emphasis on benefit compensation in a larger employment market characterized by salary compensation; and
5. Annual medical cost inflation several times greater than wage growth.

The cumulative effect of these plan and societal changes has been to limit revenue growth and accelerate the claims potential for employee benefits. Unlike a pension plan, health insurance liabilities are "front-loaded," that is, premium amounts are expended for claims payments very soon after their receipt. In contrast, retirement plans[4] are "back-loaded" with payment streams deferred for twenty to thirty years. Moreover, retirement plans all have vesting, or benefit qualification, requirements which deny benefits for participants who fail to meet minimum multi-year service levels. State employee health insurance provides an annual open enrollment period in which individuals can change coverage and, to some extent, engage in adverse selection, or the expansion of coverage choices at greater employer but lesser employee exposure.

The principal employee workplace benefits are contained in chs. 110 and 121, F.S., in the latter case for retirement. Both chapters contain descriptive and prescriptive provisions: they describe the nature of the benefits and prescribe the precise method of funding. These provisions are then converted into dollar amounts through the estimating conference process and, then, ultimately into payroll amounts and included in the agency legislative budget request. Section 8 of the General Appropriations Act is the location in which salary and benefit provisions are funded. The FY 2004 Governor's Recommended Budget did not contain any provisions for funding of

[3] This experience alone was the subject of a Statewide Grand Jury presentment (OWSP No. 96-292-NFB) that found no criminal wrongdoing but did recommend criminalizing culpable negligence.

[4] A defined benefit, or percent-of-final-pay plan, assures an annuitized pension benefit at a known level. A defined contribution plan makes no such promise but does provide the participant with an equity interest unrealizable in the defined benefit counterpart. Hybrid plans contain attributes of both but are essentially defined benefit plans.

the consensus deficit, noted above. Because of the benefit mandates of ch. 110, F.S., and the inability of an appropriations bill to override substantive law, many of the reported recommendations for change cannot be implemented without amendments to that chapter.

III. Effect of Proposed Changes:

Section 1 amends s. 110.123, F.S., to make changes to the state employee indemnity group health insurance plan in partial implementation of several legislative and consultant reports, the most recent of which was submitted by Mercer Human Resource Consulting to the Department of Management Services in March 2003.

The changes authorize more than one PPO plan, provide that premium contributions shall be in dollar amounts as opposed to the current percentage of price charged, and permit the department to undertake contract changes through the invitation to negotiate as well as the request for proposal process in ch. 287, F.S. The section clarifies that the state may offer different benefit plans to officers and employees exempt from the career service and the employee paid premium may vary based on the plan and coverage tier selected by the enrollee.

Sections 2 amends s. 110.161, F.S., to clarify the continued eligibility of employees of the state universities to participate in the pretax benefits program.

Section 3 amends s. 1001.74, F.S., to cross reference the continued eligibility of state universities to participate in the pretax benefits program.

Section 4 provides that the bill takes effect July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Subject to the development of specific premium contribution rates, the bill will allow more than one indemnity plan to be implemented. For example, a "standard" plan may contain high deductible coverage and be more closely aligned with catastrophic insurance. A "plus" plan may more closely resemble the current indemnity plan with increased personal expense. Based upon the Mercer report recommendations, there would be premium increases for all participating employees and retirees as well as increases in out-of-pocket expenses, deductibles, and co-payments for prescription drugs. The conversion of the incidence of premium payments from a percentage to a fixed dollar amount will limit the employer's expenses and shift some of the additional burden to the employee.

C. Government Sector Impact:

The following table, taken from the Mercer report, indicates one possible premium scenario. It must be noted, however, that the dollar and coverage amounts are subject to change. These should be considered illustrative of those recommendations but not determined as a result of this bill.

Coverage Tiers and Personal Expense Thresholds Presented in Mercer Report on State Group Health Insurance, 2003

Benefit	Current	Plus	Standard
Deductible			
In-network	$ 150/300	$ 250/500	$ 1000/2000
Out-of-network	$ 300/600	$ 750/1500	$ 3000/6000
Coinsurance			
In-network	10%	20%	20%
Out-of-network	30%	40%	40%
Out-of-Pocket			
In network	$ 2500/5000	$ 3000/6000	$ 5000/10000
Out-of-network	Cross accum.	Cross accum.	Cross.accum.
Per admission deductible			
In network	$ 150	$ 250	$ 500
Out-of-network	$ 300	$ 500	$ 1000
Physician Office Visit			
In network	$ 10 + 10%	$ 15/25	$ 25/35
Out-of-network	$ 20 + 30%	40%	40%
Emergency Room			
In network	$25+CYD+10%	$ 50	$ 100
Out-of-network	30%	40%	40%
Pharmacy			
Generic retail	$ 7	$ 10	$ 10
Generic mail-order	$ 10.50	$ 20	$ 20

Formulary retail	$ 20	$ 25	$ 25
Formulary mail-order	$ 30	$ 50	$ 50
Non-formulary retail	$ 35	$ 40	$ 40
Non-formulary mail order	$ 52.50	$ 80	$ 80

VI. Technical Deficiencies:

None.

VII. Related Issues:

It is anticipated that the General Appropriations Act will act as the instrument through which future payment and service levels will be executed. The Mercer report also recommends a change from the current two-tier plan (employee/family) to a four-tier plan [employee/employee plus spouse/employee plus child(ren)/ family]. Generally, such an arrangement will increase premiums charged for single employees and family coverage while decreasing it for employee plus spouse and the single parent with child. Central to the Mercer report recommendations is an elimination of the spousal program, that is, the financial forgiveness of all employee insurance premium expense for dually employed spouses. The report also recommends development of a single parent plus child(ren) coverage tier. For the roughly one in eleven covered employees in this status there will be a lessening of premium expense.

In its current form the bill makes no changes to the equalization of premiums charged active and retired employees.

VIII. Amendments:

None.