The Florida Senate

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Committee on Governmental Oversight and Productivity Senator James E. "Jim" King, Jr., President

IMPROVED CHOICES FOR AND LONG-TERM FINANCIAL SECURITY OF STATE EMPLOYEE HEALTH INSURANCE

SUMMARY

The State of Florida provides wide-ranging health and prescription drug benefit coverage for its active and retired workforce. A combination of demographic, economic, and structural factors now present significant obstacles to its financial stability. Legislative actions are required to address the internal factors effecting recurring annual deficits, few of which suggest easy and painless choices. The report identifies the factors affecting the financial imbalance and presents several alternatives to address the structural and financial underpinnings of the program's operations. It recommends combinations of alternatives to address plan design, funding, incidence of cost, and further recommends the Legislature examine the scope and purpose of coverage in light of systemic changes to the deployment of public services.

BACKGROUND

Like many large public and private employers, the State of Florida uses employment-based benefits as an important adjunct to salary compensation. The principal non-federal benefit components – pension, health and life insurance, and leave – equate to some one-third of salary. The State of Florida also sponsors voluntary enrollment in a pre-tax medical reimbursement, childcare expense, and deferred compensation programs and offers its employees supplemental insurance coverage through approved providers.

Active state employees may select from either a universally accessible self-insured indemnity plan or one of several managed care providers based upon geographic availability. Both plans also include a prescription drug benefit with tiers of employee co-payments based upon drug type and dispensing means. The employer provides premium-free health insurance coverage for dually employed spouses, exempt and managerial employees, and state officers. Retirees are permitted to maintain their state health insurance benefits at full cost less a separately funded health insurance premium subsidy allowance set by statute.[1] Participants in the Deferred Retirement Option Program (DROP) receive the lower premium exposure of active employees until their termination of employment.

The Division of State Group Insurance in the Department of Management Services is responsible for plan administration. That entity contracts with Blue Cross and Blue Shield of Florida for third party administrator (TPA) services for the self-insured indemnity plan. The TPA provides the physician and hospital network and operates the medical cost control systems. The division negotiates separately with the multiple managed care providers and retains a pharmaceutical benefits manager. The general parameters of coverage are established in s. 110.1234, F.S., with the components of plan benefits established in the contract. A conference process for the development of consensus funding estimates is provided by s. 216.136(11), F.S.[2]

That health insurance estimating conference reported operating deficits in the state employee health insurance program exceeding $120 million in FY 2002, and $94 million by June 30, 2003, net of FY 2002 premium increases. Under the financial outlook prepared on November 18, 2002, solvency will be maintained only through April 2004. An earlier financial collapse was averted in fiscal years 1997-99 only through a combination of cash infusions by the

[1] Section 112.363, F.S.

[2] No consensus estimates were reached in 2001. The Governor is also required to make state employee health insurance premium recommendations in the annual Recommended Budget submission to the Legislature.

Legislature, three separate emergency loans from the state treasury, and additional increases in employer, employee and retiree contributions. In only one of the past several plan years dating from FY 96 was there *not* an estimated cash balance deficit. The indemnity plan has only recently recovered from an adverse managerial and financial experience with a prior TPA in 1995. The State of Florida indemnity health plan will conclude FY 2003 out of money and with its reserves depleted. As a result, it is in its most difficult financial position since 1995.

METHODOLOGY

The report gathered materials from the Division of State Group Insurance, the legislative estimating conference process, and statutory directives for study initiatives given by the 2001 Legislature. Staff has also assembled and analyzed source materials from employee benefit consulting firms that review the cost and deployment of workplace benefits. Lastly, the staff has reviewed materials from the State's TPA discussing alternative approaches to benefit expense payment and administration.

FINDINGS

Cost Controls

The indemnity plan employs multiple design and management cost control features. The principal ones are higher out-of-pocket expense for use of out-of-network care, co-payments and deductibles for approved care, lower cost generic drug availability including mail-order multiple refills, utilization review, a more visible disease management program, and a new pharmaceutical benefits manager. A recently issued legislative report outlined the possible changes within each of these categories.[3] Cost controls alone contain inherent limitations. *First*, they accept the delivery structure and philosophy of coverage as a constant, varying only the incidence of burden; they do not address the difficult but more powerful issues of wellness and proactive disease management. *Second*, front-end cost controls alone are not terribly powerful unless they are substantial. Significant increases in office visit co-payments produce relatively insignificant results. *Third*, higher financial barriers to primary care may act as a disincentive to seek care. This could risk greater employee and plan exposure to deferred, more costly events.

The cost control experience with prescription drugs – with its costs doubling every 5 years - is illustrative of just such a dilemma. Employee co-payments have risen to meet cost increases while the plan attempts to secure longer-term solutions for expanded purchasing discounts. The ability to secure such discounts is itself embroiled in a larger national debate about pricing, distribution rights, and allocation of research costs over which the State of Florida can exercise little, immediate impact, short of negotiating direct agreements with manufacturers or testing the limits of litigious choices.

Incidence of Cost and True Cost

The PPO apportions premium expense on a 25% employee/75% employer basis. About 9,000 dually employed spouses receive insurance coverage without premium expense, a premium forgiveness feature also provided to exempt and managerial employees and state officers. A civil service reform initiative of the 2001 Legislature expanded this premium benefit feature to a larger category of exempt workers, expanding beneficiaries from 19,000 to 35,000. Requiring all employees to pay for their coverage could make an additional $41 million to $54 million available for funding.

Philosophy of Coverage

Inherent to the PPO plan is a philosophy of first day coverage to the employee and all immediate family members. But changing national demographics of household formation and child rearing are witnessing more single-parent families as well as grandparents raising their grandchildren. The PPO provides a single premium structure regardless of family size, thus providing a subsidy to larger households and a greater relative cost to smaller ones. Many large plans that permit dependent coverage permit spouse, dependent, and other benefit eligibility with different coverage and eligibility assumptions for their workforces.

The 1997 Legislature's enactment of DROP has also affected the premium cost structure. The DROP program permits participating employees to enjoy the deferred receipt of pension benefits in an interest-bearing account while staying as salaried employees for up to five years. In that capacity DROP participants are not exposed to the full insurance premium less the subsidy payment. They receive the more generous 25%/75% cost-sharing arrangement, or full forgiveness, as active employees. This subsidy phenomenon is not unique to the DROP participants.

[3] Office of Program Policy Analysis and Government Accountability. *Special Review*, "Options to Redesign State Employee Health Insurance Benefits Presented," Report No. 01-21, March 2001, Tallahassee, FL, 11 pp.

As the below table indicates there are parallels elsewhere in the PPO:

PPO Costs and Enrollment Subsidies, FY 2001, Per Subscriber

TYPE	COST/MO	PRM/MO	SUBSIDY
Act - Sgl	$ 244	$ 224	($ 20)
Act - Fam	$ 487	$ 508	$ 21
Sgl < 65	$ 440	$ 224	($ 217)
Fam < 65	$ 696	$ 508	($ 188)
M'care I	$ 254	$ 119	($ 135)
M'care II	$ 653	$ 343	($ 310)
M'care III	$ 464	$ 238	($ 226)

Single and family coverage for active employees now is priced at or above cost. Eligible retiree groups received coverage at a per-enrollee premium deficit ranging from $135 to $310 a month in 2001. But too abrupt a change could pose significant intergenerational inequities and undermine the concept of group coverage.[4,5] As discussed below, equally significant though subtle changes have been occurring concurrently with their own cost consequences.

Privatization, Outsourcing, and Demographics

The Legislature first established a statutory preference for contracted over directly provided public services with the 1975 reorganization of the then Department of Health and Rehabilitative Services and the creation of a Department of Corrections.[6] In the ensuing years the use of contracted providers has grown many fold. Today, some 40% of the state budget is directly vendor delivered. Over time this has suppressed on-budget position growth and shifted benefit responsibility from the treasury to the vendors themselves.[7] Accompanying this suppression has been the natural retirement of the children of World War II-era parents, the ones who populated the expansion of direct government services in the 1960s and 1970s. Technology has permitted replacement of their labor-intensive activities with ones emphasizing force multiplier, process-based improvements. These events have exacted two costs: *first*, the insurance plan is losing the replenishment factor of new workers, especially single males, who pay premiums but make few claims. S*econd*, the residual workforce has aged as positions are eliminated, employees terminate, and benefit claims increase. Increasing DROP enrollments have allowed employees to remain on the payroll at higher *employer* insurance premium expense. Some state contract vendors are beginning to experience similar insurance difficulties.[8]

Technology, Expectations, and Economics

Advances in medical technology produce improvements in diagnosis and treatment permitting a productive return to the active workforce following illness or injury. Yet the innovations themselves are expensive and produce curious results. Brand name drugs are championed as being therapeutically superior, but at a higher price; generic equivalents may produce the same results but over a longer term at less cost. But is the purpose of the choice, or of the public enterprise itself, to produce better or cheaper? Is the employee who stays out shorter because of a more expensive but successful intervention a hero, or is the employee who stays out longer but costs less the one to be celebrated? In spite of the advancement of public sector performance measurement, a decision on whether the quality of the effort and its effectiveness is better than the quantity of its volume and its expense is still far from settled. As governments continue to examine the durability of the silent employment contract – "we will always take care of you" – mixed policy and

[4] The Division of State Group Insurance asked the TPA to evaluate a proposal to pay employees $100 a month not to enroll in the state PPO. Such an alternative, while saving money in the short term, could result in adverse selection as healthy subscribers depart and may create a public policy of paying employees to sign up for public assistance. The TPA recommended against this concept in February 2001 and suggested consideration of several alternative benefit platforms with greater employee selectivity on cost exposure. Section 8 of the General Appropriations Act for FY 2002, ch. 2001-253, Laws of Florida, required a review of this option along with an independent actuarial review of many of the other issues discussed in the March 2001 OPPAGA report (fn. 5, below) for delivery by January 1, 2002.

[5] The 2000 Legislature also directed the DMS to complete a feasibility study for development of an insurance subsidy for the children of low-income state employees.

[6] Chs. 75-48, 75-49, Laws of Florida.

[7] One report estimated the total state-funded workforce at nearly 500,000 despite a formal recognition in the budget of only one-third of this number. Office of Program Policy Analysis and Government Accountability, *Special Review.* "Government Outside Workforce Exceeds Number of State Personnel System Employees," Report No. 01-16, Tallahassee, FL: March 2001.

[8] One recent consultant report indicated that the University of Miami, a recipient of state aid for many of its health programs, would experience a 45% increase in its own employee health insurance costs.

financial signals will endure.[9]

In early 2002 the Legislature received an actuarial report on financial and structural alternatives for the plan.[10] That report presented fifteen ideas for the distribution of risk, equitable apportionment of contributions, and subscriber coverage choices that would lessen the recurring negative cash flows.

RECOMMENDATIONS

It is unlikely that any single change will durably address the multiple factors at work in the PPO plan. The effects have been incremental but unmistakable: plan revenues are insufficient to meet demand levels. A systemic reengineering of plan design and funding is required. Several levels of recommended alternatives are advanced based upon scope of intervention and depth of change:

Short Range/Limited Change

1. **Examine deductibles, out-of-pocket expenses, and stop-loss provisions**. The nominal amounts in effect are low and have not changed in years.
2. **Provide coverage and deductible choices consistent with changes in family formation and personal risk assumption.** Patterns of child-rearing and family formation have changed dramatically over the years. But the plan does not recognize the phenomenon of the single parent household as a matter of policy or permit employees to assume greater deductible risk.
3. **Shift premium cost sharing arrangements from a percentage to a fixed dollar amount.** This option clearly fixes the employer's liability at a set amount predictable solely as a function of enrollment patterns. It would shift to the employee either assumption of the residual cost or use of pre-tax reimbursement, supplemental, or higher risk choices as mitigating alternatives.

Medium Range/Moderate Change

1. **Address the significant subsidies provided for retirees in the health insurance plan.** This approach would more equitably allocate premium costs among the retiree population and minimize greatly the subsidy ranges now reflected in the premium distribution. Florida law requires retirees to pay the same premium contribution as active employees in spite of the increasing claims potential.
2. **Expand plan membership eligibility to permit contract vendors to purchase coverage.** Current law permits local governments and contract vendors to purchase telecommunications (SUNCOM) services from the state. Small local governments were given this authority beginning in 2003 for their health plan needs. Such an approach may mitigate some of the generational and employee loss now being experienced by the indemnity plan and expand coverage options for vendors in an increasingly difficult insurance environment. Any savings they realize as contract vendors is passed through to the public as a lower governmental cost. There is no assurance, however, that this change would be considered acceptable for maintenance of the plan's tax-qualified status under federal law.

Medium Range/Significant Change

1. **Reconstitute the PPO as a defined contribution plan with employee ownership of the premiums.** This change is sweeping in scope and would give the participants themselves ownership of the premium dollars outside of the state treasury. The state would provide the same coverage options – PPO with a TPA or HMO – with the availability of selecting higher or lower insurable exposure. This approach permits more assertive use of TPA wellness and disease management programs. In combination with a changed human resources infrastructure it could make knowledge of benefits much more tangible to the participant and create ownership in a set of healthy, shared choices. Piloting such a change with exempt and managerial employees would provide proof of concept should a systemic change be desired. Caution must be used that any selective implementation does not jeopardize the favorable federal tax-status of the plan.
2. **Use pre-tax medical reimbursement accounts in ways to minimize net out-of-pocket expenses.** If embedded in some of the above restructuring, this feature could provide non-forfeitable amounts that could be used for a variety of other spending purposes. It would minimize the effect of shifting greater financial burdens to employees and permit greater focus on the cost drivers and utilization.

[9] In addition the retirement and insurance benefits, the state maintains a significant leave liability which stood at more than $570 MM through December 31, 2001.

[10] *Actuarial Report on Plan and Funding Design Alternatives*, Buck Consultants, January 29, 2002.