

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

BUDGET
Senator Alexander, Chair
Senator Negron, Vice Chair

MEETING DATE: Thursday, October 20, 2011
TIME: 2:00 —5:00 p.m.
PLACE: *Pat Thomas Committee Room, 412 Knott Building*

MEMBERS: Senator Alexander, Chair; Senator Negron, Vice Chair; Senators Altman, Benacquisto, Bogdanoff, Fasano, Flores, Gaetz, Hays, Joyner, Lynn, Margolis, Montford, Rich, Richter, Simmons, Siplin, Sobel, Thrasher, and Wise

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Presentation on Estimating Conference Revisions by Amy Baker, Office of Economic and Demographic Research		Presented
2	Presentation on Department of Management Services Report: Strategic Health Plan Options for the State of Florida		Presented
Other Related Meeting Documents			

Update: Long-Range Financial Outlook

October 20, 2011

Presented by:



The Florida Legislature
Office of Economic and
Demographic Research
850.487.1402
<http://edr.state.fl.us>

Eurozone Problems Escalated

- The sovereign debt crisis in the Eurozone has led to banking instability with spillover effects on the global credit market.
 - Greek default likely within the next six months.
 - Ireland and Portugal have already been assisted.
 - Spain and Italy continue to have serious problems.
 - Belgium needs potential rescue.
 - Other countries, like France, face credit downgrades / outlook changes.
 - The region's banks need to be recapitalized.
- It now expected that the Eurozone will experience at least a mild recession.
- These conditions have led to an increased risk of a second recession in the United States if no improvement is made.
 - Tighter credit conditions.
 - Reduced exports and corporate earnings.

National Situation Darkened

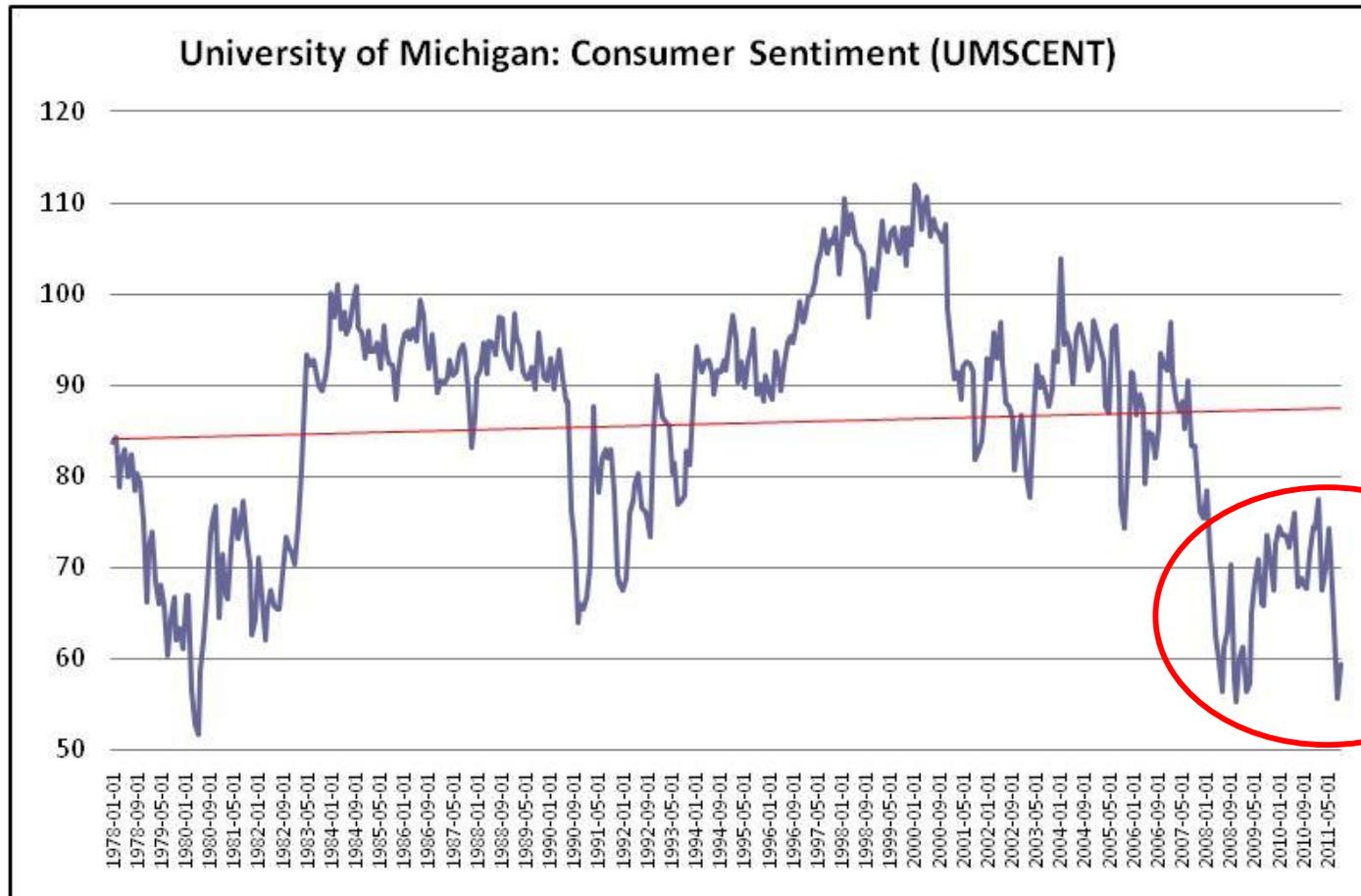
- GDP Revised Downward

- Second-quarter real GDP growth came in at only 1.3%, and revisions to previous quarters showed a deeper recession and a weaker recovery than previously thought.

- Debt Ceiling Crisis, S&P Downgrade, and Federal Budget Deficit Discussion & Sequester

- Federal legislation immediately enacted 10-year discretionary spending caps generating approximately \$917 billion in deficit reduction in defense and non-defense spending.
- Bipartisan committee process charged with identifying an additional \$1.5 trillion in deficit reduction over the next 10 years. If this outcome comes to pass, there would be a total of \$2.4 trillion in deficit reduction over 10 years from the two components acting in concert.
- If the committee or Congress fails to adopt at least \$1.2 trillion in a deficit reduction package (including an allowance for interest savings), an enforcement mechanism scaled to ensure an additional \$1.2 trillion in spending reductions kicks in—falling equally on defense and non-defense spending.

Perceptions Plummeted in August

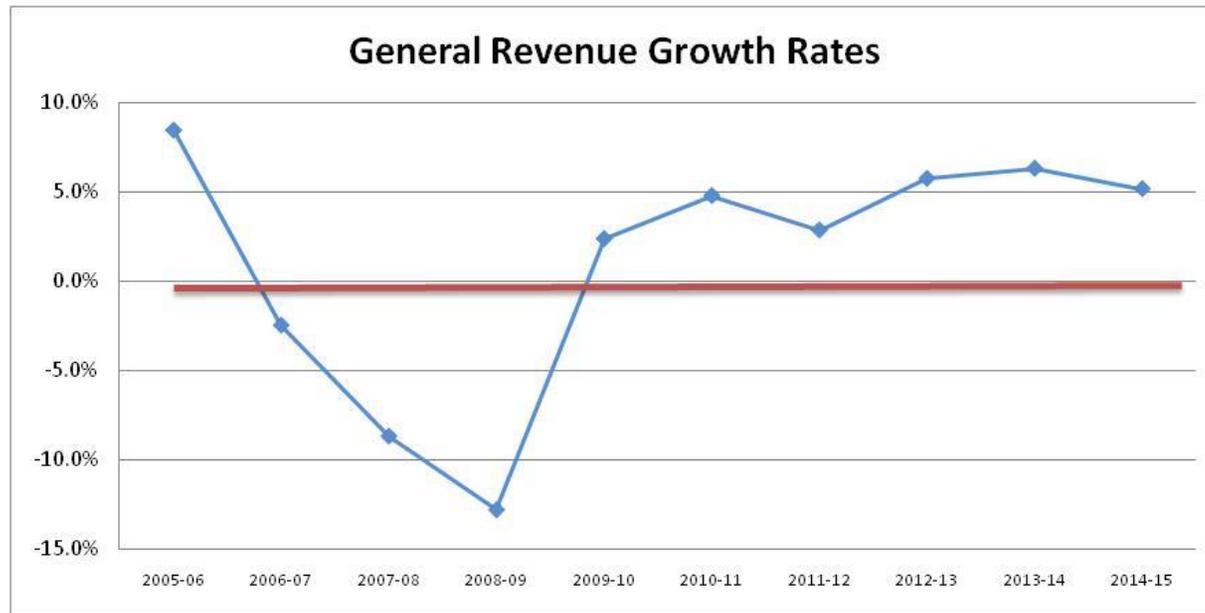


- Consumer sentiment can be a leading indicator of recession: it had been improving, but fell in August to near the lowest level of the Great Recession and not far from the lowest level ever posted. September was still weak, but better. (59.4 in September versus 51.7 in May 1980)
- Spending is holding up better than sentiment would suggest, judging by better September vehicle and chain-store sales on the national level.

Impact on Florida's Economy

- Population growth slowed.
- Housing recovery delayed.
- Employment growth suppressed.
- Revenue sources displayed mixed results with August as a significant turning point—especially for Sales Tax collections.
 - At the end of the 2010-11 fiscal year, overall collections were \$139.1 million above estimate.
 - In contrast, preliminary results for the first quarter of the current fiscal year indicate a loss from the overall estimate of approximately \$106 million.

General Revenue Forecast



Fiscal Year	July* Forecast	October Forecast	Difference (Oct - July)	Incremental Growth	Growth
2005-06	27074.8				8.4%
2006-07	26404.1				-2.5%
2007-08	24112.1				-8.7%
2008-09	21025.6				-12.8%
2009-10	21523.1				2.4%
2010-11	22551.6	22551.6	0.0	1028.5	4.8%
2011-12	23795.1	23195.5	(599.6)	643.9	2.9%
2012-13	25495.1	24526.8	(968.3)	1331.3	5.7%
2013-14	27063.6	26071.8	(991.8)	1545.0	6.3%
2014-15	28340.9	27417.9	(923.0)	1346.1	5.2%

GR Revenue Adjustments (2011-12)

	FY 2011-12
	Shade = Adj
Funds Available:	
Balance Forward	433.0
BALANCE FORWARD RETROSPECT ADJUSTMENT	313.4
Unused Reserve From Prior Year	0.0
Revenue Estimate	23,795.1
FALL CONFERENCE ADJUSTMENT TO ESTIMATE	-599.6
Non-operating Funds	125.2
Transfer From Trust Funds	388.5
MISCELLANEOUS OUTLOOK ADJUSTMENTS	-120.4
Total Funds Available	<u>24,335.2</u>

General Revenue Receipts	Total
Original Plan	24741.8
Fall Revision	24335.2
Difference	-406.6

GR Outlook Balance for FY 2011-12

REVENUES	REC	N/R	TOTAL
BALANCE ON OFFICIAL OUTLOOK: July 27, 1011	811.7	545.9	1357.5
-MINUS- Loss to Funds Available	-495.6	89.0	-406.6
-PLUS- Net Adjustments to Appropriations	0.0	-3.1	-3.1
BALANCE ON CURRENT OFFICIAL OUTLOOK	316.1	631.8	947.8

ADJUSTMENTS			
-MINUS- Reserve for Projected Medicaid Shortfall	0.0	-66.8	-66.8
-MINUS- Reserve for Projected Courts Shortfall	0.0	-110.1	-110.1
ADJUSTMENTS TOTAL	0.0	-176.9	-176.9

BALANCE FOR LONG-RANGE FINANCIAL OUTLOOK 770.9

A projected remaining balance of \$770.9 million in nonrecurring dollars is assumed to be available for use in FY 2012-13.

GR Revenue Adjustments (2012-13)

	FY 2012-13
	Shade = Adj
Funds Available:	
Balance Forward	770.9
BALANCE FORWARD RETROSPECT ADJUSTMENT	0.0
Unused Reserve From Prior Year	0.0
Revenue Estimate	25,495.1
FALL CONFERENCE ADJUSTMENT TO ESTIMATE	-968.3
Non-operating Funds	81.3
Transfer From Trust Funds	0.0
MISCELLANEOUS OUTLOOK ADJUSTMENTS	13.5
Total Funds Available	<u>25,392.5</u>

General Revenue Receipts	Total
Original Plan	26817.0
Fall Revision	<u>25392.5</u>
	-1424.5

GR Expenditure Adjustments (2012-13)

FALL CONFERENCES ('+' = Savings; '-' = Cost)	<u>2012-13</u>
ADD'L DEFICIT: Courts from Article V Conference (\$62.5 LRFO)	0.0
ADD'L DEFICIT: Medicaid for 2010-11 and 2011-12 (\$54.4 LRFO)	0.0
CHANGE TO DRIVER: Temporary Assistance for Needy Families	9.6
CHANGE TO DRIVER: GR Impact from State Courts Rev TF	17.6
CHANGE TO DRIVER: Criminal Justice Estimating Conference	0.0
CHANGE TO DRIVER: FEFP & VPK (Ad Val Conf + Enrollment)	-322.9
CHANGE TO DRIVER: Kidcare Conference	8.0
CHANGE TO DRIVER: Florida Retirement System--UAL	-39.5
CHANGE TO DRIVER: Risk Management Trust Fund	-9.3
CHANGE TO DRIVER: State Employees' Health Insurance	152.1
CHANGE TO DRIVER: Higher Ed & Student Financial Aid	76.2
NEW DRIVER: Higher Ed-Annualize Prior Year New Space	-1.1
CHANGE TO DRIVER: FMAP Savings in Other HHS Agencies	19.1
CHANGE TO DRIVER: Traditional Medicaid Program	44.9
TOTAL ADDITIONAL COST (NET)	-45.3

General Revenue Expenditures	Total
Original Plan	25,543.1
Reserve	1,000.0
Fall Conference Revision	45.3
<u> TOTAL</u>	<u>26,588.4</u>

Putting It Together for the First Year

OUTLOOK PROJECTION – FISCAL YEAR 2012-13 <i>(in millions)</i>			
	RECURRING	NON-RECURRING	TOTAL
AVAIL GR	\$24,307.3	\$ 1,085.2	\$25,392.5
<i>Base Budget</i>	\$22,784.3	\$ 0.0	\$22,784.3
<i>Transfer to BSF</i>	\$ 0.0	\$ 214.5	\$ 214.5
<i>Previous Needs</i>	\$ 2,249.0	\$ 295.3	\$ 2,544.3
<i>Fall Conference Adj</i>	\$ 45.3	\$ 0.0	\$ 45.3
<i>Reserve</i>	\$ 0.0	\$ 1,000.0	\$ 1,000.0
TOTAL	\$25,078.6	\$ 1,509.8	\$26,588.4
BALANCE	\$ -771.3	\$ -424.6	\$ -1,195.9

Combined, recurring and nonrecurring General Revenue program needs – with a minimum reserve of \$1 billion – are more than the available General Revenue dollars, meaning there is now a budget gap for Fiscal Year 2012-13. Anticipated expenditures (including the reserve) cannot be fully funded.

The Bottom Line Across Years...

	FY 2012-13	FY 2013-14	FY 2014-15
New Ending Balance	-1,195.9	-274.8	-166.4
<u>Original Ending Balance in Long-Range Financial Outlook</u>	<u>273.8</u>	<u>692.1</u>	<u>840.6</u>
Difference	-1,469.7	-966.9	-1,007.0

- Fiscal Years 2012-13, 2013-14 and 2014-15 all show projected budget needs greater than the available revenue for Critical and Other High Priority Needs, plus the set-aside of a \$1 billion reserve in each year.
- Fiscal Strategies are required for all years in the Outlook period; the budget gaps are persistent indicating a systemic imbalance.
- Negative balances are not allowed to carry-forward to subsequent years; the assumption is that each year is addressed with a nonrecurring solution leaving the base budget intact for the following year.

Add'l Issues Discussed in the Senate

	FY 2011-12	FY 2012-13
ADD'L ISSUES---SENATE ('+' = Savings; '-' = Cost)		
ADD'L DEFICIT: Agency for Persons with Disabilities	-10.5	0.0
ADD'L DEFICIT: Clerks from Article V Conference	-54.3	-52.1
CHANGE TO DRIVER: Higher Ed - New Space Operations	0.0	10.5
NEW DRIVER: Impact of Gross Receipts Revenue Decline	-100.0	0.0
NEW DRIVER: Education Jobs Allocation - Restore NR	0.0	-554.8
TOTAL ADDITIONAL COST (NET)	-164.8	-596.4

General Revenue Expenditures	Total
Original Plan	25,543.1
Reserve	1,000.0
Fall Conference Revision	45.3
Additional Issues---Senate	596.4
TOTAL	27,184.8

Revised Bottom Line...

	FY 2012-13	FY 2013-14	FY 2014-15
New Ending Balance	-1,957.1	-888.7	-787.2
<u>Original Ending Balance in Long-Range Financial Outlook</u>	<u>273.8</u>	<u>692.1</u>	<u>840.6</u>
Difference	-2,230.9	-1,580.8	-1,627.8

Note that the ending balance beginning in FY 2012-13 was affected by the lower balances forward caused by nonrecurring expenditures of \$164.8 million in FY 2011-12.

Impact of Prior Year's Actions...

- The analysis uses *nonrecurring* means to resolve each shortfall, which leaves the following year's base budget intact and shown as originally projected.
- If the Legislature closes the projected budget gaps through *recurring* means, they positively impact the state's bottom line in subsequent years.
- In this regard, total estimated expenditures for future years will be constrained by the amount of recurring expenditure reductions taken in Fiscal Year 2012-13.

LONG-RANGE FINANCIAL OUTLOOK FOR GENERAL REVENUE UPDATED FOR FALL CONFERENCES

TIER 2 ISSUES - CRITICAL NEEDS AND OTHER HIGH PRIORITY NEEDS

\$1 BILLION RESERVE - NO FISCAL STRATEGIES

(\$ MILLIONS)

	FY 2011-12			FY 2012-13			FY 2013-14			FY 2014-15		
	Recurring	Non-recurring	Total	Recurring	Non-recurring	Total	Recurring	Non-recurring	Total	Recurring	Non-recurring	Total
1 Funds Available:												
2 Balance Forward	0.0	433.0	433.0	0.0	606.1	606.1	0.0	0.0	0.0	0.0	0.0	0.0
3 BALANCE FORWARD RETROSPECT ADJUSTMENT	0.0	313.4	313.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
4 Unused Reserve From Prior Year	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1,000.0	1,000.0	0.0	1,000.0	1,000.0
5 Revenue Estimate	23,615.3	179.8	23,795.1	25,275.8	219.3	25,495.1	26,871.9	191.7	27,063.6	28,261.1	79.8	28,340.9
6 FALL CONFERENCE ADJUSTMENT TO ESTIMATE	-499.6	-100.0	-599.6	-968.3	0.0	-968.3	-1,091.8	100.0	-991.8	-923.0	0.0	-923.0
7 Non-operating Funds	-4.3	129.5	125.2	-4.3	85.6	81.3	-4.3	85.6	81.3	-4.3	85.6	81.3
8 Transfer From Trust Funds	0.0	388.5	388.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9 MISCELLANEOUS OUTLOOK ADJUSTMENTS	4.0	-124.4	-120.4	4.1	9.4	13.5	4.1	9.4	13.5	3.1	9.4	12.5
10 Total Funds Available	23,115.4	1,219.8	24,335.2	24,307.3	920.4	25,227.7	25,779.9	1,386.7	27,166.6	27,336.9	1,174.8	28,511.7
12 Estimated Expenditures:												
13 Base Budget				22,799.3	0.0	22,799.3	25,033.3	0.0	25,033.3	26,855.7	0.0	26,855.7
14 Annualization of Cost Savings From Prior Year				-15.0	0.0	-15.0	0.0	0.0	0.0	0.0	0.0	0.0
15 RECURRING CHANGES FROM PRIOR YR FORECAST ADJ				0.0	0.0	0.0	641.7	0.0	641.7	-313.0	0.0	-313.0
New Issues by GAA Section:												
18 Section 2 - Pre K-12 Education	8,635.1	0.9	8,636.0	270.0	0.0	270.0	134.0	5.2	139.2	66.4	0.0	66.4
19 Section 2 - Higher Education	3,219.3	20.4	3,239.8	149.0	3.4	152.4	160.1	3.4	163.5	138.4	3.4	141.8
20 Section 3 - Human Services	6,925.0	32.4	6,957.5	1,095.1	11.8	1,106.9	252.0	21.3	273.3	693.7	21.3	715.0
21 Section 4 Criminal Justice	3,209.3	7.1	3,216.3	0.9	4.4	5.3	5.1	4.4	9.5	14.8	4.5	19.3
22 Section 7 - Judicial Branch	44.6	0.0	44.6	96.2	0.4	96.6	82.3	0.4	82.7	35.0	0.4	35.4
23 Section 5 & 6 - Transportation & Economic Development	203.7	178.4	382.1	3.8	158.6	162.4	0.0	155.7	155.7	0.0	154.4	154.4
24 Section 5 - Natural Resources	134.0	52.7	186.8	0.0	87.7	87.7	0.0	80.7	80.7	0.0	79.5	79.5
25 Section 6 - General Government	218.9	33.5	252.4	2.4	29.0	31.4	0.8	26.9	27.7	0.9	26.9	27.8
26 Section 2 & 6 - Administered Funds - Statewide Issues	209.5	45.5	255.1	631.6	0.0	631.6	546.3	0.0	546.3	605.7	0.0	605.7
27 Total New Issues				2,249.0	295.3	2,544.3	1,180.7	298.1	1,478.8	1,554.8	290.4	1,845.2
28 Outlook Adjustments --- Expenditures		2.5	2.5									
29 Current Year Operating Deficits (Medicaid, State Courts)		116.9	116.9									
30 Transfer to Budget Stabilization Fund		214.5	214.5		214.5	214.5		214.5	214.5		214.5	214.5
35 Total Estimated Expenditures	22,799.3	704.9	23,504.3	25,033.3	509.8	25,543.1	26,855.7	512.6	27,368.3	28,097.6	504.9	28,602.4
37 FALL CONFERENCES ('+' = Savings; '-' = Cost)												
38 ADD'L DEFICIT: Courts from Article V Conference (\$62.5 LRFO)	0.0	-47.6	-47.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39 ADD'L DEFICIT: Medicaid for 2010-11 and 2011-12 (\$54.4 LRFO)	0.0	-12.4	-12.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
40 CHANGE TO DRIVER: Temporary Assistance for Needy Families	0.0	0.0	0.0	9.6	0.0	9.6	5.4	0.0	5.4	3.6	0.0	3.6
41 CHANGE TO DRIVER: GR Impact from State Courts Rev TF	0.0	0.0	0.0	17.6	0.0	17.6	31.6	0.0	31.6	-19.8	0.0	-19.8
42 CHANGE TO DRIVER: Criminal Justice Estimating Conference	0.0	0.0	0.0	0.0	0.0	0.0	4.2	0.0	4.2	11.2	0.0	11.2
43 CHANGE TO DRIVER: FEFP & VPK (Ad Val Conf + Enrollment)	0.0	0.0	0.0	-322.9	0.0	-322.9	-40.8	0.0	-40.8	9.0	0.0	9.0
44 CHANGE TO DRIVER: Kidcare Conference	0.0	0.0	0.0	8.0	0.0	8.0	-8.8	0.0	-8.8	-12.9	0.0	-12.9
45 CHANGE TO DRIVER: Florida Retirement System--UAL	0.0	0.0	0.0	-39.5	0.0	-39.5	362.2	0.0	362.2	396.4	0.0	396.4
46 CHANGE TO DRIVER: Risk Management Trust Fund	0.0	0.0	0.0	-9.3	0.0	-9.3	2.5	0.0	2.5	1.8	0.0	1.8
47 CHANGE TO DRIVER: State Employees' Health Insurance	0.0	0.0	0.0	152.1	0.0	152.1	55.9	0.0	55.9	38.2	0.0	38.2
48 CHANGE TO DRIVER: Higher Ed & Student Financial Aid	0.0	0.0	0.0	76.2	0.0	76.2	-42.3	0.0	-42.3	0.5	0.0	0.5
49 NEW DRIVER: Higher Ed--Annualize Prior Year New Space	0.0	0.0	0.0	-1.1	0.0	-1.1	0.0	0.0	0.0	0.0	0.0	0.0
50 CHANGE TO DRIVER: FMAP Savings in Other HHS Agencies	0.0	0.0	0.0	19.1	0.0	19.1	0.0	0.0	0.0	0.0	0.0	0.0
51 CHANGE TO DRIVER: Traditional Medicaid Program	0.0	0.0	0.0	44.9	0.0	44.9	-39.4	0.0	-39.4	-117.6	0.0	-117.6
53 ADD'L ISSUES--SENATE ('+' = Savings; '-' = Cost)												
54 ADD'L DEFICIT: Agency for Persons with Disabilities	0.0	-10.5	-10.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
55 ADD'L DEFICIT: Clerks from Article V Conference	0.0	-54.3	-54.3	-52.1	0.0	-52.1	-17.5	0.0	-17.5	-6.9	0.0	-6.9
56 CHANGE TO DRIVER: Higher Ed - New Space Operations	0.0	0.0	0.0	10.5	0.0	10.5	0.0	0.0	0.0	0.0	0.0	0.0
57 NEW DRIVER: Impact of Gross Receipts Revenue Decline	0.0	-100.0	-100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
58 NEW DRIVER: Education Jobs Allocation - Restore NR	0.0	0.0	0.0	-554.8	0.0	-554.8	0.0	0.0	0.0	0.0	0.0	0.0
59 Reserves					1,000.0	1,000.0		1,000.0	1,000.0		1,000.0	1,000.0
60 Ending Balance	316.1	290.1	606.1	-1,367.7	-589.4	-1,957.1	-762.8	-125.9	-888.7	-457.2	-330.1	-787.2

NOTE: Negative balances are not allowed to carry-forward to subsequent years; the assumption is that each year is addressed with a nonrecurring solution leaving the base budget intact for the following year.

Strategic Health Plan Options for the State of Florida



DEPARTMENT OF MANAGEMENT
SERVICES

John P. Miles
Secretary

Presented by Michelle Robleto, Director
Division of State Group Insurance

October 20, 2011



Agenda

- Purpose
- Current Program
- Options
 - Active Employees
 - Early Retirees
 - Medicare Retirees
 - Pharmacy Benefits
 - Population Health Management
 - Administrative Considerations and Communication



Purpose

Per Senate Bill 2000: The Division of State Group Insurance developed and reported “different plan alternatives and options for the state employee health insurance program.”



Current Program

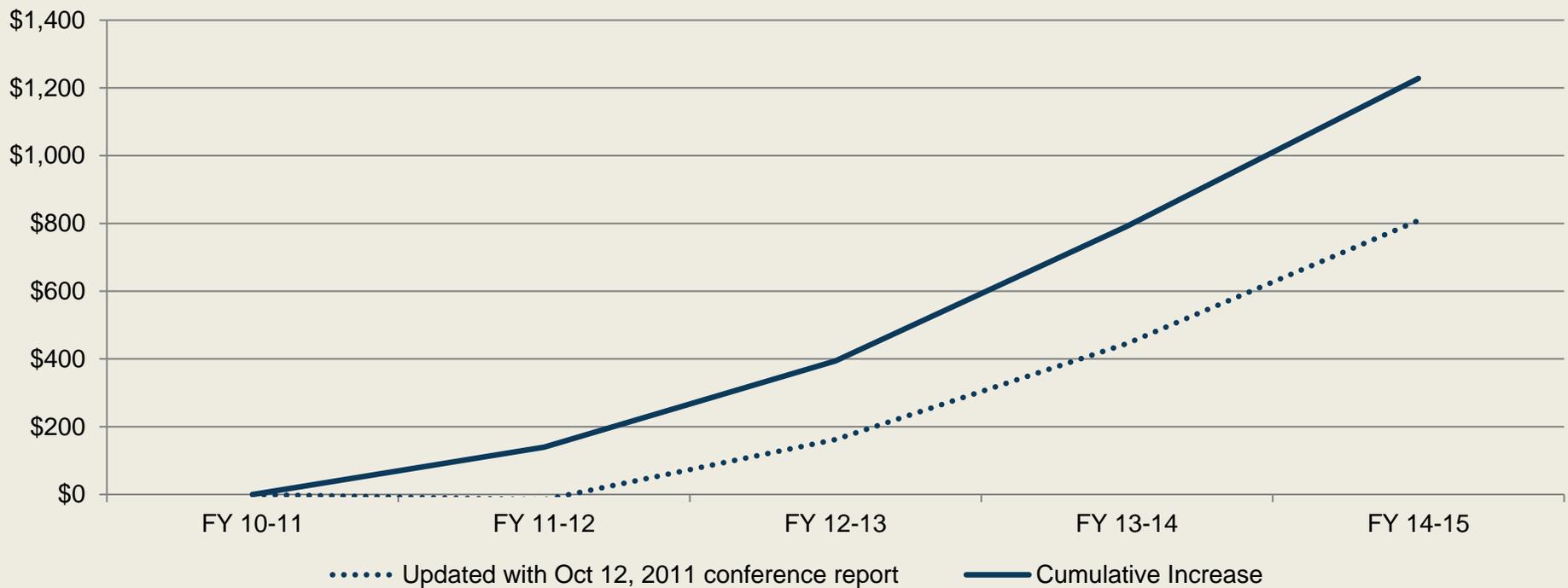
Plan Designs and Contributions

	HMO Standard	PPO Standard		PPO and HMO HIHP	
		In-network	Out-of-network	In-network	Out-of-network (PPO Only)
Deductible	None	\$250/\$500	\$750/\$1,500	\$1,250/\$2,500	\$2,500/\$5,000
Annual State Health Savings Account Deposit	N/A	N/A		\$500/\$1,000	
Primary Care	\$20	\$15	40% after deductible	20% after deductible	40% after deductible
Specialist	\$40	\$25			
Hospital	\$250 copayment	20% after \$250 copay	20% after \$500 copayment		
Generic/ Preferred/ Non-Preferred Prescriptions	\$7/\$30/\$50 Retail	\$7/\$30/\$50 Retail		30% after deductible/ 30% after deductible/ 50% after deductible	
	\$14/\$60/\$100 Mail	\$14/\$60/\$100 Mail			
Out-of-pocket Maximum	\$1,500/\$3,000 employee/family	\$2,500/\$5,000 plus deductible employee/family		\$3,000/\$6,000 employee/family	
		HMO and PPO Standard		HMO and PPO HIHP	
Employee		\$50.00		\$15.00	
Family		\$180.00		\$64.30	

Current Program

Anticipated Health Care Trend

Projected Increase in Total Expenses under State Employees' Group Health Program
(Dollars in Millions)





Options: Active Employees

Types of Plans and Benefit Designs

OPTIONS – TYPES OF PLANS		
Conservative	Moderate	Aggressive
Eliminate HMO HIHP option	Eliminate the HMO Standard and HMO HIHP options; continue the PPO Standard and PPO HIHP options	Eliminate HMO Standard, HMO HIHP and PPO Standard Options; enroll all employees in PPO HIHP option

OPTIONS – BENEFIT DESIGNS		
Conservative	Moderate	Aggressive
<p>Adjust HMO plan design to include more cost sharing through deductibles and coinsurance:</p> <ul style="list-style-type: none"> 90 percent coinsurance except for office visits Increase out-of-pocket maximum from two to three times individual <p>Adjust PPO plan out-of-pocket maximum for consistency with HMO</p> <ul style="list-style-type: none"> Increase out-of-pocket maximum from two to three times individual 	<p>Enhance PPO HIHP plan design:</p> <ul style="list-style-type: none"> Increase in health savings account deposit to 50 percent of deductible (from \$500 to \$625) prefund health savings account in first year cover generic preventive drugs at 100 percent prior to deductible 	<p>Only plan type is PPO HIHP – Enhance PPO HIHP plan design:</p> <ul style="list-style-type: none"> Increase in health savings account deposit to 50 percent of deductible (from \$500 to \$625) prefund health savings account in first year cover generic preventive drugs at 100 percent prior to deductible



Options: Active Employees

Types of Plans and Benefit Designs

Savings/Cost Avoidance Estimates

		FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Conservative	Plan Design Change Savings/Cost Avoidance	2% PPO 6% HMO	2% PPO 6% HMO	2% PPO 6% HMO	2% PPO 6% HMO
	Savings/Cost Avoidance Estimate	\$60.1 million	\$67.0 million	\$74.4 million	\$82.4 million
Moderate	Eliminate HMOs	4% – 6%	4% – 6%	4% – 6%	4% – 6%
	Midpoint Savings/Cost Avoidance Estimate	\$101.9 million	\$114.7 million	\$134.5 million	\$156.3 million
Aggressive	PPO HIHP Only with Design Changes	10.5% – 13.5%	10.5% – 13.5%	10.5% – 13.5%	10.5% – 13.5%
	Midpoint Savings/Cost Avoidance Estimate	\$244.6 million	\$275.2 million	\$322.9 million	\$375.2 million

Note: Savings estimates are applied to full fiscal years and do not include impact of new 2012 pharmacy benefits manager contract or 2012 HMO contracts. Changes in enrollment may impact projected savings. Savings estimates across approaches (conservative, moderate, aggressive) are not additive.

Options: Active Employees *Employee Contributions*

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Adjust current two-tier structure to four tiers Adjust employee contributions to better reflect the relative value of the plan options (HMO Standard highest, PPO Standard middle and PPO HIHP lowest required contribution) but employees do not pay the full difference in cost between the plans. 	<ul style="list-style-type: none"> Adjust current two-tier structure to four tiers Adjust employee contributions to reflect the relative value of the plan options using a fixed percentage or fixed dollar amount for the state contribution (HMO Standard highest, PPO Standard middle and PPO HIHP lowest required contribution), requiring employees to “buy up” to the greater valued plans by paying the full difference in cost between the plans. 	<ul style="list-style-type: none"> Adjust current two-tier structure to four tiers Adjust employee contributions to reflect the relative value of the plan options using a fixed dollar amount for the state contribution: <ol style="list-style-type: none"> Fixed amount per year for all employees <ol style="list-style-type: none"> Fixed amount per year for individual contracts Fixed amount per year for family contracts Phase out the differential in employer contributions between individual and family contracts over a period of three to five years Fixed state contribution could purchase state-sponsored option(s) or via a state-based private exchange.

Options: Early Retirees

Types of Plans and Contributions

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Maintain same plan options as actives Adjust current two-tier structure to four tiers (as discussed in active employee section) Adjust early retiree contributions to reflect actuarially sound rates (based on blended underwriting of actives and early retirees) with early retirees continuing to contribute 100% of the premium cost. 	<ul style="list-style-type: none"> Maintain same plan options as actives Adjust current two-tier structure to four tiers (as discussed in active employee section) Underwrite early retiree costs on an actuarially sound, stand-alone basis, eliminating the state implicit subsidy of early retiree cost. Alternatively, existing early retirees and employees close to retirement can be grandfathered. 	<ul style="list-style-type: none"> No longer offer state-sponsored or subsidized plans for early retirees. Instead, facilitate early retirees' purchase of coverage through a state (as the employer) sponsored exchange that includes tools and resources to help retirees select the most appropriate medical and drug plan based on cost and coverage needs.

Options: Medicare Retirees

Types of Plans and Contributions

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> • Eliminate the PPO HIHP and HMO HIHP options • Maintain the PPO Standard and HMO Standard options with the same design as active employees • Continue current state implicit subsidy approaches for both plans • Convert prescription benefit to Employer Group Waiver Program (EGWP) for savings/cost avoidance and Government Accounting Standards Board (GASB) liability reduction 	<ul style="list-style-type: none"> • Eliminate the PPO HIHP and HMO HIHP options • Maintain the PPO Standard and HMO Standard options with the same design as active employees • Eliminate or phase out PPO Standard implicit subsidy and underwrite total costs on an actuarially sound basis • Consider converting prescription benefit to EGWP for savings/cost avoidance to retirees and GASB liability elimination 	<ul style="list-style-type: none"> • No longer offer state-subsidized plans for Medicare retirees. Instead, facilitate Medicare retirees' purchase of coverage through a state (as the employer) sponsored exchange that includes tools and resources to help retirees select the most appropriate medical and drug plan based on cost and coverage needs. GASB liability is eliminated.

Options: Pharmacy Benefits

Plan Design and Program Management

OPTIONS – PLAN DESIGN AND PROGRAM MANAGEMENT		
Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Cover generic preventive drugs at 100% in the PPO HIHP Increase mail order copay to 2½ or 3 times the retail copay Exclude lifestyle-related drugs Introduce mandatory generic program and appropriate prior authorization programs Offer compliance programs for targeted populations 	<ul style="list-style-type: none"> For Standard plans continue generic copayment and cover brands and non-preferred brands at 20% and 30% respectively, with maximum copayments Cover generic preventive drugs at 100% in the PPO HIHP Increase mail order copay to 2½ or 3 times the retail copay Exclude lifestyle-related drugs Introduce a mandatory or penalized maintenance drug program and a robust suite of clinical programs including multiple step therapy programs, duration of therapy limits and quantity limits Implement strategies to limit or eliminate use of medications that are available over the counter Offer compliance programs for targeted populations 	<ul style="list-style-type: none"> For Standard plans continue generic copayment and cover brands and non-preferred brands at 20% and 30% respectively, with minimum and maximum copayments Cover generic preventive drugs at 100% in the PPO HIHP Increase mail order copay to 2½ or 3 times the retail copay Change to a closed formulary and a very limited network of pharmacy providers Exclude lifestyle-related drugs, brand prescription coverage for drug categories where two or more products are available over the counter, and brand medications in specific therapy classes where multiple generics are available Mandate use of lowest cost distribution channel Introduce multiple step therapy programs and penalties for non-compliance with prescribed therapy



Options: Pharmacy Benefits

Plan Design and Program Management

Savings/Cost Avoidance Estimates

OPTIONS - CLINICAL AND ADMINISTRATIVE PROGRAMS		
Conservative	Moderate	Aggressive
2% – 6%	5% – 19%	10% – 31%
\$ 12 million – \$ 36 million	\$ 30 million – \$ 114 million	\$ 60 million – \$ 185 million

See report for important notes, design details, etc.



Options: Population Health Management

- Reduce health risks related to behaviors such as smoking, poor nutrition, physical fitness, stress, etc.
- Encourage employees to become more involved in medical care
- Increase use of preventive services for early diagnosis
- Improve compliance with prescribed treatments
- Reduce lost work days due to illness
- Minimize the risk of disability

Options: Population Health Management

Conservative	Moderate	Aggressive
<p>Activity-based Incentives</p> <ul style="list-style-type: none"> Conduct a population risk analysis Introduce incentives for health risk assessment completion and biometric screenings Implement tobacco cessation initiative 	<p>Achievement-based Incentives</p> <ul style="list-style-type: none"> Implement population health management programs targeted to address results of population risk analysis Use health risk assessment completion and biometric screenings as gateway to earning incentives for population health management program and biometric “achievements” Introduce tobacco user surcharge for employees 	<p>Adherence-based Incentives</p> <ul style="list-style-type: none"> Monitor results and continue population health management programs targeted to address results of population risk analysis Use health risk assessment completion and biometric screenings as gateway to earning incentives for population health management program and biometric “achievement” Introduce “adherence-based” incentives to reward members that meet clinical and biometric targets Continue tobacco user surcharge for employees and add surcharge for tobacco user spouses.



Options: Administrative Considerations and Communications

- Data aggregation
- Health savings account administration improvements
- Health risk assessment integration
- Incentive administration
- Health care flexible spending account participation
- Dependent eligibility review processes
- Benefits enrollment process
- Significant changes require thorough and effective communication



RICK SCOTT
Governor

DEPARTMENT OF MANAGEMENT
SERVICES

JOHN P. MILES
Secretary

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September 30, 2011

The Honorable Mike Haridopolos, President
The Florida Senate
409 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear President Haridopolos:

The Department of Management Services is pleased to provide the attached report of “plan alternatives and options for the state employee health insurance program” (program) pursuant to the instructions provided in Chapter 2011 – 069, Laws of Florida (Senate Bill 2000):

From the funds provided in Specific Appropriations 2654 through 2667, the Division of State Group Insurance shall develop health insurance plan alternatives for the state’s health insurance offerings. The department shall provide a report by October 1, 2011, to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives of the different plan alternatives and options for the state employee health insurance program.

Like other employers, large and small, the state faces significant challenges in providing the correct mix of insurance benefits to its employee workforce and to retirees. The attached report, *Strategic Health Plan Options for the State of Florida*, provides options for consideration. As you will see, the options generally move the program to a more contemporary approach to providing health insurance benefits, commonly known as “consumerism.” This consumerism concept engages the health plan participant to work alongside the employer with shared accountability, supported by information and technology to allow members to make the best possible choices for themselves and their families. The progression to a consumerism type of model is presented in the report with conservative, moderate, and aggressive approaches to provide decision-makers with the maximum array of options to consider.

To provide additional context for the attached report, I would like to share other information that may be useful to you and your working committees as we approach the upcoming legislative session. The focus on a consumerism model is supported by information available from well-respected resources, including the National Business Group on Health and the Mercer’s National Survey of Employer-Sponsored Health Plans .

¹ *National Business Group on Health (NBGH) is a non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical solutions to its members' most important health care problems. NBGH members are primarily Fortune 500 companies and large public sector employers – including the nation's most innovative health care purchasers – who provide health coverage for more than 50 million U.S. workers, retirees, and their families.*

In January 2011, the *National Business Group on Health's Institute on Health Care Costs and Solutions*¹ issued the following list of the top ten solutions employers should integrate into their programs to control health care costs:

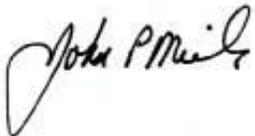
1. Establish a Comprehensive Strategy Aimed at Controlling Costs and Improving Quality and Safety
2. Use Employee Cost-Sharing to Manage Costs and Engage Employees
3. Use Account-Based Plan and Optimize Vendors
4. Contract with Centers of Excellence for Selected Conditions
5. Aggressively Manage the Pharmacy Benefit
6. Vigorously Manage Overuse and Inappropriate Use of Services
7. Audit Eligibility and Reassess Dependent Coverage Pricing
8. Actively Promote Targeted Health Improvement Programs and Resources
9. Insist on Transparency and Provide Comparative Information to Employees
10. Manage Retiree Health Care

In addition, recent benchmarking of the state group insurance program to large and small employers also highlights the need to modernize the program. For your reference, please see the attached benchmarking analyses performed for the State of Florida by Mercer:

1. 2010 State of Florida Benchmarking Report
2. 2010 State of Florida Benchmarking Report, Featuring Small Employer Data

Challenging times continue to face our great state. We stand ready to work with you on important decisions, such as considering the appropriate approach to benefits for state employees and retirees.

Sincerely,



John P. Miles
Secretary

Attachments

¹ *National Business Group on Health (NBGH) is a non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical solutions to its members' most important health care problems. NBGH members are primarily Fortune 500 companies and large public sector employers — including the nation's most innovative health care purchasers — who provide health coverage for more than 50 million U.S. workers, retirees, and their families.*



DEPARTMENT OF MANAGEMENT
SERVICES

Strategic Health Plan Options for the State of Florida

September 29, 2011

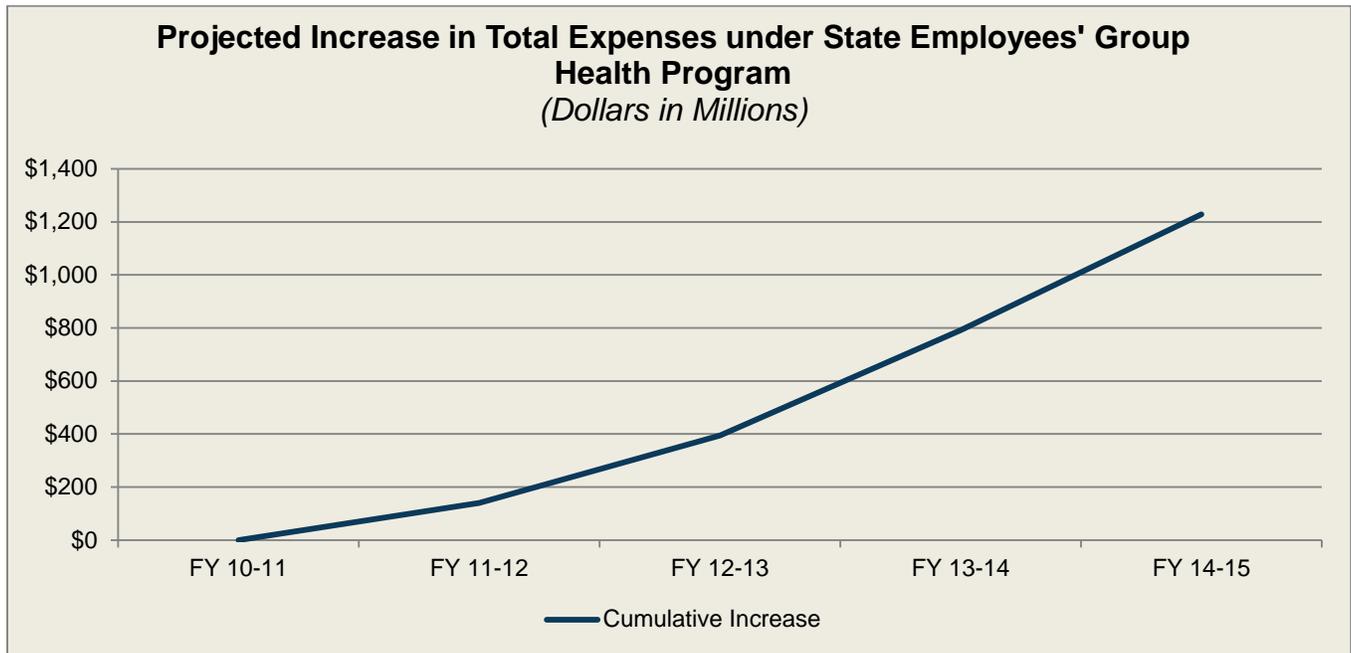


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I. Executive Summary

In accordance with Senate Bill 2000, this report provides “plan alternatives and options for the state employee health insurance program.” As shown in the graph below, projected total expenses under the State Employees Group Health Program are expected to increase by more than \$1 billion from just over \$2.0 billion in fiscal year 2011 - 2012 to more than \$3.1 billion in fiscal year 2014 - 2015. Under any circumstances, but more so given the current economic environment, these increases are unsustainable and must be addressed.



The state’s current approach to its health plan is best described as paternalistic, whereby the state serves as the architect/custodian of the plan, providing generous benefits and allowing employees to be passive and perhaps even entitled, with little concern about costs. Historically prevalent among large and governmental employers, this approach is rapidly being replaced by initiatives that focus on increasing and improving consumerism behaviors. In the consumerism approach the employer and employees maintain shared accountability, with the employer providing a supportive environment, partnering with employees and enabling them to make informed decisions, considering costs and outcomes of the health care services they seek and receive.

The report that follows describes a broad range of options for increasing and improving consumerism behaviors. Three alternative approaches to each option are included and are labeled as conservative, moderate and aggressive. In addition to describing these options and alternative approaches, the report also contains administrative considerations to be addressed as part of the decision-making process as well as future considerations for longer term strategic planning purposes. A summary of the options for increasing and improving consumerism behaviors is provided for reference at the end of the report.

II. Our Purpose

In accordance with Senate Bill 2000, this report provides “plan alternatives and options for the state employee health insurance program” (Program). The State of Florida – Department of Management Services (DMS), Division of State Group Insurance (DSGI) – retained Buck Consultants to provide support in developing the alternatives for the state’s health insurance offerings contained in this report.

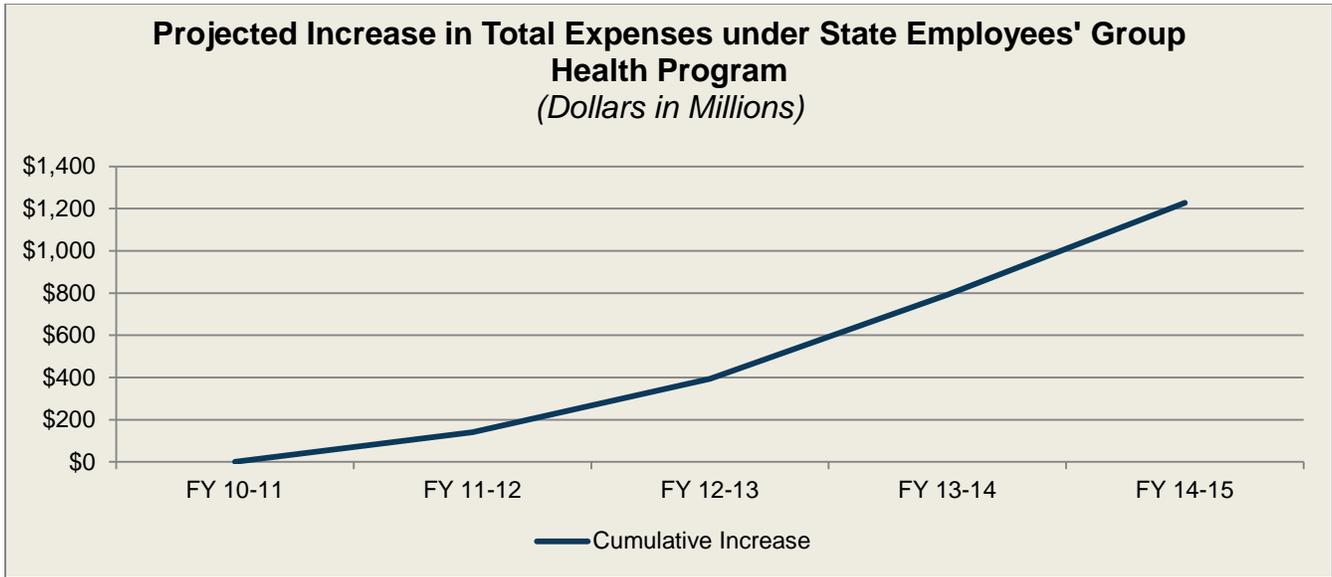
The table below highlights the projected expenses of the State of Florida Employees’ Group Health Insurance Program (the Health Program) as presented in the August 3, 2011 Conference Report. The increases in projected total expenses represent an average increase of more than 13 percent annually and, as shown in the graph that follows, represent an increase of more than \$1 billion from just over \$2.0 billion in fiscal year 2011 - 2012 to more than \$3.1 billion in fiscal year 2014 – 2015. Under any circumstances, but more so given the current economic environment, these increases are unsustainable. As indicated by the last line in the table, even a one percent expense reduction will save millions of dollars.

Projected Total Expenses Under State Employees’ Group Health Program*

Expenses	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
PPO Medical Claims/Fees	\$637.8	\$680.7	\$724.6	\$771.7	\$822.2
PPO Prescription Claims/Fees	\$257.9	\$279.7	\$302.8	\$333.6	\$367.6
HMO Payments	\$988.4	\$1,092.7	\$1,241.6	\$1,406.5	\$1,590.7
Other Expenses	\$7.7	\$7.7	\$7.7	\$7.7	\$7.7
PPACA	\$7.1	(\$22.1)	\$16.4	\$171.2	\$338.7
Total	\$1,898.9	\$2,038.7	\$2,293.1	\$2,690.7	\$3,126.9
Increase from FY 2010-11		\$139.80	\$394.20	\$791.80	\$1,228.00
Savings/cost avoidance from 1% Reduction in Costs	\$19.0 million	\$20.34 million	\$22.9 million	\$26.9 million	\$31.3 million

* Projected total expenses in the chart above are outlined as presented in the August 3, 2011 Conference Report. Expenses do not include the impact of new 2012 pharmacy benefits manager contract or 2012 HMO contracts. Changes in enrollment may impact projected savings.

II. Our Purpose



The information and options contained in this report address the three broad categories of covered participants and their dependents: 1) active employees (includes members on continuing coverage under COBRA¹), 2) early retirees (not eligible for Medicare), and 3) Medicare-eligible retirees. Options that reduce costs and/or reduce expected cost *increases* over time are provided, including alternatives where appropriate. Savings/cost-avoidance estimates are included where data was readily available. In some cases, the estimates are specific to the state's Health Program and are based on prior studies Buck conducted for DSGI. In other cases, estimated savings/cost avoidance percentages have been applied to the Health Program costs to provide a range of probable savings/cost avoidance. Detailed analysis can be performed on selected options as needed.

In addition, alternative approaches have been labeled as conservative, moderate, and aggressive to provide a range of options that, in many cases, represent the level of impact the changes may have on the plan participants. These alternative approaches are illustrated throughout the report in the following format:

ALTERNATIVE APPROACHES

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> • Option • Option • Option 	<ul style="list-style-type: none"> • Option • Option • Option 	<ul style="list-style-type: none"> • Option • Option • Option

¹ Consolidated Omnibus Budget and Reconciliation Act that gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time.

III. Setting the Strategic Direction: What Path Should the State Take?

The chart below represents the spectrum of the employment relationship approaches ranging from paternalism to consumerism to individualism. The chart highlights the essence of the employment relationship, the role of the employer, and the role of the employee under each approach.

Consumerism is the most prevalent approach among large employers seeking to improve overall health plan performance.

Employment Relationship Spectrum

	Paternalism	Consumerism	Individualism
Essence of Employment Relationship	“We’ll take care of it for you”	“We support each other and share responsibility”	“You’re on your own”
Employer Role	Architect/custodian providing at a minimum, adequate benefits, fair policies	Partner, enabling employees to make informed decisions for their well-being	Limited obligation or involvement in the individual’s choices
Employee Role	Passive, “entitled”; waits for employer to make decisions; little concern about costs or impact	Engaged consumer; seeks information, weighs alternatives, considers cost and outcomes	Like an independent contractor; simply minimizes cost and maximizes personal outcomes

The current health plan most closely aligns with a “paternalistic” approach, whereby the state serves as the architect/custodian of the plan, providing generous benefits and allowing employees to be passive and perhaps even “entitled,” with little concern about costs. This approach is historically prevalent among large and governmental employers, with whom employees spent entire careers with a single employer and received “cradle to grave” benefits.

The opposite end of the spectrum shows an “individualistic” approach, whereby employees are treated as independent contractors, perhaps receiving a lump sum payment and left to find, evaluate, and purchase benefits on their own, frequently in the individual insurance market. This approach is more common among employers that utilize contract employees, such as in highly specialized or project-based engagements. For most large employers in the U.S. and governmental employers in general, this extreme end of the spectrum does not adequately represent the employer’s full self-interest in the employment relationship, where the benefit is used as a valued attraction and retention tool and integral part of the total compensation package.

For most large employers in the U.S. and increasingly more prevalent for governmental employers, the preferred employment relationship is represented by a “consumerism” approach. Here the employer and employee maintain shared accountability, with the employer providing a supportive environment of “consumerism,” partnering with employees and enabling them to make informed decisions, considering costs and outcomes of the health care services they seek and receive.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

Approaches to support consumerism initiatives can vary widely, but for purposes of this report are divided into the following categories:

1. Active Employees

- Overview – Types of Plans and Benefit Designs
- Observations – Types of Plans
- Observations – Benefit Designs

Alternative Approaches

- Summary – Types of Plans and Benefit Designs
- Savings/Cost Avoidance Estimates

- Overview and Observations – Employee Contributions

Alternative Approaches

- Discussion – Employee Contributions
- Summary – Employee Contributions

2. Early Retirees

- Overview and Observations – Types of Plans and Contributions

Alternative Approaches

- Discussion – Types of Plans and Contributions
- Summary – Types of Plans and Contributions
- Illustrative Savings/Cost Avoidance

3. Medicare Retirees

- Overview and Observations – Types of Plans and Contributions

Alternative Approaches

- Discussion – Types of Plans and Contributions
- Summary – Types of Plans and Contributions
- Illustrative Savings/Cost Avoidance

4. Pharmacy Benefits

- Tools to Manage Pharmacy Benefits
- Overview and Observations – Plan Design
- Overview and Observations – Program Management

Alternative Approaches

- Discussion – Plan Design and Program Management
- Summary – Plan Design and Program Management
- Savings/Cost Avoidance Estimates

5. Population Health Management and Incentives

- Overview and Discussion

Alternative Approaches

- Discussion and Summary

6. Communications: Required for Success

- Overview and Discussion

Alternative Approaches

- Summary – Successful Communication Strategy
- Roll Out Strategy

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees

OVERVIEW - TYPES OF PLANS AND BENEFIT DESIGNS

More than 140,000 active employees participate in the Health Program. This represents the majority of those eligible to participate, with approximately 15,000 employees opting out of coverage (electing not to participate in the state Health Program). The enrollment numbers shown below are from January 2011, and correlate to the savings estimates from analyses that were performed in early 2011 and that are provided in the following pages. Current enrollment numbers are similar to those provided below.

Active employees currently have four primary health insurance benefit plans from which to choose:

1. **PPO Standard** – A self-insured plan administered by BlueCross BlueShield and CVS Caremark in 2011, with the prescription drug benefits administration moving to Medco in 2012. Currently, 44.3 percent of active employees (62,403 as of January 2011) participating in the Health Program are enrolled in this plan. The PPO plan is available nationwide.
2. **HMO Standard** – In 2011, HMOs are offered on a fully-insured basis by five different carriers who administer both the medical and prescription drug benefits. Depending on where employees live or work, they may be eligible for more than one HMO. In 2012, all except two of the HMOs will be self-insured, with prescription drug benefits administered by Medco. The plan will be offered by different HMOs, depending on where the employee lives or works. Currently, 54.9 percent of active employees (77,238 as of January 2011) participating in the Health Program are enrolled in this plan.
3. **PPO HIHP (Health Investor Health Plan)** – This is a self-insured, high-deductible plan administered by BlueCross BlueShield and CVS Caremark in 2011, with the prescription drug benefits administration moving to Medco in 2012. Currently, 0.5 percent of active employees (670 as of January 2011) participating in the Health Program are enrolled in this plan. The PPO HIHP plan is available on a nationwide basis.
4. **HMO HIHP (Health Investor Health Plan)** – In 2011, HMO HIHPs are offered on a fully-insured basis by four different carriers who administer both the medical and prescription drug benefits. Depending on where employees live or work, they may be eligible for more than one HMO. In 2012, some HMO HIHP plans will be self-insured with prescription drug benefits administered by Medco. The plans will be administered by different HMOs, depending on where the employee lives or works. Currently, 0.3 percent of active employees (443 as of January 2011) participating in the Health Program are enrolled in this plan.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees, continued

A chart summarizing the current provisions of each plan is provided below.

	HMO Standard	PPO Standard		PPO and HMO HIHP	
		In-network	Out-of-network	In-network	Out-of-network (PPO Only)
Deductible	None	\$250/\$500	\$750/\$1,500	\$1,250/\$2,500	\$2,500/\$5,000
Annual State Health Savings Account Deposit	N/A	N/A		\$500/\$1,000	
Primary Care	\$20	\$15	40% after deductible	20% after deductible	40% after deductible
Specialist	\$40	\$25			
Hospital	\$250 copayment	20% after \$250 copay	20% after \$500 copayment		
Generic/ Preferred/ Non-Preferred Prescriptions	\$7/\$30/\$50 Retail	\$7/\$30/\$50 Retail		30% after deductible/ 30% after deductible/ 50% after deductible	
	\$14/\$60/\$100 Mail	\$14/\$60/\$100 Mail			
Out-of-pocket Maximum	\$1,500/\$3,000 employee/family	\$2,500/\$5,000 plus deductible employee/family		\$3,000/\$6,000 employee/family	

OBSERVATIONS – TYPES OF PLANS

PPO Standard

The PPO plan contains a combination of copayments for physician office visits and coinsurance for hospital and other services after satisfaction of an annual deductible. This plan design encourages participants to make wise purchasing decisions through its use of variable cost sharing provisions (coinsurance).

HMO Standard

Because of their fixed copayment structure, typical HMO plan designs require annual “tweaking” in order for employee cost sharing to keep pace with medical/pharmacy price inflation. The current copayment structure isolates participants from the true cost of services and does not encourage participants to make prudent purchasing decisions or otherwise “shop” for care. The behavior that often occurs within this plan does not align well with many employer initiatives around consumerism, including wellness and encouraging positive behavior changes that will improve the health and well-being of participants and help manage plan costs. For these reasons, some employers are discontinuing this HMO plan design.

PPO and HMO HIHP

The HIHP plans are considered by the industry to be consumer driven health plans and include an annual employer-provided deposit into a health savings account for participants to use prior to incurring any out-of-pocket expenses. Cost sharing is encouraged through the use of coinsurance after satisfaction of the deductible. Similar designs are commonly seen on PPO network platforms and are commonly referred to as High Deductible Health Plans with Health Savings Accounts.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees, continued

Conversely, HMO HIHP plans are not typical. HMOs in general, are not viewed as “consumer driven health plans.” Traditional HMO models, built on capitated reimbursement rates to providers (contracted rates paid to providers for each member assigned, regardless of the number or nature of services provided) and fixed copayments to members, encourage members to seek services from a member-selected primary care physician that directs the members’ care. Because the member has little out-of-pocket expenses at the point of service, members receive the physician-recommended/prescribed services without the need to consider or even be aware of the cost of the service. This is contrary to the premise of consumer driven health plans that encourage members to effectively shop for providers and services and make wise purchasing decisions through the use of transparency pricing tools and resources. Given these contradictory models, the HMO HIHP plan could be eliminated as an option from the Health Program.

OBSERVATIONS – BENEFIT DESIGNS

HMO and PPO Standard

The HMO Standard benefit design could be adjusted to include more cost sharing provisions, such as coinsurance. However, that would make it more closely mirror the existing PPO plan benefit design. Unless there are distinguishable differences from the PPO in the HMO networks and/or health plan management, offering additional plans with similar designs is not necessary given the PPO is available nationwide. The PPO Standard plan already includes adequate cost sharing provisions and competitive deductibles. One change that can be made to the PPO Standard benefit design to more closely align with the market is to increase the family deductible and out-of-pocket maximum from two times family to three times family. Since all self-insured plans’ pharmacy benefits will be carved out to Medco effective January 1, 2012, options for the pharmacy benefits design part of the plan are discussed in a subsequent section of this report.

PPO HIHP

The current PPO HIHP design is lower in relative value than the PPO and HMO Standard plans, meaning that the PPO HIHP plan provides less financial coverage and members incur more out-of-pocket expenses than the Standard plans for the same members’ incurred claims. Despite the employees’ lower contribution required per paycheck for the PPO HIHP plan, very few participants are currently enrolled in this option. This may be partly because the employee contributions are relatively low in general, and the per-paycheck difference between the options is not compelling enough to forego the additional benefit value offered by the other Standard options.

An alternative reason, however, could be the risk aversion that participants may have to one particular widely-utilized benefit provision, pharmacy benefits. In general, a much greater percentage of plan participants utilize the pharmacy benefits than utilize the medical benefits and with more frequency (up to ten prescriptions per member per year on average). For a health plan participant that utilizes one maintenance drug per month, the requirement to pay the difference between the deductible and the health savings account fund ($\$1,250 - \$500 = \$750$) can be uninviting as a known financial exposure.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees, continued

To retain the tax-favored status of the health savings accounts, the deductible must be satisfied before the plan pays benefits. However, under the regulations, preventive services may be covered at 100 percent. Under the state's current Health Program, this includes only preventive medical services. An option to make the HIHP more appealing to employees is to consider preventive pharmaceuticals under preventive services covered at 100 percent. Examples of preventive pharmaceuticals include cholesterol-lowering medications (such as simvastatin) which help prevent heart attacks and ace inhibitors (such as benzapril) which help prevent kidney damage and heart damage. Preferred drug lists are maintained by pharmacy benefits managers and may vary by vendor. The state can consider enhancing the PPO HIHP to include preventive drug coverage. The most cost-effective way to implement this change is to cover only generic preventive drugs and not all preventive drugs. The cost to add this benefit is estimated to increase by approximately one percent for generic only preventive drugs, versus approximately three percent for all preventive drugs.

Because the relative value of the PPO HIHP plan is lower than the current PPO and HMO Standard plans and there is little enrollment in this HIHP plan currently, there would be a minimum impact to overall Program costs to add generic preventive drug coverage at 100 percent. Instead, enhancing the benefits of this plan will make it more attractive and may shift members from the Standard plans to the HIHP, which will result in lower costs overall.

ALTERNATIVE APPROACHES

SUMMARY – TYPES OF PLANS AND BENEFIT DESIGNS

The alternative types of plans and benefit design options are provided below. Using the expense projections originally provided, savings/cost avoidance estimates of the three approaches are outlined below. Changes to the PPO Standard option have been included for market competitiveness and consistency with the HMO and are described below along with the other changes.

OPTIONS – TYPES OF PLANS		
Conservative	Moderate	Aggressive
Eliminate HMO HIHP option	Eliminate the HMO Standard and HMO HIHP options; continue the PPO Standard and PPO HIHP options	Eliminate HMO Standard, HMO HIHP and PPO Standard Options; enroll all employees in PPO HIHP option

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees, continued

OPTIONS – BENEFIT DESIGNS		
Conservative	Moderate	Aggressive
Adjust HMO plan design to include more cost sharing through deductibles and coinsurance: <ul style="list-style-type: none"> 90 percent coinsurance except for office visits Increase out-of-pocket maximum from two to three times individual Adjust PPO plan out-of-pocket maximum for consistency with HMO <ul style="list-style-type: none"> Increase out-of-pocket maximum from two to three times individual 	Enhance PPO HIHP plan design: <ul style="list-style-type: none"> Increase in health savings account deposit to 50 percent of deductible (from \$500 to \$625) prefund health savings account in first year cover generic preventive drugs at 100 percent prior to deductible 	Only plan type is PPO HIHP – Enhance PPO HIHP plan design: <ul style="list-style-type: none"> Increase in health savings account deposit to 50 percent of deductible (from \$500 to \$625) prefund health savings account in first year cover generic preventive drugs at 100 percent prior to deductible

SAVINGS/COST AVOIDANCE ESTIMATES

		FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Conservative	Plan Design Change Savings/Cost Avoidance	2% PPO 6% HMO	2% PPO 6% HMO	2% PPO 6% HMO	2% PPO 6% HMO
	Savings/Cost Avoidance Estimate	\$60.1 million	\$67.0 million	\$74.4 million	\$82.4 million
Moderate	Eliminate HMOs	4% – 6%	4% – 6%	4% – 6%	4% – 6%
	Midpoint Savings/Cost Avoidance Estimate	\$101.9 million	\$114.7 million	\$134.5 million	\$156.3 million
Aggressive	PPO HIHP Only with Design Changes	10.5% – 13.5%	10.5% – 13.5%	10.5% – 13.5%	10.5% – 13.5%
	Midpoint Savings/Cost Avoidance Estimate	\$244.6 million	\$275.2 million	\$322.9 million	\$375.2 million

Note: Savings estimates are applied to full fiscal years and do not include impact of new 2012 pharmacy benefits manager contract or 2012 HMO contracts. Changes in enrollment may impact projected savings. Savings estimates across approaches (conservative, moderate, aggressive) are not additive.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees, continued

OVERVIEW AND OBSERVATIONS - EMPLOYEE CONTRIBUTIONS

Tier Structure

The state Health Program currently uses two tiers for enrollment purposes, employee only and employee plus family. Large employers generally have three or four tiers from which employees can elect to enroll. Additional tiers provide a more equitable distribution of cost and contributions for tiers with dependents and provide some financial relief to those with fewer dependents (e.g., a single employee covering one child no longer pays the same per paycheck as an employee who covers a spouse and four children). A move to an increased number of tiers would be disruptive to employees covering full families (assuming the state does not increase its contribution for family coverage); however, an increased number of tiers would result in a more equitable cost sharing arrangement with employees and employee contributions relating more directly to the number and type (adult spouse vs. children) of covered dependents.

There is no cost savings/cost avoidance to the plan by changing the tier structure alone, unless the employer contribution is adjusted in conjunction with the change. The state can consider expanding the tier structure to four tiers (employee, employee plus spouse, employee plus child(ren), employee plus family), in conjunction with a change in its contribution strategy, as discussed below. The state already uses the four tiers noted above for its dental and vision plans.

Contribution Strategy

In 2011, full-time, Career Service employee contributions for the PPO and HMO Standard plans are the same – \$50 a month for single coverage, and \$180 a month for family coverage. PPO and HMO HIHP contributions are also the same – \$15 per month for single coverage and \$64.30 for family coverage. Full-time SES/SMS (“payalls”) monthly contributions are the same for both Standard and HIHP plans: \$8.34 for single coverage and \$30 for family coverage. Spouse Program premiums are \$30 per month for family coverage (\$15 per spouse).

Despite the variance in relative benefit value and projected total cost of the plan options (with the HMO being higher benefit value and cost than the PPO), the PPO and HMO Standard plans require the same contribution by employees. This approach insulates employees from the true cost of the benefit and precludes them from making an informed enrollment decision that considers all the factors that impact the total cost of the plan, not just to the employee, but to the state as well. Not surprisingly, enrollment in the HMO Standard is the highest of all options, with 54.9 percent of actives (representing 77, 238 employees) electing the HMO Standard. **This approach runs contrary to consumerism initiatives that encourage participants to make informed purchasing decisions and elect plan options based on the value of the benefits, the per paycheck contributions, as well as the out-of-pocket exposure from the plan’s cost sharing provisions.**

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees, continued

ALTERNATIVE APPROACHES

DISCUSSION - EMPLOYEE CONTRIBUTIONS

Conservative Approach

Employee contributions for the PPO and HMO Standard plans can be updated to better reflect the relative value of the benefits, with the HMO option priced higher than the PPO due to its greater benefit value (up to 10 percent higher). PPO HIHP plan design enhancements can also be made to encourage increased enrollment in the HIHP options, and this plan could be priced to better reflect the relative value of the benefits as compared to the PPO and HMO Standard options (up to 15 percent lower than the PPO Standard).

Moderate Approach

Employee contributions for all options can be updated to reflect the *full* benefit value difference in the options. This could be done by either basing state contributions on a fixed percentage of cost for *each plan* (such as a state contribution of 80 percent of the cost of each plan) or, to better insulate the state from enrollment migration risk, the state contribution percentage, (i.e., the amount the state contributes to the Trust Fund for each participant as a percentage of the total costs) should be based off the *lowest cost plan*, requiring employees to pay the full cost difference to elect a greater valued option. A fixed dollar amount state contribution (such as \$500 a month for single coverage and \$1,100 for family coverage) would also limit the state's financial exposure due to enrollment migration. For example, the state contribution could be based on the amounts provided under the PPO HIHP plans by coverage tier and employees would pay the full cost difference to "buy up" to the higher benefit levels of the PPO and HMO Standard options. Under this approach, the state's financial exposure would be limited to the migration across enrollment tiers (adding family members to coverage), and not by plan option elections (from PPO Standard to HMO Standard). This approach can be phased in over a period of two to three years, starting from the current contribution levels.

Aggressive Approach

Option 1: the state can limit its contribution toward medical plans to a defined contribution dollar amount per employee, such as \$6,000 per year. This amount could be indexed in future years on either an ad hoc basis or tied to an index, such as Consumer Price Index (CPI), CPI for health costs, or wages. Employees could select any plan and cover any eligible dependents, but would receive the same state contribution, regardless of position, salary or family composition.

Option 2: alternatively, as described in the Moderate approach above, the state could provide a higher state contribution for family coverage (for example \$6,000 for single coverage and \$12,000 for family coverage) and, instead, phase out the higher family state contribution over three to five years. This approach would fix the state cost and also provide the greatest incentive to employees to enroll in the most cost effective plan option.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

1. Active Employees, continued

For both options, this approach can be phased in over a period of three to five years, starting from the current contribution levels. The state’s contribution could be used to purchase state-sponsored plans or, alternatively, the state can make the contributions available to employees to purchase coverage through a state-based private exchange.

If this approach is used with state-sponsored plans, it is important to note that other types of plan design changes, population health management and incentives (the latter two are discussed subsequently in this report) be incorporated so that the total cost of the available plans is affordable to employees. To further improve the cost-effectiveness of the health plans a total replacement approach could be used, whereby the only plans available to employees are the consumer driven high-deductible plan with a health savings account (e.g., the PPO HIHP plan).

SUMMARY – EMPLOYEE CONTRIBUTIONS

The alternative contribution approaches as previously discussed are summarized below. Financial modeling has not been performed on these approaches but can be completed upon request with assumed or requested savings/cost avoidance to cost sharing targets.

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> • Adjust current two-tier structure to four tiers • Adjust employee contributions to better reflect the relative value of the plan options (HMO Standard highest, PPO Standard middle and PPO HIHP lowest required contribution) but employees do not pay the full difference in cost between the plans. 	<ul style="list-style-type: none"> • Adjust current two-tier structure to four tiers • Adjust employee contributions to reflect the relative value of the plan options using a fixed percentage or fixed dollar amount for the state contribution (HMO Standard highest, PPO Standard middle and PPO HIHP lowest required contribution), requiring employees to “buy up” to the greater valued plans by paying the full difference in cost between the plans. 	<ul style="list-style-type: none"> • Adjust current two-tier structure to four tiers • Adjust employee contributions to reflect the relative value of the plan options using a fixed dollar amount for the state contribution: <ol style="list-style-type: none"> 1. Fixed amount per year for all employees 2. <ol style="list-style-type: none"> a. Fixed amount per year for individual contracts b. Fixed amount per year for family contracts c. Phase out the differential in employer contributions between individual and family contracts over a period of three to five years • Fixed state contribution could purchase state-sponsored option(s) or via a state-based private exchange.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

2. Early Retirees

OVERVIEW AND OBSERVATIONS - TYPES OF PLANS AND CONTRIBUTIONS

More than 7,000 early retirees participate in the Health Program. The enrollment numbers shown below are from January 2011, and correlate to the savings estimates from analyses that were performed in early 2011 and that are provided in the following pages. Current enrollment numbers are similar to those provided below.

Early retirees (pre-Medicare) currently are offered the same types of plans and benefit designs as active employees – the PPO and HMO Standard plans and the PPO and HMO HIHP plans – except that early retirees do not receive the employer provided contribution to a health savings account for the HIHP plans. The majority of the early retirees (63.8 percent representing 4,769 early retirees) are enrolled in the PPO Standard plan. The balance of the early retirees (35.6 percent representing 2,658 early retirees) is enrolled in the HMO Standard plan. A small number of early retirees (0.6 percent representing 46 early retirees) are enrolled in the HIHP – almost entirely in the PPO HIHP.

In 2011, early retirees contribute the same total amount for the PPO and HMO Standard options (\$549.80 per month for single coverage; \$1,243.34 for family) and for the PPO and HMO HIHP plans (\$473.12 per month for single coverage; \$1,044.32 for family), with no employer contribution. The Standard and HIHP PPO plans are self-funded but the total costs noted above do not reflect actuarially sound rates. Based on Buck underwriting using actuarially sound rates, early retirees currently contribute 60 percent of the cost of the PPO Standard option and 65 percent of the cost of the PPO HIHP option; therefore, there is an implicit state subsidy to cover the unpaid portion of early retirees' costs.

In 2011, the HMOs are fully insured, and early retirees pay approximately 92 percent of the fully insured premium cost. However, these HMO rates reflect the *blended cost* of actives and retirees as underwritten by the HMOs. If the HMOs were to be underwritten on a stand-alone basis reflecting retiree experience (and not blended with the active costs), the early retiree HMO cost would be significantly higher than the current blended cost. Buck estimates that early retirees pay approximately 57 percent of the stand-alone early retiree HMO cost. In 2012, some HMOs will be self-funded and, due to the elimination of insurer costs such as premium tax and margin, we expect that the percentage of cost covered by retirees will be somewhat increased.

Because the early retirees do not pay the full actuarial cost of their coverage, this results in a liability for the State under Governmental Accounting Standards Board (GASB) accounting rules. (GASB is an independent, private-sector, not-for-profit organization that establishes and improves standards of financial accounting and reporting for U.S. state and local governments. The State of Florida follows the GASB standards.) In its November 2, 2010 report Milliman, the State's actuary for GASB purposes, determined the State's GASB liability for all current and future early retirees and Medicare retirees at \$4.67 billion as of July 1, 2011. This amount is called the "Actuarial Accrued Liability", or AAL, and represents the present value of retiree medical plan benefits allocated to service through that date which is not provided by future retiree contributions.

The options for plans and plan designs previously outlined for the active employees can also be applied to the early retirees. **Currently, according to statute, early retirees must be offered the same plans as active employees, and the costs must be blended with actives for underwriting purposes.**

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

2. Early Retirees, continued

The employer, however, is not required to directly contribute to that blended cost; therefore, there are some contribution alternatives that can be considered for early retirees. Current statutory requirements aside, viable plan option approaches for early retirees are currently limited and are described in the Aggressive Approach section below.

ALTERNATIVE APPROACHES

DISCUSSION – TYPES OF PLANS AND CONTRIBUTIONS

Conservative Approach

Early retirees continue to be offered the same types of plans and benefit designs as active employees, but with blended rates (of actives and early retiree costs) on an actuarially sound basis for each plan with early retirees paying that full premium cost. Instead of the retiree contributions for the PPO and HMO Standard offerings being the same, the contribution for these plans would now be based on the relative value of the benefits, thereby encouraging retirees to enroll in the most cost-effective plan that best meets their coverage needs. Under this approach the state would not contribute directly to the early retiree premium costs but, because of the blended underwriting of actives with early retirees, would still have a Government Accounting Standards Board (GASB) liability due to the implicit subsidy.

Moderate Approach

Early retirees continue to have the same types of plans and benefit designs as active employees but, current statutory requirements notwithstanding, early retirees would pay the full actuarial cost of the health plan coverage based on stand-alone early retiree cost underwriting. Since there would be no state implicit subsidy towards the cost of coverage, this approach would eliminate any GASB liabilities for the state for early retirees. Given the current implicit subsidy based on early-retiree only underwriting (57 percent – 65 percent of the totals costs paid by early retirees), early retiree premium contributions would increase significantly, almost doubling in some cases.

This approach can be phased in by grandfathering existing early retirees at the current contribution structure model, or by grandfathering active employees who are close to retirement – for example all active employees over a given age (such as 55 or 60), or a combination of age and service (such as age 55 with at least 10 years of service) along with existing early retirees. Grandfathering of identified groups can be done for the remaining life of the participant and is often done since these groups have little or no time to plan for increased premium contributions nor earn additional money to cover the loss of the state implicit subsidy. The non-grandfathered groups generally include active employees that have adequate time remaining in their employment to plan for a transition to fully actuarial contributory coverage upon their retirement.

Aggressive Approach

The state no longer sponsors a medical plan for early retirees, nor provides an implicit subsidy for coverage. Instead, the state makes available to retirees an “exchange” or “connector” model that helps retirees select the most appropriate medical and drug plan based on cost and coverage needs. This approach does not yet exist within the geography of the State of Florida for early retiree populations,

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

2. Early Retirees, continued

but the state can play a key role in helping establish a program that would be available to not only state retirees (and potentially to employees), but also could be available to other employers in the state. The benefit design and other features of the program will depend on federal regulations and guidance for health programs offered outside of the health reform exchanges.

With no state contribution towards the cost of coverage or administration, this approach would also eliminate any GASB liabilities for the state for early retirees.

In addition to the state-sponsored exchange described above, in 2014 early retirees may have access to the exchanges required under the Patient Protection and Affordable Care Act (federal health reform) and may also be eligible for federal subsidies for the cost of coverage.

SUMMARY – TYPES OF PLANS AND CONTRIBUTIONS

The alternative types of plans and contribution approaches for early retirees as previously discussed are summarized below. Financial modeling has not been performed on these approaches but can be completed upon request.

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Maintain same plan options as actives Adjust current two-tier structure to four tiers (as discussed in active employee section) Adjust early retiree contributions to reflect actuarially sound rates (based on blended underwriting of actives and early retirees) with early retirees continuing to contribute 100% of the premium cost. 	<ul style="list-style-type: none"> Maintain same plan options as actives Adjust current two-tier structure to four tiers (as discussed in active employee section) Underwrite early retiree costs on an actuarially sound, stand-alone basis, eliminating the state implicit subsidy of early retiree cost. <p>Alternatively, existing early retirees and employees close to retirement can be grandfathered.</p>	<ul style="list-style-type: none"> No longer offer state-sponsored or subsidized plans for early retirees. Instead, facilitate early retirees' purchase of coverage through a state (as the employer) sponsored exchange that includes tools and resources to help retirees select the most appropriate medical and drug plan based on cost and coverage needs.

ILLUSTRATIVE SAVINGS/COST AVOIDANCE

To illustrate the savings/cost avoidance potential of eliminating the early retiree state implicit subsidy, the results of a previous study are provided. Based on an analysis that Buck completed in April 2011 for fiscal year 2011-2012, early retiree contributions totaled \$61.4 million for the PPO and HMO programs. The cost of those programs using actuarially based rates was \$103.8 million; therefore, **early retirees were receiving an implicit subsidy of approximately \$42.4 million.** However, since early retirees and active employees are currently rated on a combined basis, the use of actuarially based rates for early retirees will reduce the total cost of coverage for active employees when underwritten on a stand-alone basis.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

3. Medicare Retirees

OVERVIEW AND OBSERVATIONS – TYPES OF PLANS AND CONTRIBUTIONS

More than 28,000 Medicare-eligible retirees participate in the Health Program. The enrollment numbers shown below are from January 2011, and correlate to the savings estimates from analyses that were performed in early 2011 and that are provided in the following pages. Current enrollment numbers are similar to those provided below.

Medicare retirees have plan options that are similar to active employees and early retirees – the PPO and HMO Standard plans and the PPO and HMO HIHP plans. The benefit designs are also primarily the same as the active employee and early retiree designs, except for coordination with Medicare for medical services. As with the early retirees, no employer contribution is made to the Health Savings Account for the HIHP plans.

The majority of the Medicare retirees (83.4 percent representing 23,352 in January 2011) are enrolled in the PPO Standard plan. Some Medicare retirees (16.5 percent; 4,628 in January 2011) enroll in one of the available HMO Standard vendors, two of which are group Medicare Advantage Prescription Drug plans. A group Medicare Advantage Prescription Drug plan is an employer-sponsored Medicare plan that generally has lower premiums due to the subsidy received by the vendor from the federal government. A small number of Medicare retirees (approximately 0.1 percent; 29 in January 2011) enroll in one of the HIHP plans; almost all of which (28 of the 29) are in the HIHP PPO plan.

The PPO Standard and HIHP plans are self-funded, and based on costs as underwritten by Buck, Medicare retirees contribute approximately 66 percent of the cost of single coverage for the PPO Standard plan (\$305.82 of the \$459.15 single rate) and approximately 64 percent of the cost of single coverage for the PPO HIHP plan (\$230.52 of the \$361.80 single rate) when underwritten on an actuarially sound basis for FY2011-2012. The HMO Standard plans are currently fully insured and Medicare retirees pay the full premium.

Because the PPO Medicare enrollees do not pay the full actuarial cost of their coverage, this results in a liability for the state under Governmental Accounting Standards Board (GASB) accounting rules. (as described in the Early Retiree section, GASB is an independent, private-sector, not-for-profit organization that establishes and improves standards of financial accounting and reporting for U.S. state and local governments. The State of Florida follows the GASB standards.) In its November 2, 2010 report Milliman, the State's actuary for GASB purposes, determined the State's GASB liability for all current and future early retirees and Medicare retirees at \$4.67 billion as of July 1, 2011. This amount is called the "Actuarial Accrued Liability", or AAL, and represents the present value of retiree medical plan benefits allocated to service through that date which is not provided by future retiree contributions.

For the PPO Medicare enrollees, the state files for the Retiree Drug Subsidy reimbursement payments available under federal law. The Retiree Drug Subsidy program was established in 2006 when prescription drug coverage was added to Medicare under Part D as an incentive for plan sponsors to continue to provide prescription drug coverage to Medicare eligible retirees. Under GASB rules, the Retiree Drug Subsidy payments cannot be used to offset the accounting liability for retiree medical benefits.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

3. Medicare Retirees, continued

ALTERNATIVE APPROACHES

DISCUSSION – TYPES OF PLANS AND CONTRIBUTIONS

Alternatives are available that can reduce the cost and/or GASB liability for the state. Unlike the early retirees that have limited options in the market, there are alternatives available to Medicare retirees that can offer more choice and potentially lower costs.

Conservative Approach

The current PPO Standard and HMO Standard plans are continued, with the current state implicit subsidy provided to Medicare retirees in the PPO continued as well. While the amount of the Medicare retiree contribution varies between each HMO and the PPO, the contribution amounts generally are in the same range. However, to improve the financial effectiveness of the programs, the prescription drug benefits would be carved out of all plans and would be provided through an Employer Group Waiver Program administered by the state's pharmacy benefits manager vendor, Medco. The current prescription drug plan design could be continued largely as it is currently designed, which would limit the impact on retirees, but with greater financial benefits to the state. Due to additional federal and pharmaceutical manufacturer funding available for this approach, the Employer Group Waiver Program approach would produce cash savings/cost avoidance over the current delivery model. In addition, unlike the Retiree Drug Subsidy approach, the financial benefits of the Employer Group Waiver Program approach can be reflected under GASB.

Based on their very limited enrollment, and to simplify administration, consideration could be given to eliminating the PPO HIHP and HMO HIHP plans for Medicare retirees. When health savings account plans were first implemented under federal law in 2006, health savings account programs for Medicare eligible individuals were included in the law. However, an effective and attractive model for those programs has not been developed.

Moderate Approach

The state continues to sponsor the PPO Standard as well as the HMO Standard plans; however, the current implicit subsidy provided by the state for the current PPO Standard plan is eliminated by charging Medicare retirees actuarially sound rates. This could be done immediately, or phased in over a period of several years. Grandfathering of existing Medicare retirees in a PPO Standard plan could also be considered. This would ensure retirees access to a plan sponsored and managed by the state.

The financial benefit of this approach is that it would eliminate all cash and accounting (GASB) expenses for providing medical benefits to Medicare-eligible retirees. In addition, due to the Retirement Health Insurance Subsidy provided to retirees, the state may still be eligible for the Retiree Drug Subsidy. Conversely, if the Employer Group Waiver Program approach is used for Medicare prescription drug benefits, the state would no longer be eligible for Retiree Drug Subsidy, but retirees would benefit from lower premium rates than they would pay under the current prescription drug design with actuarially sound rates.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

3. Medicare Retirees, continued

Aggressive Approach

The state no longer sponsors a medical plan for Medicare eligible retirees. Instead, the state makes available to Medicare retirees an “Exchange” or “Connector” model that helps retirees select the most appropriate medical and prescription drug plan based on cost and coverage needs. These programs can typically be provided at no cost to the employer. Since there is no state implicit subsidy towards the cost of coverage or administration, this approach eliminates any GASB liabilities for the state for Medicare retirees.

“Connector” models are offered by private firms, consulting firms, and insurance carriers. While the models vary, they typically include similar features. For example, the retiree can review coverage options in the area where they live, either through a website or a call center, or a combination of the two. The programs typically allow Medicare retirees to compare plans by modeling various claim assumptions, or the program may utilize the retiree’s actual claims experience. Once the Medicare retiree enrolls in the plan, there is typically ongoing support with the program, and each year the retiree can elect a new program during open enrollment. The administrative cost of the program is typically paid through the commissions available from the Medicare plan. The insurance carrier models typically limit choice to Medicare plans sold by that insurer, while the models used by other firms typically include a broader range of options from various carriers.

SUMMARY – TYPES OF PLANS AND CONTRIBUTIONS

The alternative types of plans and contribution approaches for Medicare retirees as previously discussed are summarized below. Financial modeling has not been performed on these approaches but can be completed upon request.

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Eliminate the PPO HIHP and HMO HIHP options Maintain the PPO Standard and HMO Standard options with the same design as active employees Continue current state implicit subsidy approaches for both plans Convert prescription benefit to Employer Group Waiver Program (EGWP) for savings/cost avoidance and Government Accounting Standards Board (GASB) liability reduction 	<ul style="list-style-type: none"> Eliminate the PPO HIHP and HMO HIHP options Maintain the PPO Standard and HMO Standard options with the same design as active employees Eliminate or phase out PPO Standard implicit subsidy and underwrite total costs on an actuarially sound basis Consider converting prescription benefit to EGWP for savings/cost avoidance to retirees and GASB liability elimination 	<ul style="list-style-type: none"> No longer offer state-subsidized plans for Medicare retirees. Instead, facilitate Medicare retirees’ purchase of coverage through a state (as the employer) sponsored exchange that includes tools and resources to help retirees select the most appropriate medical and drug plan based on cost and coverage needs. GASB liability is eliminated.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

3. Medicare Retirees, continued

ILLUSTRATIVE SAVINGS/COST AVOIDANCE

To illustrate the savings/cost avoidance potential of eliminating the Medicare retiree implicit subsidy, the results of a previous study are provided. Based on an analysis that Buck completed in April 2011 for fiscal year 2011-2012, Medicare retiree contributions totaled \$141.1 million for the PPO and HMO programs. The cost of those programs using actuarially based rates was \$200.9 million therefore ***Medicare retirees were receiving an implicit subsidy from the state of approximately \$59.8 million.***

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

4. Pharmacy Benefits

Managing a prescription drug benefit involves developing a strategic philosophy as a basis for how that benefit is going to be administered, and then adapting the benefit to align with that philosophy. This process is complicated by the continual change in the U.S. pharmaceutical industry, requiring plan sponsors to review and update their program interventions frequently, often on a quarterly basis.

TOOLS TO MANAGE PHARMACY BENEFITS

Tools to help manage the benefit in this evolving landscape can be administered and implemented selectively to address current issues within the plan, or to prevent adverse consequences from occurring. For example, a plan sponsor may implement a step therapy program that requires the use and failure of lower-cost generic and brand medications before the use of a new, high-priced specialty drug is authorized. Interventions of this type are financially advantageous to both the plan sponsor and the patient. Additionally, they minimize disruption of treatment regimens when implemented prior to patients starting a newly available drug therapy, as opposed to implementation after patients have been introduced to a high-priced specialty drug.

Commonly utilized tools to manage the prescription drug benefit include:

- **Formularies** – Lists of products that are covered by the benefit and the cost share amounts associated with each covered drug. Some formularies are closed (no coverage unless the product is listed as being covered).
- **Cost sharing** – Can be fixed as in a copay amount or flexible as in a coinsurance (a percentage of the prescription costs) or can be mixed (e.g., a minimum fixed amount per prescription, plus a percentage of the additional costs).
- **Quantity limits** – Only a specific maximum amount of any drug is provided either per prescription or over a longer period of time. Limits are generally based on clinical evidence of Food and Drug Administration (FDA) guidelines.
- **Duration of therapy limits** – Therapy is provided according to FDA guidelines (e.g., for X months).
- **Limited networks** – Similar to the medical plan, smaller network provider panels generally offer improved discounts for the plan sponsor but some disruption for the plan beneficiaries.
- **Prior authorizations** – An official set of criteria must be met before a prescription medication will be provided under the plan. Most prior authorization guidelines are clinically based.
- **Step therapies** – The use of a less expensive medication that is considered generally efficacious is mandated before a more expensive medication will be provided by the plan. Normal step therapy programs commonly include generic medications as the first, or even first and second steps, before a brand name drug is covered. Treatment failures by the generics must be proven.
- **Maintenance fills at-home delivery** – Commonly termed mail service or mail order, these prescriptions are normally provided in larger quantities (up to 90 days) and have improved discounts for the plan sponsor. Cost sharing has historically offered a savings/cost avoidance to the member for using home delivery, although those margins have been declining with convenience a bigger motivator.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

4. Pharmacy Benefits, continued

- **Mandatory generic programs** – If a generic version of a medication is available, the related cost is the maximum for which the plan will reimburse the provider. If the member wants the brand name medication, a financial penalty applies for the member.
- **Plan exclusions** – Certain prescriptions with a negligible or non-existent medical return on investment are not covered by the prescription drug plan (e.g., erectile dysfunction medications).
- **Over-the-counter strategies** – Many prescription medications are considered safe and effective enough to be sold without a physician’s prescription after a period of time (normally several years). Common examples include antihistamine products (Benadryl or Allegra), stomach medications (Zantac or Prilosec), some anti-infective creams (Neosporin) or non-steroidal anti-inflammatory disease medications (Motrin or Aleve).
- **Subrogation** – Billing for prescription drug claims to “another” payer where appropriate (such as when the DSGI program is secondary). This could happen with Medicare Part B medications, Medicaid or in the case of active employees other commercial insurance for a spouse, for example.
- **Audits** – These can be financial or administrative or clinical and are a comprehensive review of the performance of the vendor.
- **Contract management** – Managing the “market check” provisions, pricing, administrative costs and programs are foundational components of managing a prescription drug plan.
- **Compliance programs** – Improving the patient’s track record of adhering to the prescribed therapy. These may include a copayment waiver or reduction programs.

To effectively manage prescription drug benefit costs, the state can apply these tools to meet the needs of the plan and the covered population. There are many variations of how each of the above tools can be applied to a given prescription drug benefit. Each component can be made mandatory, such as requiring certain maintenance medications to be filled through mail order as is currently required in the PPO plan, or can be implemented as a penalized benefit (such as a retail refill allowance penalty if the plan does not have a mandatory mail benefit, but wants the consumer to utilize mail service). Each tool can be customized to fit the needs of the plan sponsor, assuming the Pharmacy Benefit Manager (PBM) is willing and capable of administering the desired benefit.

The PBM business model will also impact the vendor’s options and tools that are implemented on how to best control costs for the plan sponsor. If the PBM makes the majority of its profit from mail service, then it is common to see the PBM make this recommendation to plan sponsors. If the PBM generates profit from retained rebate revenue, the formulary may be more broad (covers more available medications) and may include many brand name medications that are promoted heavily. Audits can assist the plan in evaluating whether these programs successfully conserve plan resources. Member cost sharing should be reviewed on an ongoing basis to retain plan savings and encourage the appropriate use of lower-cost drugs, where possible.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

4. Pharmacy Benefits, continued

OVERVIEW AND OBSERVATIONS – PLAN DESIGN

The current plan provisions that apply to the pharmacy benefit plan designs are outlined below. The current plan includes an open formulary that encourages use of listed drugs through lower participant cost sharing. As discussed in the Medical Plan design section, 100 percent preventive drug coverage for generics drugs can be added to the PPO HIHP benefit to enhance the attractiveness of this option and to encourage use of, and compliance with, preventive drug therapy to avoid larger medical expenses in the future. The cost to add this coverage is estimated at less than one percent of total costs.

	HMO Standard	PPO Standard		PPO and HMO HIHP	
		In-network	Out-of-network	In-network	Out-of-network (PPO Only)
Deductible	None	\$250/\$500	\$750/\$1,500	\$1,250/\$2,500	\$2,500/\$5,000
Annual State Health Savings Account Deposit	N/A	N/A		\$500/\$1,000	
Generic/ Preferred/ Non-Preferred Prescriptions	\$7/\$30/\$50 Retail	\$7/\$30/\$50 Retail		30% after deductible/ 30% after deductible/ 50% after deductible	
	\$14/\$60/\$100 Mail	\$14/\$60/\$100 Mail			
Out-of-pocket Maximum	\$1,500/\$3,000 employee/family	\$2,500/\$5,000 plus deductible employee/family		\$3,000/\$6,000 employee/family	

Alternative approaches to managing the pharmacy benefits are outlined below. State-specific plan financial modeling has not been performed on these approaches but ranges of savings/cost avoidance estimates have been provided. More detailed analysis can be performed if desired.

Both of the Standard plan options include pharmacy benefit coverage at fixed copayments for generic, preferred brand, and non-preferred brand drugs. Mail order copayments are two times the retail copayments for up to a 90-day supply. Generally, mail order copayments need to be set at two-and-a-half times the retail copayments in order to be cost effective for both the plan and the members; therefore, this change could be considered.

The tiering of the benefits as discussed above does provide a financial incentive to utilize generic drugs, which are generally lower cost than brand name drugs; however, contrary to preferred consumerism approaches, fixed copayments do not promote price conscious behaviors within tiers and insulate members from the true cost of the drug. Changing from fixed copayments to coinsurance would better promote behavior changes that are financially advantageous to the member and to the plan. Including maximum payment thresholds limits financial exposure to plan participants, while minimum payment thresholds can preserve the current cost sharing so that a disproportionate share of the cost of lower priced drugs is not shifted back to the employer.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

4. Pharmacy Benefits, continued

OVERVIEW AND OBSERVATIONS – PROGRAM MANAGEMENT

As listed above in the common tools to manage pharmacy benefits, there are numerous clinical and administrative programs that include limitations or mandates. For simplicity of reference, these have been categorized below:

Administrative Programs

- Limited networks
- Maintenance fills at-home delivery
- Plan exclusions
- Over-the-counter strategies
- Subrogation
- Contract management
- Audits

Clinical Programs

- Quantity limits
- Step therapies
- Mandatory generic programs
- Duration of therapy limits
- Prior authorizations
- Compliance programs
- Audits

As recommended previously, plan design changes could be made to align with the recommended strategic direction of increasing consumerism options and improving consumerism behaviors. Program management is a critical component of successful consumerism initiatives and must be done on a regularly scheduled, proactive basis throughout the year, with interventions adjusted and/or implemented whenever appropriate. Alternative approaches to this are provided below.

ALTERNATIVE APPROACHES

DISCUSSION – PLAN DESIGN AND PROGRAM MANAGEMENT

Conservative Approach

The state continues to offer an open formulary. The plan continues to exclude cosmetic use medications and excludes lifestyle-related drugs (e.g., erectile dysfunction medications such as Viagra and Cialis). A mandatory generic program is introduced, along with appropriate prior authorization programs. Compliance programs are offered for targeted populations to improve patient adherence to prescribed therapies. Contract management and subrogation activities occur on an ongoing basis.

Moderate Approach

The state continues to offer an open formulary. The plan continues to exclude cosmetic use medications and excludes lifestyle-related drugs. A limited network of pharmacy providers (vs. broad network) is offered (as is currently planned for implementation January 2012). A mandatory or penalized maintenance drug program is introduced, along with a robust suite of clinical programs, including multiple step therapy programs; duration of therapy limits and quantity limits. Over-the-counter strategies are implemented to limit or eliminate use of medications that are available over the counter.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

4. Pharmacy Benefits, continued

Compliance programs are offered for targeted populations to improve patient adherence to prescribed therapies. Contract management and subrogation activities occur on an ongoing basis.

Aggressive Approach

The state offers a closed formulary and a **very** limited network of pharmacy providers. The limited network that is going into effect January 2012 reduces the number of participating pharmacies by 7,800 from approximately 62,000 nationally. Limiting the network further could involve eliminating another pharmacy chain, retailer or other outlets, thereby reducing the number of participating pharmacies by as few as 4,000 or by up to half the number of currently participating pharmacies. The plan continues to exclude cosmetic use medications and excludes lifestyle-related drugs along with:

- Brand prescription coverage for drug categories where two or more products are available over the counter
- Brand medications in specific therapy classes where multiple generics are available

Use of the lowest cost distribution channel is mandated. Multiple step therapy programs are introduced along with penalties for non-compliance with prescribed therapy. Contract management and subrogation activities occur on an ongoing basis.

SUMMARY – PLAN DESIGN AND PROGRAM MANAGEMENT

OPTIONS – PLAN DESIGN		
Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> • Cover generic preventive drugs at 100% in the PPO HIHP • Increase mail order copay to 2½ or 3 times the retail copay 	<ul style="list-style-type: none"> • For Standard plans continue generic copayment and cover brands and non-preferred brands at 20% and 30% respectively, with maximum copayments • Cover generic preventive drugs at 100% in the PPO HIHP • Increase mail order copay to 2½ or 3 times the retail copay 	<ul style="list-style-type: none"> • For Standard plans continue generic copayment and cover brands and non-preferred brands at 20% and 30% respectively, with minimum and maximum copayments • Cover generic preventive drugs at 100% in the PPO HIHP • Increase mail order copay to 2½ or 3 times the retail copay

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

4. Pharmacy Benefits, continued

OPTIONS – PROGRAM MANAGEMENT		
Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Maintain open formulary Exclude lifestyle-related drugs Introduce mandatory generic program and appropriate prior authorization programs Offer compliance programs for targeted populations Contract management and subrogation activities occur on an ongoing basis 	<ul style="list-style-type: none"> Maintain open formulary Exclude lifestyle-related drugs Introduce a mandatory or penalized maintenance drug program and a robust suite of clinical programs including multiple step therapy programs, duration of therapy limits and quantity limits Implement strategies to limit or eliminate use of medications that are available over the counter Offer compliance programs for targeted populations Contract management and subrogation activities occur on an ongoing basis 	<ul style="list-style-type: none"> Change to a closed formulary and a very limited network of pharmacy providers Exclude lifestyle-related drugs, brand prescription coverage for drug categories where two or more products are available over the counter, and brand medications in specific therapy classes where multiple generics are available Mandate use of lowest cost distribution channel Introduce multiple step therapy programs and penalties for non-compliance with prescribed therapy Contract management and subrogation activities occur on an ongoing basis

Other than the cost to add preventive drug coverage of generics at 100 percent in the PPO HIHP, savings/cost avoidance estimates for the proposed plan design changes have not been calculated. These estimates can be provided upon request and may also be obtained by the PBM vendor via detailed re-pricing analysis.

The estimated savings/cost avoidance and costs associated with the Clinical and Administrative programs recommended under the three approaches are summarized below and result in the following savings/cost avoidance ranges. The savings/cost avoidance ranges are applied to estimated total prescription costs for the PPO and HMO plans for fiscal year 2011-12 of \$598 million (based on the August 3, 2011 Conference Report), and assume the percentage of the prescription costs for the PPO plans is the same as for the HMOs.

SAVINGS/COST AVOIDANCE ESTIMATES *

OPTIONS - CLINICAL AND ADMINISTRATIVE PROGRAMS		
Conservative	Moderate	Aggressive
2% – 6%	5% – 19%	10% – 31%
plus compliance program cost increase (TBD based on current compliance rates)	plus compliance program cost increase (TBD based on current compliance rates)	plus compliance program cost increase (TBD based on current compliance rates)
\$ 12 million – \$ 36 million	\$ 30 million – \$ 114 million	\$ 60 million – \$ 185 million

* The savings/cost avoidance estimates provided in the summary above are based on the estimates for each program as outlined below.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

4. Pharmacy Benefits, continued

Conservative Approach

- Mandatory generic programs (1 percent – 2 percent of drug spend)
- Compliance programs (potentially higher pharmacy benefit costs)
- Prior Authorization (0.5 percent – 2 percent)
- Subrogation (0.5 percent – 2 percent)
- Contract management

Moderate Approach

- Step therapy (multiple can be implemented, with potential savings/cost avoidance 1 percent – 3 percent of drug spend)
- Plan exclusions
- Mandatory or penalized maintenance drug program savings/cost avoidance (1 percent – 4 percent)
- Limited networks of pharmacy providers (1 percent – 3 percent savings/cost avoidance for medium-sized networks)
- Quantity limits savings/cost avoidance (0.5 percent – 1.5 percent)
- Duration of therapy limits savings/cost avoidance (0.5 percent – 1.5 percent)
- Over-the-counter strategies savings/cost avoidance (1 percent – 6 percent)
- Incentives for improved compliance (lowered medical costs over time with higher pharmacy benefit costs)

Aggressive Approach

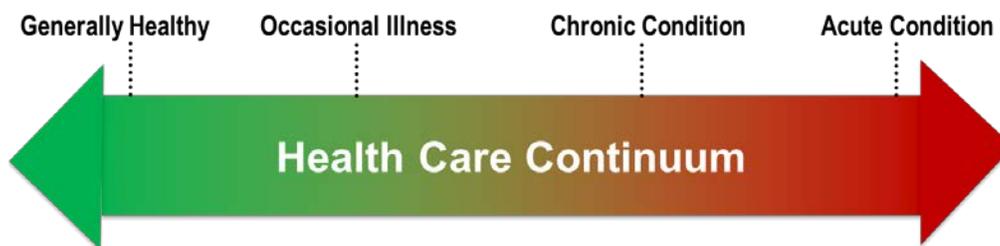
- Very limited networks (4 percent – 7 percent)
- Multiple step therapy programs (1 percent – 3 percent)
- Removal of brand prescription coverage for drug categories where two or more products are available over the counter (1 percent – 5 percent)
- Closed formulary (1 percent – 5 percent)
- Plan exclusions for brand medications in specific therapy classes where multiple generics are available (1 percent – 4 percent)
- Mandatory use of lowest cost distribution channel (1 percent – to 4 percent)
- Penalties for non-compliance with therapy (1 percent – 3 percent)

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives

OVERVIEW AND DISCUSSION

A significant portion of rising health care expenditures can be attributed directly or indirectly to lifestyle. There is a growing economic, clinical, and public health imperative to address behavioral or lifestyle issues as a part of Population Health Management in order to adequately manage risk, reduce the frequency and severity of acute events, and slow disease progression and related health care costs. Population health management promotes preventive measures and personal health management for healthier members and those at lower levels of predicted health risk (noted as generally healthy and occasional illness below), while managing existing conditions of the more severely ill, higher-cost members (noted below as members with chronic and acute conditions). Over time, this approach can result in a lower percentage of high-risk, high-cost members in the population mix.

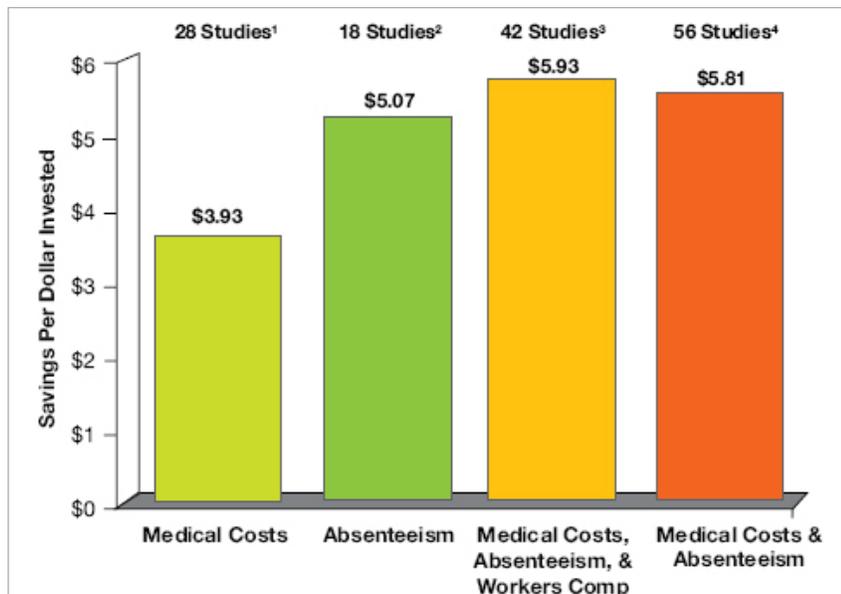


Examples of programs included within population health management are lifestyle management initiatives, tobacco cessation programs, chronic disease management, maternity management, on-site health services, and programs that promote and foster a culture of health, to name a few. All of these programs align well with improving consumerism behaviors by encouraging accountability and personal responsibility for one's own health while providing members with the tools, education, programs, and other resources to help them achieve the targeted goals.

The business case for population health management initiatives is well documented. A review of multiple published studies on worksite wellness found that the average Return on Investment (ROI) is \$3.93:1 due to reduced medical costs and \$5.81:1 due to reduced absenteeism and medical costs combined over a **three- to five-year** period.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued



1. Aldana, SG, Financial impact of health promotion programs: a comprehensive review of the literature, American Journal of Health Promotion, 2001, volume 15:5: pages 296-320.
2. Aldana, SG, Financial impact of health promotion programs: a comprehensive review of the literature, American Journal of Health Promotion, 2001, volume 15:5: pages 296-320.
3. Chapman, LS, Meta-evaluation of worksite health promotion economic return studies, Art of Health Promotion, 2003, 6:6, pages 1-16.
4. Chapman, LS, Meta-evaluation of worksite health promotion economic return studies: 2005 Update Art of Health Promotion, 2005, p. 1-16.

Investing in a successful population health management program involves understanding multiple factors:

- The current health care environment,
- Population demographics,
- Current and projected costs associated with preventable health risks,
- The burden of chronic disease, and
- Employee/employer relationships and dynamics.

This investment could be approached with a process that involves assessing the needs of the population and developing the strategy that will best meet the short- and long-term objectives. A population risk analysis of demographics and claims experience will identify and quantify the specific illness burdens and risk factors within a population and those most likely to be positively impacted by a population health management program and provide the greatest return on investment. Specifically, results could include:

- **Prevalence Analysis** – actual chronic disease prevalence within the group
- **Financial Analysis** – actual costs associated with each chronic condition within the population and percentage of total claims attributed to each chronic condition
- **Stratification of Risk** – identification of risk factors on a group and individual level

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued

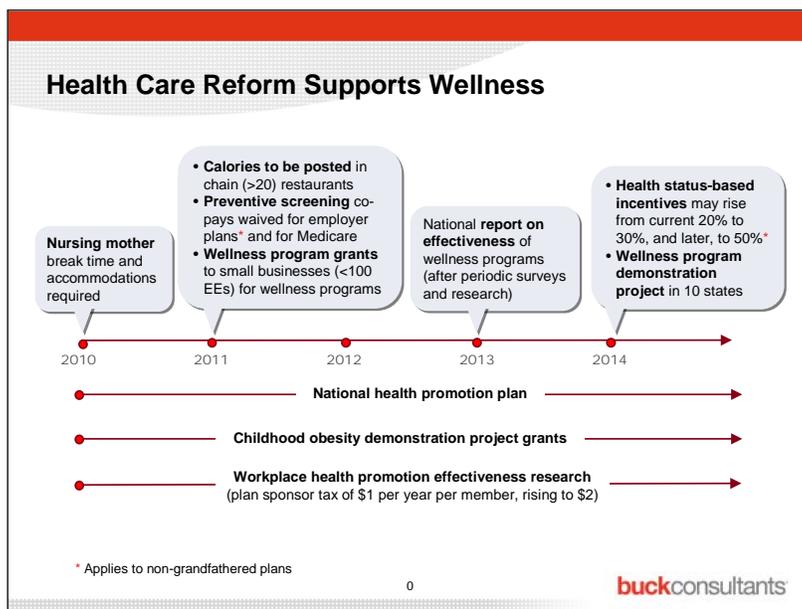
Key areas of opportunity can be identified for health plan members to:

- Reduce health risks related to behaviors such as smoking, poor nutrition, physical fitness, stress, etc.
- Become more involved in medical self-care
- Increase use of preventive care services for early diagnosis and better condition management
- Realize fewer complications and improved well-being as chronic conditions become better managed due to improved compliance with prescribed treatments
- Reduce lost work days due to illness
- Minimize the risk of disability

After this assessment, a comparison to the capabilities of the state's current vendors could be conducted to determine if the capabilities meet the state's members' identified needs. Based on the outcome of the analysis and gaps identified, it may be necessary to conduct a vendor search of population health management providers who can partner with the state to best meet the care management needs of the membership or fill any gaps going forward.

In light of federal health care reform, the time is right to implement and/or enhance wellness programs. Provisions in the Act require group health plans to report on wellness and health promotion activities, including efforts around tobacco cessation, weight management, stress management, physical fitness, nutrition, etc. These reports will be available to the public generally and to enrollees during open enrollment periods.

As noted previously, examples of programs included within population health management are lifestyle management initiatives, tobacco cessation programs, chronic disease management, maternity management, and on-site health services. Brief discussions of two of these initiatives are provided below. Once the population risk analysis has been completed, targeted population health management program interventions can be recommended to address the identified issues within the state's employee population, providing the state with the best opportunity for return on its investment in such programs.



IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued

TOBACCO CESSATION

Tobacco cessation programs are one of the most prevalent interventions for employers with Population Health Management initiatives. Based on published data as noted below, with smokers representing 21 percent of the population on average, and \$3,391 greater annual medical costs than non-smokers, the ROI of such programs is readily apparent. Combined with the additional medical costs of members exposed to second hand smoke, the numbers are even more compelling per the illustration below.

Potential tobacco cessation program savings/cost avoidance for the state, based on an average quit rate of 35 percent and a 150,000-employee population, are impressive.

Employees	Covered Family Members Subjected to Second Hand Smoke
<p style="text-align: center;">~150,000 employees $\times 21\%^1$ 31,500 smokers $\times 40\%^2$ 12,600 will try to quit $\times 35\%$ 4,410 will succeed</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> $\times \\$3,391$ medical costs³ \$14,954,310 medical savings/cost avoidance </div> <div style="text-align: center;"> $\times \\$2,013$ work comp costs³ \$8,877,330 work comp savings/cost avoidance </div> </div> <p style="text-align: center;">\$23,831,640 employee savings/cost avoidance</p>	<p style="text-align: center;">4,410 successful quitters $\times 2$ dependents 8,820 family members subjected to second hand smoke $\times \\$490$ medical costs³</p> <p style="text-align: center;">\$4,321,800 medical savings/avoidance</p>
<p>\$28,153,440 annual potential savings/cost avoidance employee + covered family members subjected to second hand smoke</p>	

- If a \$50.00 monthly surcharge were in place for the 60 percent who choose not to try to quit, an annual surcharge could be; \$11,340,000/year = 18,900 employees x \$600.00.

1. The percentage of a population that smokes: <http://www.cdc.gov/nchs/fastats/smoking.htm>

2. The percentage of smokers who will attempt to quit: <http://www.otc.ie/article.asp?article=474>

3. The costs of smoking: http://www.biocaretherapy.com/Business_cost_of_smoker_employees.htm

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued

ON-SITE CLINICS

An example of a population health management program not currently utilized by the state but one that offers opportunities to integrate and coordinate with the existing Health Department services are on-site clinics. A wealth of data now show that comprehensive on-site clinics, used in combination with a health plan, provide dramatically better care at lower costs and are an extremely productive investment for any organization. Reasons to establish an on-site clinic are varied and include:

Convenience – Employees can get care at work, significantly reducing the lost work time required to seek care off-campus. Clinics can also offer extended hours, which means that families can get care conveniently as well. Per the March 2008 report by the National Association of Community Health Centers and the American Academy of Family Physicians, 20 percent of Americans have inadequate or no access to PCPs with Florida, Texas and California being the hardest hit.

Trading Higher Network Care Costs for Lower Costs Inside the Clinic – Well-configured clinics can save money by providing equal or better services at much lower cost than the network. To produce an acceptable ROI, it is recommended that 750 to 1,000 covered lives be in close proximity to the clinic. That number should be closer to 1,750 when pharmacy services are considered. Usage can be higher if community-based care is inconvenient or difficult to access (e.g., a shortage of primary care physicians). In order to drive the population to the clinic, some employers offer incentives in the form of reduced or waived copayments/deductibles. Clinic costs are generally accounted for as part of the overall Health Program costs

Comprehensive Clinics Provide Care for Standard Health and Occupational Health

Issues – Clinics can be established to provide the full range of primary, acute, chronic, pharmacy and work-related care. An assessment of costs of these existing programs could be completed to determine what services provide the most opportunity for ROI.

High Touch and Compliance – Medical providers spend, on average, seven minutes with patients during routine office visits. The current health care system provides incentives for providers to take care of the sick, rather than focus on prevention. Also, with more than 90 million Americans presently living with chronic illness, patient non-compliance with physician-recommended and prescribed treatment is approaching 50 percent. On-site clinics offer opportunities for higher touch interventions, including education that can lead to improved compliance and lower costs.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued

INCENTIVES

An integral component of any successful population health management PHM initiative is the incentives, which are the techniques an employer utilizes to encourage or motivate specific behaviors. These behaviors include making appropriate health care decisions such as controlling cost or utilization, selecting providers with better outcomes or higher “quality” ratings, and making personal lifestyle choices that reduce the risk of future chronic diseases. The use of such rewards has increased significantly in the last several years, and is expected to continue.

The two components of an incentive are the behavior rewarded and form of the reward. Behaviors typically rewarded can fall into three categories:

1. Activities (specific behaviors), such as:
 - Completion of health risk appraisal
 - Education (on-site or online) – e.g., nutrition, fitness, stress management
 - Adherence to a prescribed regimen – e.g., exercise, nutritional guidelines
 - Program participation – e.g., smoking cessation
2. Achievements (measurable results) such as:
 - Lifestyle improvements, such as quitting smoking or achieving a specific weight loss target
 - Beneficial biometric accomplishments such as reducing cholesterol, losing weight, or maintaining a low overall health risk score
3. Adherence (maintaining lifestyle goals), such as:
 - Remaining tobacco free for 12 months
 - Maintaining a target body mass index (BMI)

Forms of rewards often include cash, vacation days, points, prizes/merchandise, raffles, reductions in health premium, and contributions to health accounts (such as flexible spending accounts and health savings accounts). In addition, intangible incentive rewards (such as personal challenges, group competitions, recognition, and peer acceptance) also can be effective and should not be underestimated. Incentives can be *carrots* (desirable rewards) or *sticks* (undesirable consequences).

Historically, most health promotion programs have tried to maximize the use of carrots, using sticks only when necessary, preferring to be perceived as giving something positive to their employees rather than taking something away (or disciplining). However, in recent years more employers have moved to sticks, in part spurred by a frustration with the lack of effectiveness of previous carrot-based approaches. Similarly, some employers have started to move away from incentives and instead of incorporating disincentives or sticks, choosing a more aggressive approach of “mandates.” These mandates require an activity (completion of a health risk assessment, biometric screenings, preventive care exams, etc.) in order to qualify to receive a specified benefit (richer plan option, employer deposit into a health savings account, etc.).

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued

When comparing the state's programs to best practices, the state compares favorably in the design of incentives such as coinsurance and cost sharing for its provider networks (higher benefits for use of network contracted providers). Also, the state's employee premium contribution strategy (which favors the lower cost plan option – the HIHP) and incentives for encouraging use of preventive care benefits by providing 100 percent coverage for these services, are generally in line with best practices, although options to enhance the effectiveness of these practices are warranted.

Currently the state does not offer any type of health improvement-related incentives, thus providing an opportunity to greatly enhance the effectiveness of recommended population health management initiatives. Since the state's data is not yet aggregated, it would be challenging to initiate any achievement or adherence-based incentive programs immediately. However, while the foundation is being built with a data aggregation vendor, the state could launch an incentive program for completion of health risk assessments and for biometric screenings. These two components are crucial elements in assessing opportunities for targeted health improvement intervention programs, and as importantly, for documenting the outcomes and effectiveness of such initiatives.

To quickly establish the baseline of the population's health status and plan for future initiatives (including the areas in which plan participants note a readiness to change), a relatively aggressive approach for the launch of these first two incentives would be needed. Premium differentials (higher contributions for those that did not complete the requested activities by a specified date, or the reverse, lower contributions for those that did) provide immediate impact and encouragement to take action to avoid the increased costs (or realize the reduced costs). The state could launch the program as soon as practical in 2012, encouraging participants to complete the health risk assessment and biometric screenings. For participants that do not complete the health risk assessment and biometric screenings before a specified date prior to open enrollment (August 1st, for example), a higher per-paycheck contribution could be required for the next plan year. An increased contribution of \$500 annually generally is large enough to encourage participants to take the action required to avoid the increased costs.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued

Incentives for Disease Management Programs

Another best practice organizations offer is incentive rewards for participating in disease management programs. The incentives may be offered to employees and also to covered spouses. The incentives are most typically positive (carrots) but some employers are moving to punitive incentives (sticks). The form of incentive is most typically cash, contribution reduction, or spending account contribution. A common incentive amount is in the range of \$50-\$100, and may vary in amount and form depending on the managed condition (e.g., diabetes, maternity, etc.).

A notable example of the value-based incentive for a condition is reflected in the experience of the “Asheville Project,” where plan participants with a targeted condition (in this case it began with a diabetes program) receive “free” prescription drugs to help manage their condition, ideally coupled with disease and care management coaching support. Over time, the program has been proven to reduce the health care cost of these patients and improve their health status.

Another successful program is currently offered by a Florida county through its on-site clinic. This program includes a more aggressive approach, requiring participant compliance in order to receive the incentive. Polk County implemented a diabetes management program and shortly thereafter expanded it to hypertension patients. At Polk County an on-site pharmacist counsels, educates, and monitors patients through a structured “Contract for Care” program that **requires patient engagement and compliance**. In exchange for program participation and compliance, copayments for the prescription drugs to treat those conditions are waived. Studies of the programs have shown improved health status of participants and reduced costs, as well as high participant satisfaction levels.

ALTERNATIVE APPROACHES

DISCUSSION AND SUMMARY

Population Health Management program initiatives could be targeted to address specific issues identified within the state’s population. The state could conduct a population risk analysis to identify its members’ health issues and implement targeted intervention programs. Upon completion of the population risk analysis, an on-site clinic feasibility study may be conducted to determine if on-site services and programs can more effectively and efficiently help the state achieve its desired outcomes.

An incentive program could be implemented to immediately begin enhancing the state’s ability to assess its population’s health needs and to encourage or motivate specific behaviors that will improve members’ health status. The behaviors typically rewarded can fall into three categories: activities, achievements, and adherence, which align well with alternative approaches of conservative, moderate and aggressive. Instead of three different approaches, however, for incentives the approaches can be adjusted to a three-tier approach that can be phased in over time (three or more years), starting with activity-based incentives and progressing to achievements and ultimately to adherence, if appropriate based on the population risk analysis results.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

5. Population Health Management and Incentives, continued

Combining population health management initiatives with incentives will enable the state to develop a multi-year population health management strategy that can be built upon each year, including incentives and participant responsibility for positive outcomes.

Financial modeling has not been performed on these approaches but can be completed upon request.

Conservative	Moderate	Aggressive
Activity-based Incentives	Achievement-based Incentives	Adherence-based Incentives
<ul style="list-style-type: none"> • Conduct a population risk analysis • Introduce incentives for health risk assessment completion and biometric screenings • Implement tobacco cessation initiative 	<ul style="list-style-type: none"> • Implement population health management programs targeted to address results of population risk analysis • Use health risk assessment completion and biometric screenings as gateway to earning incentives for population health management program and biometric “achievements” • Introduce tobacco user surcharge for employees 	<ul style="list-style-type: none"> • Monitor results and continue population health management programs targeted to address results of population risk analysis • Use health risk assessment completion and biometric screenings as gateway to earning incentives for population health management program and biometric “achievement” • Introduce “adherence-based” incentives to reward members that meet clinical and biometric targets • Continue tobacco user surcharge for employees and add surcharge for tobacco user spouses.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

6. Communications: Required for Success

OVERVIEW AND DISCUSSION

Greater employee engagement in healthy lifestyles and better informed health care purchasing decisions requires a combination of attitudinal and behavioral change. The state can support and accelerate this transition to greater employee responsibility and behavior change through the options contained in this report. Successful transitions, however, require extensive communication and education campaigns to properly prepare and equip employees for the changes ahead.

Lack of knowledge contributes to a portion of poor health behaviors but is not fully responsible for day-to-day decisions that increase health risks – both in lifestyle and in health management. For the state to move the needle on unnecessary health care costs and improve health outcomes, both areas must be addressed by benefit design and education and motivation. A comprehensive communication plan will help support both organizational change management, and individual acceptance of changes that require their more active involvement in their health, in exchange for a greater likelihood of managing related costs to the state and to the individual.

Attributes of a successful program to communicate and support health include:

- **Leadership endorsement** – This includes role modeling and support for activities that promote healthy decision-making and responsibility. Such championing helps transform the organizational culture to one that embraces health and wellness.
- **A supportive environment** – Surroundings are not only an infrastructure enabler; they also send a message regarding the culture and “how we do things around here.” Healthy cafeteria and vending machine options, supported by education on ingredients, have been proven to move the needle on individuals’ choices. Even small actions, such as managers’ encouragement of healthy meeting refreshments, communicates that the organization supports good choices. On-site gyms aren’t necessary, but “walking breaks” (instead of donut breaks) can be encouraged, along with taking the stairs rather than the elevator.
- **Face-to-face benefit meetings**, where possible – While consuming time from work schedules, investment in these events enables employees to slow down and *focus* on the information being shared. Research on consumer-driven health plan introductions demonstrates a direct correlation between attendance at information meetings and elective enrollment in such plans. In employee survey and focus group research on preferences for education on complex concepts, meetings routinely rate as a top preferred source of information.
- **Early and ongoing introduction of new concepts** – Communication plans that allow sufficient time for education efforts help participants absorb new concepts, assess the personal implications, and begin to accept significant change. Change is difficult, but especially so when it’s as personal as the need to take more responsibility for one’s day-to-day lifestyle decisions and habits, plus acceptance of the trade-off that high deductibles impose – lack of prevention, adherence, or simply effort to research alternative treatments and costs, can result in not only poorer health, but higher costs for the individual. In turn, consumer driven health plan experience underscores the value of early and aggressive education. Further, the traditional emphasis on annual enrollment sends the incorrect message that health is a once-a-year decision process. Given that health events occur sporadically during the year, ongoing education is also vital.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

6. Communications: Required for Success, continued

- **Multiple communication channels** – Adults learn in many different ways. Traditional benefit guides pack a great deal of information into booklets that too frequently are not read carefully, or at all. Attention may be maximized by leveraging a combination of techniques such as:
 - Simple tools such as engaging posters and table tent reminders at job sites, and other traditional “push” communication vehicles such as emails, newsletters and brochures
 - 24/7 online resources such as easy-to-navigate, interactive websites that make it easier for individuals to find and “pull” needed information just in time, when needed
 - Online training programs that help the learner acquire new insights and skills, and can assess/test knowledge to confirm understanding

In addition, social media tactics can be engaging and leverage the power of technology and virtual support systems. Research demonstrates a high correlation between one’s weight and general health and the people in one’s social circle. Further, online applications are growing rapidly as consumers recognize the convenience of hand-held devices as trackers, coaches and even motivators. Examples of such tactics and tools include:

- Quick Response (QR) codes in communication materials, that smartphone users can leverage to be led conveniently to online resources
 - TXT4BABY and related services that can enhance health for mother and baby (TXT4BABY, a free service, has been proven to help a wide range of socioeconomic groups, including mothers on Medicaid whose smartphone ownership can be high since it is their mobile PC device)
 - Online support groups of like-minded individuals pursuing a health goal, such as weight management, physical fitness and related hobbies, or tobacco cessation.
- **Variety of examples** – Help participants see how various scenarios could be similar to their situations, and how their costs can be affected by their decisions on their health.
 - **Personalized modeling tools** – Online resources enable individuals to visualize the impact based on their differing situations. Because each person’s health situation is unique, as well as his or her tolerance for risk (as reflected in the consumer-driven health, high-deductible plan), these calculators can be helpful in two ways:
 - First, they allow the individual to model various scenarios for health needs – from low to high health care use and costs.
 - Second, and ideally, these tools can be pre-loaded with participants’ actual historical claims data. In turn, a side-by-side comparison can be generated illustrating what would have happened to out-of-pocket costs if the participant had been enrolled in a consumer-driven health plan, or in another type of health plan, during that time period. Often, employees can be pleasantly surprised by the results.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

6. Communications: Required for Success, continued

- **Total rewards statements** – Typically now online and interactive, with ongoing updates to personalized information, today’s total rewards “statements” provide a “sticky” experience to encourage employees to continually return for information on the value of their benefits and compensation programs. A more “rewarding” user experience can promote greater engagement in using benefits wisely, as well as a heightened appreciation for resources as employees more readily find links to websites providing tools and assistance.

ALTERNATIVE APPROACHES

SUMMARY – SUCCESSFUL COMMUNICATION STRATEGY

Alternative approaches to supporting the transition to greater employee responsibility and behavior change follow, along with a high-level outline of a proposed communication rollout strategy (see next section).

Conservative	Moderate	Aggressive
<p>Elements include:</p> <ul style="list-style-type: none"> • communication is sponsored by DSGI and DMS • announce any major changes or initiatives two to three months ahead to start communicating • hold benefit fairs for face-to-face; use paper newsletters, workbooks • include worksheets with selection tips • include online health risk assessment • promote healthy choices • communicate annually during open enrollment 	<p>Includes conservative approach elements and adds:</p> <ul style="list-style-type: none"> • support by senior leadership • announce major changes or initiatives four to six months ahead for more in-depth preparatory education and change management • hold local meetings • use online resources for 24/7 availability • use online modeling tools • include personalized action plans • provide annual personalized benefit statements to increase appreciation of total value 	<p>Includes conservative and moderate approaches and adds:</p> <ul style="list-style-type: none"> • support by the governor • announce major changes and initiatives as much as a year ahead, with targeted pre-education plans for subgroups • get “all” employees to attend meetings • engaging online tools, training modules and apps • online modeling tool is pre-populated with individuals’ claims history to aid in decisions • periodic push/pull updates • provide online, interactive total rewards “statements” including resources/tools for engagement

When implementing any of the approaches outlined in this report, a comprehensive communication plan will help reduce disruption and allow participants to see how their efforts can contribute to both savings and better quality of life through better health. Sharing and transparently communicating how savings can help lower health care contributions or at least “bend the cost trend line” to enable wiser use of that element within employees’ total compensation from the state, can help improve acceptance of health management programs. Most importantly, plan members need to understand the objective of continued access to quality care and needed pharmacological support, but at more reasonable cost to the plan and participants.

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

6. Communications: Required for Success, continued

PROPOSED COMMUNICATION ROLLOUT STRATEGY

Experience shows the following sequence to be critical to successful introductions of high-deductible health plans and other major health and incentive changes, in order to build understanding, acceptance/buy-in, and desired behavior change. This rollout strategy should be part of any communication strategy approach.

1. **Planning** – An effective communication campaign requires an initial strategy session to confirm the following:
 - Objectives (including measurable outcomes)
 - Audiences (including external influencers or partners) and their profile, challenges or barriers in reaching them, etc.
 - Key messages to be conveyed
 - Tactics or channels most successful with these audiences
 - Branding – for a graphic identity
 - Timing – a milestone-based communication plan of events
 - Evaluation and feedback – how results will be measured
2. **Pre-announcement** – Activities here could include:
 - Heads-up memo emailed to key leadership and HR constituents: what’s happening, when, why and how and to whom, and what is needed of them in supporting and championing the changes
 - Advance briefings with the above constituents, familiarizing them with the proposed changes and rationale, overcoming their first reactions of “what does this mean for me,” helping them see the advantages of the new strategy, and getting their feedback and input to ensure a successful communication plan and change management
 - If time allows and a confidential subgroup can be formed, pre-testing of the communication plan, from branding and message to proposed tactics, in order to refine and finalize the communication strategy (note: this is not a “vote” on the program changes, but input from those who can serve as “voice of the customer” and help ensure success)
3. **Announcement** – The purpose here is to be transparent about future intentions and begin to acclimate the audiences to the upcoming plan and program redesign, allowing plenty of time for subsequent training, education, and selection and decision support activities:
 - Heads-up email to those with email access
 - Article(s) in state publication(s) highlighting the state’s intentions, rationale, advantages of the new approach, and timeline for upcoming rollout events
 - Other methods of reaching the state’s audiences, as appropriate

IV. Options for Increasing Consumerism and Improving Consumerism Behaviors

6. Communications: Required for Success, continued

4. **Train-the-trainer** – Because of the complexity of the change challenge in a transition to a high-deductible health plan with value based benefit design, and/or aggressive health and wellness incentives, and/or other interventions or programs requiring active employee involvement, it's vital to prepare key spokespersons for their role via training, such as:
 - Advance materials and background on the state's decision process in outlining the new strategy
 - Face-to-face, or webcast if needed due to travel constraints, training activities designed to educate, clarify the HR managers' role (including do's and don'ts, hand-offs to expert third parties, etc.)
 - Advance copies of employee meeting presentations that may be used to cascade messages
5. **Education** – Activities here should include conveying key content regarding the upcoming changes, the rationale (why), what it means to the employee, when and how they can learn more; sample tactics include:
 - Newsletter articles (online or on paper)
 - eMagazines reviewing key concepts
 - Posters
 - Postcards
 - Table tents
 - Social media
 - Online resources
6. **Selection and enrollment** – This is the typical annual enrollment decision process. If employees need to make a decision between a traditional and a consumer-drive health plan design, then decision support tools become imperative – to help individuals see the impact on their out-of-pocket costs if they choose the consumer-driven health plan.

In addition, carriers will supply enrollees with ID cards. New participants in the consumer-driven health plan will likely receive a health savings account “Welcome Kit.”
7. **Feedback/evaluation** – Major initiatives are not “one and done.” Both quantitative and qualitative feedback and results should be considered. Examples include:
 - Quantitative – percentage who enroll and/or go tobacco free
 - Qualitative – employee attitudes, perceptions and even anecdotes about their reactions and impediments to their follow through
8. **Ongoing reinforcement** – Healthy behaviors take time to become second nature, but forward progress is critical. Even Prochaska's well-known model for healthy changes (first designed to capture the phases in successful tobacco cessation) acknowledges it is common to see frequent “relapses” to old behaviors.

As the state chooses to “raise the bar” every year, the expectations for results should also rise. In turn, the impact on return on investment will become more apparent because the program has been set up for success, all keys stakeholders understand what's needed of them, and support resources, infrastructure and information are provided on an ongoing basis for continual improvement.

V. Administrative Considerations

Following are administrative considerations to be addressed as part of the decision-making process.

Data Aggregation: The Importance of a Data-Driven Approach to Strategy

One of the key elements of a comprehensive strategic plan is for an employer to have access to and use of one's own health plan data that is timely and actionable. Historically, the State of Florida's health plan utilized several fully-insured HMO vendors along with its self-funded PPO and pharmacy benefits manager vendors. In general, reports provided by fully-insured HMOs are more limited in scope than that of self-funded programs. Regardless of the extent of the reports available from the various vendors, consolidating information from five HMOs, one PPO, and one pharmacy benefits manager vendor into an integrated dataset is an onerous task. Even if an employer could consolidate that volume of data into a single database, it would still consist of raw data and voluminous reports, which is not particularly useful until it is systematically analyzed. The resulting analytics can be leveraged to build targeted priorities and interventions.

The state could consider immediately procuring the services of a data aggregation vendor. Part of the requirements should be to load at least two years' worth of historical data from all the medical and pharmacy vendors to create a comprehensive database of historical data for immediate use in evaluating plan and vendor performance and for strategically focused population health initiatives.

Health Risk Assessment Integration

Using one health risk assessment survey across the state's population is required to provide integrated reporting and analysis to support the recommended population health management initiatives. Therefore, the state should decide what health risk assessment survey instrument to utilize and implement it as soon as possible. Some health plan vendors utilize nationally recognized health risk assessment surveys, such as the one developed by the University of Michigan. If one of the state's current health plan vendors has such a broad-based, widely accepted survey, the state could consider implementing it for all plan participants across health plan vendors. A data feed of results will need to be provided to health plans vendors so that the health plans have the results for their respective enrolled participants for use in their health management programs, such as disease management.

Incentive Administration

As the state considers these types of initiatives, it also could look to its health plan vendors for assistance in administering, tracking and reporting of the incentives. Some employers have handled this historically cumbersome administration process in-house; however, health plan vendors have significantly enhanced their capabilities in this area and should be able to provide some much-needed administrative relief. Due to the state's multiple-vendor health plan structure, an outside third-party vendor may be better able to integrate the tracking, reporting and administration of the incentive program on behalf of all plan participants.

V. Administrative Considerations

Health Savings Account Administration Improvements

The state health plan introduced the High Investor Health Plan (HIHP) option in 2006 and was considered an early adopter of consumer-driven health plan design. To help cover some of the deductible expenses, it includes a health savings account (HSA) feature to which the state contributes \$500 for single coverage or \$1,000 for family into a member's HSA, if an account has been opened with the HSA trustee, Tallahassee State Bank. **Based on August 2011 enrollment, 33 percent of active employees enrolled in the HIHP option have not opened a HSA, and thus are not receiving the funds available to them from the state.** Despite the per paycheck contribution required by employees for the HIHP, which is lower than the Standard PPO and Standard HMO plans, less than 1 percent of eligible members are enrolled in this plan.

Best-in-class options now feature extensive decision-making resources and tools to help employees understand how the plan works and to assess cost and quality of providers and services so members can make informed health care purchasing decisions. Based on options to migrate more members towards the state's consumer-driven (HIHP) plans, consideration could be given to improving the HSA administration services offered to members. Upon review of the state's current HIHP option, many of the best practices outlined below are not currently in place and could be implemented to enhance the effectiveness and attractiveness of this plan.

- Employer-paid administrative fees (reduces participant dissatisfaction)
- Debit cards, checkbooks – convenient payment options
- Autopayment of claims for less participant paperwork
- A choice to spend from the HSA (autopay) or save (choose to pay out of one's pocket instead)
- Choice of paperless vs. mailed statements
- 24/7 Web support
- Phone customer service support
- Good range of investment choices from multiple fund families
- Automatic investing as new funds are added to the account
- Reasonable level after which funds can be invested in higher interest-bearing options
- Account opening integrated with benefit annual enrollment process (also, ideally, beneficiary designation)
- No limits such as minimum deposits or minimum balance or minimum withdrawals
- Integrated administration, investment options, timing of funds (allow automatic payments, saver vs. spender, debit card)

V. Administrative Considerations

Health Care Flexible Spending Accounts

Health care flexible spending accounts (FSA) are accounts for active employees that allow them to reimburse themselves with pretax dollars for eligible out-of-pocket health care costs. With these accounts, employees decide the annual amount they want to contribute before the start of a plan year and deductions are taken on a per pay period basis throughout the year. Employees must submit claims for the plan year by April 15 of the following year for the entire amount withheld so they do not lose the unused money. FSAs offered by the state include Medical Reimbursement Accounts and Limited Purpose Medical Reimbursement Accounts (for HIHP plan participants). Dependent Care Reimbursement Accounts are also available to state employees to reimburse themselves for qualified dependent care expenses.

FSAs are a valuable benefit but are widely underutilized. In fact, less than 10 percent of the state's eligible employees participate in the FSA options. Increasing education efforts and communicating to employees about the benefits of these accounts will help increase participation, providing both employees and the state with financial savings.

Other

The items below are important administrative issues related to member enrollment and should also be considered:

1. Assure dependent eligibility review processes are in place, especially around new elections and open enrollment.
2. Ensure that the benefits enrollment processes related to coverage effective dates and termination dates are in line with best industry practices.

VI. Future Considerations

The approaches described in this section are new ways that are being developed and utilized to help control health plans costs. Few employers have currently adopted these approaches but many are being explored. Some of the foundational components of implementing these approaches do not yet exist in the state's program and would need to be implemented prior to considering these approaches. Thus they are provided here for future consideration.

Value Based Benefit Design

Value based benefit design is applying the concept that *value in health care* equals the health outcome divided by the dollar cost expended to achieve that health outcome. Value based benefit design has recently been applied as a benefit philosophy and an engagement tool for plan sponsors, consumers and health care providers.

It could be characterized as a ***moderate approach*** to managing health. To apply these principles of a value based benefit design as a strategy within a health program, plans need to include the following attributes:

- Data analytics capability
- Benefit designs that incentivize appropriate and desired behaviors and engagement (applying the principles of behavioral economics) by consumers and health care providers
- Addresses the delivery of services provided by health care providers
- Identifies quality standards and behavioral performance that have demonstrated improved health status for patients and populations moving forward

The data analytics component of value based benefit design is the foundation of applying the concept. It needs to begin early and continue on throughout the duration of the value based benefit design effort. By collecting claims, encounter and outcomes data from carriers, pharmacy benefits managers, providers and supplemental services (such as lab, vision and dental providers), the plan sponsor can identify:

- Prevention and wellness activities that are being utilized and produce a return on investment (ROI) for the plan sponsor
- Providers by cost and quality of care
- Readmission and complication rates for medical procedures and events for sites of care
- Inappropriate use of expensive sites of care (e.g., emergency room or expensive diagnostics)
- Reactive versus proactive activity by providers and consumers
- Most cost-effective and quality-oriented providers and sites of care

VI. Future Considerations

Value Based Benefit Design, continued

The data analytics functionality will allow the plan sponsor to identify where resources are best placed to provide the highest ROI for the patient and plan, while also allowing the plan to identify and address the following:

- Waste reduction activity (current and moving forward)
- Areas for reductions in future health risks
- Individual accountability
- Vendor and provider operational performance
- Overall quality of the health care services provided
- Incentives for all parties

The adoption of value based benefit design within a health program is not a one-time activity and normally takes several years to implement. Implementation steps include the following:

- Data integration and analytics capability
- Claims data analysis
- Member, provider and carrier engagement, normally including incentives and disincentives
- Inclusion of a prevention and wellness strategy and activities
- A program of chronic care management, engagement and aligned incentives
- A review and analysis of care delivery options on an ongoing basis
- Member educational and communication activities
- Provider education and communication activities

The data analytics minimum required functionality includes the ability to integrate complete medical claim and encounter activity coding pharmacy claim, lab and other health claim information with eligibility, health account information, plan paid and member-paid cost information. The aggregator will need to have the ability to track incentives and participation activity by the plan members in the data base and to “talk” to the providers of incentives, such as the plan sponsor. The data aggregator will need to be able to report on diagnostic-related groupings, treatment episodes, follow-up care by group, plan, member and physician engagement, and be able to develop customizable reports for incentive types of specific initiatives.

Plan administrator relationships and contracts, such as the pharmacy benefits manager and carrier, will need to be reviewed prior to the selection and implementation of a data aggregator vendor to ensure all operational and administrative needs (the organizations can talk to each other) are met from all perspectives and contractual relationships. The eligibility and enrollment vendor relationships and systems of the state will need to be reviewed in terms of capability and the potential financial impact of moving to a more active health plan program, such as any potential additional costs for individual active enrollment on an annual basis. When moving to aligned incentives, a plan sponsor requires the ability to track and communicate the incentives as well as the corresponding activity by the consumer that earns the incentives, and attach this information to the eligibility file on an ongoing and periodic basis moving forward. If the incentives include contributions to an HSA or a health reimbursement

VI. Future Considerations

Value Based Benefit Design, continued

arrangement, then this information and capability and functionality will need to be addressed also, as well as any compliance considerations.

With the inclusion of broadly based incentives into the state health program, there are several options as to how to move forward. Strategically, incentives that motivate employees to take action in areas of mutual benefit (for the employee and the state) provide the largest return on investment for all involved. These could include:

- Immunizations (for the employee and family members)
- Encourage (or eventually require) the elimination of unhealthy behaviors (smoking, for example)
- Have a workplace safety impact (take safe lifting instruction, for example)
- Promote the covered individual to learn about their health (complete a health risk assessment or biometric screening)
- Complete an educational program on how to purchase health care services, products and advice

Recent studies indicate that one-time incentives are less likely to change patient behavior over the long term than incentives that are potentially smaller and provided more frequently, such as on an activity-based foundation. Examples of this include patients who have to be compliant with their physician-prescribed therapy (medication compliance or blood testing for diabetics) each 90 days before a reduction in cost share is provided for the next 90 days. These activities need to be clearly spelled out to the plan participants on an ongoing basis, including during the open enrollment period. A scheduled ongoing communication program is an important element to the strategy moving forward. Advancements in technology have brought to light tools where incentives can be provided to consumers on an ongoing basis based on recorded activity.

Incentives can take the form of one-time incentives (e.g., cash disbursement, contribution to a savings/cost avoidance account for a consumer-driven health plan, or an employee contribution reduction on a scheduled basis), activity-based rewards (e.g., exercise X times within a month and receive Y), cumulative awards where progress is measured and reported upon on an ongoing basis (e.g., walk 15 times within a month and receive a pair of shoes). Some new tools exist in the marketplace where rewards can be provided by outside entities at limited or no cost to the employer, or funded primarily by the plan sponsor.

When implementing a value based benefit design, plan sponsors can address any number of “levers” to change health care behavior moving forward. Data integration, communication and educational activities, provider and consumer incentives and disincentives, and directing patients to the correct site of care for the appropriate treatment are only several of the options available. The concept of value based benefit design can also be applied to retirement programs, as well as health care. Holding each invested party accountable is a key component of value based benefit design, as it is in outcomes based contracting.

VI. Future Considerations

Outcomes Based Contracting

Outcomes based contracting is a term owned by the Center for Health Value Innovation (vbhealth.org) and is considered an **aggressive approach** to plan management. The concept is that for each and every health care service or product the plan sponsor provides (vision, chiropractic, dental, medical, pharmacy, etc.), the provider of those services will be held accountable not only for discounts and financial performance, but for how that product or service either improves or maintains health, based on a pre-established set of measures and criteria. Strategically, this contracting theory supports a host of strategic initiatives, such as pay for performance, improved transparency, network management, provider/patient engagement activity (e.g., the provision of prevention and wellness services), accountability, consumerism, effective and appropriate care delivery, and the enforcement of evidence-based clinical programs. Outcomes based contracting also leads to the ability for additional consumer engagement initiatives and the removal of waste within the system, which can conserve the utilization of resources for the plan and consumer on a long-term basis.

In an outcomes based contract for a drug, for example, a preferred drug on the formulary would need to actually provide the clinical results claimed (assuming consumers actually take the medication as prescribed) in an overall population, or the pharmaceutical manufacturer would be liable for the additional health care costs associated with the lesser outcome, such as bone fractures as a result of osteoporosis therapy that was less than successful. Obviously, compliance by the patient, proper prescribing by the physician, consistent availability of the medications, and appropriate monitoring of the patient would all have to take place. This concept can be carried to chiropractic services, dental procedures, pharmaceutical therapy, some surgical procedures, and a variety of other health care procedures, activities, and therapies.

When contracting in this fashion, the strategic direction of the parties should be designed in a stepped fashion, based on plan sponsor goals, such as:

- **Reduce current waste within the system** – decrease the prescribing of procedures where they are not indicated, for example; or diminish the unnecessary use of emergency rooms where other sites of care delivery are acceptable; eliminate the prescribing of brand name medications where generic or over-the-counter alternatives are appropriate; quickly cease therapy where the anticipated clinical result is not produced
- **Reduce future waste within the system** – create patient care plans for surgical patients so that they spend the shortest appropriate period of time at the highest cost levels of care; this type of planning would encourage physicians to move patients through the system and be released in the most efficient manner with the highest level of clinical results
- **Improve clinical measures when patients are on specified therapies** – test to see if the therapy produces the clinical results promised
- **Measure organizational performance** – reduce post-surgical infection rates or re-admission rates for competing institutions
- **Engage patients and providers for increased accountability in health status over time** – increase prevalence of preventive screenings or compliance with prescribed therapy measures

VI. Future Considerations

Outcomes Based Contracting, continued

The process itself is complicated and takes diligence. These types of contracts are currently applied to the following areas, which can provide an outline of a stepped approach to outcomes based contracting:

- Disease or condition management
- Specific categories of drugs within a prescription drug benefit
- Medical and/or network management
- Reduction of medical errors either within the physician office or facilities
- Workers compensation management (e.g., return to work or expense measures)
- Clinical improvements from specified therapies or procedures

Metrics that can be included in these types of contracting activities include:

- Financial measures (direct at first, then indirect)
- Health care or disease specific cost trend management over time
- Improvements in health status over time for a given population or subpopulation based on biometrics or lab results
- Reduction in post-surgical infections
- Reduction in re-admission rates for specific conditions or procedures
- Health care risk reductions for a population or for specific patients (reduction in smoking rates)
- Improved patient functionality (in the case of certain therapies of surgeries) and return-to-work time frames as a result of prescribed therapies
- Maintained weight loss after surgery/therapy intervention

Incorporating outcomes based contracting components into vendor and provider contracts takes planning (normally when renegotiations occur), time and a true sense of partnership between all parties. For current vendors, discussions could begin immediately as to what future expectations will be for the relationship (normally at a more senior level than the local account management) moving forward. Starting small and expanding the concept is the currently accepted approach. Financial penalties for non-performance by all parties should attain the level of being sufficient to make the plan sponsor whole in the event the outcomes are not attained.

The plan sponsor must communicate with the vendors the need to include the outcomes based contracting infrastructure in their own provider contracts to support these outcomes based contracting efforts (these do not commonly exist across the country) moving forward. Network provider contracts, such as physician and institution contracts, will need to be reviewed and potentially reconstructed. In the case of ancillary services (vision, pharmacy, dental, chiropractic, physical therapy, etc.), outcomes measures and reporting will need to be addressed during these discussions. Outcomes based contracting is considered to be innovative and aggressive at this time with few carriers being committed to, and capable of, incorporating these measures and activities across a broad spectrum of services.

VI. Future Considerations

Outcomes Based Contracting, continued

However, from Buck's perspective, this is a very reasonable approach to managing health care resource utilization moving forward. For this reason, a stepped approach to incorporating outcomes based contracting into the vendor relationships may be appropriate at this time.

Reference Based Pricing

Reference based pricing is simply establishing a fair financial value for a defined quality product or service within the existing marketplace, which could include medical tourism factors, and capping the plan sponsor liability for that defined quality product or service at that established fair market value. This is considered an **aggressive approach** to managing plan assets. Areas where this approach has proven successful are with prescription drug programs, endoscopic and colonoscopy exams, diagnostic imaging, physical exams, and a variety of other medical activities and procedures. There is a fair amount of disruption to the network during the implementation of a reference based pricing program and an adjustment period is normally required before a consumer or provider population understands and learns how to utilize the system and turn reference based pricing into an advantage for all involved.

When implementing a reference based pricing program for services, competition is required within the geographic area covered by the plan sponsor enrollees, which could include a medical tourism component depending on how aggressive the plan sponsor wishes to be. Competition is what will drive resource savings/cost avoidance. High-cost providers will have a very real threat to their utilization of services, including profit and revenue. The goal is to drive innovation within the high-cost provider community to deliver the same high-quality services at lower costs and, hopefully, with improved consumer service levels. Lower-cost providers will have an advantage of increased volume of services being performed and profit during the early phases of the program and will have to innovate to maintain their financial and service edge over other competitors who are becoming more efficient. Site of care of the procedure can play into the cost equations, as well as the availability of "contingency" resources, such as the availability of a surgical unit in case of an adverse event.

When establishing reference based pricing for services, the following factors need to be addressed:

- Patient risk factors and the need for emergency preparedness and access
- Overall procedural risk (cardiac catheterizations should not be performed at a stand-alone clinic, for example)
- Access and availability of quality services by trained professionals within the area
- Needs of the population
- Overall financial impact to the plan sponsor
- Communication and education needs of the population and providers

When researching and identifying the services for consideration of reference based pricing initiatives, those services that have a wide variation of costs, a fairly consistent outcome, utilize a large amount of plan resources, and exist in a competitive environment, should be researched and targeted as a higher priority. Common targeted areas include diagnostics imaging and activities, lab services, minor

VI. Future Considerations

Reference Based Pricing, continued

outpatient surgical services, infusion activities, pharmaceutical therapies, wellness exams and physical therapy. Diagnostic Related Groupers (DRGs) are an early example of reference based pricing.

Reference based pricing can only be established if a plan sponsor has the correct information and analytical abilities to set appropriate reimbursement levels for targeted products and services within the target geographic area. Data collection and integration is a foundation activity that needs to take place, as well as cost and quality transparency within the health care delivery environment, and access to health improvement information, and cost data for consumers. Consumer engagement will increase with this approach over time but not always in a positive fashion in the early stages of the program. Communication is a key component of implementing reference based pricing in a smooth and non-disruptive manner.

Communication with the providers, institutions, and to the consumers will help ensure that all parties involved in the consumption and delivery of health care are aware of and invested in the reference based pricing program. Providers need to be aware of how the program is to be implemented and given some lead time to become part of the provider panel where the reference based pricing is acceptable reimbursement. This applies to each and every service where reference based pricing is incorporated into the plan design. Institutions negotiate reimbursement levels in a variety of methodologies and will need to be able to provide services or contract for them in a fashion that allows for participation in this type of program. Lead time for these institutional providers may be required.

Employees need to be aware of the reference based pricing program, have the resources available to identify accessible providers willing to accept the reference based pricing, and be invested in the financial risk by having a coinsurance or a risk amount associated with the reference based pricing procedure. In most of these programs, the plan liability is calculated at the reference based pricing level. The member pays the cost share amount (and deductible if appropriate) plus the additional procedure costs above the reference based pricing charged by the provider. Having this information readily available for consumers before they engage in the health activity is considered a requirement for a reference based pricing program.

Reference based pricing programs can produce plan savings/cost avoidance without adversely impacting the health of the covered population. In the prescription drug benefit, reference based pricing programs can produce saving in excess of 10 percent of plan prescription drug costs; however, it is more realistic to see savings/cost avoidance ranging from 4 percent to 8 percent of plan prescription drug costs, as reference based pricing programs are normally instituted only for specific drug classes with high cost differential between products, and a perceived low therapeutic differential between the same products. Drug therapy classes where reference based pricing can be applied include statin therapies, proton pump inhibitor therapies, high blood pressure treatments, and some inflammatory diseases.

For procedures, estimating savings/cost avoidance is more difficult, the frequency of use of the targeted services and procedures utilized within the target population needs to be examined, and then develop the reference based pricing for those same targeted services and procedures. The literature tells us these programs can save low to mid-single digit plan cost savings/cost avoidance annually when incorporated aggressively into the health plan, with little or no visible deterioration in the quality of health care service delivery.

VI. Future Considerations

Concierge Medicine Approach for High Risk Members

For patients with multiple disease states, an elevated number of risk factors beyond behavioral control, and that represent high resource utilization to the plan sponsor, a Concierge Medicine approach to managing these patients is gaining momentum. The concept is that an identified population would have access to a selection of physicians who are trained in addressing the needs of these complex patients. Several organizations exist where these types of physicians are identified within specific geographic areas. The physicians agree to see specific patients in a limited practice of fewer than 600 total patients. Reimbursement to the physician would be a one-time payment up front (market rate is currently under \$1,500 annually in most areas) and then normal insurance level reimbursements for services rendered, and the physician then provides certain specific contracted services to these patients.

Examples include:

- Comprehensive annual physical included in the up-front cost
- Guaranteed appointments within two business days of when the member calls
- Physician is available 24/7 via cell phone number (given directly to each patient and caregiver)
- House calls can be included in the program
- Each appointment will last at least a specified time period (20 to 30 minutes is standard)
- Preventive and wellness services and monitoring will be provided by the physician

Studies are beginning to show a health improvement and lower overall health care cost for patients with multiple risk factors and chronic conditions when they are enrolled into these programs. One such program, MDVIP, based in Fort Lauderdale, may be an appropriate pilot organization for the state moving forward. This approach to patient management, combined with a value based benefit design and outcomes based contracting, is considered innovative within the industry and would be considered a ***moderate approach***.

VI. Future Considerations

Transparency

Simply defined, transparency is: “The complete and true disclosure of all costs, profit and clinical implications related to the use of identified products or services.” Transparency within the health care marketplace and environment incorporates a variety of dimensions:

- Financial considerations
- Activity-based tracking for providers, institutions and consumers
- Accountability on the part of providers, consumers and the carriers
- Sharing of detailed clinical information across channels
- Results tracking and reporting (including adverse events or issues)
- Compliance and persistency tracking by and in regards to all parts – accountability to comply with prescribed therapies and to prescribe the appropriate therapy, and accountability to perform a service correctly and without undue complications
- Comprehensive information for decision-making provided to providers, health managers and consumers
- Access to experts without a vested interest in the financial implications, for objective decision-making
- Objectivity in the presentation of therapeutic options, without regard to channel profit
- Consistency with the goals of the plan sponsor in addition to the patient and provider

In the current environment, few industries are less transparent than health care. When trying to determine the true cost of a product or service, employees need to go through a variety of intermediaries that may or may not share the information required for the plan sponsor or consumer to make informed decisions. Partially, this is based in contracting strategies of the past that have survived into today’s marketplace. When it comes to prescribing medications, physicians are often naïve to the true cost of those medications (e.g., ingredient costs, discounts, rebates, etc.), and to the alternative and potential similarly effective therapies that are available – including generic or over-the-counter options. For medical procedures, physicians are not always aware of facility charges and alternative site of care charges, other than member cost share implications because members may choose to share this with physicians.

Transparency is an early step in the progression to developing reference based pricing arrangements for many plans (at least on the medical side) and in developing a truly value based health care benefit design, plan sponsors and managers need to know where true value lies. Transparency is a foundation step before a truly comprehensive pay for performance program can be developed for providers and institutions.

Transparency rules need to be outlined in the vendor or carrier procurement process. It needs to be defined and created as part of a contract management process. Data collection methodologies need to be in place for not only the true costs of a procedure or therapy, but also for the quality implications and overall health implications of that procedure or therapy over time. *For plan sponsors*, embracing transparency as a strategic foundational pillar of the benefits philosophy, a health care delivery and benefit design review needs to take place. *For plan members* coinsurance cost sharing needs to be

VI. Future Considerations

Transparency, continued

incorporated into the benefit design via cost transparency and consumer engagement tools. Tools to provide information for clear decision-making, such as e-prescribing or websites with true provider costs for services and products need to be available for consumers and providers. Networks need to report on quality measures and adverse events after procedures and therapies, as well as how investing in complex and expensive diagnostics provides a return on investment:

- for the patient in terms of changed therapies that produce a cost effective improvement in health outcomes and
- for the plan sponsor in the form of lowered resource utilization for the same or improved health outcome for patients.

Criteria around the use of these more resource-intensive aspects of health care need to be developed, monitored, and adhered to, potentially removing waste today and imparting a sense of health care responsibility moving forward.

Support for Pay for Performance Efforts

Pay for performance programs are gaining acceptability within the health care marketplace. Providers perceive them as a potential additional revenue stream; plan sponsors see them as a way to “pay for health care results” and to avoid unnecessary additional costs due to manageable adverse events. The plan sponsor concept of rewarding high-quality performing providers is a foundation to this concept, and conversely, to cut reimbursements to low quality providers. Members see them as a way to earn rewards and potentially lower personal out-of-pocket health care costs. The pay for performance concept is generally accepted within the health care communities around the country, with the details being less universally accepted. These types of programs are becoming less aggressive in nature, and are moving into the mainstream, or generally accepted conservative health care management

Pay for performance programs need to begin with extensive data analysis. Services that are currently being performed within a given health plan should be analyzed. The physicians providing the services should be identified along with the associated costs, quality and health outcomes measures. What is then identified as the current best practice benchmarks and activities can then be expanded to a broader base of providers. Commonly, providers negotiate for pay for performance for shortening length of stays for hospitalized patients, lowering diagnostic costs, and other activity or cost based factors. In today’s environment, plan sponsors and payers are demanding more accountability, such as health status improvements for patients over the long term (diabetics with lower HbA1c levels or larger portions of the population with controlled blood pressure readings, for example). This concept and data analysis, along with detailed clinical reviews, can incorporate pay for performance measures into outcomes based contracting activities, which is an option for the state moving forward.

VI. Future Considerations

Accountability

Accountability within the health care system in the U.S. is less than ideal at this point in time. With a plethora of products and services available to provide treatments for similar conditions and illnesses, minimal oversight, and extreme complexity, accountability has been limited over time. Accountability has been associated with overall discount levels, financial measures in a broad sense, and some activity based accountability. Moving forward, strategic alignment would suggest that the state impose accountability for chronic condition management on all parties: the consumer, the physician, the institution, and the care coordinator.

The member can be held accountable for his or her own health care by being held responsible for complying with recommended wellness and diagnostic activities, prescribed therapies, and health status reporting. An approach implemented by a number of plan sponsors across the country over recent years provides for two benefit plans (one with richer benefit coverage than the other) and a single premium charged to the entire population. To be eligible for the “richer” benefit design, the consumer must behave in a healthy fashion. This includes for example:

- Complying with all screenings and wellness requirements (colonoscopy, breast exams or completion of a health risk assessment or biometric screening when indicated) as recommended
- Complying with prescribed therapies for given chronic conditions, such as taking medication as prescribed or performing blood glucose monitoring (and reporting those results)
- Contributing to some type of health savings/cost avoidance vehicle
- Attending medical professional appointments as scheduled
- Ceasing negative health behaviors (e.g., smoking)
- Engaging in healthy behaviors (e.g., walking on a regularly scheduled basis)

For patients who behave in the prescribed manner, they can earn the richer benefit, which could include lower cost sharing, potentially more incentives, and improved coverage in specified areas.

In the instance of providers, accountability takes another dimension. Physicians and other medical providers have access to any number of clinically appropriate patient engagement and treatment guidelines. Holding physicians accountable for performing these activities, according to established clinical guidelines, is a reasonable expectation. For example:

- Schedule follow-up chronic condition management visits according to accepted guidelines to actually review the patient and not just to provide new prescriptions. Follow-up activities could include a review of therapy compliance and why non-compliance may be taking place and a discussion of recommended healthy behaviors for the patient to engage in moving forward
- Discuss with the patient disease or condition progression over time, new symptoms, and how to relieve those symptoms
- Report progress or health status, as well as biometric measures where appropriate
- Disclose costs for the provision of services
- Improve the health status of the entire practice patient population
- Reduce hospitalization rates and length of stays for the patients
- Eliminate inpatient days where no activity or health care was provided

VI. Future Considerations

Accountability, continued

Physicians and other health care professionals do have a responsibility to perform these tasks and to be held accountable for the results of their actions. They should be compensated for performing those tasks, but only if on a whole the tasks performed produce improved health for the identified patient population. For providers who bill for these services and no health improvement is seen in the patient population, there should be accountability in terms of a decreased compensation.

For institutions, there are a number of clinically accepted activities that are relatively simple to implement and have a large health care cost impact overall and a dramatic health impact for the patients within the institution. These include:

- Mandating healthcare professionals wash their hands before entering and when exiting a patient's room. Placing dispensers of hand cleanser outside each patient's room to facilitate this activity
- Avoiding patient admissions on weekends if no services are available on the weekend or no charge to the payer or patient for these days
- Measuring and improving infection rates after invasive procedures
- Discussing minimally invasive procedures, where a minimally invasive alternative exists, are to be discussed with all patients who are scheduled to have a procedure
- Not performing C-sections unless there is a second (or third) opinion in institutions where the C-section rates are highest within the universe of providers
- Documenting diagnostics verifying that cardiac (and all) procedures are the most appropriate and showing definitive reasons why a lower-cost and lower-risk procedure is not appropriate.

Accountability within the health care system itself is not new and is becoming a standard of behavior. Tying reimbursements to this accountability is acceptable in the national health care industry and could be part of the strategic foundation of the state's program moving forward.

VII. Summary of Options

The information contain in this section is a summary of the alternative approaches and options discussed in the report. For complete context and details on the approaches and options, please refer to the corresponding section of the report.

1. Active Employees

ALTERNATIVE APPROACHES – TYPES OF PLANS AND BENEFIT DESIGNS

The alternative types of plans and benefit design options are provided below. Using the expense projections originally provided, savings/cost avoidance estimates of the three approaches are outlined below. Changes to the PPO Standard option have been included for market competitiveness and consistency with the HMO and are described below along with the other changes.

OPTIONS – TYPES OF PLANS		
Conservative	Moderate	Aggressive
Eliminate HMO HIHP option	Eliminate the HMO Standard and HMO HIHP options; continue the PPO Standard and PPO HIHP options	Eliminate HMO Standard, HMO HIHP and PPO Standard Options; enroll all employees in PPO HIHP option
OPTIONS – BENEFIT DESIGNS		
Conservative	Moderate	Aggressive
<p>Adjust HMO plan design to include more cost sharing through deductibles and coinsurance:</p> <ul style="list-style-type: none"> 90 percent coinsurance except for office visits Increase out-of-pocket maximum from two to three times individual <p>Adjust PPO plan out-of-pocket maximum for consistency with HMO</p> <ul style="list-style-type: none"> Increase out-of-pocket maximum from two to three times individual 	<p>Enhance PPO HIHP plan design:</p> <ul style="list-style-type: none"> Increase in health savings account deposit to 50 percent of deductible (from \$500 to \$625) prefund health savings account in first year cover generic preventive drugs at 100 percent prior to deductible 	<p>Only plan type is PPO HIHP – Enhance PPO HIHP plan design:</p> <ul style="list-style-type: none"> Increase in health savings account deposit to 50 percent of deductible (from \$500 to \$625) prefund health savings account in first year cover generic preventive drugs at 100 percent prior to deductible

VII. Summary of Options

1. Active Employees, continued

SAVINGS/COST AVOIDANCE ESTIMATES

		FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Conservative	Plan Design Change Savings/Cost Avoidance	2% PPO 6% HMO	2% PPO 6% HMO	2% PPO 6% HMO	2% PPO 6% HMO
	<i>Savings/Cost Avoidance Estimate</i>	\$60.1 million	\$67.0 million	\$74.4 million	\$82.4 million
Moderate	Eliminate HMOs	4% – 6%	4% – 6%	4% – 6%	4% – 6%
	<i>Midpoint Savings/Cost Avoidance Estimate</i>	\$101.9 million	\$114.7 million	\$134.5 million	\$156.3 million
Aggressive	PPO HIHP Only with Design Changes	10.5% – 13.5%	10.5% – 13.5%	10.5% – 13.5%	10.5% – 13.5%
	<i>Midpoint Savings/Cost Avoidance Estimate</i>	\$244.6 million	\$275.2 million	\$322.9 million	\$375.2 million

Note: Savings estimates are applied to full fiscal years and do not include impact of new 2012 pharmacy benefits manager contract or 2012 HMO contracts. Changes in enrollment may impact projected savings. Savings estimates across approaches (conservative, moderate, aggressive) are not additive.

VII. Summary of Options

1. Active Employees, continued

ALTERNATIVE APPROACHES – EMPLOYEE CONTRIBUTIONS

The alternative contribution approaches discussed in the report are summarized below. Financial modeling has not been performed on these approaches but can be completed upon request with assumed or requested savings/cost avoidance to cost sharing targets.

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> • Adjust current two-tier structure to four tiers • Adjust employee contributions to better reflect the relative value of the plan options (HMO Standard highest, PPO Standard middle and PPO HIHP lowest required contribution) but employees do not pay the full difference in cost between the plans. 	<ul style="list-style-type: none"> • Adjust current two-tier structure to four tiers • Adjust employee contributions to reflect the relative value of the plan options using a fixed percentage or fixed dollar amounts for the state contribution (HMO Standard highest, PPO Standard middle and PPO HIHP lowest required contribution), requiring employees to “buy up” to the greater valued plans by paying the full difference in cost between the plans. 	<ul style="list-style-type: none"> • Adjust current two-tier structure to four tiers • Adjust employee contributions to reflect the relative value of the plan options using a fixed dollar amount for the state contribution: <ol style="list-style-type: none"> 3. Fixed amount per year for all employees 4. <ol style="list-style-type: none"> a. Fixed amount per year for individual contracts b. Fixed amount per year for family contracts c. Phase out the differential in employer contributions between individual and family contracts over a period of three to five years • Fixed state contribution could purchase state-sponsored option(s) or via a state-based private exchange.

VII. Summary of Options

2. Early Retirees

ALTERNATIVE APPROACHES – TYPES OF PLANS AND CONTRIBUTIONS

The alternative types of plans and contribution approaches for early retirees discussed in the report are summarized below. Financial modeling has not been performed on these approaches but can be completed upon request.

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Maintain same plan options as actives Adjust current two-tier structure to four tiers (as discussed in active employee section) Adjust early retiree contributions to reflect actuarially sound rates (based on blended underwriting of actives and early retirees) with early retirees continuing to contribute 100% of the premium cost. 	<ul style="list-style-type: none"> Maintain same plan options as actives Adjust current two-tier structure to four tiers (as discussed in active employee section) Underwrite early retiree costs on an actuarially sound, stand-alone basis, eliminating the state implicit subsidy of early retiree cost. <p>Alternatively, existing early retirees and employees close to retirement can be grandfathered.</p>	<ul style="list-style-type: none"> No longer offer state-sponsored or subsidized plans for early retirees. Instead, facilitate early retirees' purchase of coverage through a state (as the employer) sponsored exchange that includes tools and resources to help retirees select the most appropriate medical and drug plan based on cost and coverage needs.

ILLUSTRATIVE SAVINGS/COST AVOIDANCE

To illustrate the savings/cost avoidance potential of eliminating the early retiree state implicit subsidy, the results of a previous study are provided. Based on an analysis that Buck completed in April 2011 for fiscal year 2011-2012, early retiree contributions totaled \$61.4 million for the PPO and HMO programs. The cost of those programs using actuarially based rates was \$103.8 million; therefore, **early retirees were receiving an implicit subsidy of approximately \$42.4 million.** However, since early retirees and active employees are currently rated on a combined basis, the use of actuarially based rates for early retirees will reduce the total cost of coverage for active employees when underwritten on a stand-alone basis.

VII. Summary of Options

3. Medicare Retirees

ALTERNATIVE APPROACHES – TYPES OF PLANS AND CONTRIBUTIONS

The alternative types of plans and contribution approaches for Medicare retirees discussed in the report are summarized below. Financial modeling has not been performed on these approaches but can be completed upon request.

Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Eliminate the PPO HIHP and HMO HIHP options Maintain the PPO Standard and HMO Standard options with the same design as active employees Continue current state implicit subsidy approaches for both plans Convert prescription benefit to Employer Group Waiver Program (EGWP) for savings/cost avoidance and Government Accounting Standards Board (GASB) liability reduction 	<ul style="list-style-type: none"> Eliminate the PPO HIHP and HMO HIHP options Maintain the PPO Standard and HMO Standard options with the same design as active employees Eliminate or phase out PPO Standard implicit subsidy and underwrite total costs on an actuarially sound basis Consider converting prescription benefit to EGWP for savings/cost avoidance to retirees and GASB liability elimination. 	<ul style="list-style-type: none"> No longer offer state-subsidized plans for Medicare retirees. Instead, facilitate Medicare retirees' purchase of coverage through a state (as the employer) sponsored exchange that includes tools and resources to help retirees select the most appropriate medical and drug plan based on cost and coverage needs. GASB liability is eliminated.

ILLUSTRATIVE SAVINGS/COST AVOIDANCE

To illustrate the savings/cost avoidance potential of eliminating the Medicare retiree implicit subsidy, the results of a previous study are provided. Based on an analysis that Buck completed in April 2011 for fiscal year 2011-2012, Medicare retiree contributions totaled \$141.1 million for the PPO and HMO programs. The cost of those programs using actuarially based rates was \$200.9 million therefore **Medicare retirees were receiving an implicit subsidy from the state of approximately \$59.8 million.**

VII. Summary of Options

4. Pharmacy Benefits

ALTERNATIVE APPROACHES – PLAN DESIGN AND PROGRAM MANAGEMENT

OPTIONS – PLAN DESIGN		
Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Cover generic preventive drugs at 100% in the PPO HIHP Increase mail order copay to 2 ½ or 3 times the retail copay 	<ul style="list-style-type: none"> For Standard plans continue generic copayment and cover brands and non-preferred brands at 20% and 30% respectively, with maximum copayments. Cover generic preventive drugs at 100% in the PPO HIHP Increase mail order copay to 2 ½ or 3 times the retail copay 	<ul style="list-style-type: none"> For Standard plans continue generic copayment and cover brands and non-preferred brands at 20% and 30% respectively, with minimum and maximum copayments Cover generic preventive drugs at 100% in the PPO HIHP Increase mail order copay to 2 ½ or 3 times the retail copay
OPTIONS – PROGRAM MANAGEMENT		
Conservative	Moderate	Aggressive
<ul style="list-style-type: none"> Maintain open formulary Exclude lifestyle-related drugs Introduce mandatory generic program and appropriate prior authorization programs Offer compliance programs for targeted populations. Contract management and subrogation activities occur on an ongoing basis. 	<ul style="list-style-type: none"> Maintain open formulary Exclude lifestyle-related drugs Introduce a mandatory or penalized maintenance drug program and a robust suite of clinical programs including multiple step therapy programs, duration of therapy limits and quantity limits Implement strategies to limit or eliminate use of medications that are available over the counter Offer compliance programs for targeted populations Contract management and subrogation activities occur on an ongoing basis. 	<ul style="list-style-type: none"> Change to a closed formulary and a very limited network of pharmacy providers Exclude lifestyle-related drugs, brand prescription coverage for drug categories where two or more products are available over the counter, and brand medications in specific therapy classes where multiple generics are available Mandate use of lowest cost distribution channel Introduce multiple step therapy programs and penalties for non-compliance with prescribed therapy Contract management and subrogation activities occur on an ongoing basis

Other than the cost to add preventive drug coverage of generics at 100 percent in the PPO HIHP, savings/cost avoidance estimates for the proposed plan design changes have not been calculated. These estimates can be provided upon request and may also be obtained by the PBM vendor via detailed re-pricing analysis.

The estimated savings/cost avoidance and costs associated with the Clinical and Administrative programs recommended under the three approaches are summarized below and result in the following savings/cost avoidance ranges. The savings/cost avoidance ranges are applied to estimated total prescription costs for the PPO and HMO plans for fiscal year 2011-12 of \$598 million (based on the August 3, 2011 Conference Report), and assume the percentage of the prescription costs for the PPO plans as the same as for the HMOs.

VII. Summary of Options

4. Pharmacy Benefits, continued

SAVINGS/COST AVOIDANCE ESTIMATES *

OPTIONS - CLINICAL AND ADMINISTRATIVE PROGRAMS		
Conservative	Moderate	Aggressive
2% – 6% plus compliance program cost increase (TBD based on current compliance rates)	5% – 19% plus compliance program cost increase (TBD based on current compliance rates)	10% – 31% plus compliance program cost increase (TBD based on current compliance rates)
\$ 12 million – \$ 36 million	\$ 30 million – \$ 114 million	\$ 60 million – \$ 185 million

* The savings/cost avoidance estimates provided in the summary above are based on the estimates for each program as outlined below.

Conservative Approach

- Mandatory generic programs (1 percent – 2 percent of drug spend)
- Compliance programs (potentially higher pharmacy benefit costs)
- Prior Authorization (0.5 percent – 2 percent)
- Subrogation (0.5 percent – 2 percent)
- Contract management

Moderate Approach

- Step therapy (multiple can be implemented, with potential savings/cost avoidance 1 percent – 3 percent of drug spend)
- Plan exclusions
- Mandatory or penalized maintenance drug programs savings/cost avoidance (1 percent – 4 percent)
- Limited networks of pharmacy providers (1 percent – 3 percent savings/cost avoidance for medium-sized networks)
- Quantity limits savings/cost avoidance (0.5 percent – 1.5 percent)
- Duration of therapy limits savings/cost avoidance (0.5 percent – 1.5 percent)
- Over-the-counter strategies savings/cost avoidance (1 percent – 6 percent)
- Incentives for improved compliance (lowered medical costs over time with higher pharmacy benefit costs)

VII. Summary of Options

4. Pharmacy Benefits, continued

Aggressive Approach

- Very limited networks (4 percent – 7 percent)
- Multiple step therapy programs (1 percent – 3 percent)
- Removal of brand prescription coverage for drug categories where two or more products are available over the counter (1 percent – 5 percent)
- Closed formulary (1 percent – 5 percent)
- Plan exclusions for brand medications in specific therapy classes where multiple generics are available (1 percent – 4 percent)
- Mandatory use of lowest cost distribution channel (340b for eligible members) (1 percent – to 4 percent)
- Penalties for non-compliance with therapy (1 percent – 3 percent)

VII. Summary of Options

5. Population Health Management and Incentives

ALTERNATIVE APPROACHES – POPULATION HEALTH MANAGEMENT AND INCENTIVES

Population Health Management program initiatives could be targeted to address specific issues identified within the state’s population. The state could conduct a population risk analysis to identify its members’ health issues and implement targeted intervention programs. Upon completion of the population risk analysis, an on-site clinic feasibility study may be conducted to determine if on-site services and programs can more effectively and efficiently help the state achieve its desired outcomes.

An incentive program could be implemented to immediately begin enhancing the state’s ability to assess its population’s health needs and to encourage or motivate specific behaviors that will improve members’ health status. The behaviors typically rewarded can fall into three categories: activities, achievements and adherence, which align well with alternative approaches of conservative, moderate and aggressive. Instead of three different approaches, however, for incentives the approaches can be adjusted to a three-tier approach that can be phased in over time (three or more years), starting with activity-based incentives and progressing to achievements and ultimately to adherence, if appropriate based on the population risk analysis results.

Combining population health management initiatives with incentives will enable the state to develop a multi-year population health management strategy that can be built upon each year, including incentives and participant responsibility for positive outcomes.

Financial modeling has not been performed on these approaches but can be completed upon request.

Conservative	Moderate	Aggressive
Activity-based Incentives	Achievement-based Incentives	Adherence-based Incentives
<ul style="list-style-type: none"> • Conduct a population risk analysis • Introduce incentives for health risk assessment completion and biometric screenings • Implement tobacco cessation initiative 	<ul style="list-style-type: none"> • Implement population health management programs targeted to address results of population risk analysis • Use health risk assessment completion and biometric screenings as gateway to earning incentives for population health management program and biometric “achievements” • Introduce tobacco user surcharge for employees 	<ul style="list-style-type: none"> • Monitor results and continue population health management programs targeted to address results of population risk analysis • Use health risk assessment completion and biometric screenings as gateway to earning incentives for population health management program and biometric “achievement” • Introduce “adherence-based” incentives to reward members that meet clinical and biometric targets • Continue tobacco user surcharge for employees and add surcharge for tobacco user spouses.

VII. Summary of Options

6. Communications: Required for Success

ALTERNATIVE APPROACHES – SUCCESSFUL COMMUNICATION STRATEGY

Alternative approaches to supporting the transition to greater employee responsibility and behavior change follow, along with a high-level outline of a proposed communication rollout strategy (see next section).

Conservative	Moderate	Aggressive
<p>Elements include:</p> <ul style="list-style-type: none"> • communication is sponsored by DSGI and DMS • announce any major changes or initiatives two to three months ahead to start communicating • hold benefit fairs for face-to-face; use paper newsletters, workbooks • include worksheets with selection tips • include online health risk assessment • promote healthy choices • communicate annually during open enrollment 	<p>Includes conservative approach elements and adds:</p> <ul style="list-style-type: none"> • support by senior leadership • announce major changes or initiatives four to six months ahead for more in-depth preparatory education and change management • hold local meetings • use online resources for 24/7 availability • use online modeling tools • include personalized action plans • provide annual personalized benefit statements to increase appreciation of total value 	<p>Includes conservative and moderate approaches and adds:</p> <ul style="list-style-type: none"> • support by the governor • announce major changes and initiatives as much as a year ahead, with targeted pre-education plans for subgroups • get “all” employees to attend meetings • engaging online tools, training modules and apps • online modeling tool is pre-populated with individuals’ claims history to aid in decisions • periodic push/pull updates • provide online, interactive total rewards “statements” including resources/tools for engagement

When implementing any of the approaches outlined in this report, a comprehensive communication plan will help reduce disruption and allow participants to see how their efforts can contribute to both savings and better quality of life through better health. Sharing and transparently communicating how savings can help lower health care contributions or at least “bend the cost trend line” to enable wiser use of that element within employees’ total compensation from the state, can help improve acceptance of health management programs. Most importantly, plan members need to understand the objective of continued access to quality care and needed pharmacological support, but at more reasonable cost to the plan and participants.

VIII. Appendix

Terms and Definitions

The terms and definitions below are provided for reference to the information contained in the strategy report.

Annual Maximum: Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Annual Out-of-Pocket Coinsurance Maximum: The maximum amount of coinsurance a PPO Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Non-coinsurance expenses such as copays, deductibles, hospital admission fees, non-covered services, charges in excess of the non-network allowance for services provided by non-network providers, and charges in excess of any Plan limitations do not apply to the annual out-of-pocket maximum.

Annual Out-of-Pocket Copay Maximum: The limit on the total copayments that you pay during a benefit year for covered services. You may be responsible for providing documentation to your HMO of the total copayment amount paid.

Capitated Reimbursement: A payment method for health care services. The physician, hospital, or other health care provider is paid a contracted rate for each member assigned, referred to as “per-member-per-month” rate, regardless of the number or nature of services provided. The contractual rates are usually adjusted for age, gender, illness, and regional differences.

Coinsurance: A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible. This includes prescription drug costs under a Health Investor Health Plan.

Consolidated Omnibus Reconciliation Act (COBRA): A federal law that allows an employee, or a dependent of an employee, who loses employer-sponsored health coverage to continue to be covered under the employer’s health plan for a certain time period and under certain conditions. The name results from the fact that the program was created under the Consolidated Omnibus Reconciliation Act.

Copayment: A set dollar amount you pay for network doctors’ office visits, emergency room services and prescription drugs.

Deductible: Total dollar amount, based on the allowed amount, you must pay out of pocket for covered medical expenses each calendar year before the State Employees’ Standard PPO Plan, the Health Investor PPO Plan or a Health Investor HMO plan pays for most services. The deductible does not apply to network preventive care and any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

Dependent Care Reimbursement Account (DCRA): A type of Flexible Spending Account for active employees that allows them to reimburse themselves with pretax dollars for eligible expenses they pay to take care of a qualified dependent.

Election: The choice for insurance benefits you make as a new hire, during Open Enrollment, or as the result of a Qualifying Status Change event.

VIII. Appendix

Terms and Definitions, continued

Employer Group Waiver Plan (EGWP): An EGWP is an employer-sponsored Medicare plan for either medical benefits or prescription drug benefits, or both, in which a Medicare eligible retiree would be enrolled instead of traditional Medicare. The “waiver” allows the plan to not comply with some Medicare requirements – the most significant being that the employer is allowed to limit enrollment in the EGWP to retirees of that employer.

Flexible Spending Account (FSA): An account for active employees that allows them to reimburse themselves with pretax dollars for eligible out-of-pocket health care costs and/or the costs associated with caring for a qualified dependent. With these accounts, employees decide the annual amount they want to contribute before the start of a plan year. They must submit claims for the plan year by April 15 of the following year for the entire amount withheld so they do not lose the unused money. FSAs include Dependent Care Reimbursement Accounts, Limited Purpose Medical Reimbursement Accounts and Medical Reimbursement Accounts.

Governmental Accounting Standards Board (GASB): GASB is an independent, private-sector, not-for-profit organization that establishes and improves standards of financial accounting and reporting for U.S. state and local governments. Governments and the accounting industry recognize the GASB as the official source of generally accepted accounting principles (GAAP) for state and local governments.

Grace Period: The period of time from January 1 until March 15 in which active employees can continue to incur eligible FSA expenses and claim them under the previous plan year’s election.

Health Investor HMO and PPO: The state’s name for two of its health insurance options where you pay a higher deductible in exchange for:

- Lower premiums than the State Employees’ Standard PPO or a Standard HMO.
- The opportunity to have a Health Savings Account to pay eligible health care expenses with pretax dollars, partially funded by the state (for active employees).

Health Maintenance Organization (HMO): A prepaid medical plan limited to restricted contracted service areas (where you live or work) and a specific network of providers.

Health Savings Account (HSA): An account associated with the Health Investor HMO and PPO Plans that allows active employees to use pretax dollars to pay their share of the cost for eligible medical, prescription, dental or vision care services not covered by their insurance plans. When employees are eligible for an HSA and have completed the appropriate steps, the state contributes money to their account; they may also add their own pretax contributions to the HSA. The HSA differs from an FSA in three ways:

- Employees must be in a Health Investor HMO or PPO plan to contribute to an HSA.
- They must open a personal HSA bank account at Tallahassee State Bank by completing the HSA bank account application.
- Any unused HSA funds at the end of a year carry forward to the next year and employees may take unused HSA balances with them if they stop working for the state.

VIII. Appendix

Terms and Definitions, continued

Limited Purpose Medical Reimbursement Account (LPMRA): A type of Flexible Spending Account that allows active employees to reimburse themselves for dental, vision and preventive care expenses not covered by their high-deductible health plan. They may also have an HSA.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Medical Reimbursement Account (MRA): A type of Flexible Spending Account that allows active employees to reimburse themselves with pretax dollars for eligible out-of-pocket health care costs. If they have an HSA, they cannot enroll in an MRA.

Patient Protection and Affordable Care Act (PPACA): As amended by the Health Care and Education Reconciliation Act (referred to collectively as PPACA), was enacted in March, 2010, and is the law that enacted federal health reform. It is more commonly known as “national health reform.”

Pre-Determination of Benefits (dental plan): A request you can submit to find out in advance how much the dental plan will pay for recommended dental care. This feature can be particularly useful in the PPO or indemnity dental plans because you pay a percentage of the cost. The process is not required but can help avoid surprises.

Preferred Provider Organization (PPO): A plan offering discounted rates on services if you use providers in the network. If you use providers outside of the network, your out-of-pocket expenses will be much greater.

Premium: The monthly or biweekly amount you pay for your insurance coverage.

Pretax Plan: A plan for active employees that is paid for with pretax money. The IRS allows for certain expenses to be paid for with tax-free dollars. The state takes premiums out of your check before taxes are calculated, increasing your spendable income and reducing the amount you owe in income taxes. Consequently, the IRS has tax laws that require you to stay in the plans you select for a full plan year (January through December). You can only make changes during Open Enrollment or if you have a Qualifying Status Change event.

Prepaid Plans: All plans in the State Group Insurance Program are prepaid, which means you pay for your coverage one month in advance; for example, you pay for July coverage in June. If you are underpaid for any reason, future premium payments are applied to the month that is underpaid.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Provider: Any type of health care professional or facility that provides services under your plan.

Provider Network: A group of health care providers, including dentists, physicians, hospitals and other health care providers, that agrees to accept pre-determined rates when serving members.

VIII. Appendix

Terms and Definitions, continued

Qualifying Status Change (QSC) Event: A specific event or change meeting federal guidelines that allows you to make changes to your benefit elections outside of the annual Open Enrollment period. A QSC event can be a change in employment status (e.g., beginning or terminating employment with a new employer), loss of insurance coverage, and certain personal status changes (e.g., marriage, having children or divorce).

Retiree Drug Subsidy (RDS): When prescription drug coverage was added to Medicare in 2006, Congress was concerned that employers would no longer provide employer-sponsored retiree prescription drug coverage to Medicare-eligible retirees. RDS payments are made to employers as financial incentives to continue to offer retiree programs that are at least as comprehensive as the Medicare program.

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March 24, 2011

**State of Florida
Benchmarking Report**

Prepared for Florida's Division of State Group Insurance



State of Florida Benchmarking Report

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I. Summary of Findings

Mercer National Survey of Employer-Sponsored Health Plans 2010

About the survey

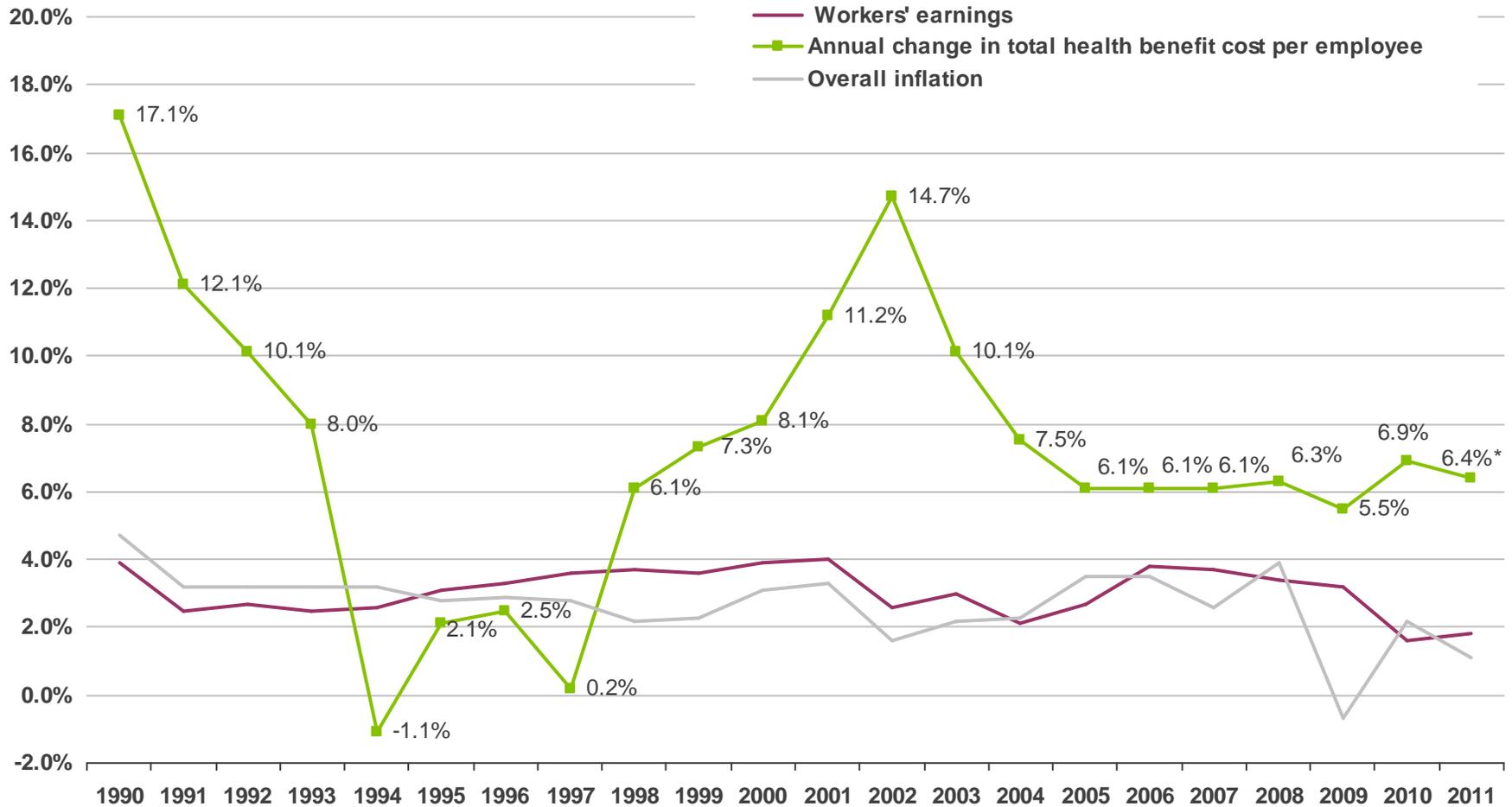
- Established in 1986, 25th anniversary of the survey; national probability sample used since 1993
- 2,833 employers participated in 2010
- All employers with 10 or more employees are surveyed using a stratified random sample; large employers are oversampled to permit robust break-outs by size
- In this presentation, we refer to:
 - **Large employers: 500+ employees (public and private)**
 - **States 500+: state government employers, 500+ employees**
 - **Florida 500+: all public and private employers in Florida, 500+ employees**
 - **National 500+: all public and private employers, 500+ employees**
- State of Florida values listed in this report reflect responses to the survey as of 2010; the State's data is also included in the States 500+, Florida 500+ and National 500+ analyses

Mercer National Survey of Employer-Sponsored Health Plans 2010

Key Findings

- After five years of cost increases averaging around 6%, growth in the average total health benefit cost per employee picked up steam in 2010, rising by nearly 7% -- three times faster than the CPI. Following a relatively low 5.5% increase in 2009, this was the biggest increase since 2004.
- Large employers experienced a sharper cost increase than smaller employers in 2010. Average health benefit cost per employee rose by 8.5% among employers with 500 or more employees, to exceed \$10,000 for the first time.
- Large employers may have been taken by surprise by the uptick in the cost increase in 2010. In our 2009 survey, they predicted that they could hold 2010 cost increases to just 5.6% on average, but actual cost increases for 2010 came in significantly higher.
- To hold down cost increases in 2010, employers continued to shift cost to employees through higher deductibles, copays, and other cost-sharing provisions. Over the past five years, among large employers the average total cost per employee and the average individual PPO deductible have each risen by about 35%.
- State governments (States 500+) reported a higher average age (46) among active employees than large employers in Florida and nationwide (42). Women account for just over half of employees for States (53%), Florida (55%), and large US employers (53%). The State of Florida reported an average age of 45 and that 53% of its employees were female.
- State governments report an average salary of \$44,536 compared to \$46,011 and \$51,215 for Florida and large US employers, respectively. The State of Florida reported an average salary of \$38,517 when responding to the survey.

Total health benefit cost per employee rises 6.9% in 2010, the sharpest increase since 2004



*Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2010; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2010.

Total health benefit cost for active employees up 8.5% in 2010

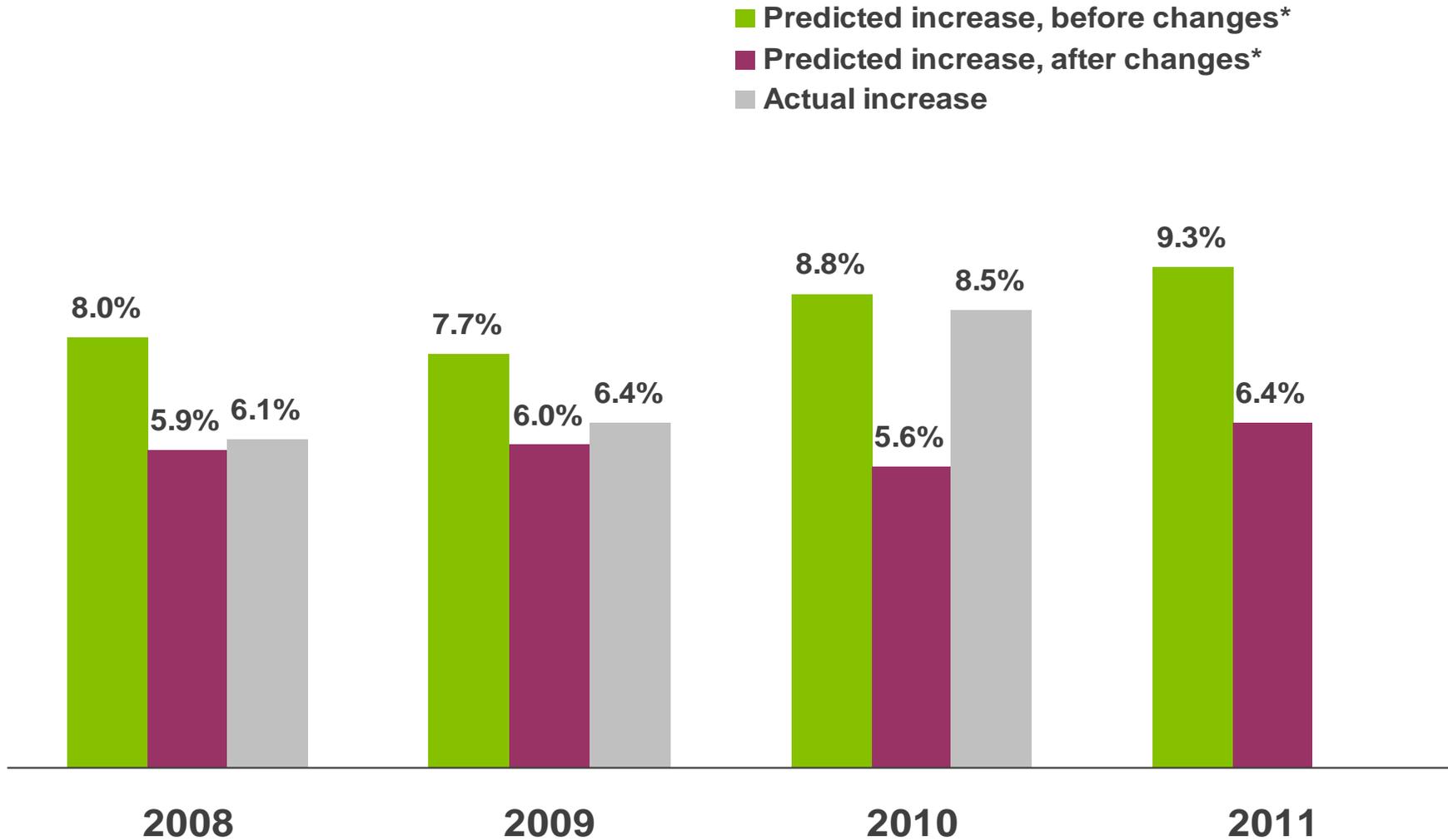
Large employers



*Average increase projected for 2011 after changes; increase of 9.3% predicted before changes

While the underlying health benefit cost trend is rising, employers will work to keep 2011 increases to about the same level as past years

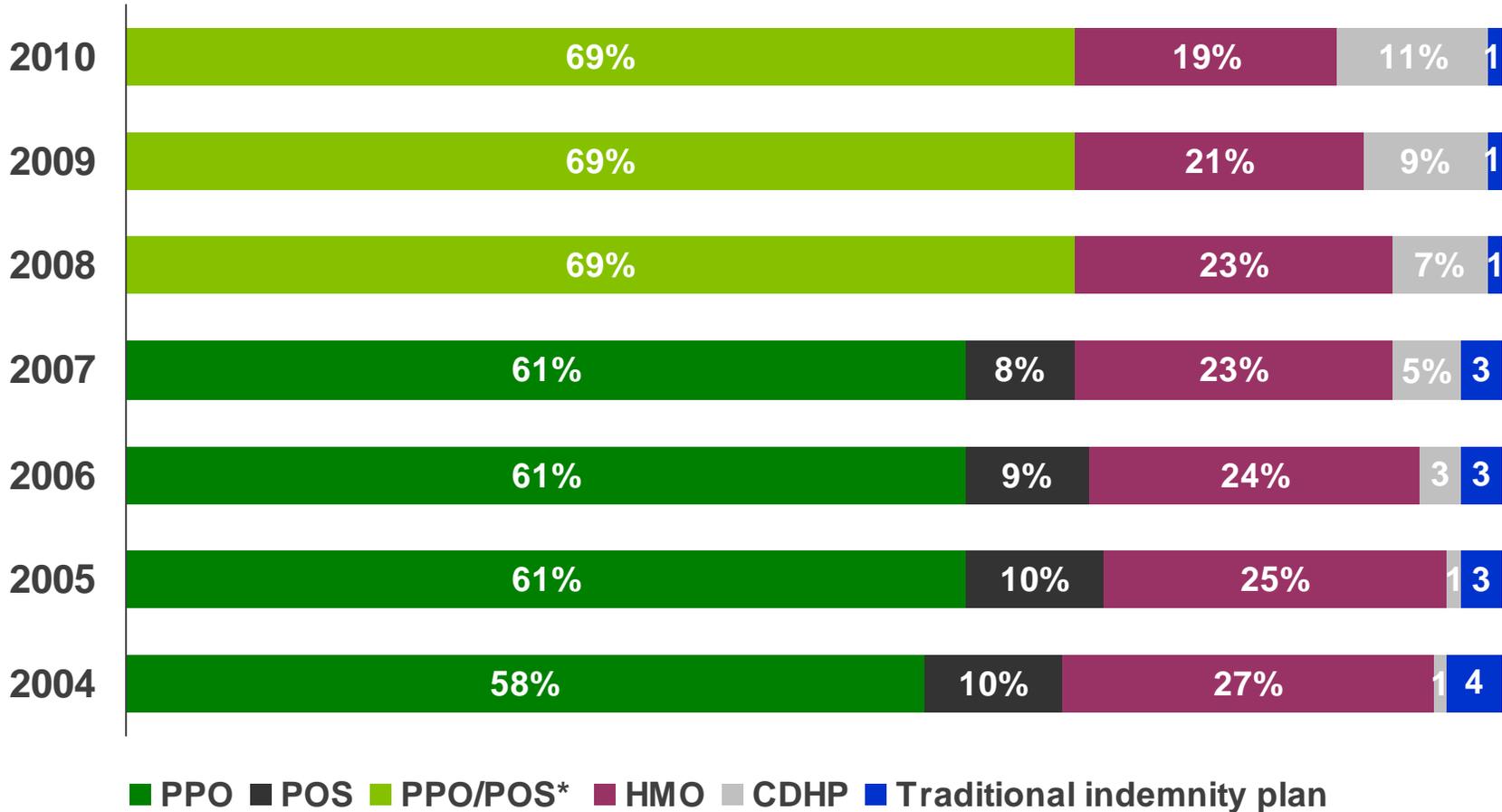
Large employers



*to plan design or health plan vendor

Enrollment in CDHPs continues to rise as HMOs lose ground

Percentage of all covered employees enrolled in each plan type

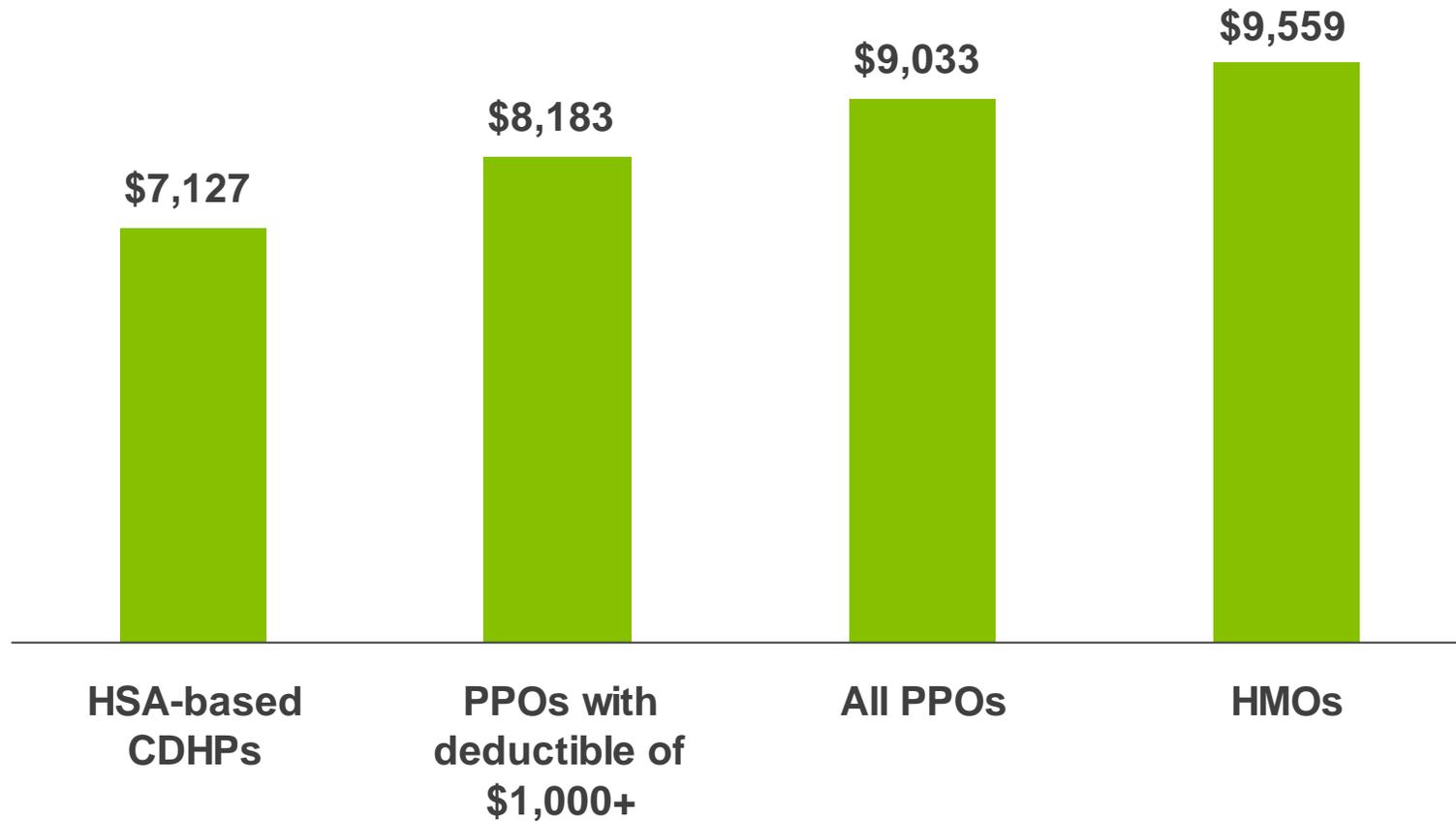


*Combined in 2008 due to declining offerings of/enrollment in POS plans.



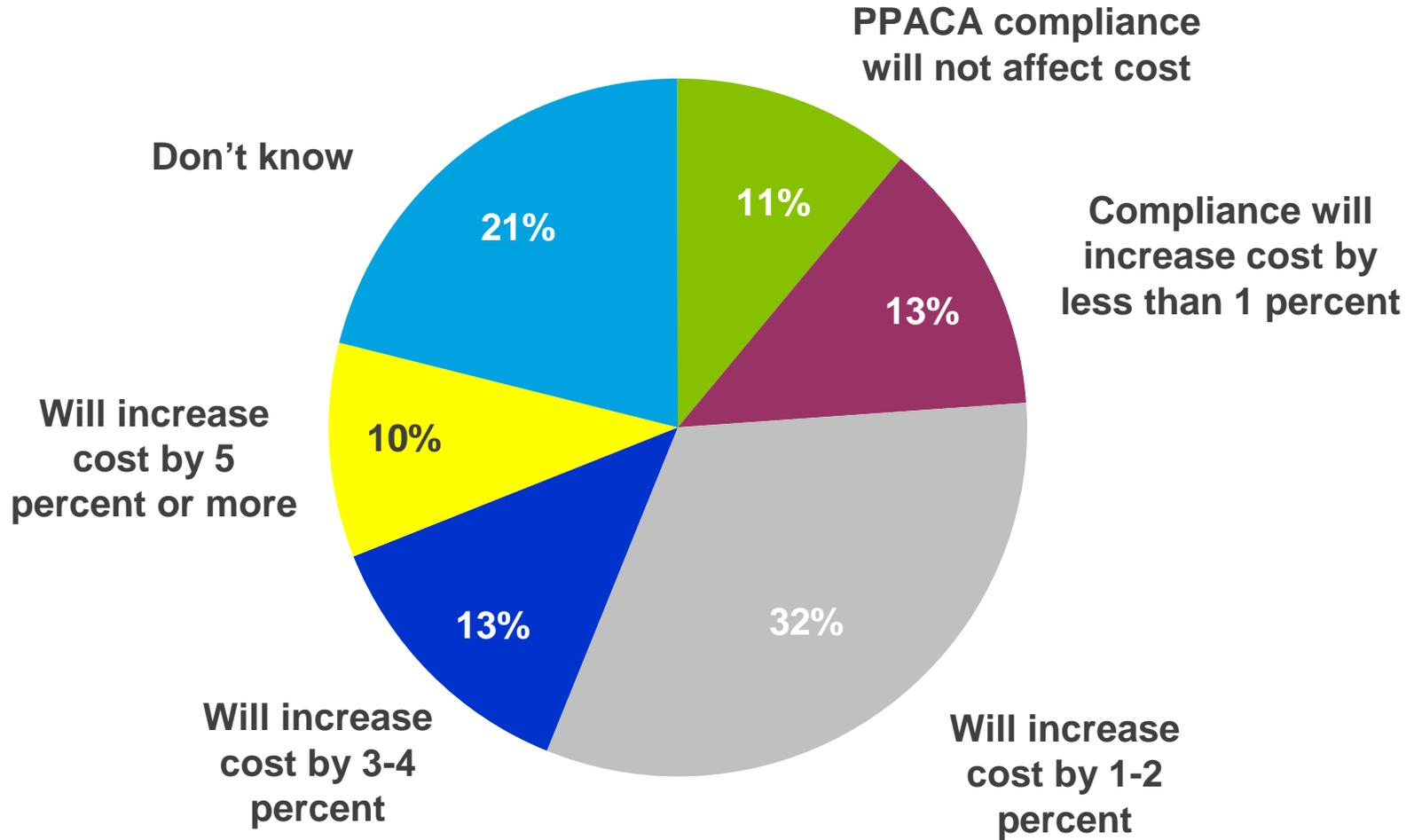
Coverage in an HSA costs significantly less than coverage in HMOs or PPOs – even high-deductible PPOs

Average cost per employee among large employers



2011 PPACA requirements will affect some employers more than others

Estimated increase in spending in 2011 among large employers due solely to complying with PPACA requirements





II. Employee Contributions

2010 State of Florida Employee Contribution Rates

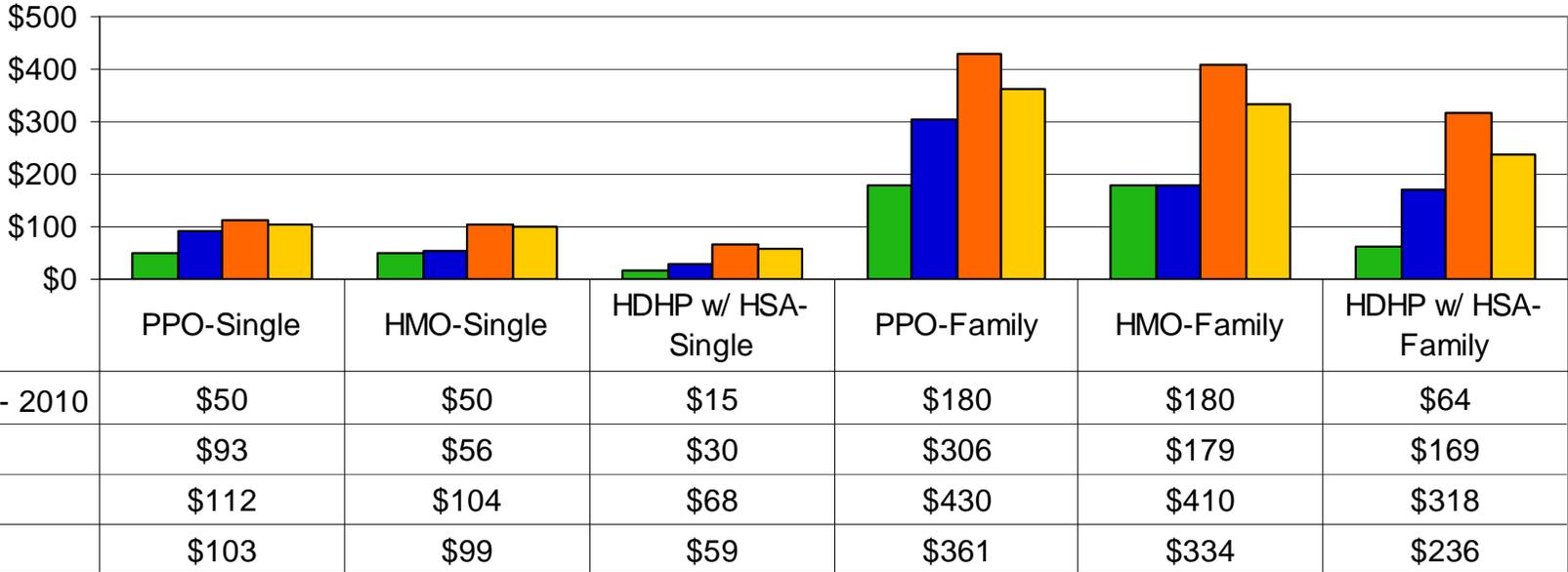
Subscriber Category/ Contribution Cycle		Coverage Type	PPO/HMO Standard			PPO/HMO HIHP		
			Employer	Enrollee	Total	Employer	Enrollee	Total
Career Service	Monthly Full-Time Employees	Single	\$473.62	\$50.00	\$523.62	\$473.62	\$15.00	\$488.62
		Family	\$1,004.14	\$180.00	\$1,184.14	\$1,004.14	\$64.30	\$1,068.44
		Spouse	\$1,154.16	\$30.00	\$1,184.16	\$1,038.44	\$30.00	\$1,068.44
	Bi-Weekly Full-Time Employees	Single	\$236.81	\$25.00	\$261.81	\$236.81	\$7.50	\$244.31
		Family	\$502.07	\$90.00	\$592.07	\$502.07	\$32.15	\$534.22
		Spouse	\$577.08	\$15.00	\$592.08	\$519.22	\$15.00	\$534.22
"Payalls"	Monthly Full-Time Employees	Single	\$515.30	\$8.34	\$523.64	\$480.28	\$8.34	\$488.62
		Family	\$1,154.14	\$30.00	\$1,184.14	\$1,038.44	\$30.00	\$1,068.44
	Bi-Weekly Full-Time Employees	Single	\$257.65	\$4.17	\$261.82	\$240.14	\$4.17	\$244.31
		Family	\$577.07	\$15.00	\$592.07	\$519.22	\$15.00	\$534.22
COBRA	Monthly	Single	\$0.00	\$534.09	\$534.09	\$0.00	\$455.90	\$455.90
		Family	\$0.00	\$1,207.82	\$1,207.82	\$0.00	\$1,004.81	\$1,004.81
Early Retirees	Monthly	Single	\$0.00	\$523.62	\$523.62	\$0.00	\$446.96	\$446.96
		Family	\$0.00	\$1,184.14	\$1,184.14	\$0.00	\$985.11	\$985.11
Medicare	Monthly	(I) One Eligible	\$0.00	\$278.02	\$278.02	\$0.00	\$209.56	\$209.56
		(II) One Under/Over	\$0.00	\$801.64	\$801.64	\$0.00	\$656.52	\$656.52
		(III) Both Eligible	\$0.00	\$556.04	\$556.04	\$0.00	\$419.12	\$419.12
Overage Dependents		Single	\$0.00	\$523.62	\$523.62	\$0.00	\$446.96	\$446.96

Source: State Employees' Group Health Self-Insurance Trust Fund Premium Rate Table, effective July 2010 for August 2010 Coverage

2010 Contribution Benchmarks vs. 2010 Plan

Monthly employee contribution (dollars)

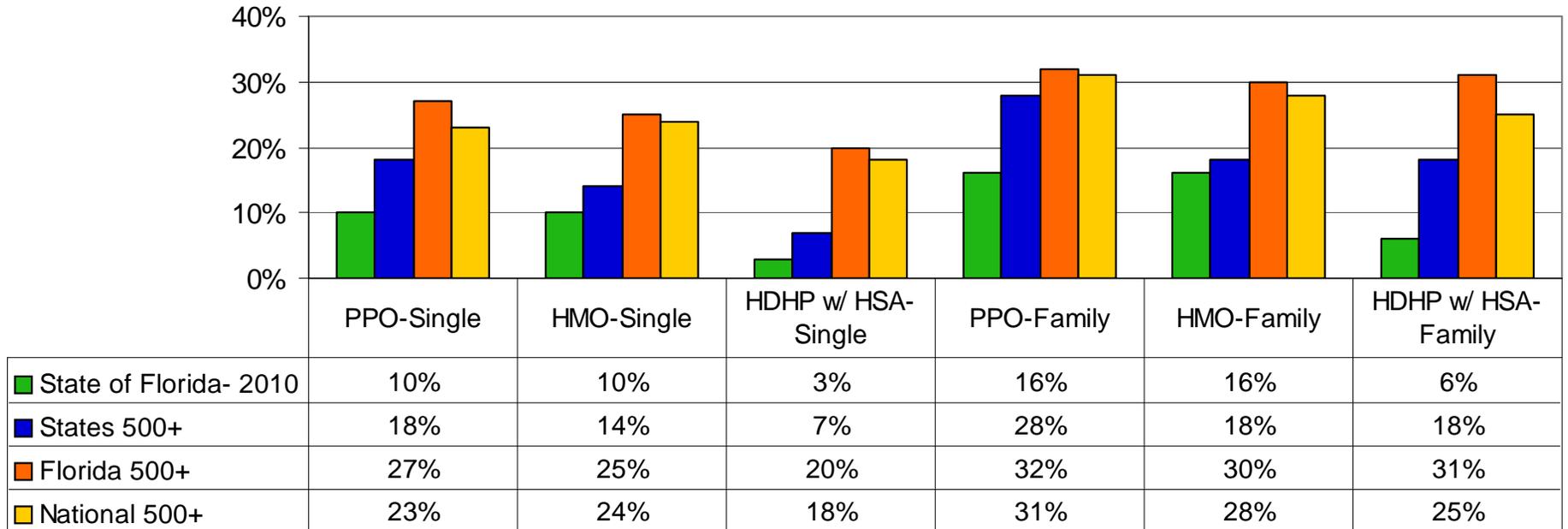
Employee Contribution Benchmarks



2010 Contribution Benchmarks vs. 2010 Plan

Monthly employee contribution (as a percentage of premium)

Employee Contribution Benchmarks



III. PPO Benchmarking

Offer PPO*, by region; percent of employees enrolled

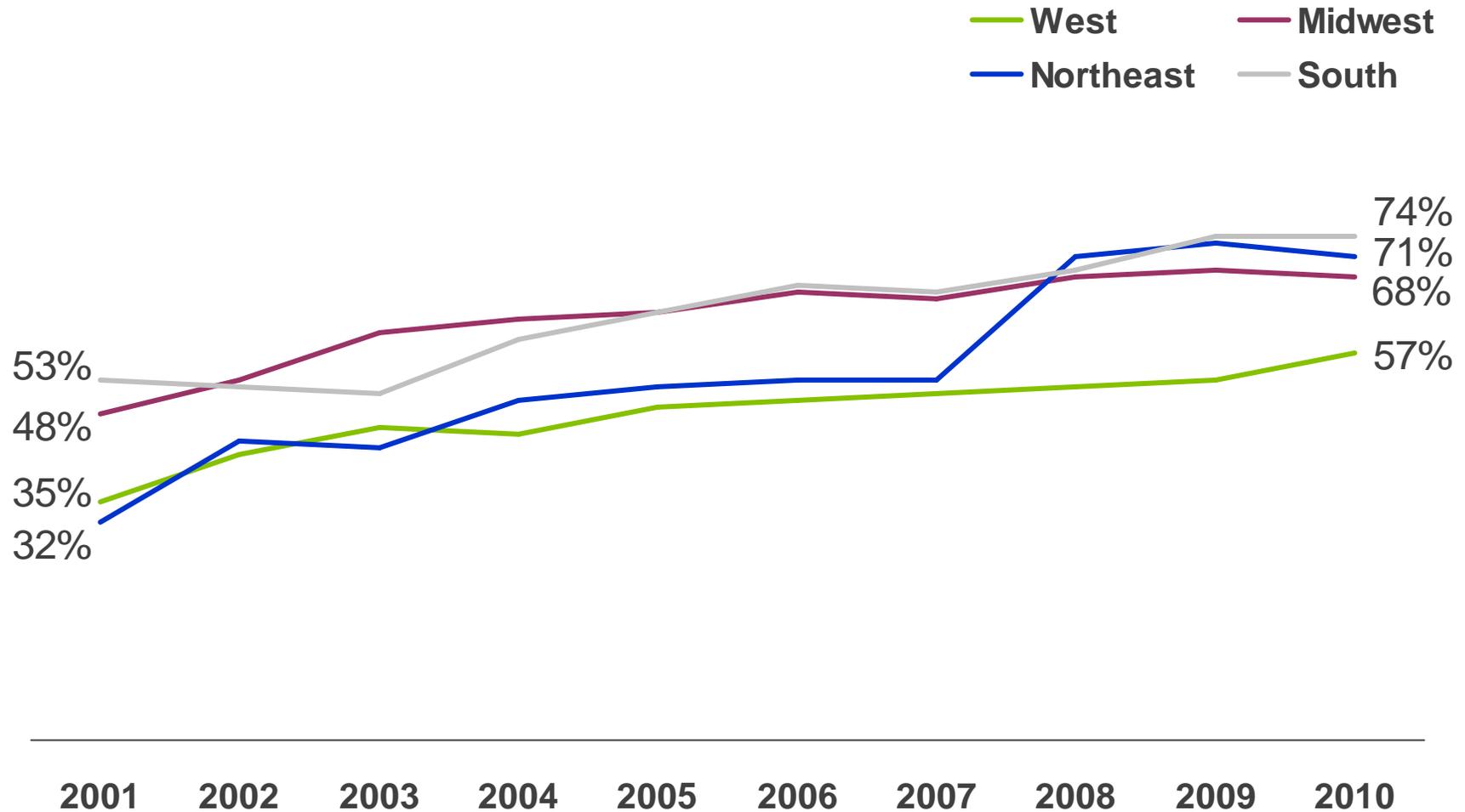
Large employers



*Includes Point-of-Service Plans.

PPO* enrollment 2001-2010, by region

Percent of covered employees enrolled, among large employers



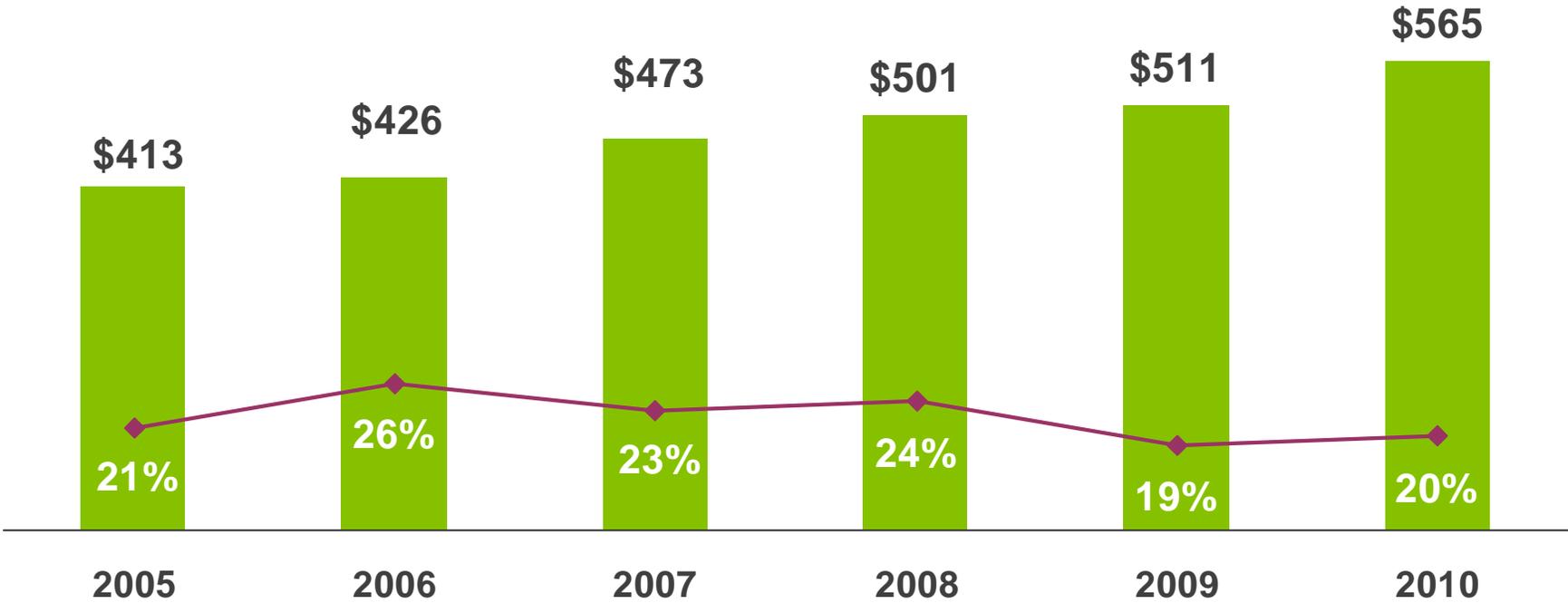
* Results for 2001 - 2007 include PPO plans only. Results beginning in 2008 include PPO and POS plans



Deductibles have risen at about the same rate as health benefit cost over the past five years

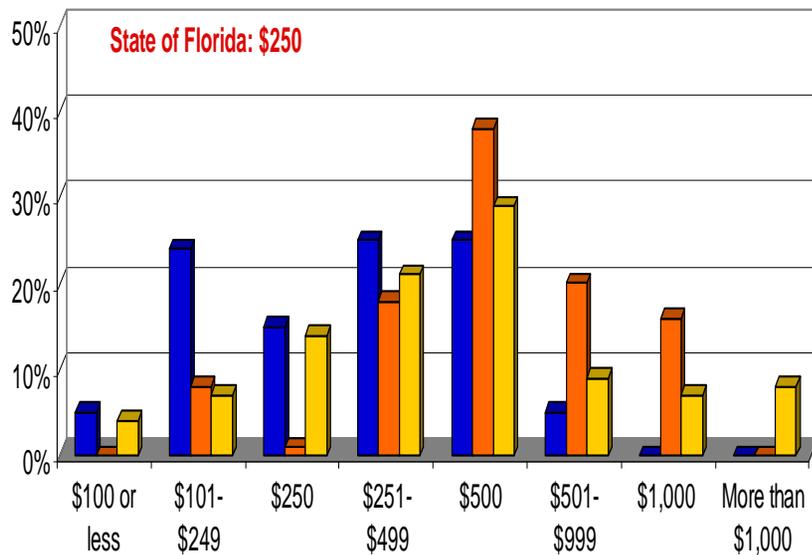
Average PPO deductible for individual, in-network coverage, among large employers

■ Average deductible among PPO sponsors requiring a deductible
◆ Percent of PPO sponsors requiring no deductible

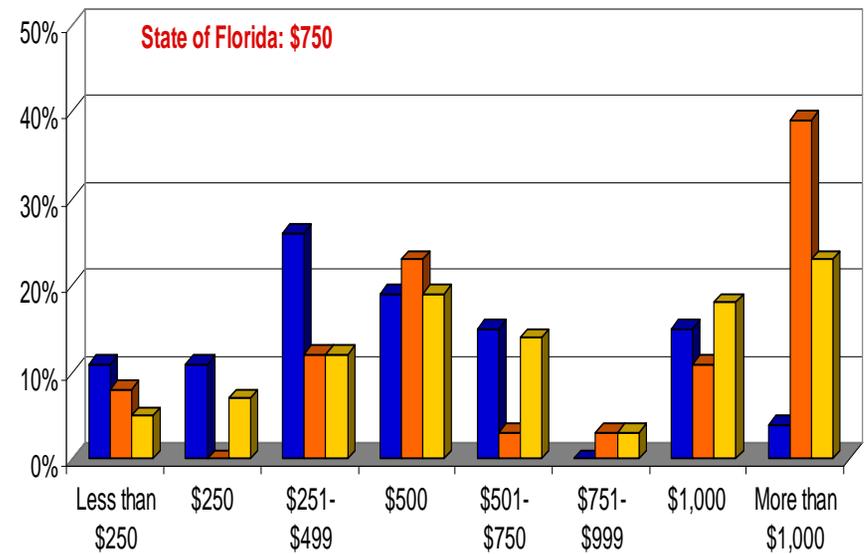


2010 PPO Benchmarks vs. 2010 Plan Individual Deductible

In Network Deductible

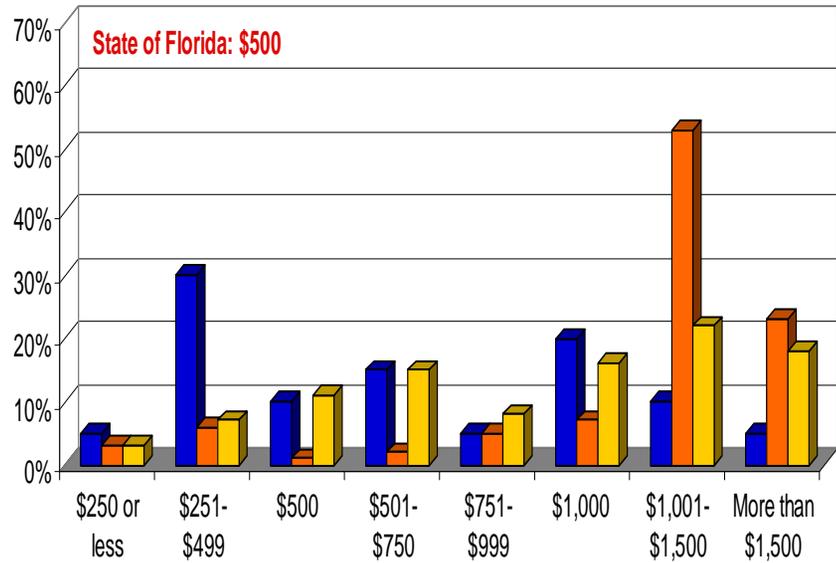


Out of Network Deductible

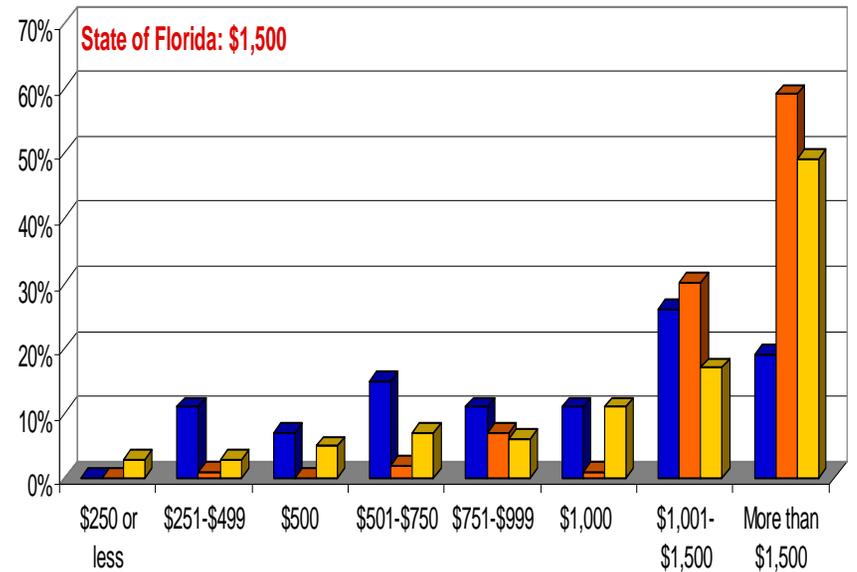


2010 PPO Benchmarks vs. 2010 Plan Family Deductible

In Network Deductible

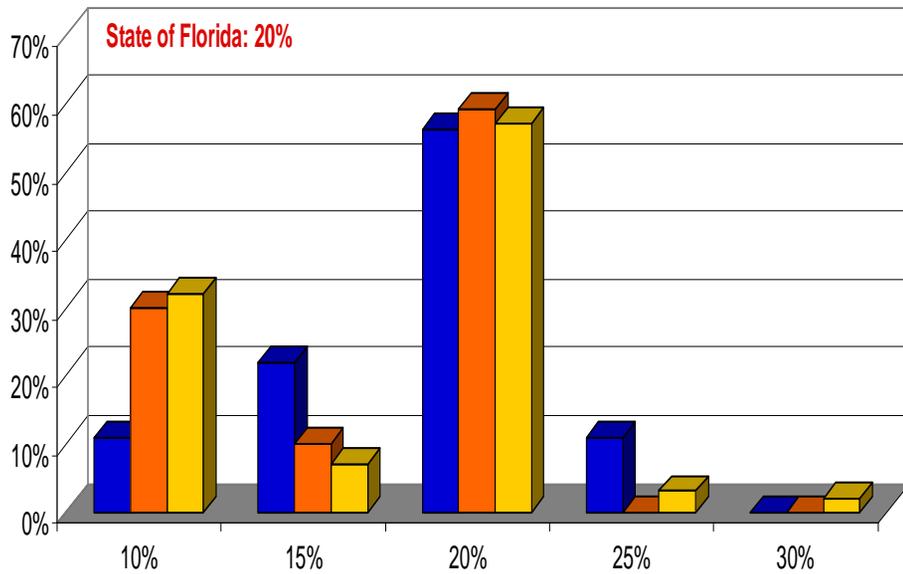


Out of Network Deductible

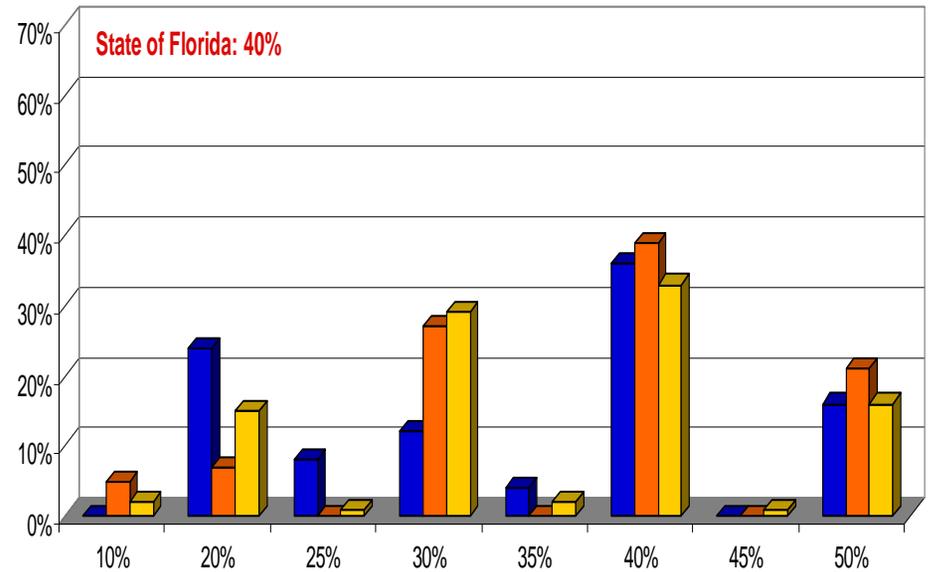


2010 PPO Benchmarks vs. 2010 Plan Participant Coinsurance

In Network Coinsurance



Out of Network Coinsurance

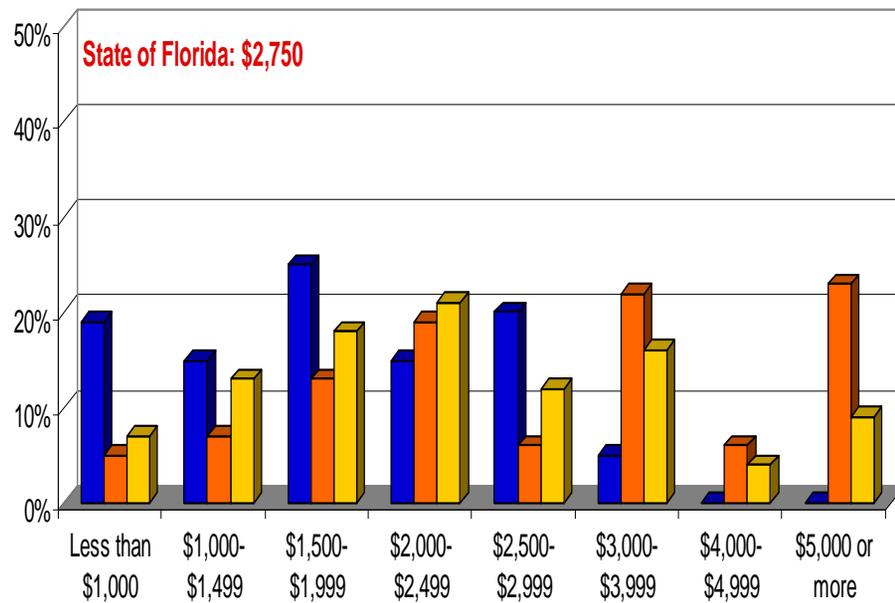


- States 500+
- Florida 500+
- National 500+

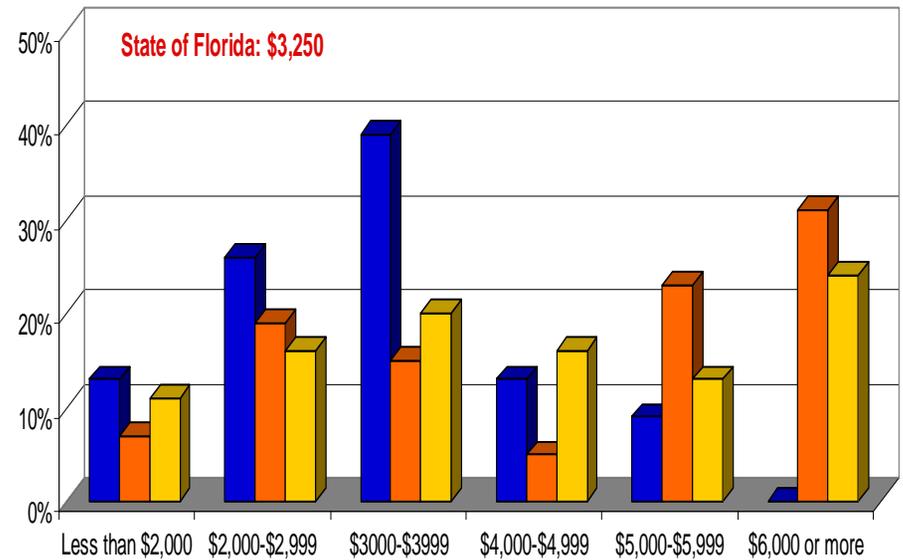
2010 PPO Benchmarks vs. 2010 Plan

Individual Out of Pocket Maximum (OOP), including deductible

In Network OOP



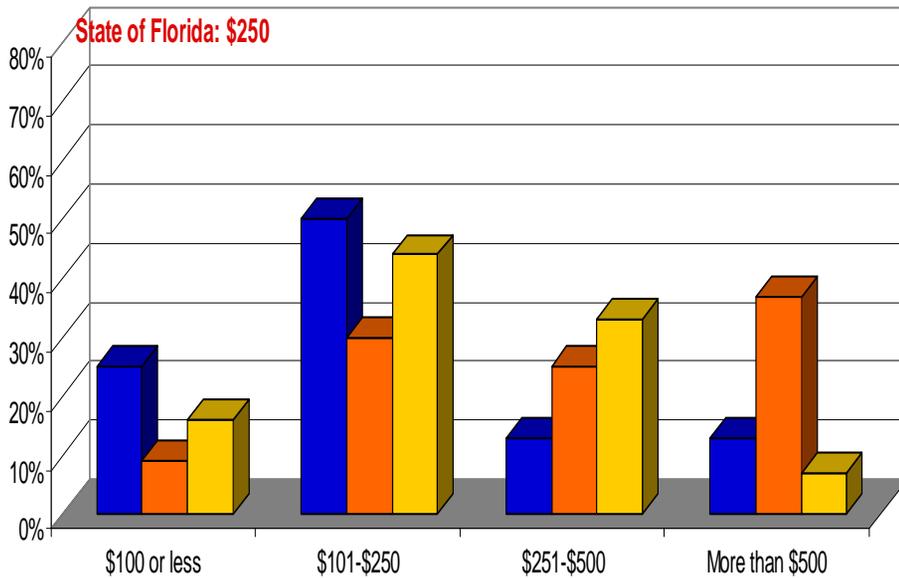
Out of Network OOP



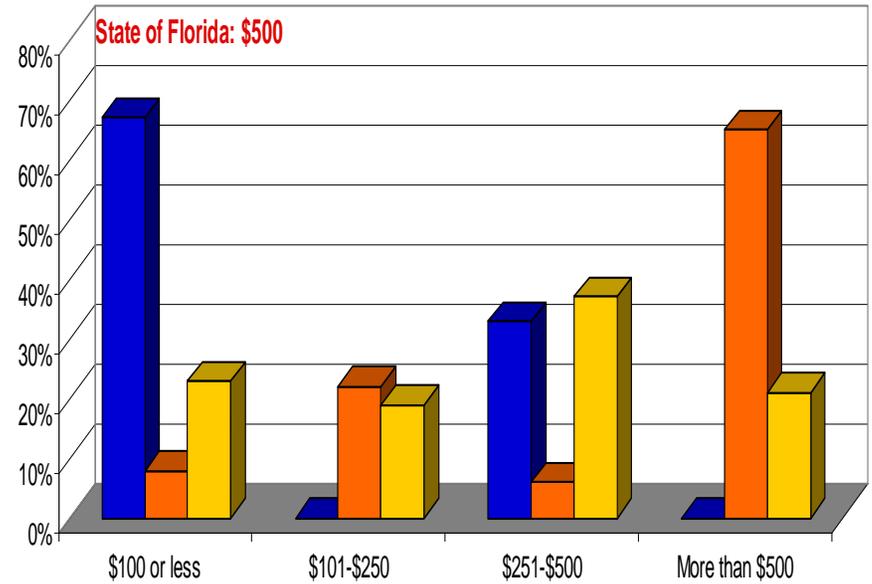
- States 500+
- Florida 500+
- National 500+

2010 PPO Benchmarks vs. 2010 Plan Inpatient/Hospital Copayment

In Network Copay



Out of Network Copay

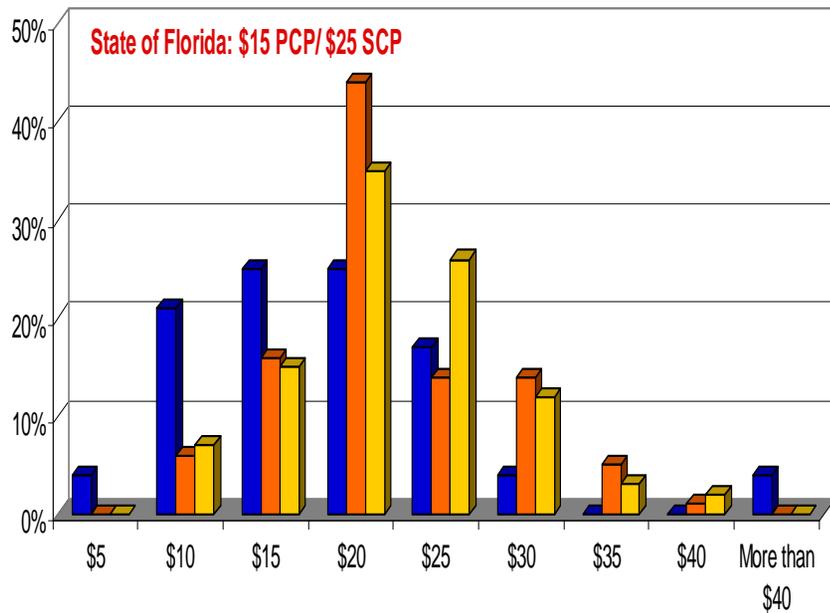


- States 500+
- Florida 500+
- National 500+

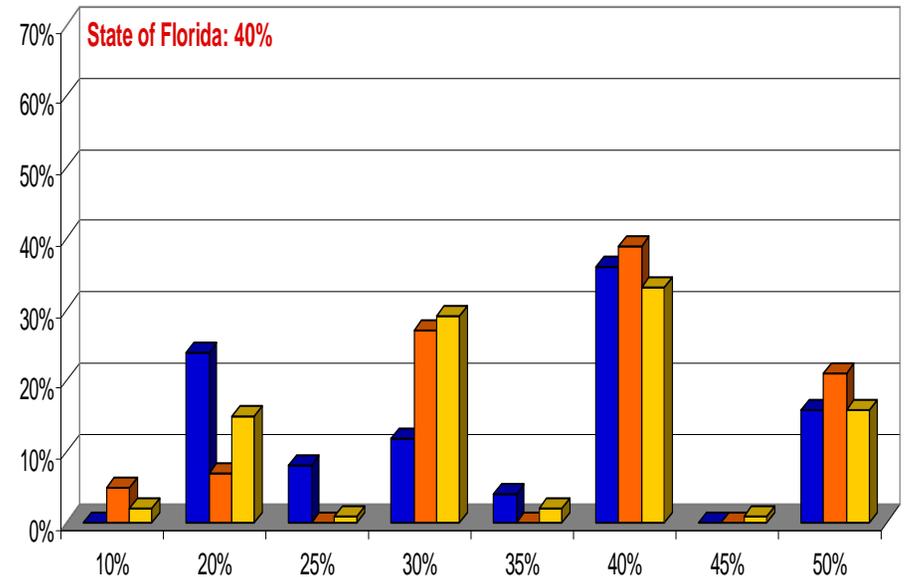
2010 PPO Benchmarks vs. 2010 Plan

PCP Office Visit Copay and Coinsurance

PCP In Network Copay



Out of Network Coinsurance



- States 500+
- Florida 500+
- National 500+

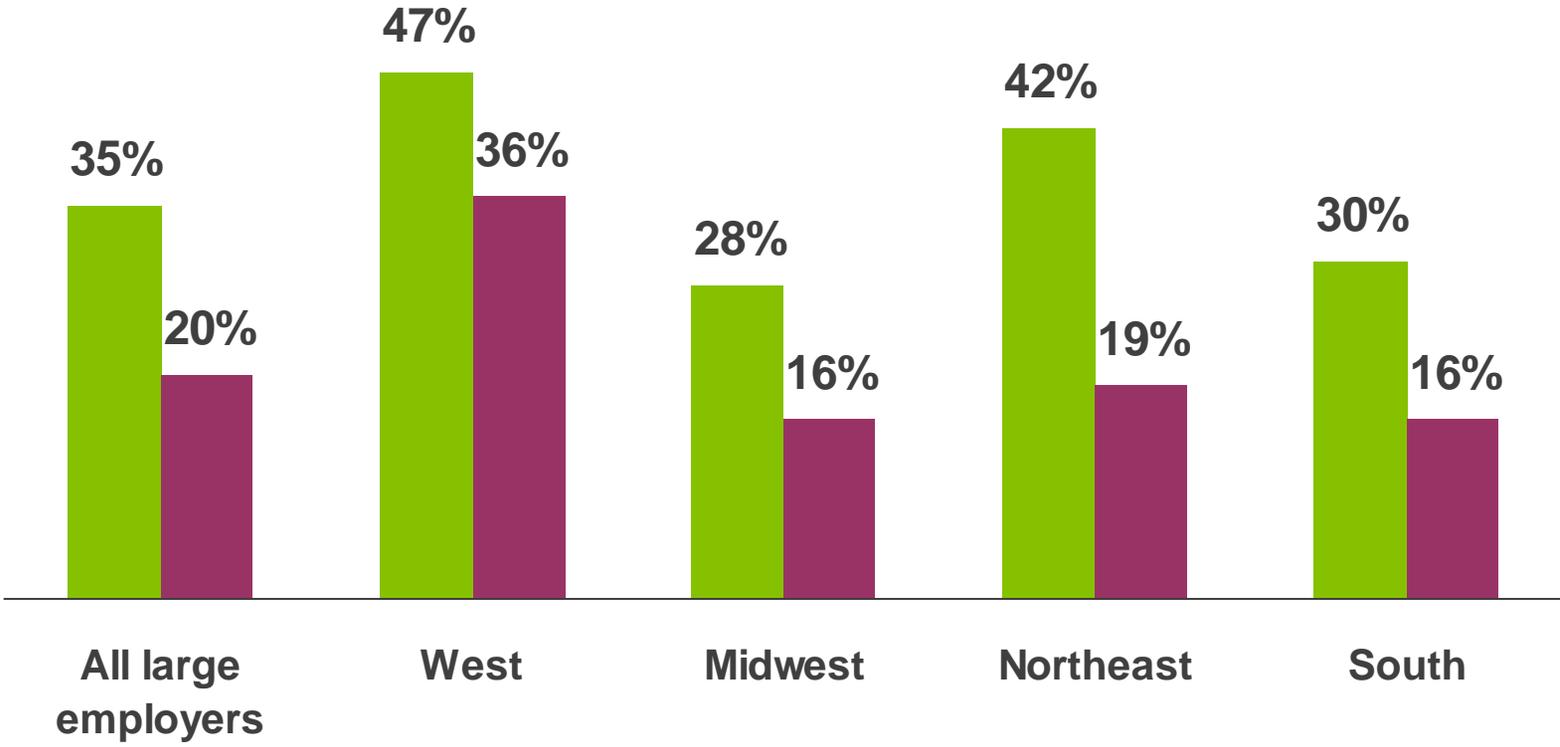


IV.HMO Benchmarking

Offer HMO by region; percent of employees enrolled

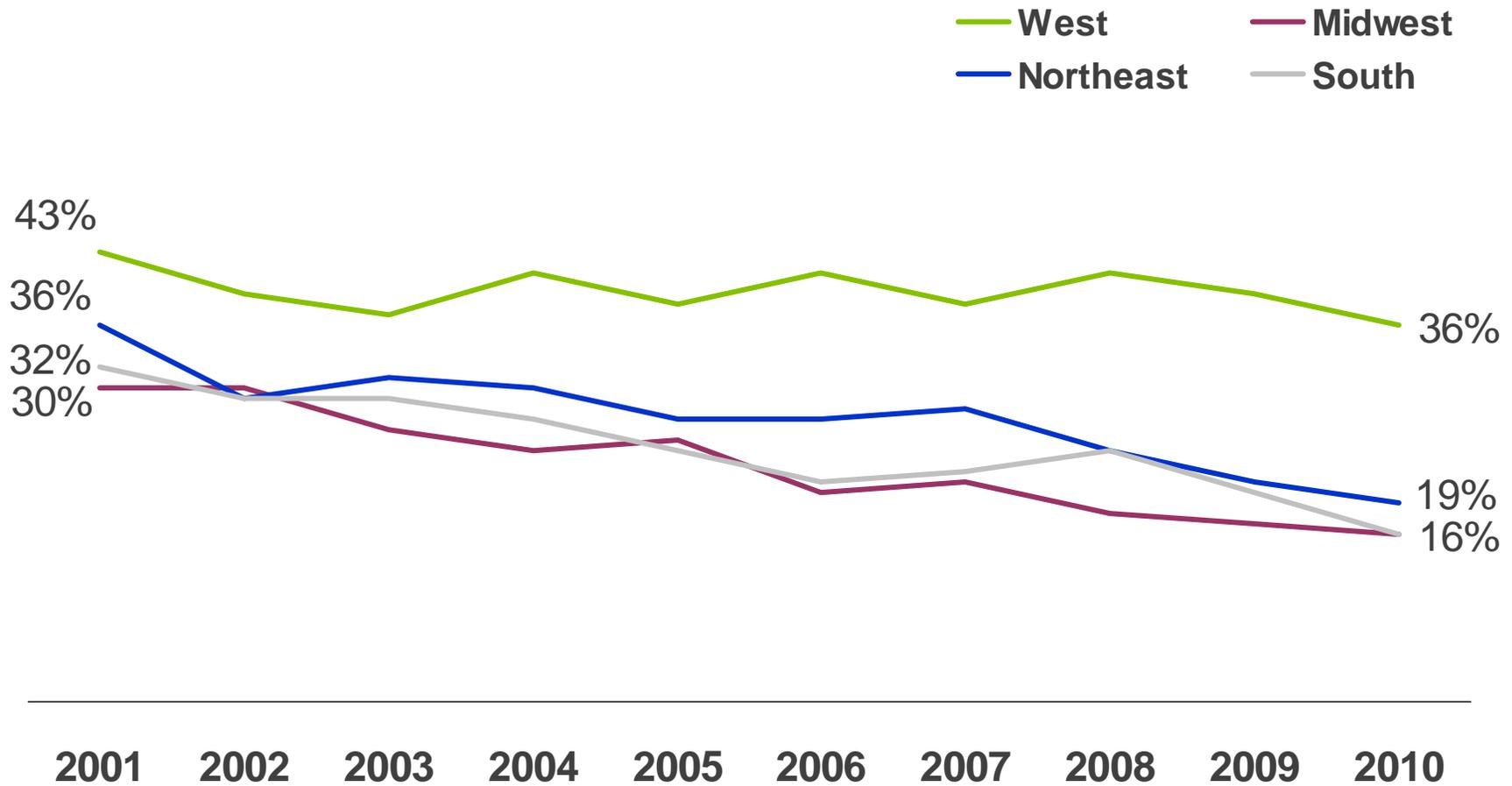
Large employers

■ Percent of employers offering plan
■ Percent of employees enrolled



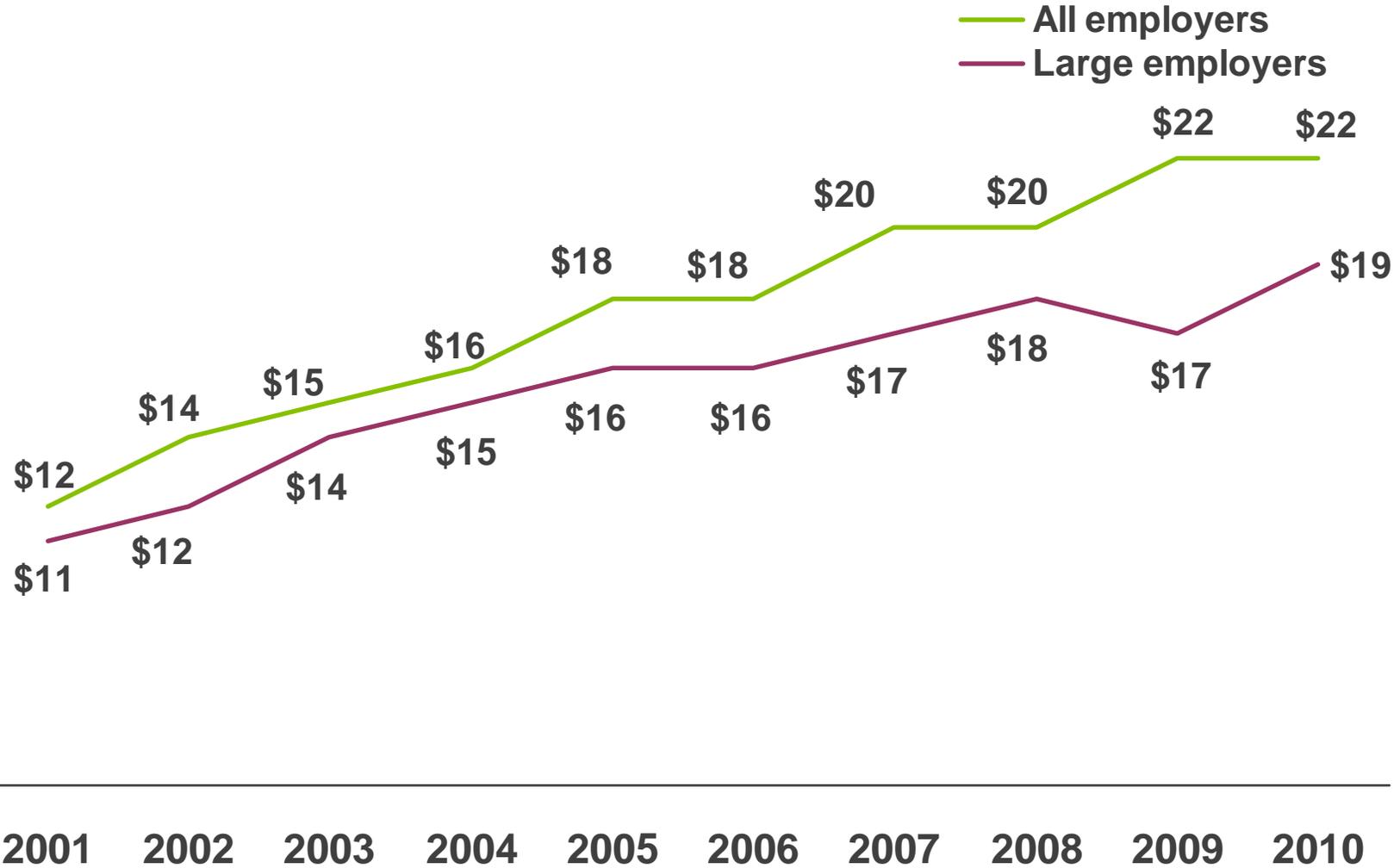
HMO enrollment 2001-2010, by region

Percent of covered employees enrolled, among large employers



HMO copay amounts have risen steadily

Average copay for physician visits

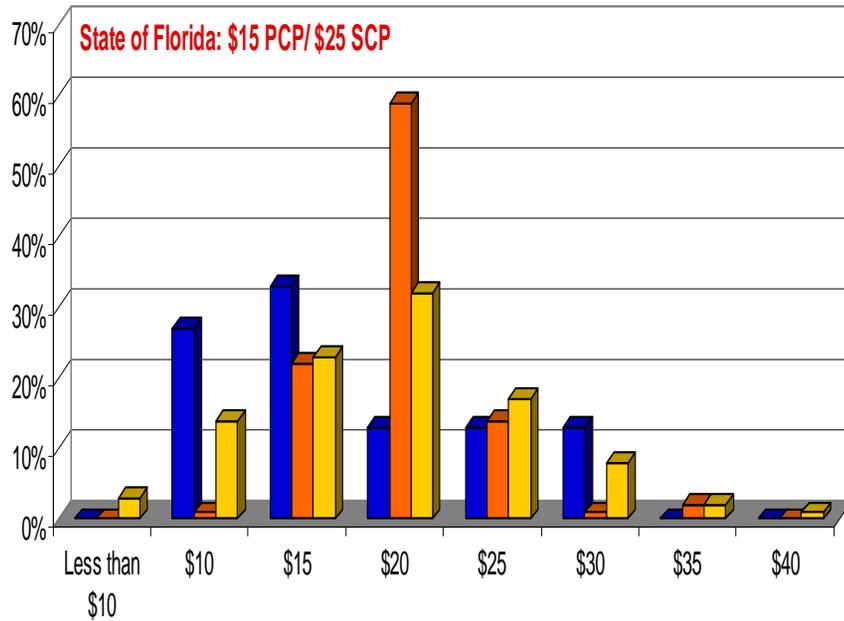




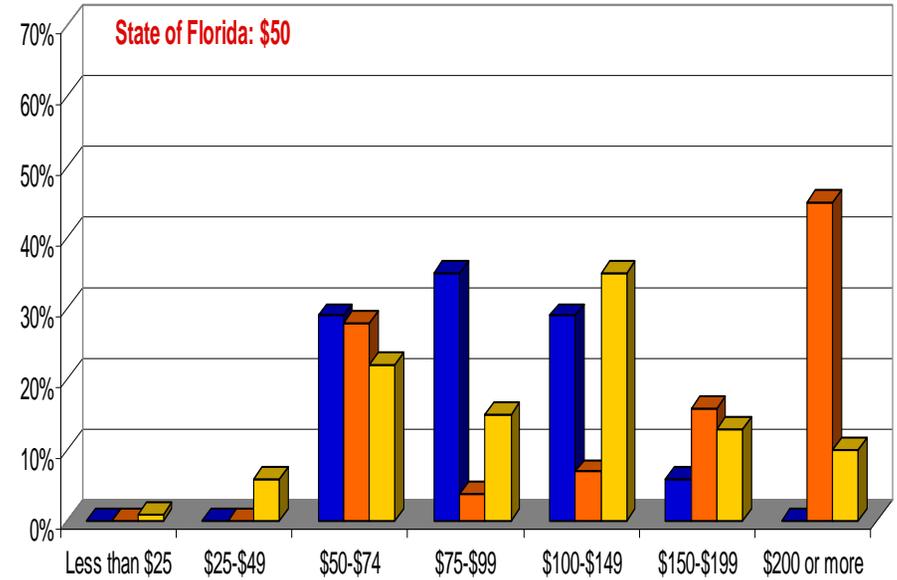
2010 HMO Benchmarks vs. 2010 Plan

PCP Office Visit and Emergency Room Copays

In Network PCP Office Visit Copay



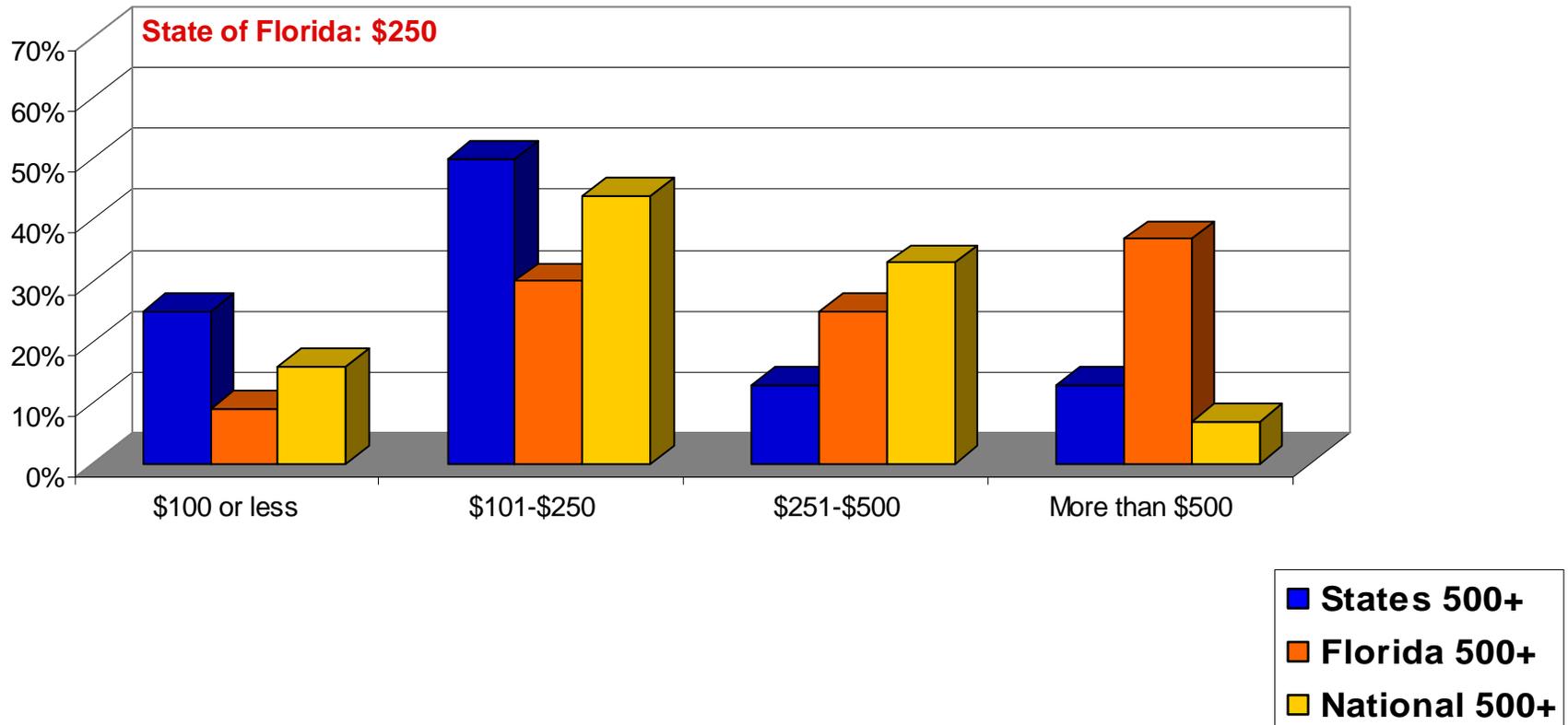
In Network Emergency Room Copay



- States 500+
- Florida 500+
- National 500+

2010 HMO Benchmarks vs. 2010 Plan Inpatient/Hospital Copay

In Network Hospital Copay



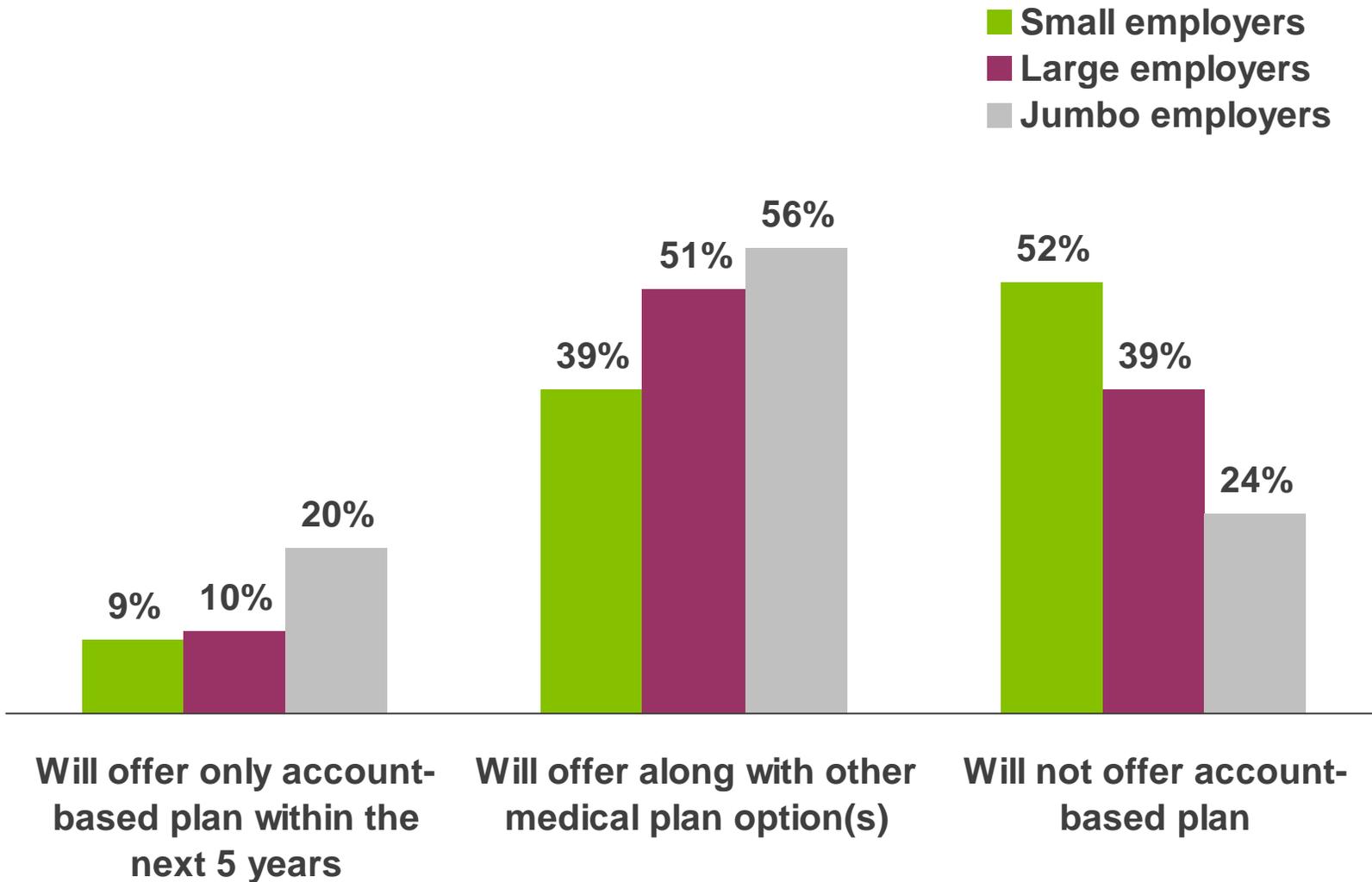
V. CDHP Benchmarking

With more than half of the nation's largest employers now offering a CDHP, enrollment is climbing

	CDHP* offered in:			Percent of employees enrolled:		
	2008	2009	2010	2008	2009	2010
Small employers (10-499 employees)	9%	15%	16%	6%	10%	12%
All large employers (500 or more employees)	20%	20%	23%	7%	8%	10%
Jumbo employers (20,000 or more employees)	45%	43%	51%	8%	9%	15%

*Based on either a health savings account or health reimbursement arrangement.

Majority of large employers expect to offer an account-based plan near-term, but not as the only plan



Objectives for HSA-eligible CDHPs

Percent of large HSA sponsors rating objective “very important”

Lower organization’s benefit cost



Promote health care consumerism



Improve package of benefit offerings; add choice



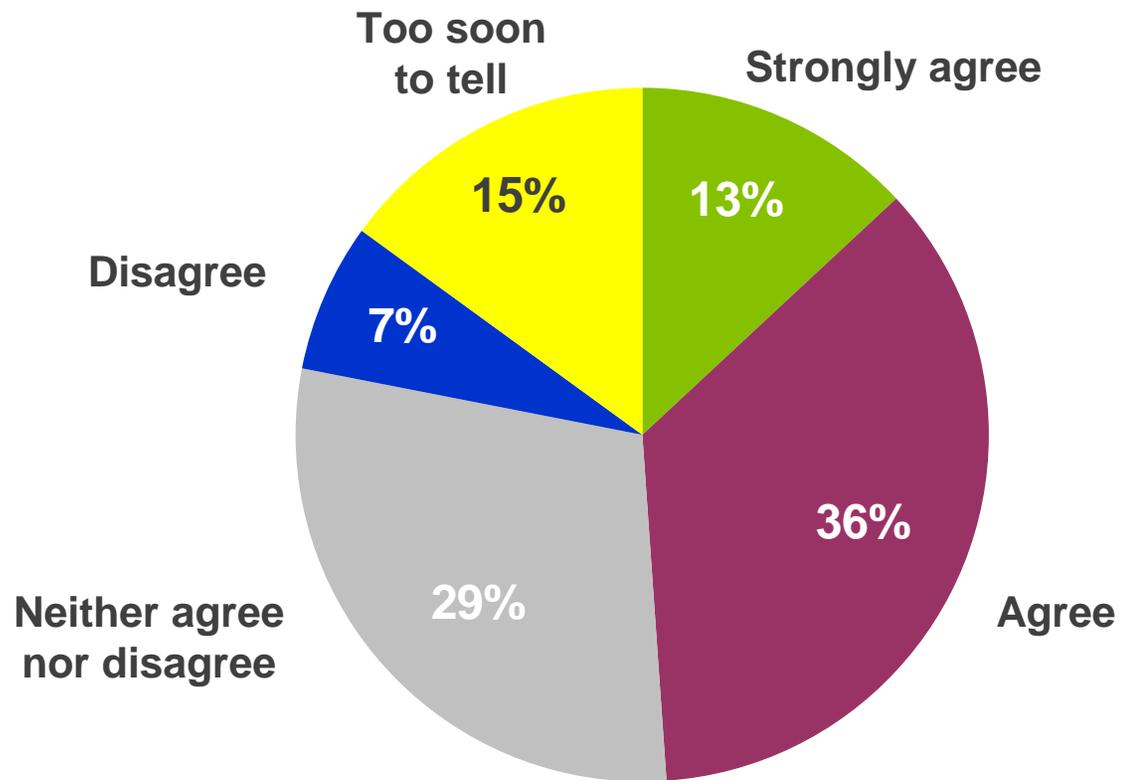
Provide tax effective savings vehicle



Provide funding vehicle for retiree medical

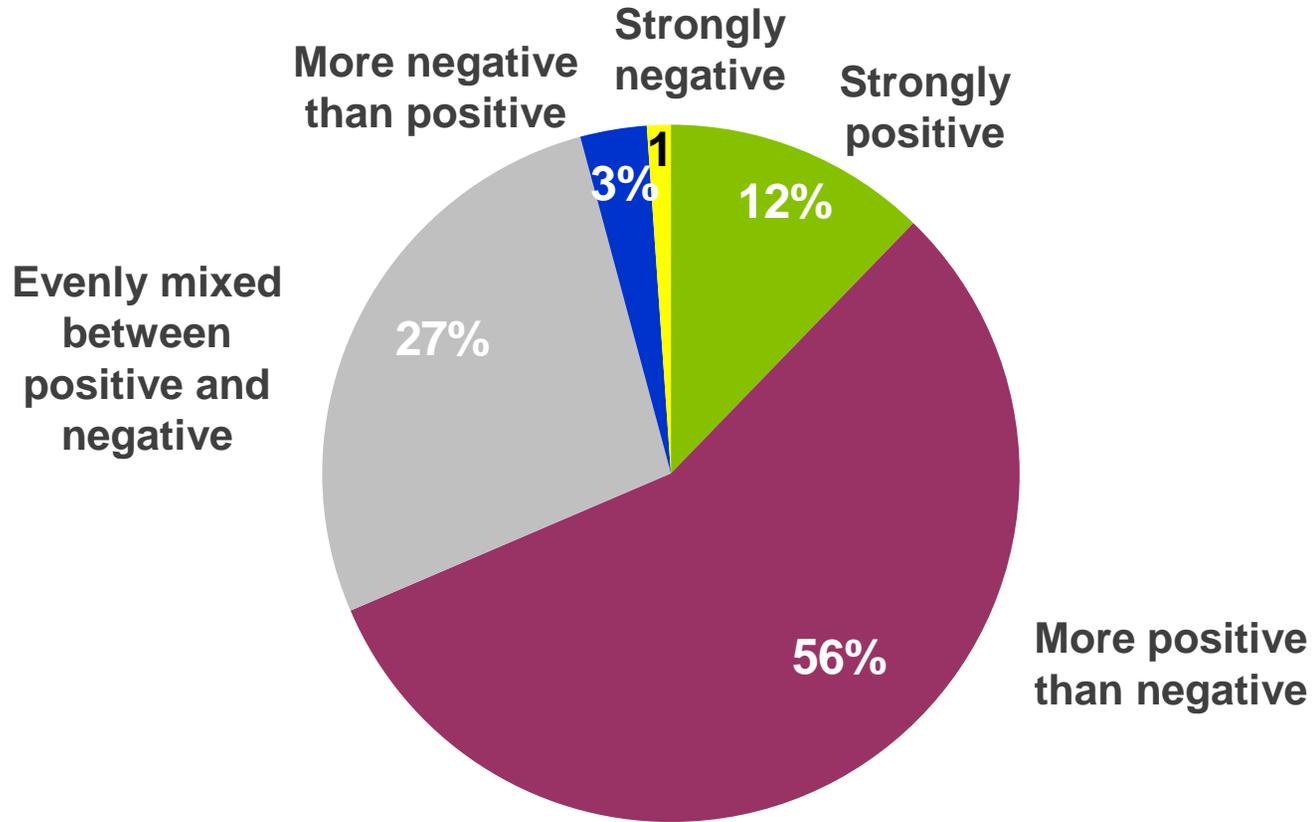


Employer reaction to HSA-eligible plan: “Most important objectives have been met”
Large HSA sponsors



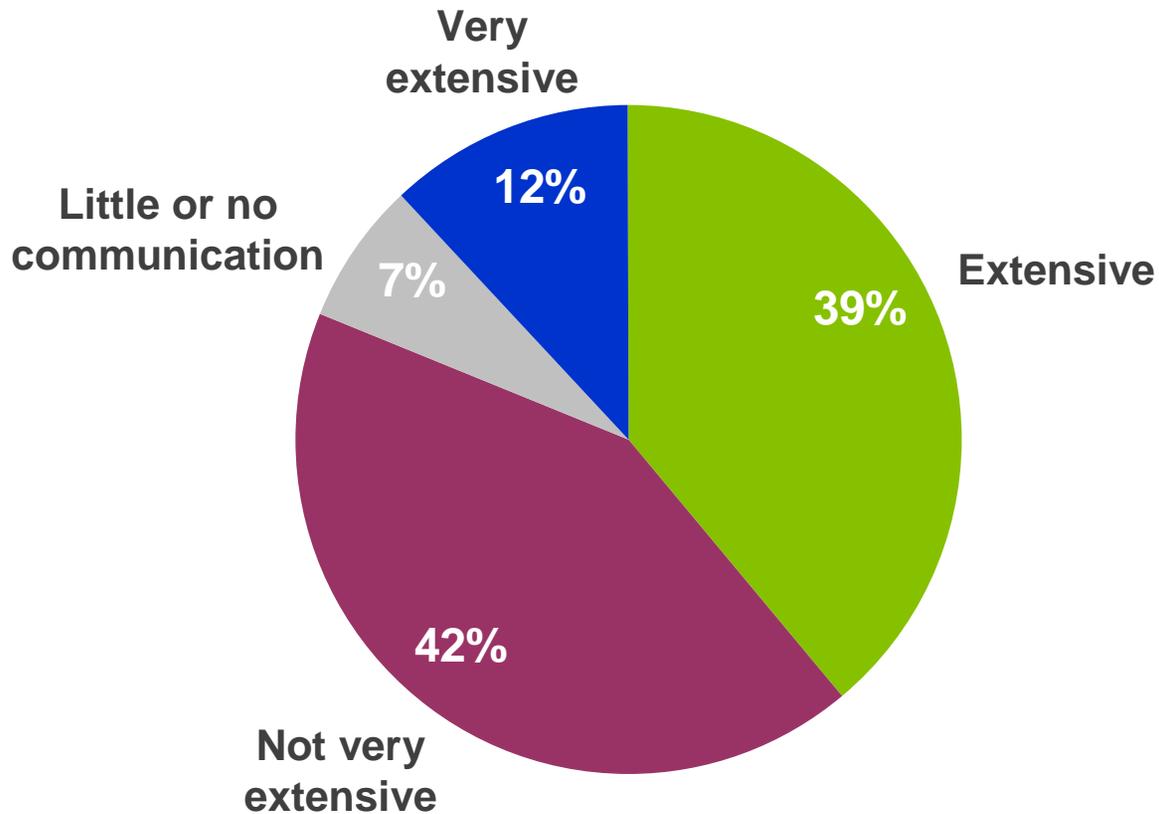
Employee reaction to HSA-eligible CDHP

Large HSA sponsors characterize the response of HSA enrollees to the plan



Level of communication efforts aimed at promoting consumerism or health-conscious behavior in HSA enrollees

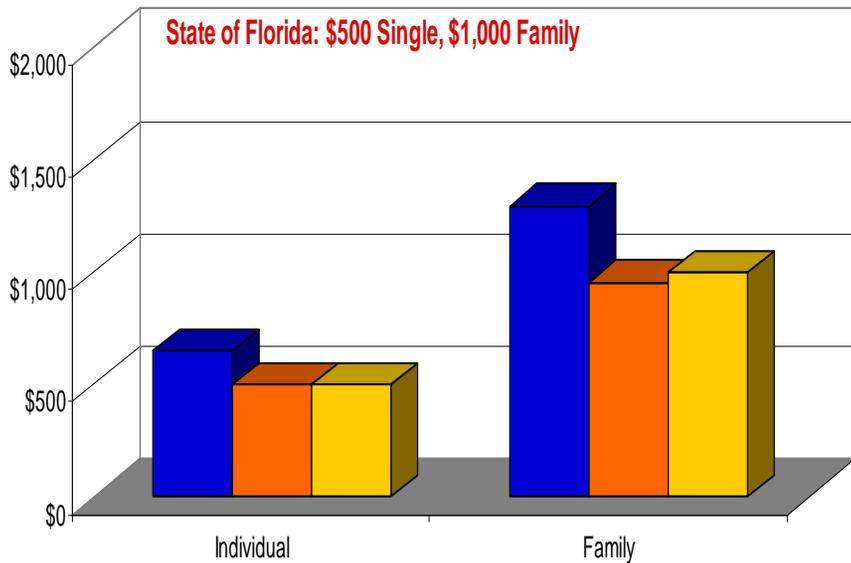
Large HSA sponsors



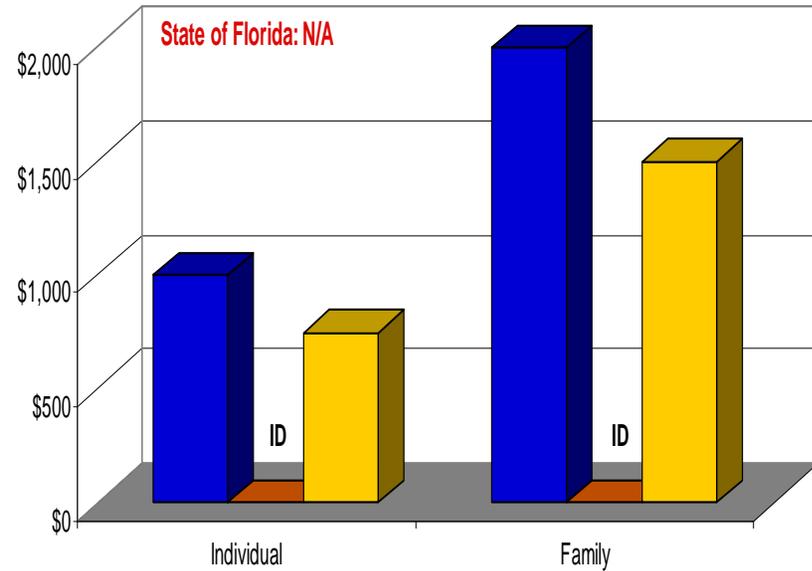
2010 CDHP Benchmarks vs. 2010 Plan

Median Employer Contribution to HSA or HRA

Health Savings Account (HSA)



Health Reimbursement Account (HRA)



“ID” indicates Insufficient Data

- States 500+
- Florida 500+
- National 500+

2010 CDHP Benchmarking

HSA-based Consumer Directed Health Plan

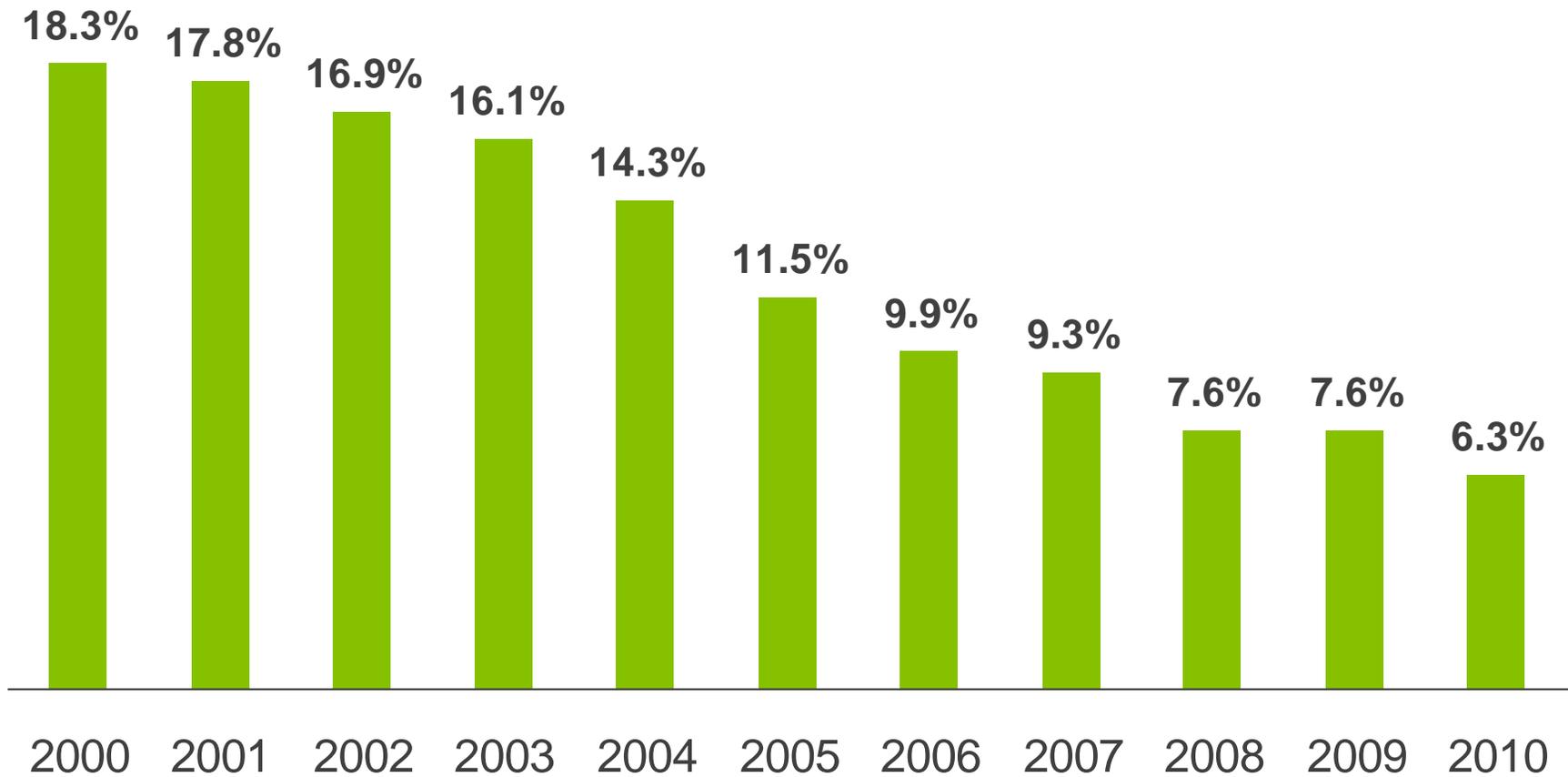
HSA Based Consumer Directed Health Plan	State of Florida	STATES 500+	FLORIDA 500+	NATIONAL 500+
Deductible				
Employee-Only Coverage	\$1,250	\$1,500	\$1,500	\$1,500
Family Coverage	\$2,500	\$3,000	\$3,000	\$3,000
Maximum OOP For Employee-Only Coverage	\$4,250	\$3,000	\$3,000	\$3,000
Maximum OOP For Family Coverage	\$8,500	\$7,500	\$6,000	\$6,000
Offer 'Limited-Purpose" FSA	Yes	70%	58%	55%
Preventive Care Coverage Under HSA-Based CDHP				
Covered at 100% For Defined Set Of Services	Yes	90%	83%	72%
Covered at 100% With Dollar Limit Per Year	N/A	0%	6%	10%
Covered Same As Other Services	N/A	10%	0%	10%
Covered Some Other Way	N/A	0%	11%	9%



VI. Prescription Drug Benchmarking

Prescription drug benefit cost is now growing at nearly the same rate as overall medical plan cost

Cost increase in primary medical plan for large employers



Drug benefits have been carved out of primary medical plan, by employer size

500-999 employees



1,000 – 4,999 employees



5,000 – 9,999 employees



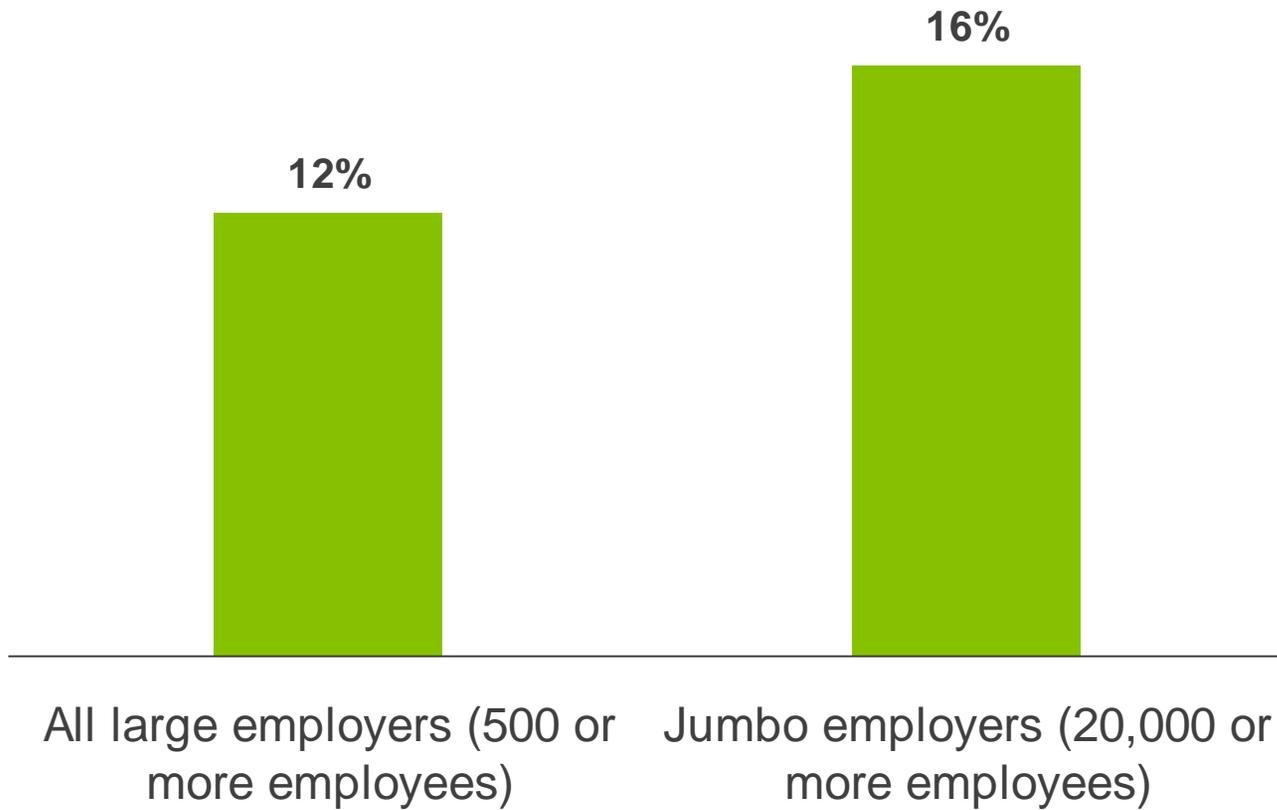
10,000 – 19,999 employees



20,000 or more employees

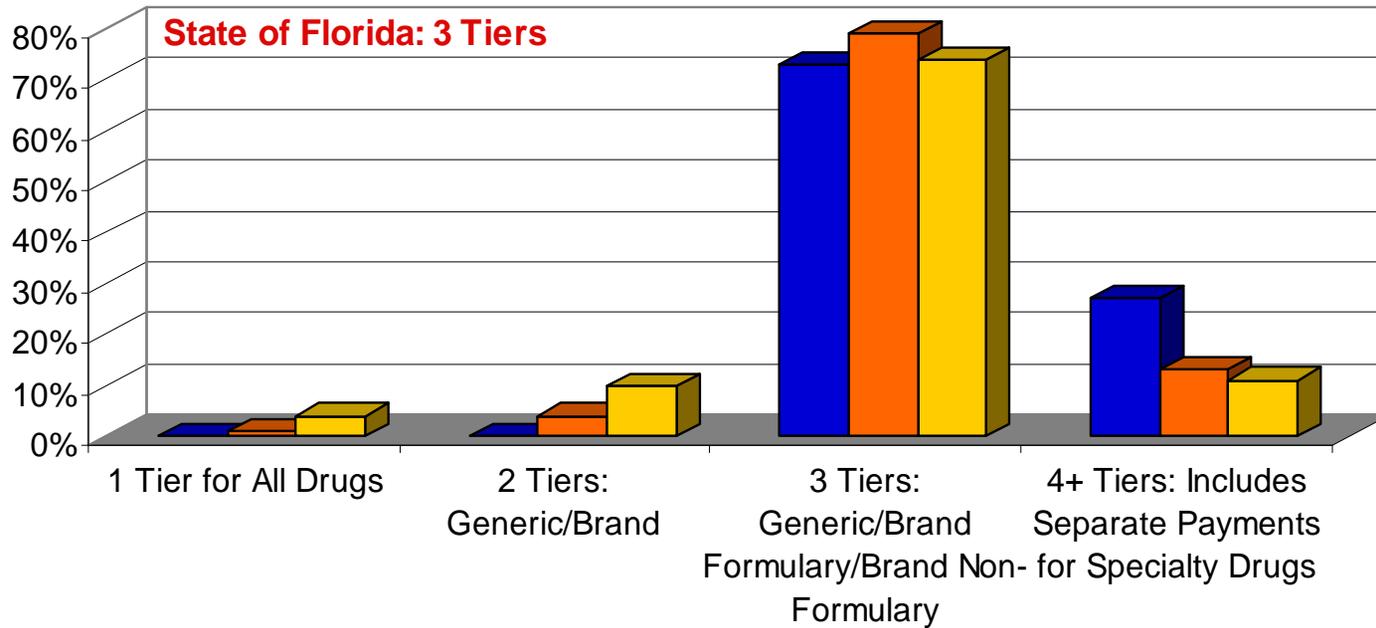


Participates in a prescription drug purchasing coalition or collective



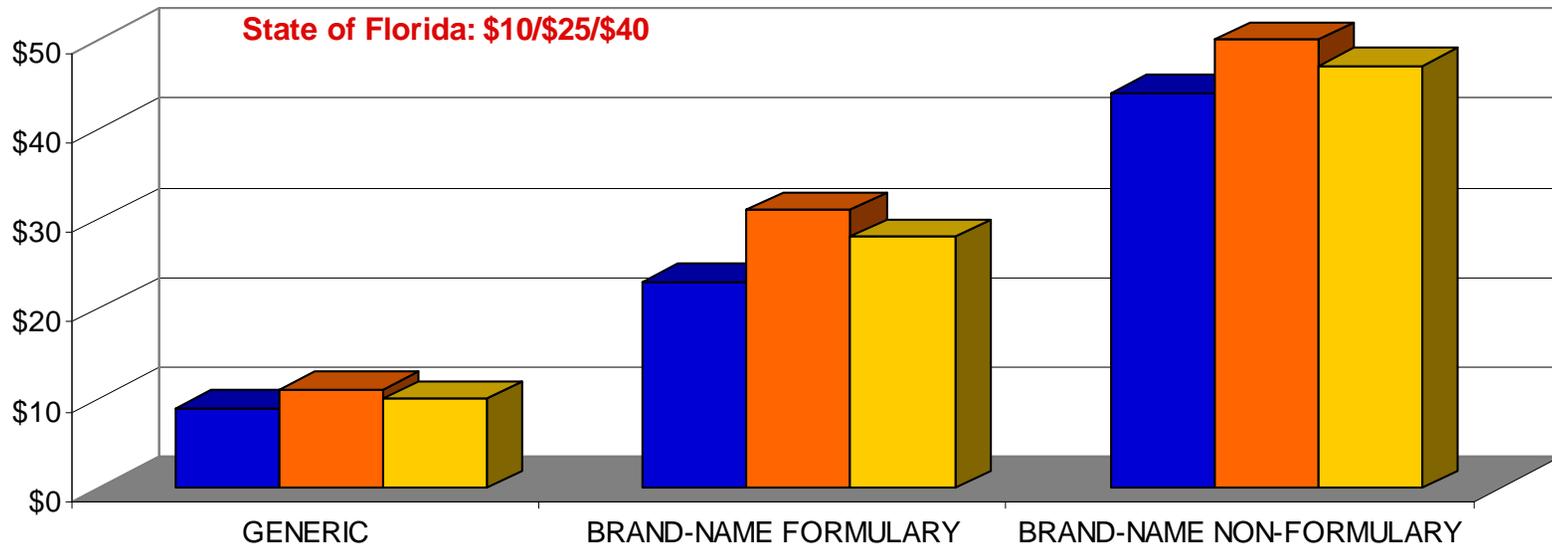
2010 PPO Benchmarks vs. 2010 Plan Prescription Drug Benefits—Plan Design

Rx Plan Design



2010 PPO Benchmarks vs. 2010 Plan Prescription Drug Benefits—Retail

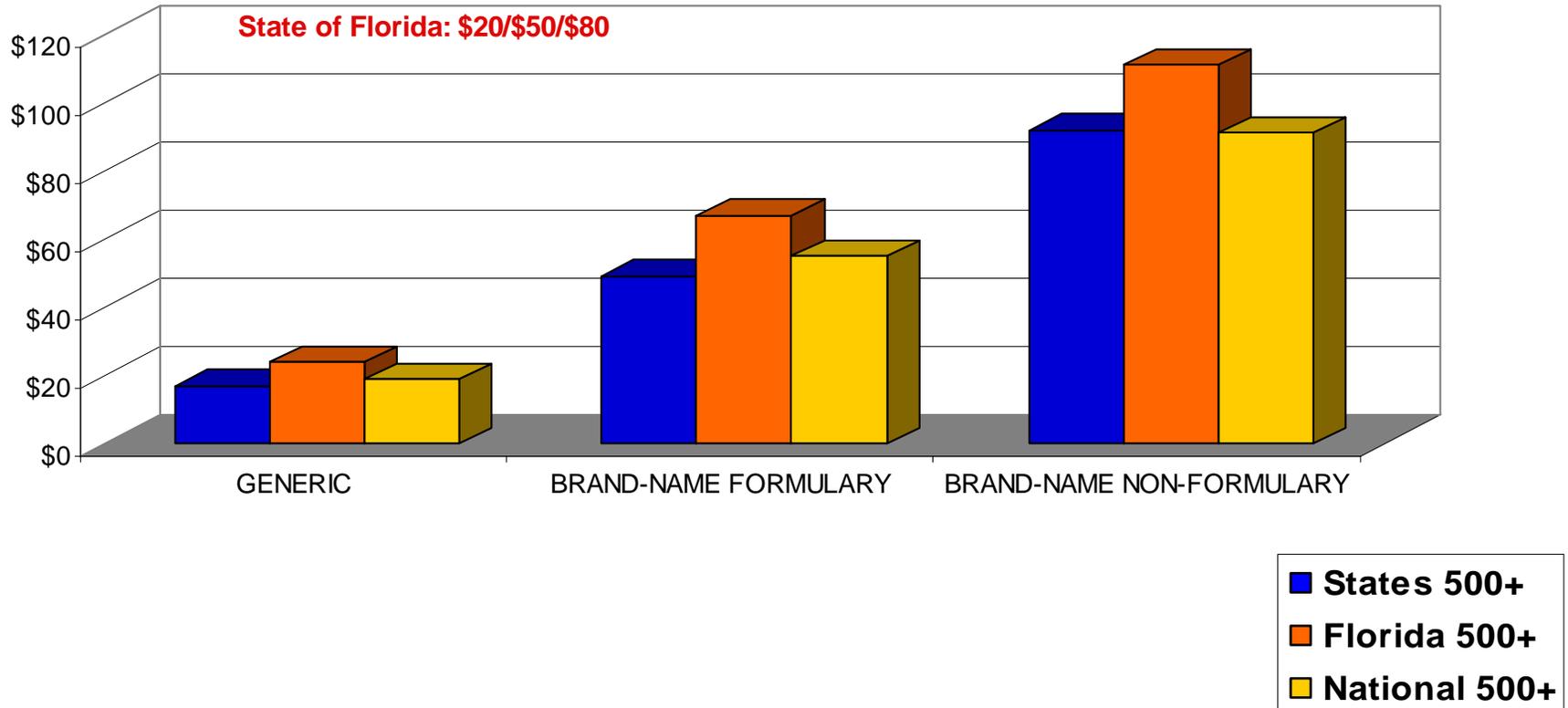
Three-Tier Retail Rx Copays



- States 500+
- Florida 500+
- National 500+

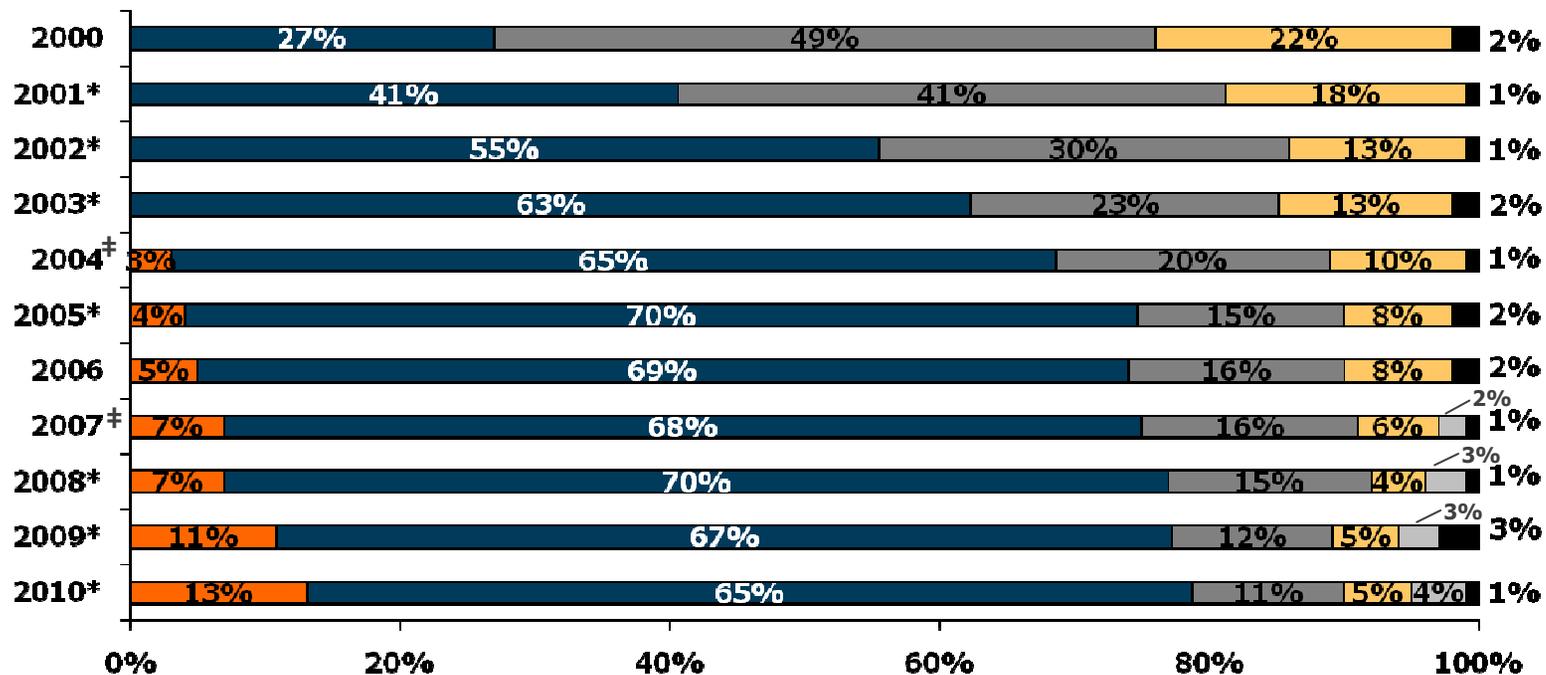
2010 PPO Benchmarks vs. 2010 Plan Prescription Drug Benefits—Mail Order

Three-Tier Mail Order Rx Copays



Distribution of Prescription Drug Cost Sharing Formulas

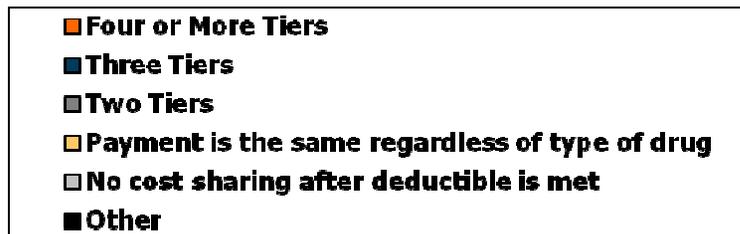
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2010



*Distribution is statistically different from distribution for the previous year shown ($p < .05$).

‡No statistical tests are conducted between 2003 and 2004 or between 2006 and 2007 due to the addition of a new category.

Note: Fourth-tier drug cost-sharing information was not obtained prior to 2004.



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March 24, 2011

**State of Florida
Benchmarking Report**
Featuring Small Employer Data

Prepared for Florida's Division of State Group Insurance



State of Florida Benchmarking Report

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I. Summary of Findings

Mercer National Survey of Employer-Sponsored Health Plans 2010

About the survey

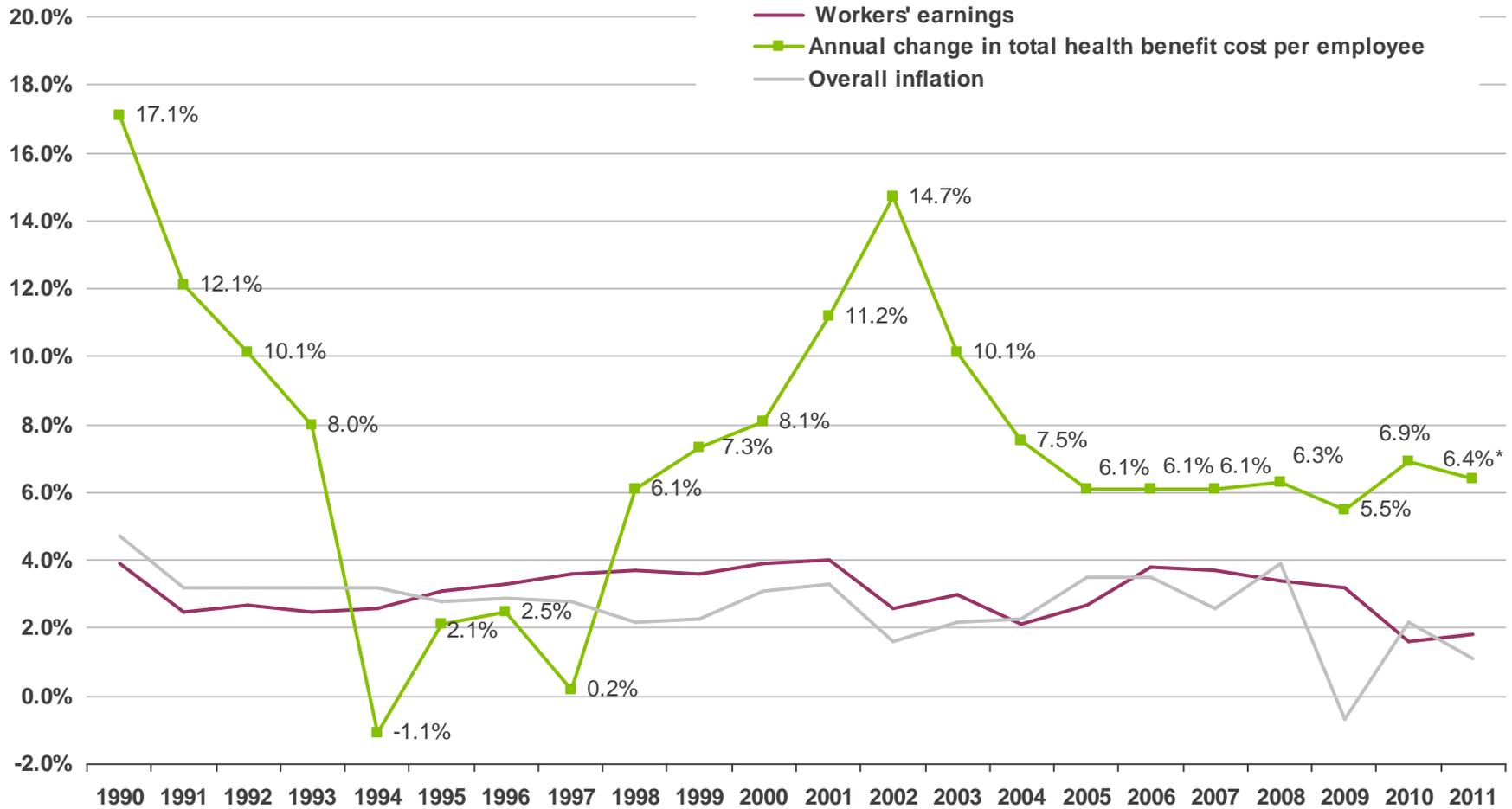
- Established in 1986, 25th anniversary of the survey; national probability sample used since 1993
- 2,833 employers participated in 2010
- All employers with 10 or more employees are surveyed using a stratified random sample; large employers are oversampled to permit robust break-outs by size
- In this presentation, we refer to:
 - **Small employers: between 10 and 499 employees (public and private)**
 - **Large employers: 500+ employees (public and private)**
 - **National 50-199: all public and private employers with between 50 and 199 employees**
 - **States 500+: state government employers, 500+ employees**
 - **Florida 500+: all public and private employers in Florida, 500+ employees**
 - **National 500+: all public and private employers, 500+ employees**
- State of Florida values listed in this report reflect responses to the survey as of 2010; the State's data is also included in the States 500+, Florida 500+ and National 500+ analyses

Mercer National Survey of Employer-Sponsored Health Plans 2010

Key Findings

- After five years of cost increases averaging around 6%, growth in the average total health benefit cost per employee picked up steam in 2010, rising by nearly 7% -- three times faster than the CPI. Following a relatively low 5.5% increase in 2009, this was the biggest increase since 2004.
- Small employers experienced less of a cost increase than larger employers in 2010. Average health benefit cost per employee rose by 4.4% among employers with between 10 and 499 employees.
- Average health benefit cost among small employers was \$8,825 per employee compared to \$10,073 for large employers.
- Small employers have been quicker to shift cost to employees than mid-sized employers. Studies have shown that when employees are asked to pay a greater share of the cost of health care services, utilization slows. With 49% of small employers now requiring a deductible of \$1,000 or more (compared to just 15% of mid-sized employers), they seem to have been better insulated from cost increases.
- State governments (States 500+) reported a higher average age (46) among active employees than large employers in Florida and US (42) as well as small employers nationwide (National 50-199). Women account for just over half of employees for States (53%), Florida (55%), and large US employers (53%); small employers were slightly lower at 49%. The State of Florida reported an average age of 45 and that 53% of its employees were female.
- State governments report an average salary of \$44,536 compared to \$46,011 and \$51,215 for Florida and large US employers, respectively. Small employers' salaries were lower, at \$43,189. The State of Florida reported an average salary of \$38,517 when responding to the survey.

Total health benefit cost per employee rises 6.9% in 2010, the sharpest increase since 2004



*Projected

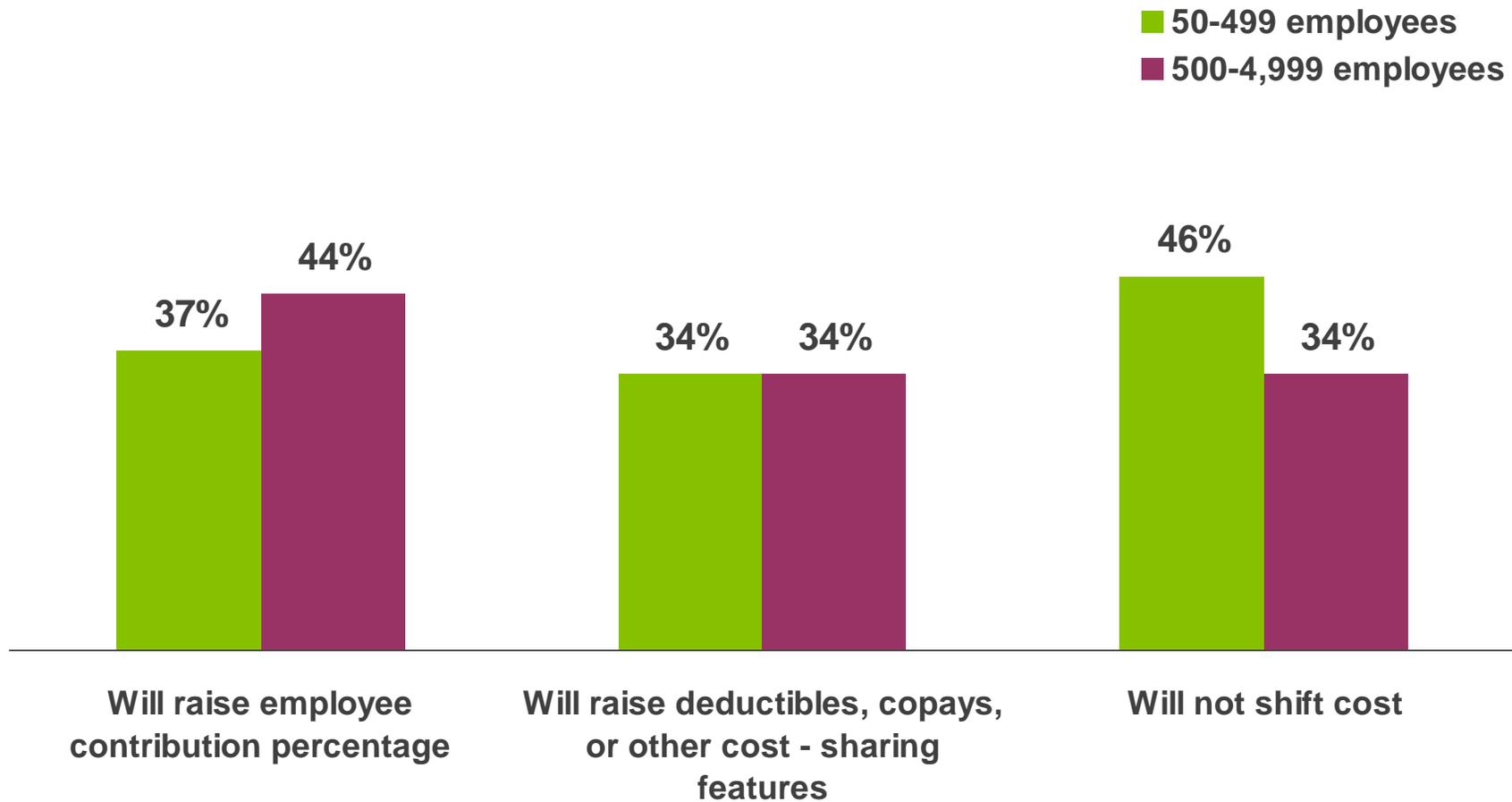
Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2010; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2010.



Average total health benefit cost per employee, by employer size

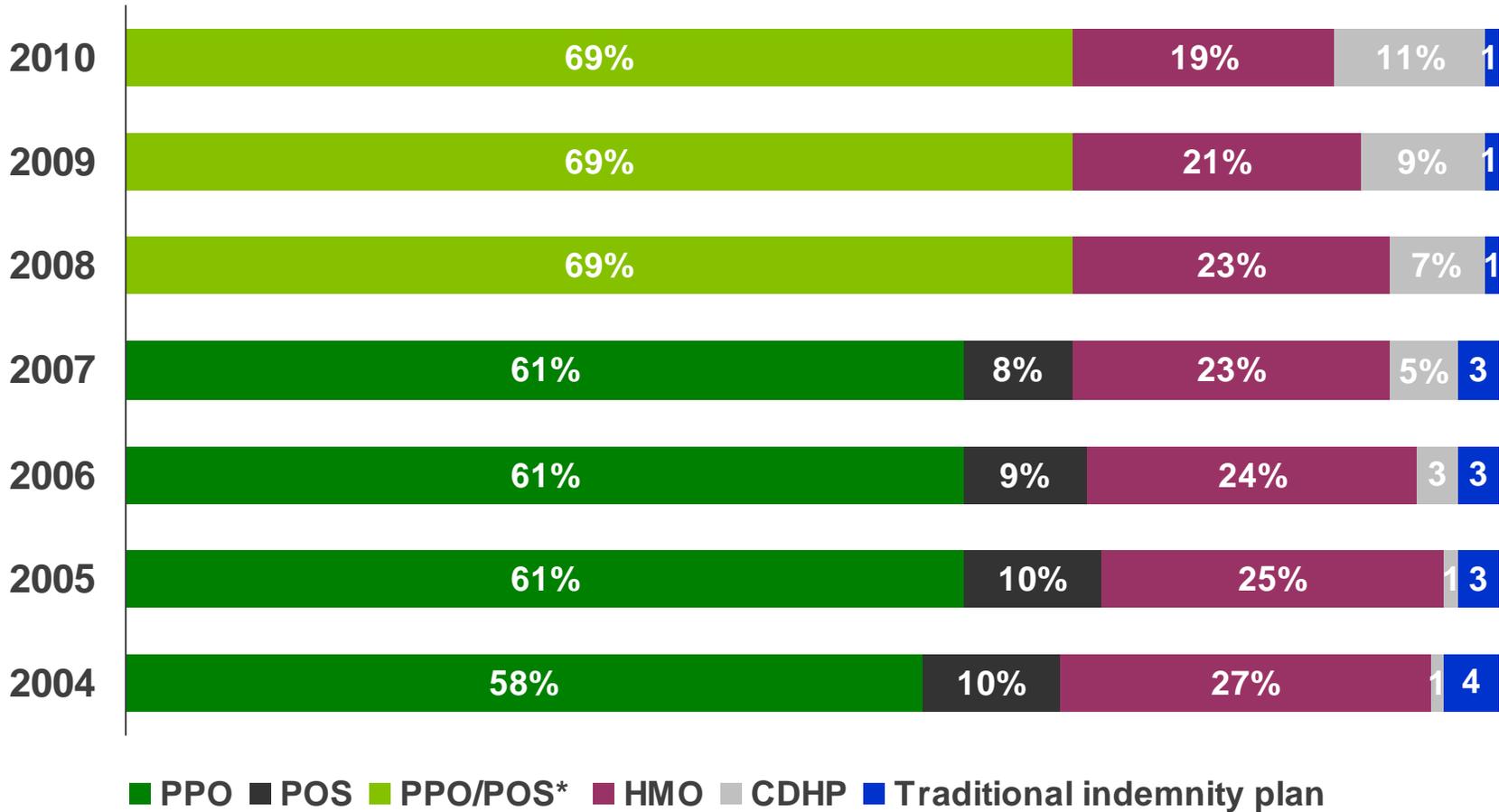


Cost-shifting likely to continue in 2011



Enrollment in CDHPs continues to rise as HMOs lose ground

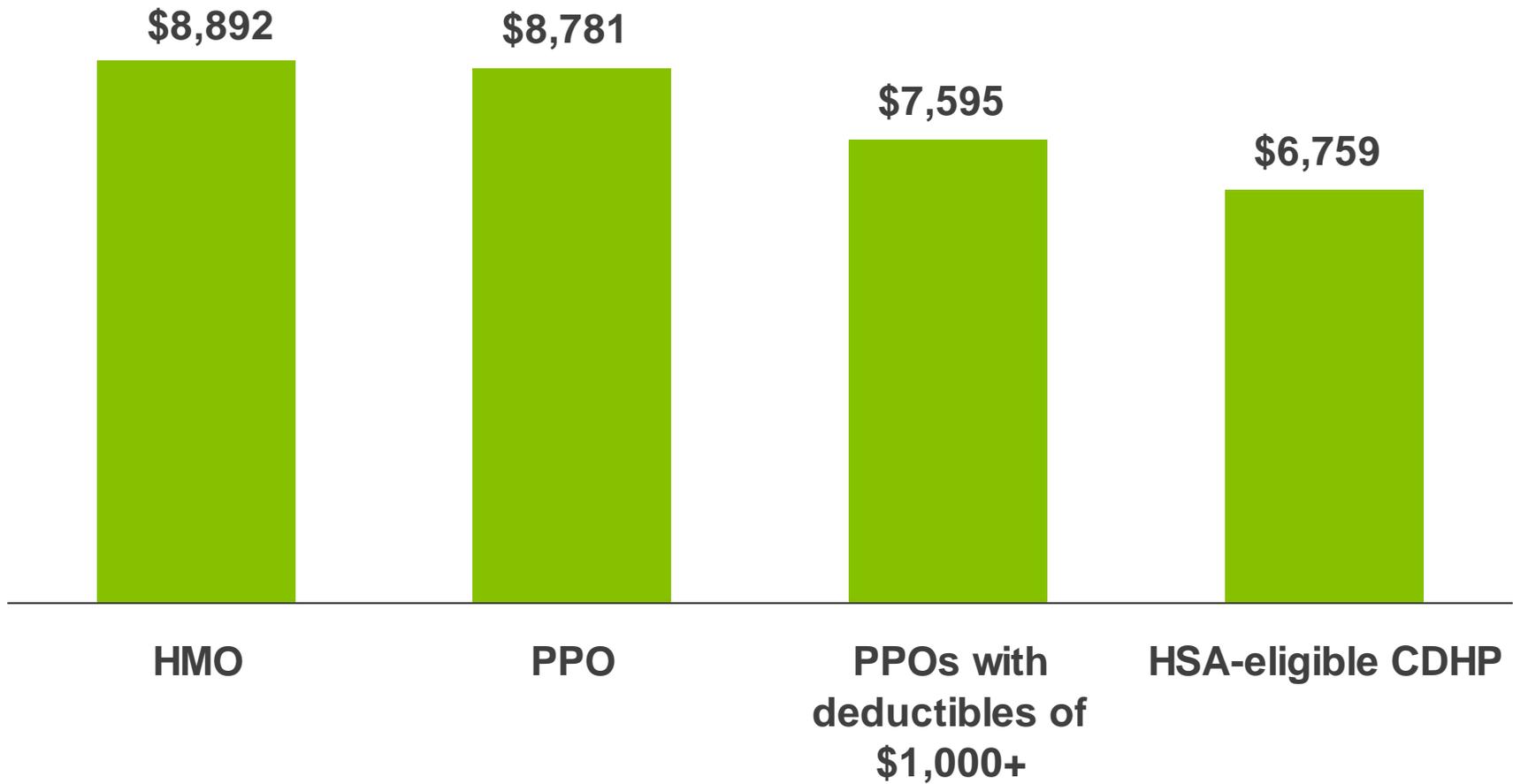
Percentage of all covered employees enrolled in each plan type



*Combined in 2008 due to declining offerings of/enrollment in POS plans.

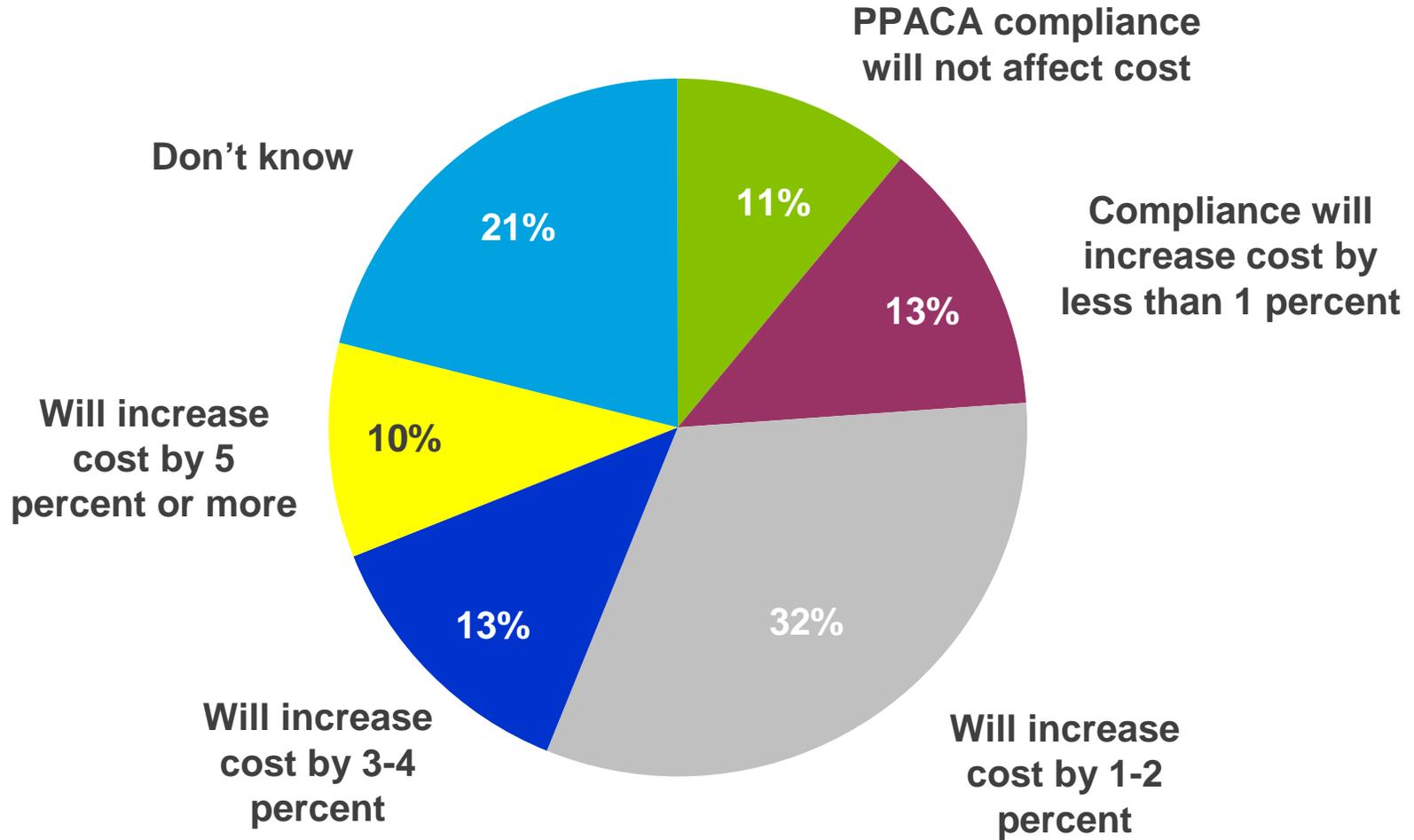
Coverage in an HSA-based CDHP cost nearly 25% less than coverage in other medical plan types in 2010

Medical plan cost per employee (includes employer contributions to HSA accounts)



2011 PPACA requirements will affect some employers more than others

Estimated increase in spending in 2011 among large employers due solely to complying with PPACA requirements





II. Employee Contributions

2010 State of Florida Employee Contribution Rates

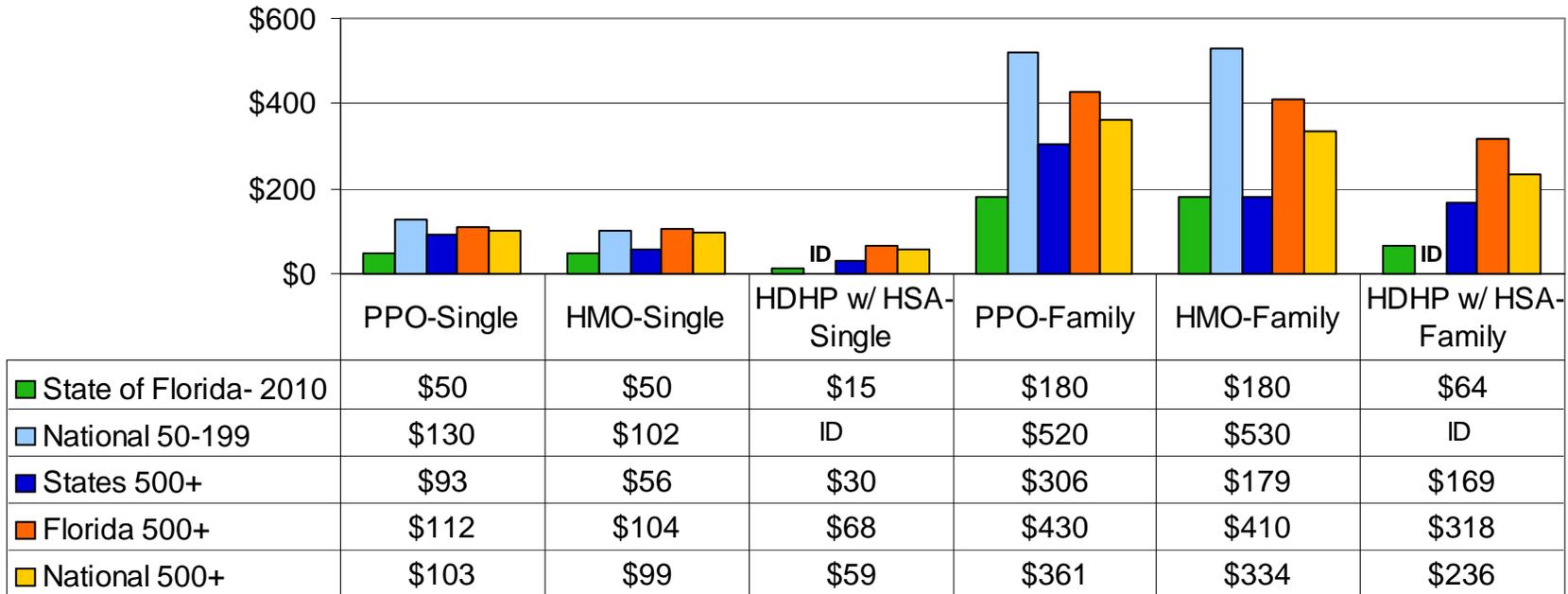
Subscriber Category/ Contribution Cycle		Coverage Type	PPO/HMO Standard			PPO/HMO HIHP		
			Employer	Enrollee	Total	Employer	Enrollee	Total
Career Service	Monthly Full-Time Employees	Single	\$473.62	\$50.00	\$523.62	\$473.62	\$15.00	\$488.62
		Family	\$1,004.14	\$180.00	\$1,184.14	\$1,004.14	\$64.30	\$1,068.44
		Spouse	\$1,154.16	\$30.00	\$1,184.16	\$1,038.44	\$30.00	\$1,068.44
	Bi-Weekly Full-Time Employees	Single	\$236.81	\$25.00	\$261.81	\$236.81	\$7.50	\$244.31
		Family	\$502.07	\$90.00	\$592.07	\$502.07	\$32.15	\$534.22
		Spouse	\$577.08	\$15.00	\$592.08	\$519.22	\$15.00	\$534.22
"Payalls"	Monthly Full-Time Employees	Single	\$515.30	\$8.34	\$523.64	\$480.28	\$8.34	\$488.62
		Family	\$1,154.14	\$30.00	\$1,184.14	\$1,038.44	\$30.00	\$1,068.44
	Bi-Weekly Full-Time Employees	Single	\$257.65	\$4.17	\$261.82	\$240.14	\$4.17	\$244.31
		Family	\$577.07	\$15.00	\$592.07	\$519.22	\$15.00	\$534.22
COBRA	Monthly	Single	\$0.00	\$534.09	\$534.09	\$0.00	\$455.90	\$455.90
		Family	\$0.00	\$1,207.82	\$1,207.82	\$0.00	\$1,004.81	\$1,004.81
Early Retirees	Monthly	Single	\$0.00	\$523.62	\$523.62	\$0.00	\$446.96	\$446.96
		Family	\$0.00	\$1,184.14	\$1,184.14	\$0.00	\$985.11	\$985.11
Medicare	Monthly	(I) One Eligible	\$0.00	\$278.02	\$278.02	\$0.00	\$209.56	\$209.56
		(II) One Under/Over	\$0.00	\$801.64	\$801.64	\$0.00	\$656.52	\$656.52
		(III) Both Eligible	\$0.00	\$556.04	\$556.04	\$0.00	\$419.12	\$419.12
Overage Dependents		Single	\$0.00	\$523.62	\$523.62	\$0.00	\$446.96	\$446.96

Source: State Employees' Group Health Self-Insurance Trust Fund Premium Rate Table, effective July 2010 for August 2010 Coverage

2010 Contribution Benchmarks vs. 2010 Plan

Monthly employee contribution (dollars)

Employee Contribution Benchmarks

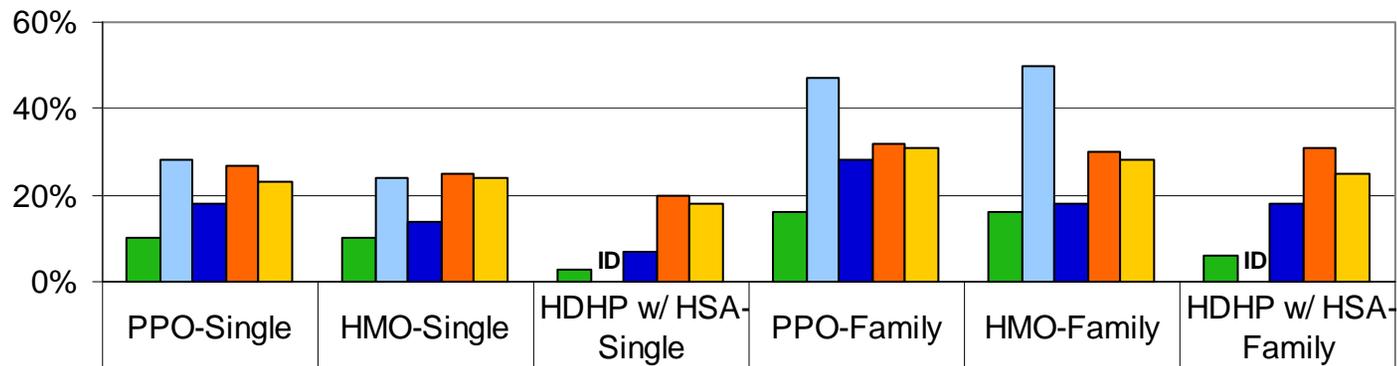


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2010 Contribution Benchmarks vs. 2010 Plan

Monthly employee contribution (as a percentage of premium)

Employee Contribution Benchmarks

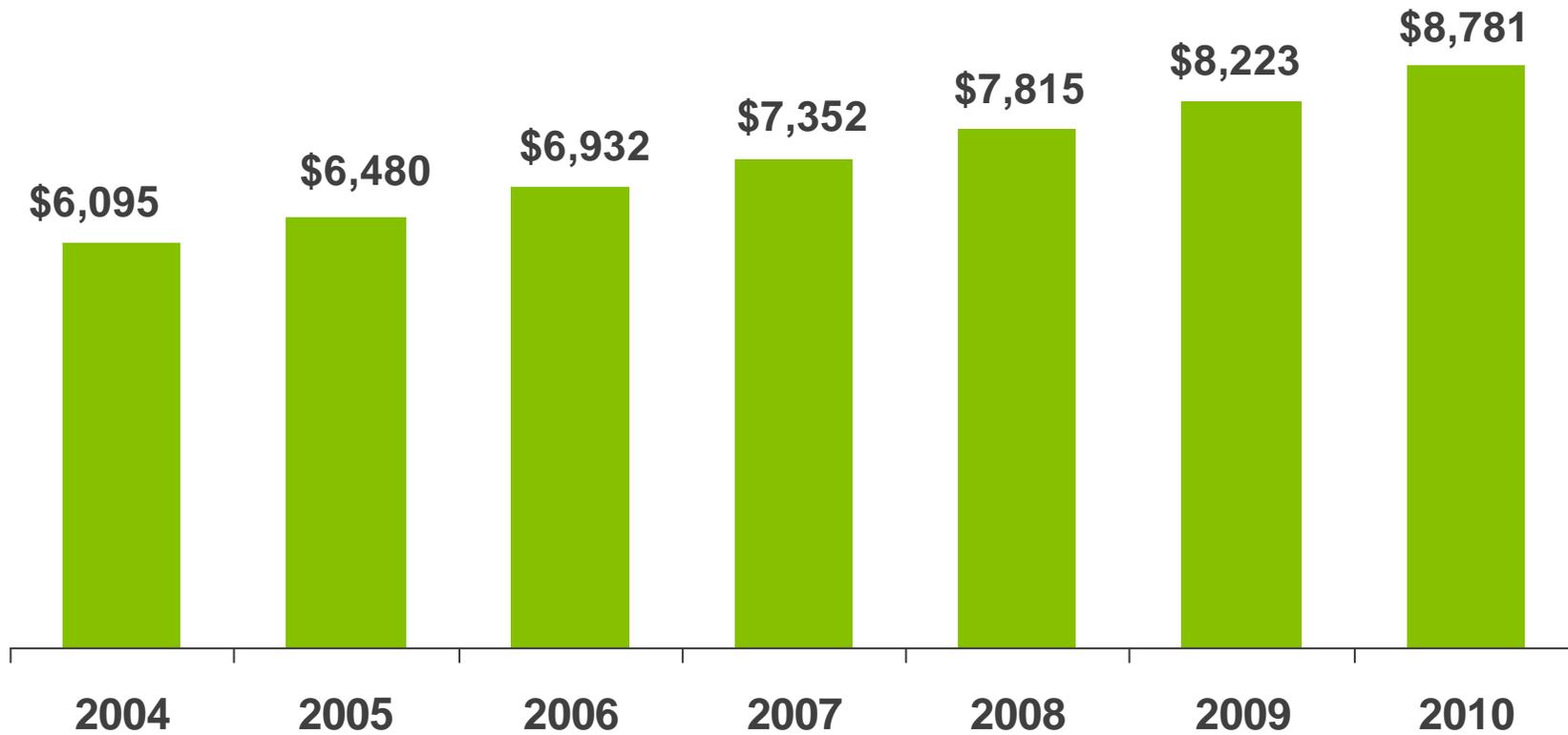


“ID” indicates Insufficient Data



III. PPO Benchmarking

PPO cost per employee, 2004-2010
All employers



*Beginning in 2008, due to declining enrollment in point-of-service plans, we did not collect separate information on POS plans as in past years. POS plans were combined with PPOs.



Offer PPO; percent of employees enrolled

	50-499 employees	500-4,999 employees
Percent of employers offering PPO	85%	94%
Percent of employees enrolled in PPO	70%	75%

Deductibles continue to climb

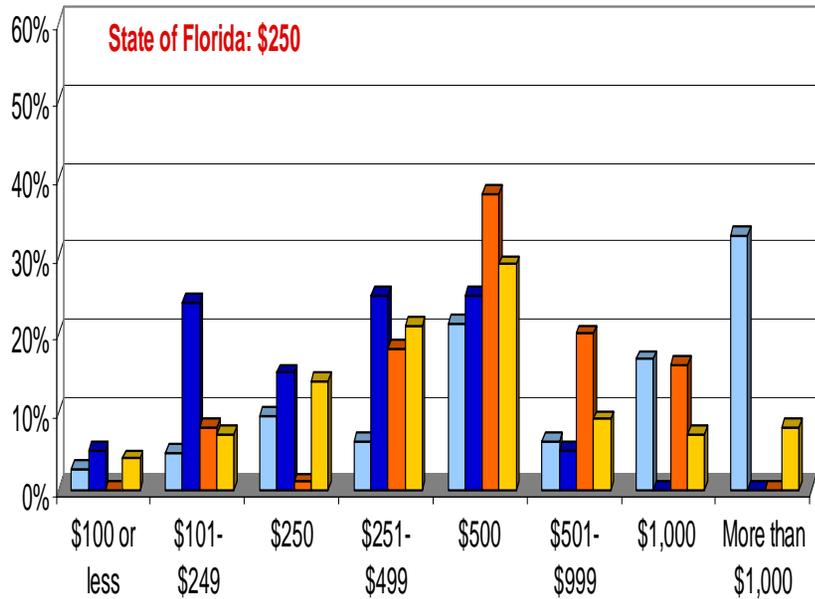
Average PPO deductible for individual, in-network coverage (all employers)

- Average deductible among PPO sponsors requiring a deductible
- Percent of PPO sponsors requiring no deductible

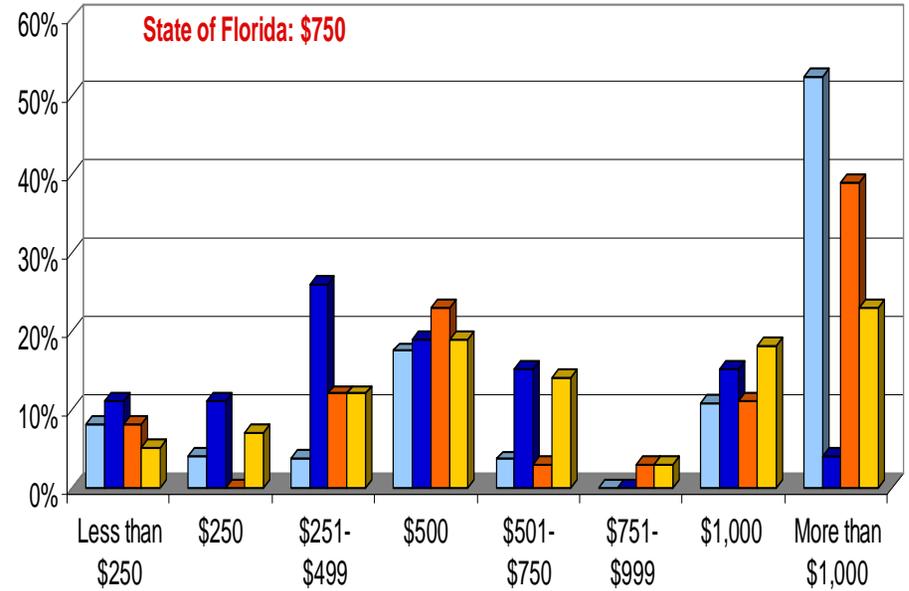


2010 PPO Benchmarks vs. 2010 Plan Individual Deductible

In Network Deductible



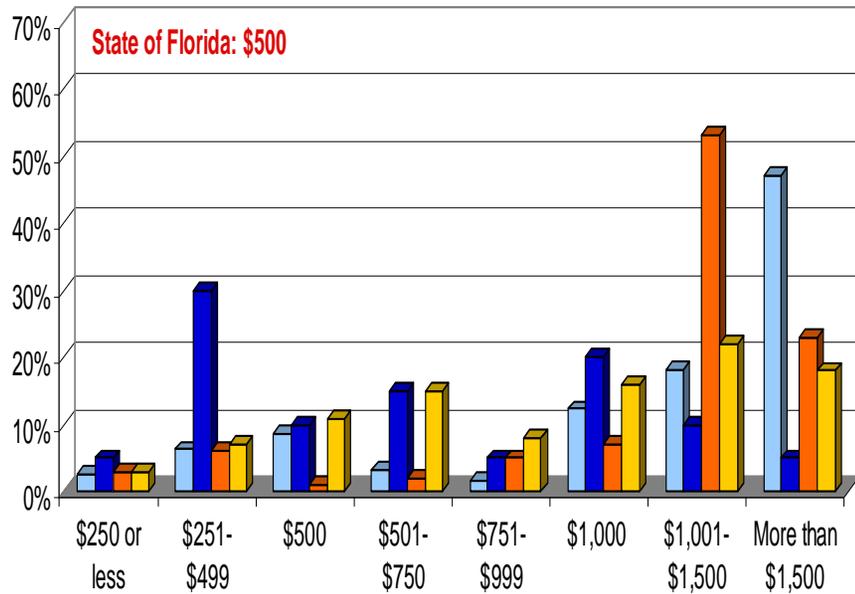
Out of Network Deductible



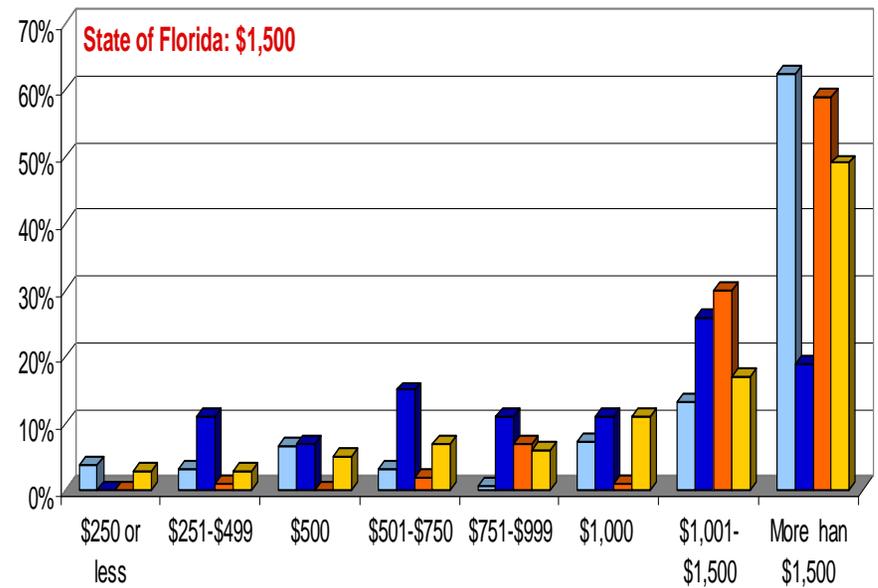
- National 50-199
- States 500+
- Florida 500+
- National 500+

2010 PPO Benchmarks vs. 2010 Plan Family Deductible

In Network Deductible



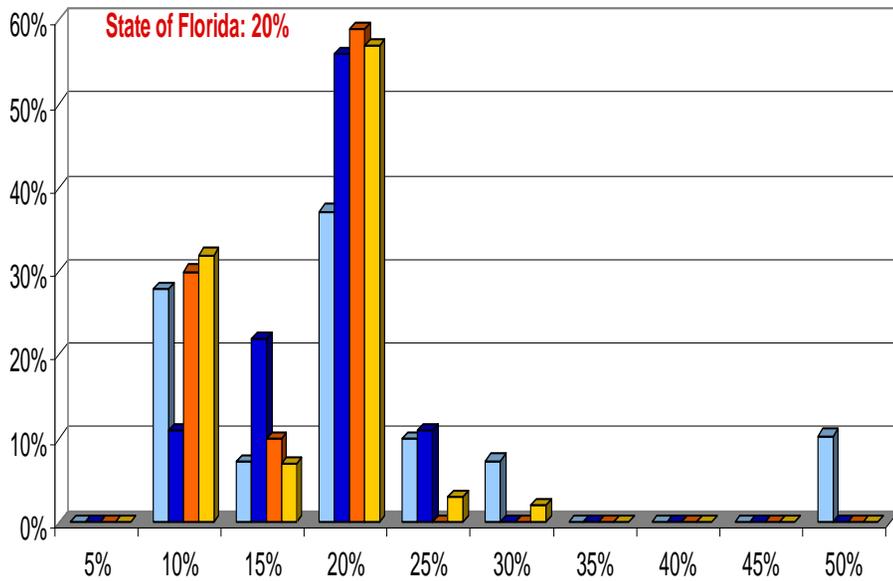
Out of Network Deductible



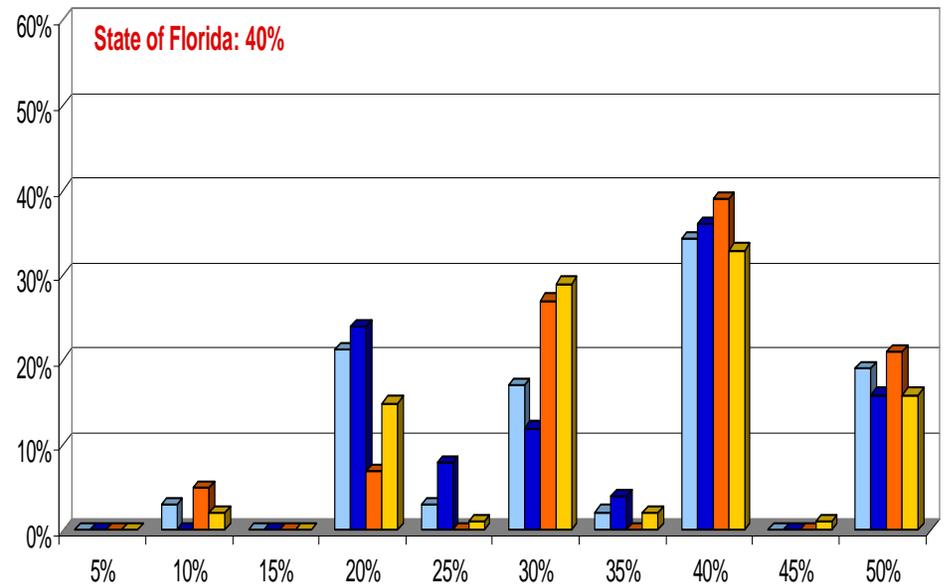
- National 50-199
- States 500+
- Florida 500+
- National 500+

2010 PPO Benchmarks vs. 2010 Plan Participant Coinsurance

In Network Coinsurance



Out of Network Coinsurance

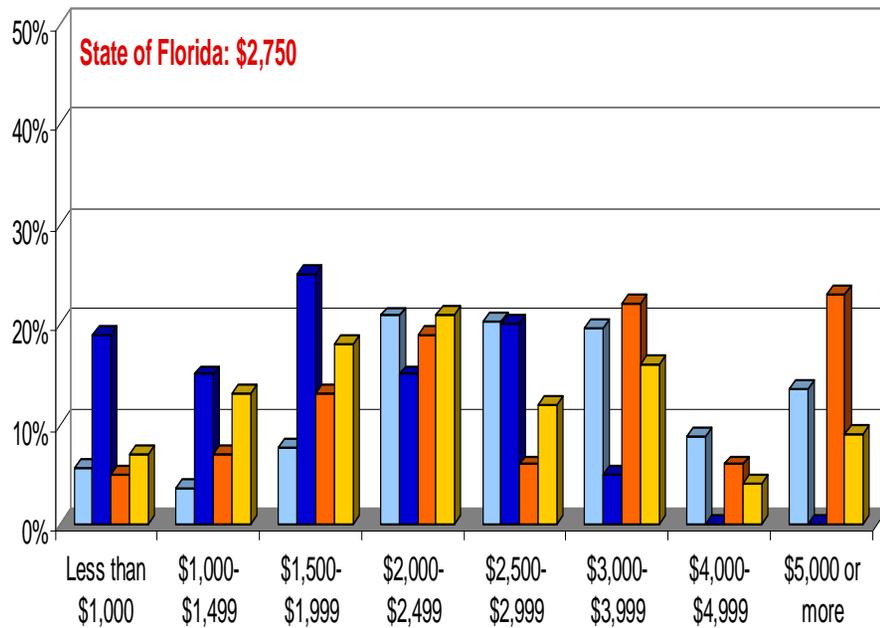


- National 50-199
- States 500+
- Florida 500+
- National 500+

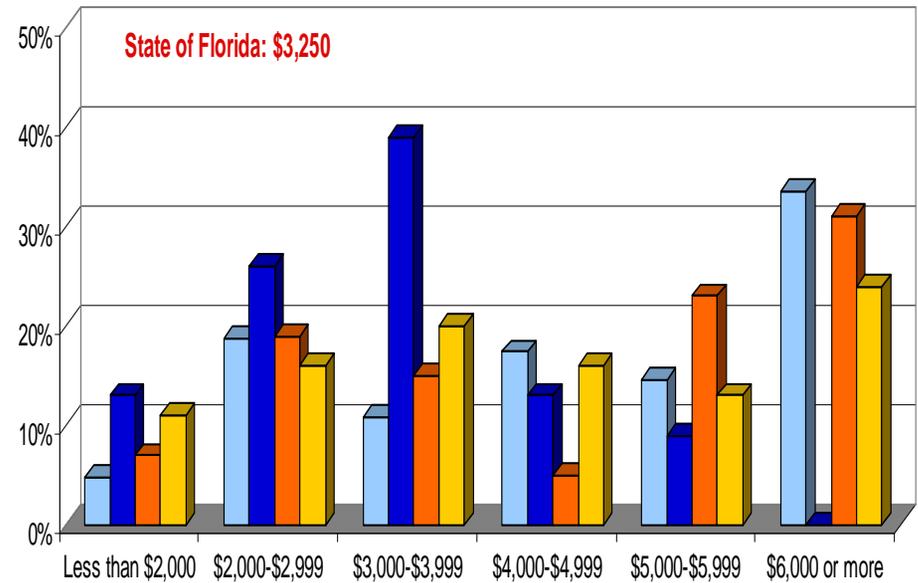
2010 PPO Benchmarks vs. 2010 Plan

Individual Out of Pocket Maximum (OOP), including deductible

In Network OOP



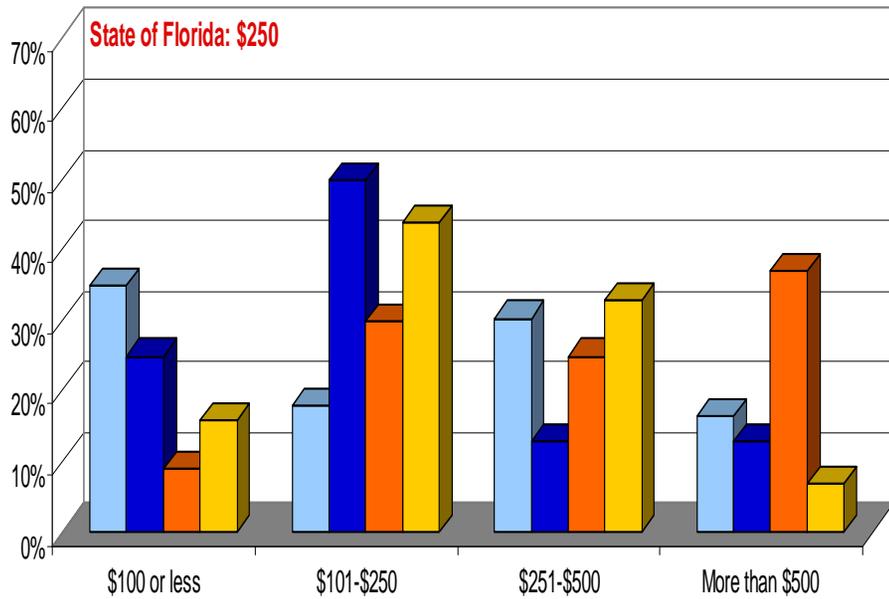
Out of Network OOP



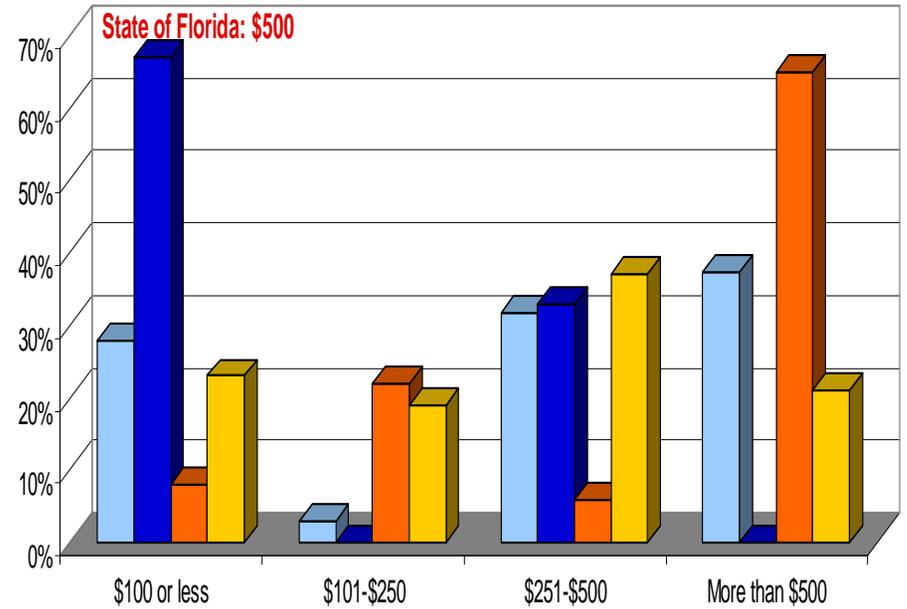
- National 50-199
- States 500+
- Florida 500+
- National 500+

2010 PPO Benchmarks vs. 2010 Plan Inpatient/Hospital Copayment

In Network Copay



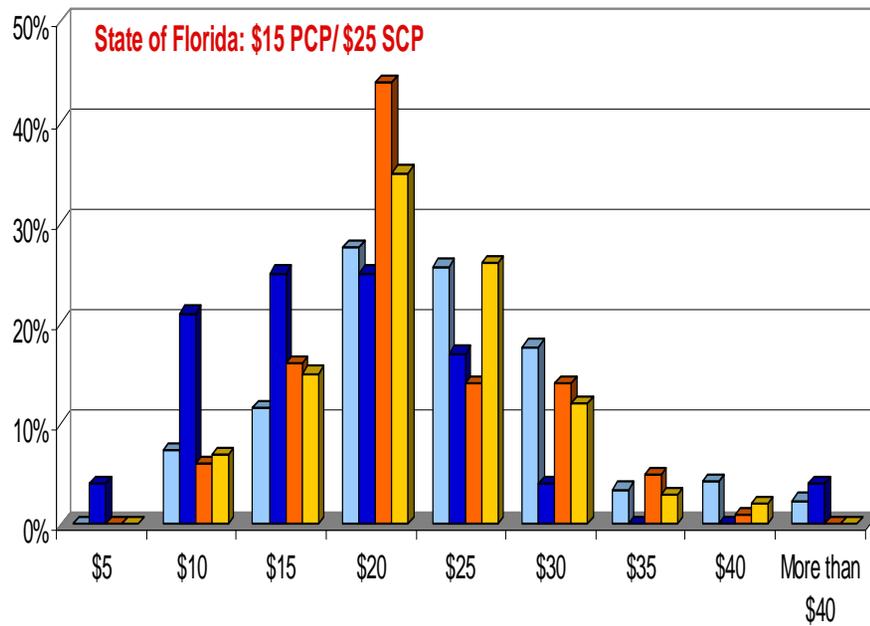
Out of Network Copay



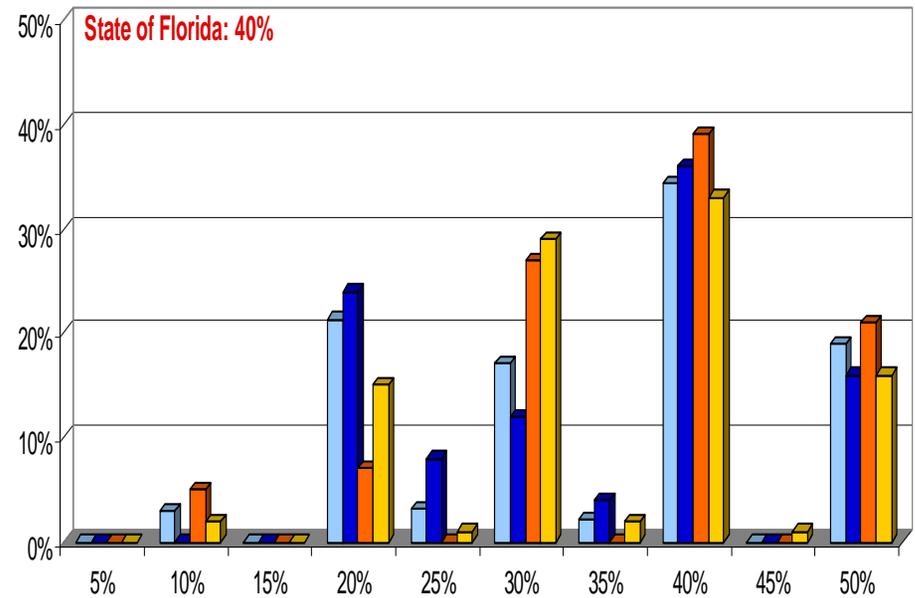
- National 50-199
- States 500+
- Florida 500+
- National 500+

2010 PPO Benchmarks vs. 2010 Plan PCP Office Visit Copay and Coinsurance

PCP In Network Copay



Out of Network Coinsurance



- National 50-199
- States 500+
- Florida 500+
- National 500+



IV.HMO Benchmarking

HMO plan cost per employee, 2004-2010
All employers



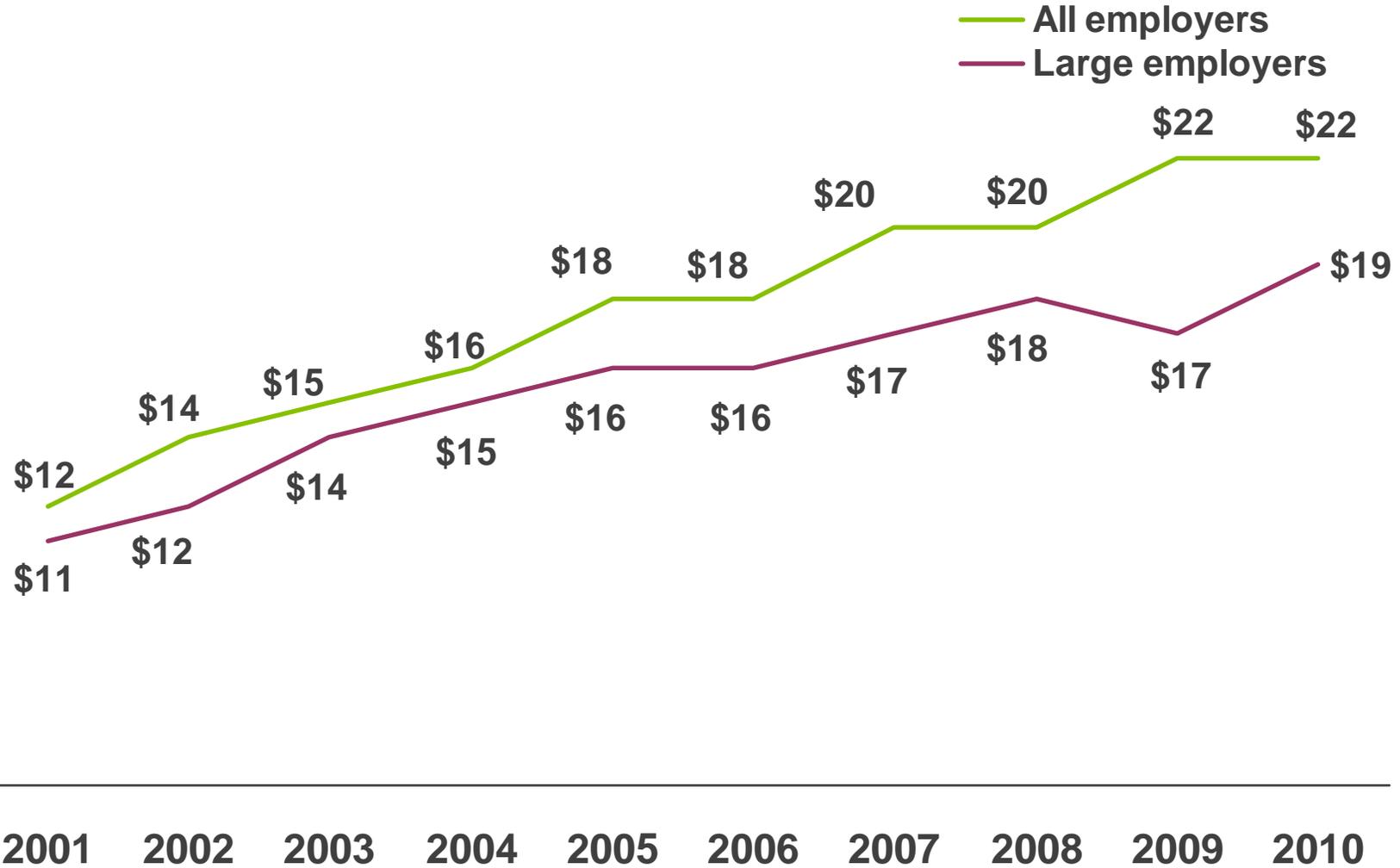


Offer HMO; percent of employees enrolled

	50-499 employees	500-4,999 employees
Percent of employers offering HMO	26%	33%
Percent of employees enrolled in HMO	16%	18%

HMO copay amounts have risen steadily

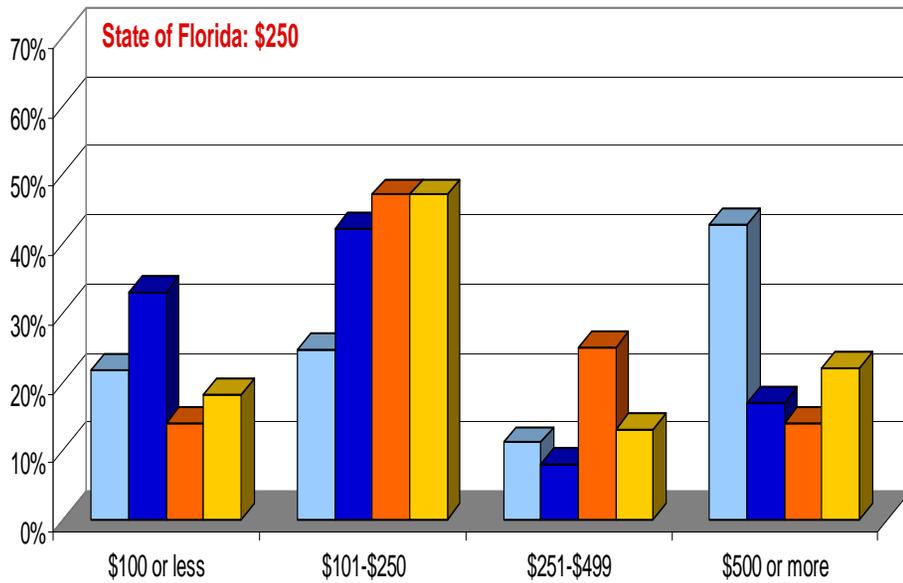
Average copay for physician visits



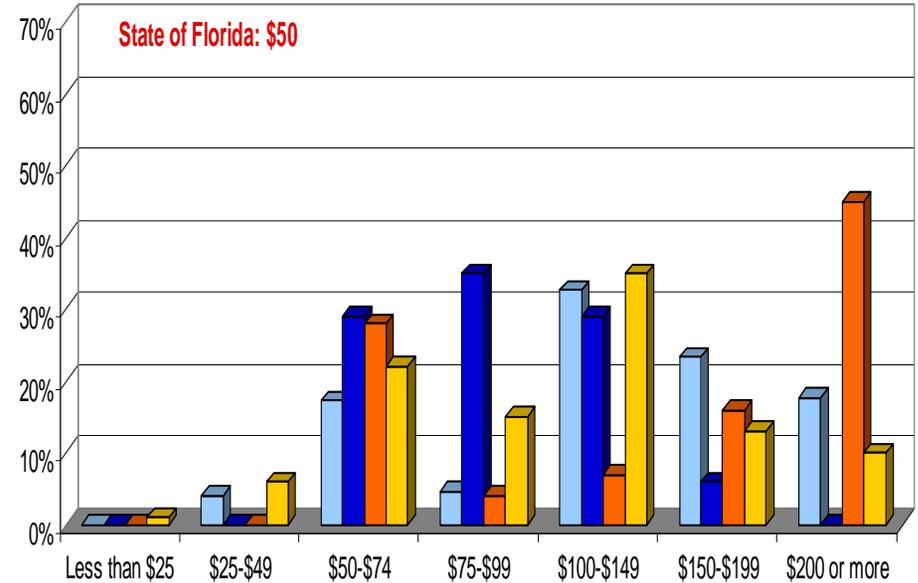


2010 HMO Benchmarks vs. 2010 Plan PCP Office Visit and Emergency Room Copays

In Network Hospital Copay



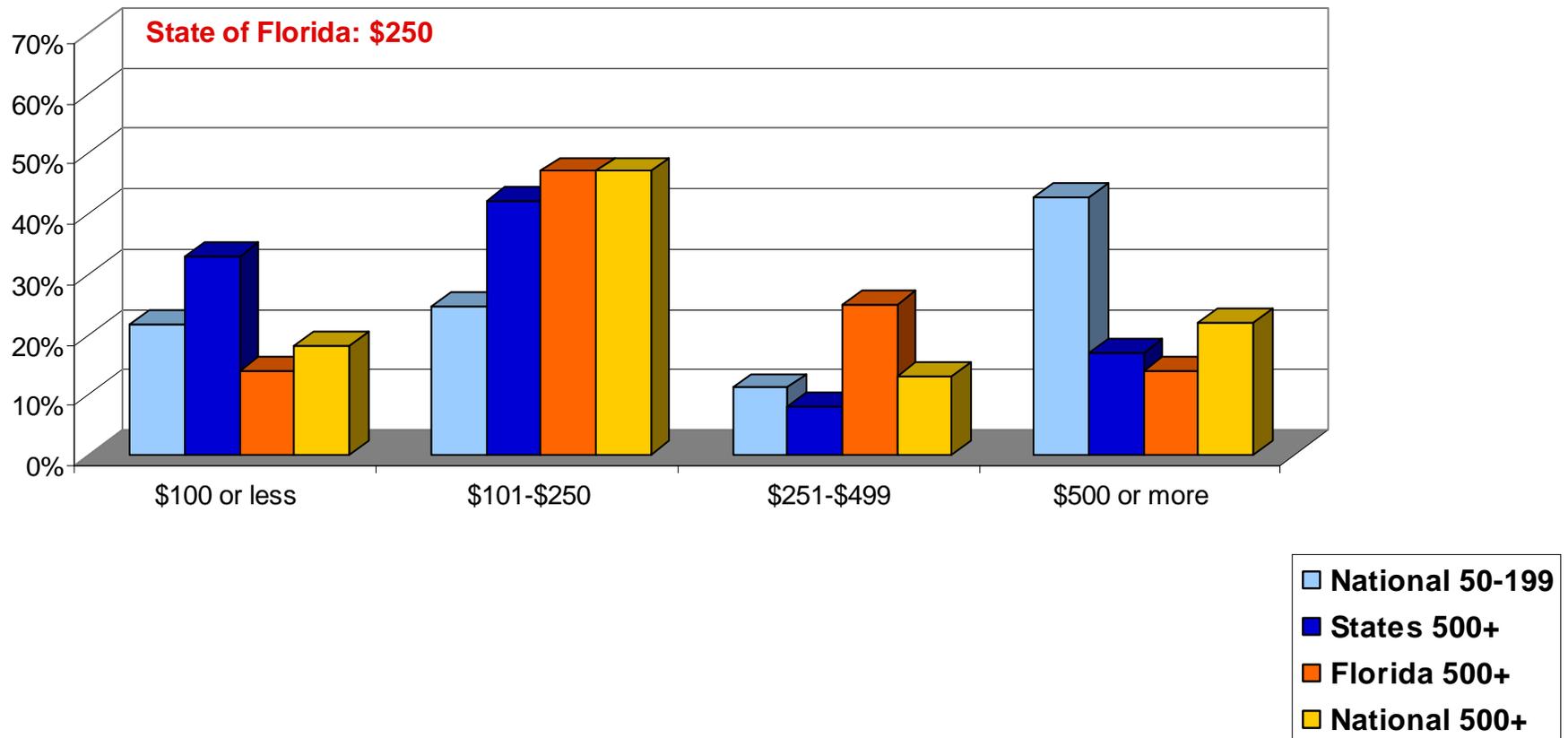
In Network Emergency Room Copay



- National 50-199
- States 500+
- Florida 500+
- National 500+

2010 HMO Benchmarks vs. 2010 Plan Inpatient/Hospital Copay

In Network Hospital Copay



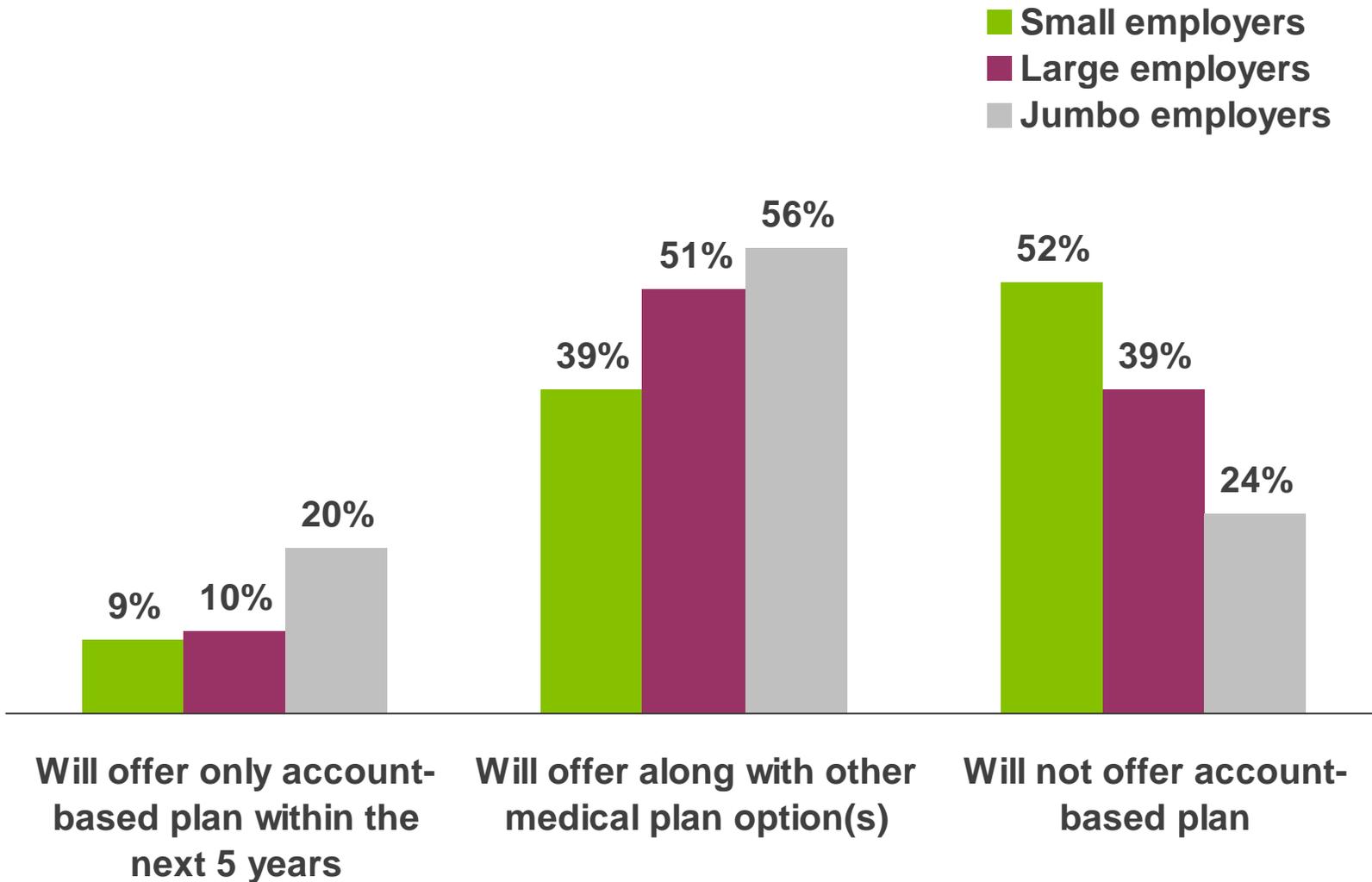
V. CDHP Benchmarking

Small and mid-sized employers added CDHPs in 2010

	<u>CDHP* offered in:</u>			<u>Percent of covered employees enrolled:</u>		
	2008	2009	2010	2008	2009	2010
All employers	10%	15%	17%	7%	9%	11%
50-499 employees	14%	17%	24%	7%	8%	13%
500-4,999 employees	18%	18%	21%	5%	6%	6%
5,000 or more employees	35%	41%	42%	8%	9%	14%

*Based on either a health savings account or health reimbursement arrangement.

Majority of large employers expect to offer an account-based plan near-term, but not as the only plan



Objectives for HSA-eligible CDHPs

Percent of large HSA sponsors rating objective “very important”

Lower organization’s benefit cost



Promote health care consumerism



Improve package of benefit offerings; add choice



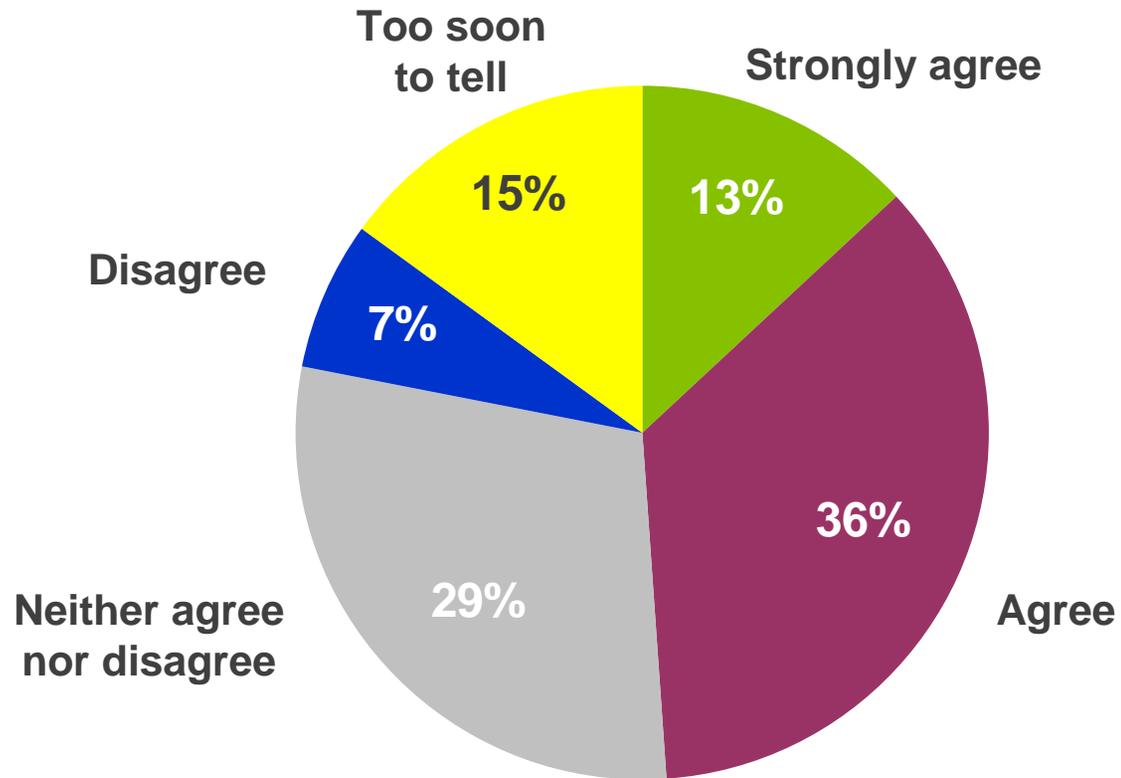
Provide tax effective savings vehicle



Provide funding vehicle for retiree medical

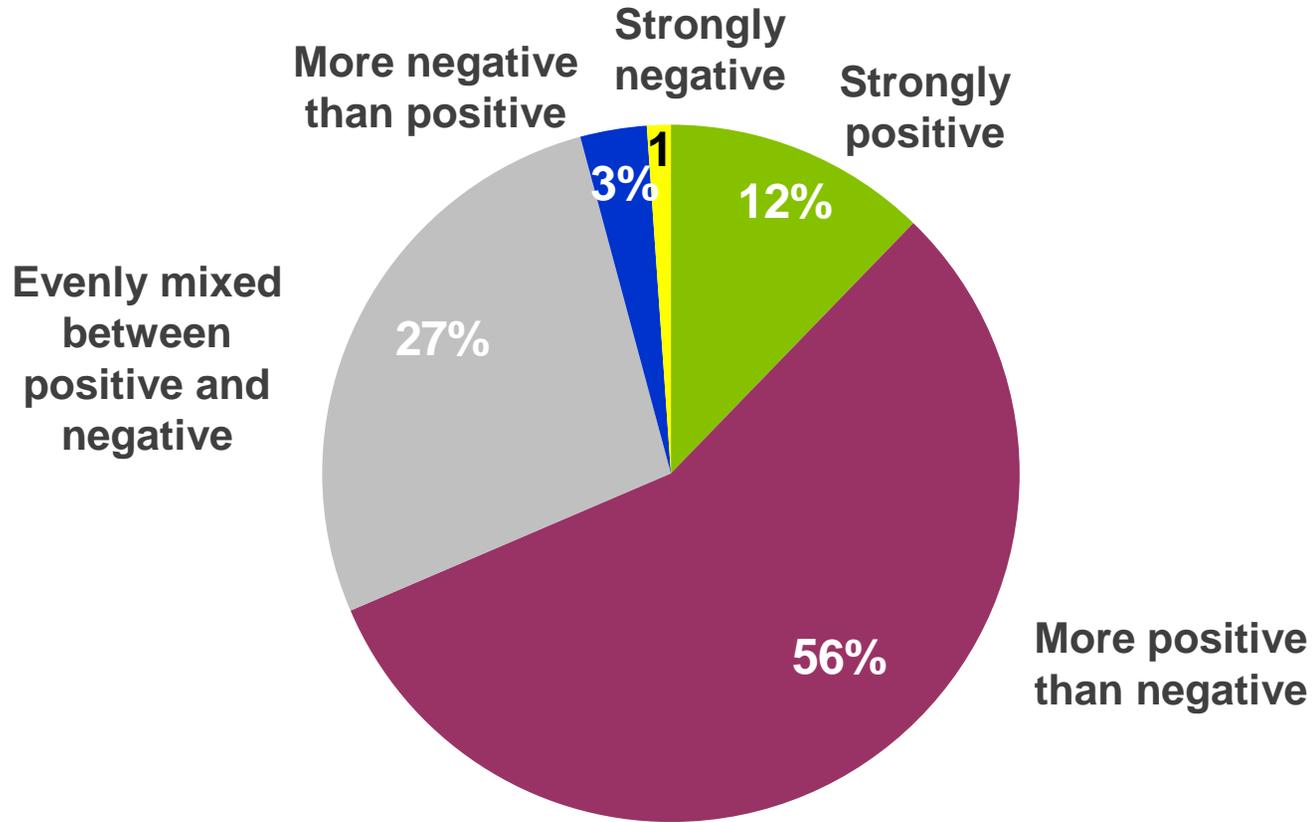


Employer reaction to HSA-eligible plan: “Most important objectives have been met”
Large HSA sponsors



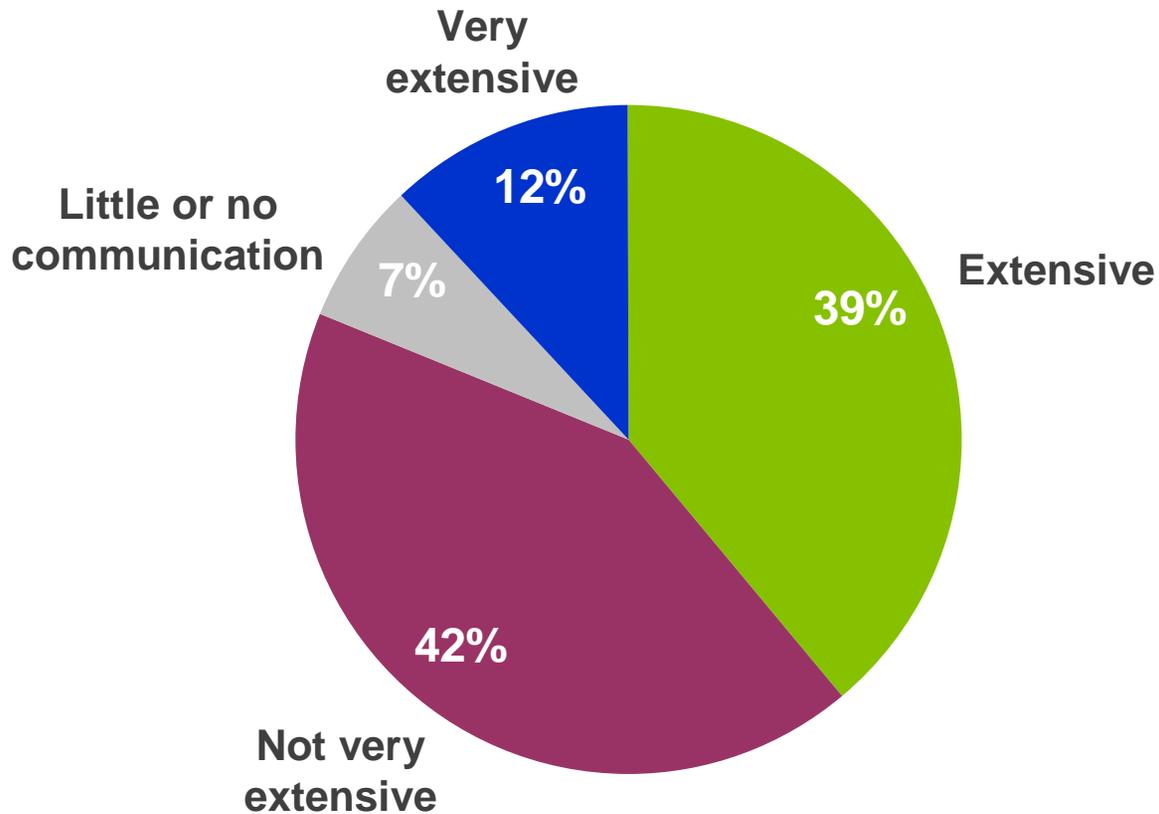
Employee reaction to HSA-eligible CDHP

Large HSA sponsors characterize the response of HSA enrollees to the plan



Level of communication efforts aimed at promoting consumerism or health-conscious behavior in HSA enrollees

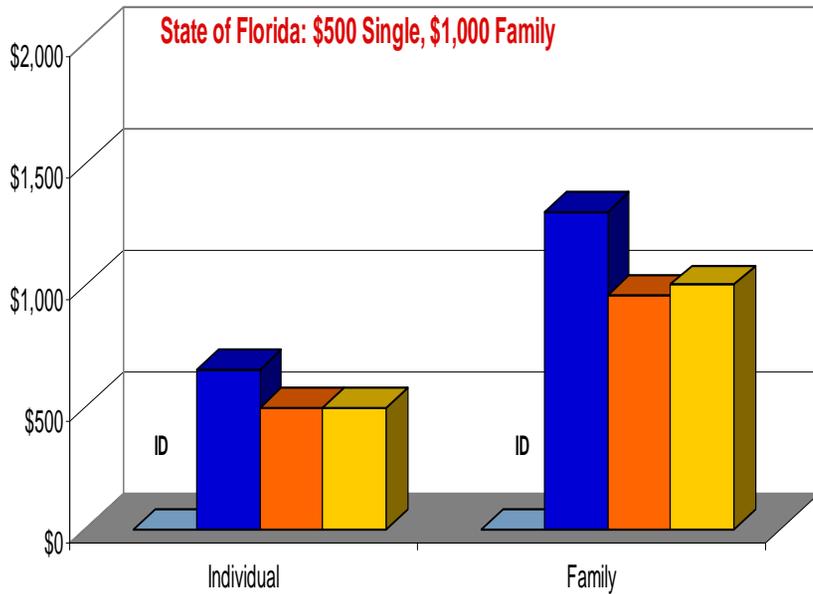
Large HSA sponsors



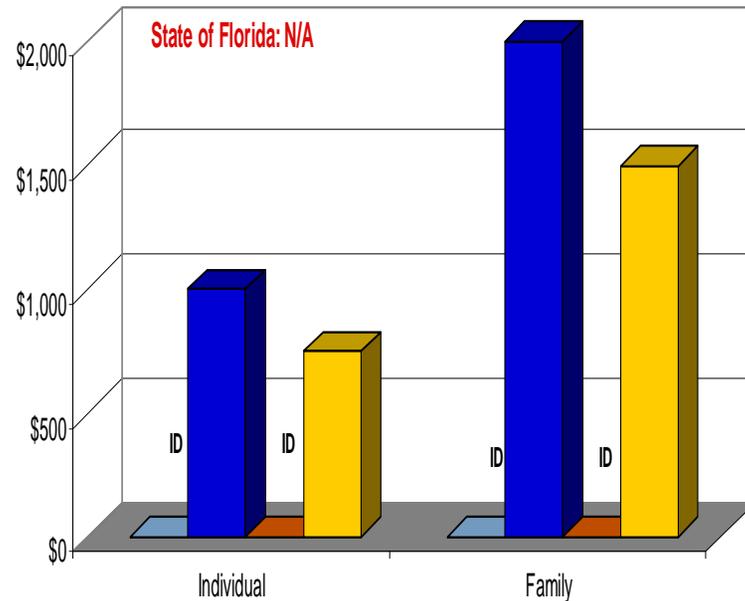
2010 CDHP Benchmarks vs. 2010 Plan

Median Employer Contribution to HSA or HRA

Health Savings Account (HSA)



Health Reimbursement Arrangement (HRA)



“ID” indicates Insufficient Data

- National 50-199
- States 500+
- Florida 500+
- National 500+

2010 CDHP Benchmarking

HSA-based Consumer Directed Health Plan

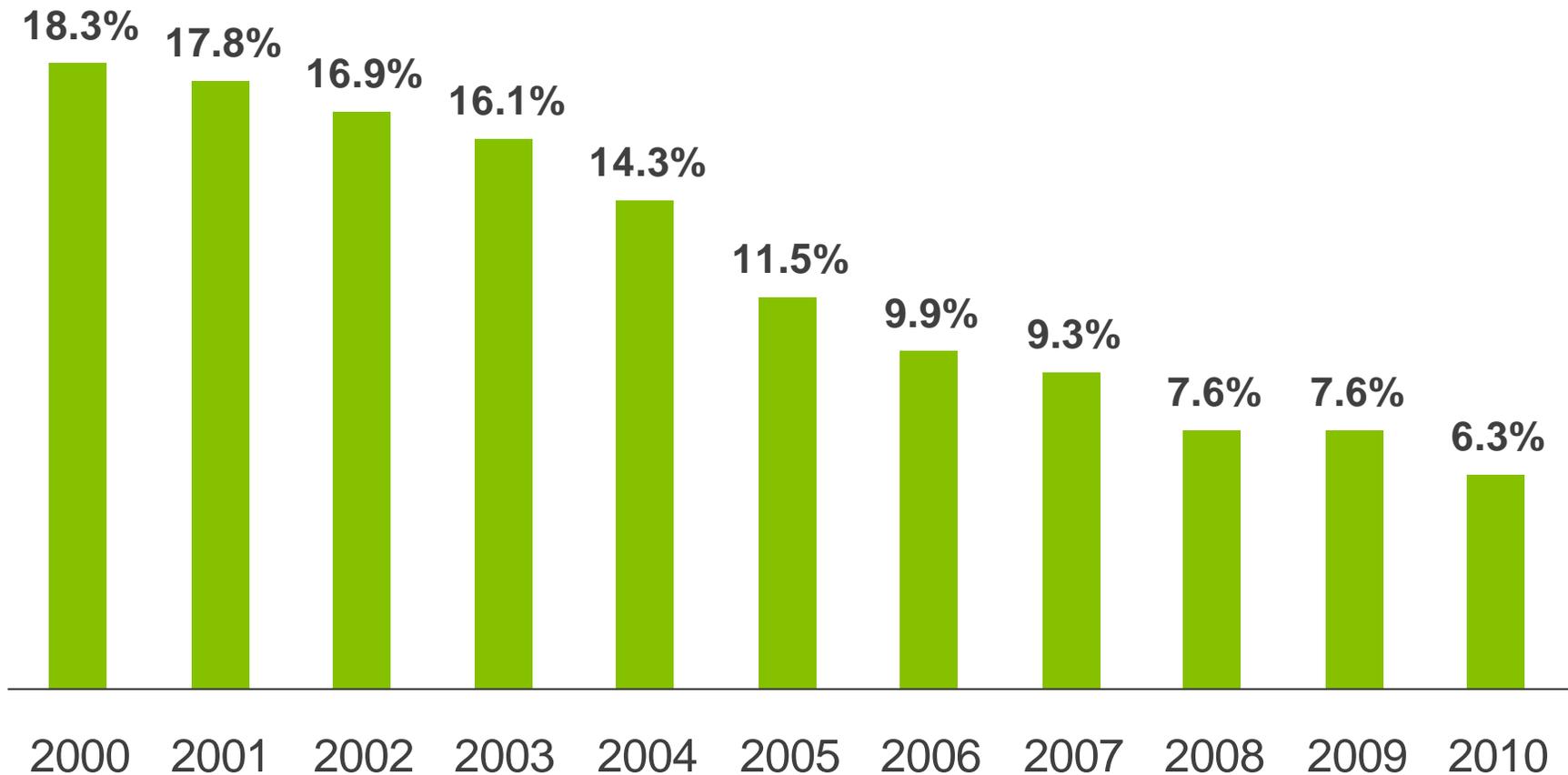
HSA Based Consumer Directed Health Plan	State of Florida	National 50-199	STATES 500+	FLORIDA 500+	NATIONAL 500+
Deductible					
Employee-Only Coverage	\$1,250	\$2,500	\$1,500	\$1,500	\$1,500
Family Coverage	\$2,500	\$5,000	\$3,000	\$3,000	\$3,000
Maximum OOP For Employee-Only Coverage	\$4,250	\$2,850	\$3,000	\$3,000	\$3,000
Maximum OOP For Family Coverage	\$8,500	\$5,600	\$7,500	\$6,000	\$6,000
Offer "Limited-Purpose" FSA	Yes	38%	70%	58%	55%
Preventive Care Coverage Under HSA-Based CDHP					
Covered at 100% For Defined Set Of Services	Yes	47%	90%	83%	72%
Covered at 100% With Dollar Limit Per Year	N/A	23%	0%	6%	10%
Covered Same As Other Services	N/A	12%	10%	0%	10%
Covered Some Other Way	N/A	18%	0%	11%	9%



VI. Prescription Drug Benchmarking

Prescription drug benefit cost is now growing at nearly the same rate as overall medical plan cost

Cost increase in primary medical plan for large employers



Drug benefits have been carved out of primary medical plan, by employer size

50 – 499 employees



500 – 999 employees



1,000 – 4,999 employees



5,000 or more employees



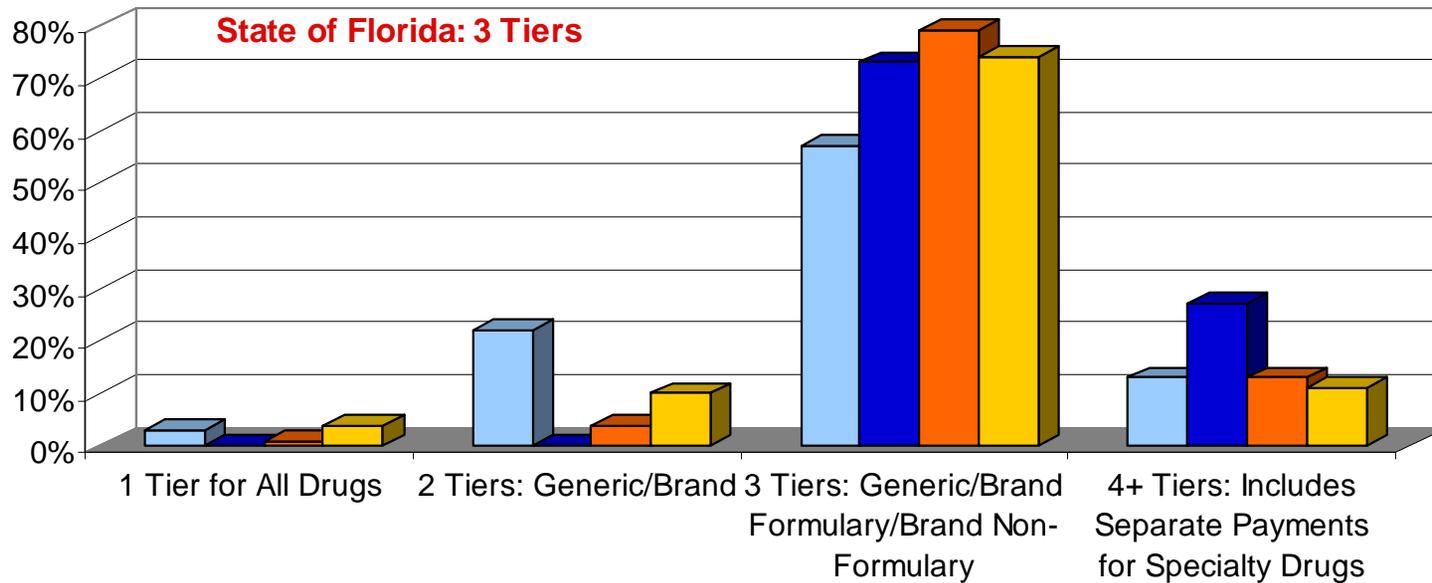
Use of coinsurance in drug plans

Percent of employers requiring coinsurance

	50-499 employees		500-4,999 employees	
	Retail	Mail-order	Retail	Mail-order
Generic drugs	2%	2%	6%	5%
Formulary brand	4%	4%	10%	9%
Non-formulary brand	5%	6%	14%	12%
Specialty / biotech	8%	8%	4%	3%
Any drug category	16%	16%	22%	18%

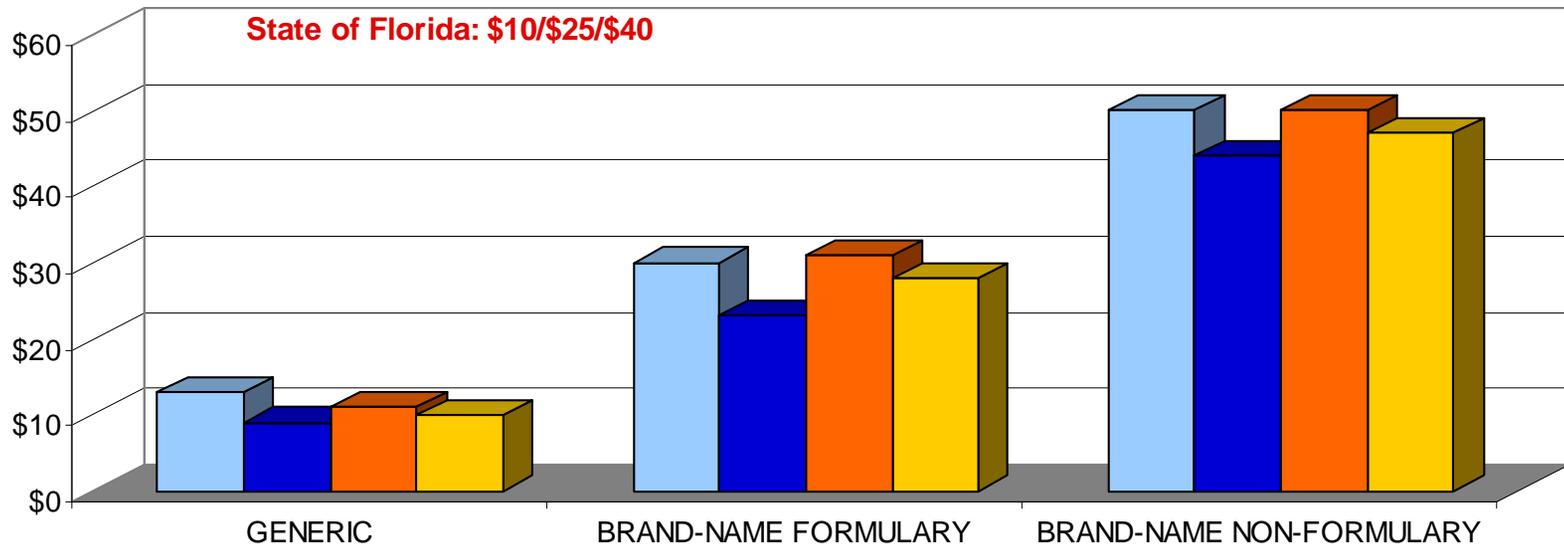
2010 PPO Benchmarks vs. 2010 Plan Prescription Drug Benefits—Plan Design

Rx Plan Design



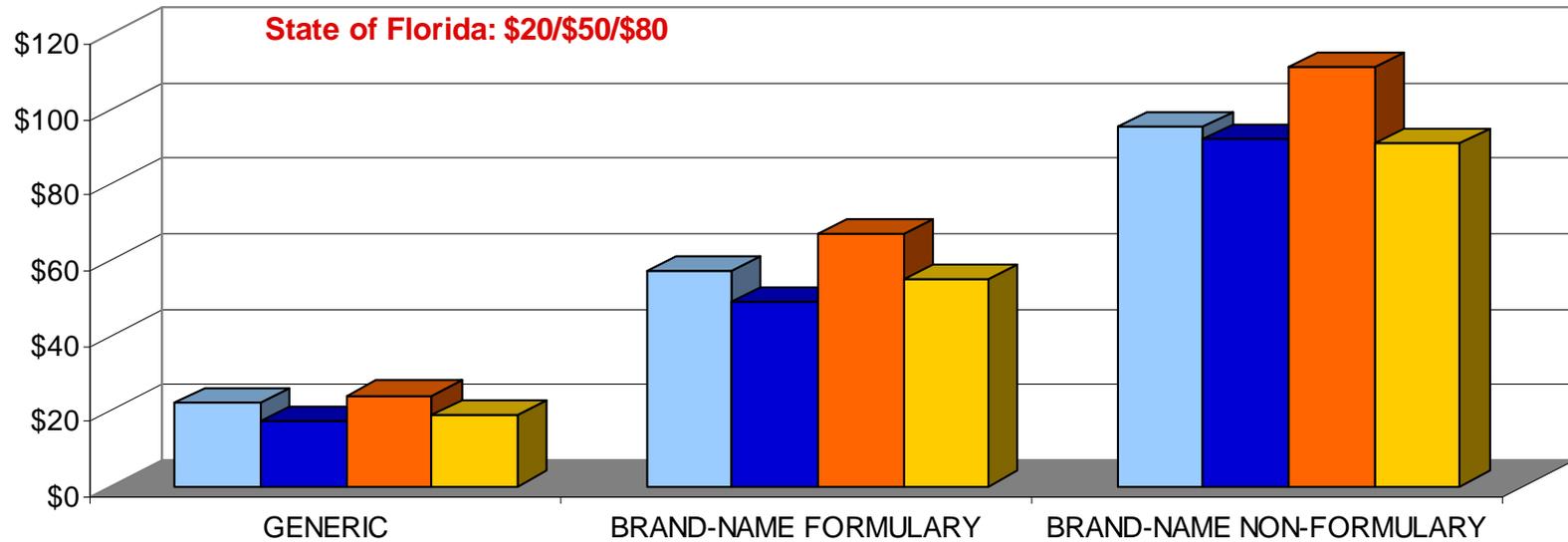
2010 PPO Benchmarks vs. 2010 Plan Prescription Drug Benefits—Retail

Three-Tier Retail Rx Copays



2010 PPO Benchmarks vs. 2010 Plan
Prescription Drug Benefits—Mail Order

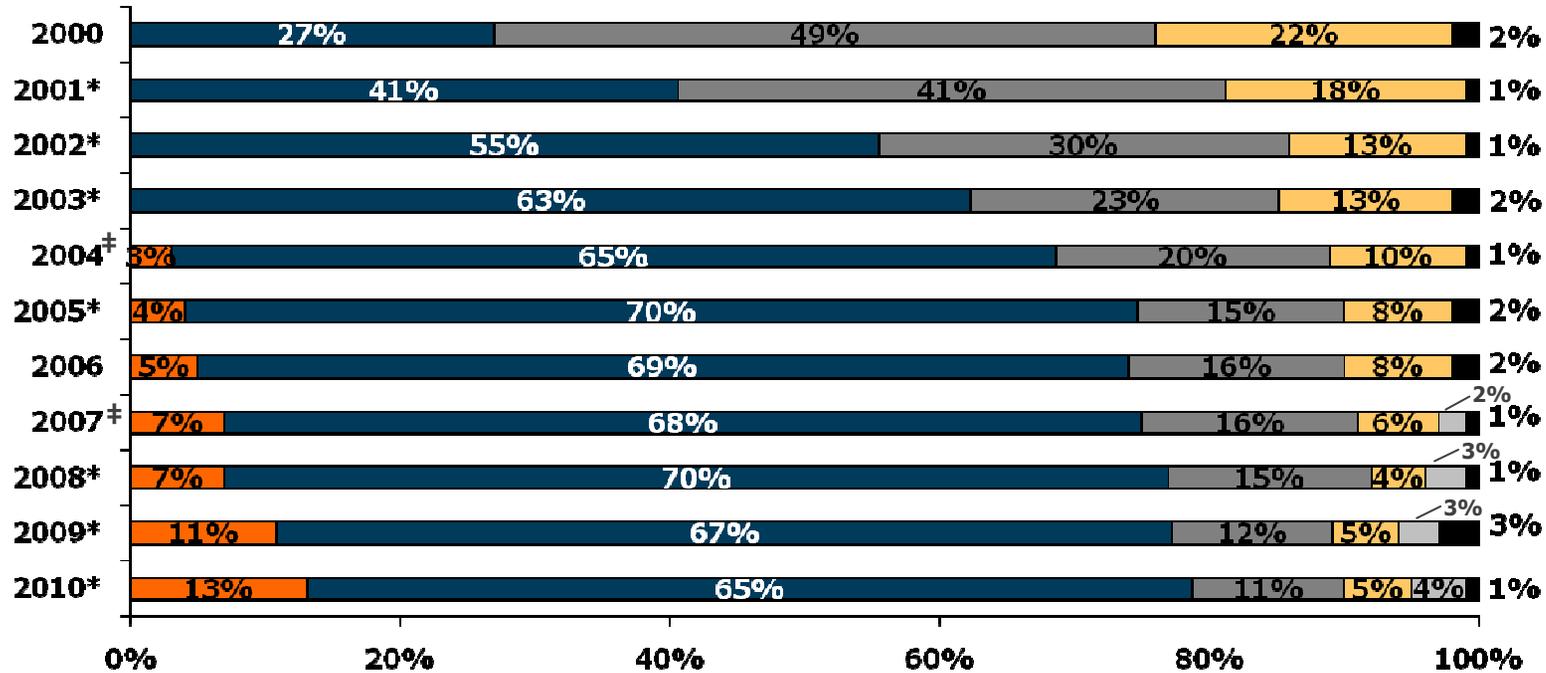
Three-Tier Mail Order Rx Copays



- National 50-199
- States 500+
- Florida 500+
- National 500+

Distribution of Prescription Drug Cost Sharing Formulas

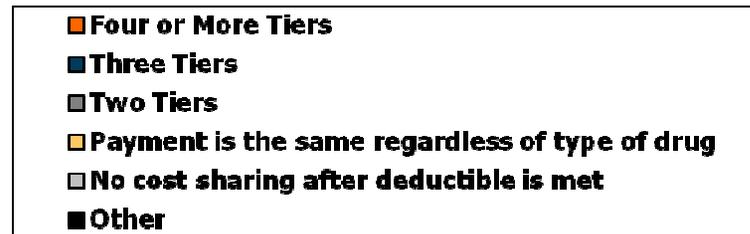
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2010



*Distribution is statistically different from distribution for the previous year shown ($p < .05$).

‡No statistical tests are conducted between 2003 and 2004 or between 2006 and 2007 due to the addition of a new category.

Note: Fourth-tier drug cost-sharing information was not obtained prior to 2004.



MERCER

THE FLORIDA SENATE

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(Submit to Committee Chair or Administrative Assistant)

10-20-11

Date

Bill Number

Barcode

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Tallahassee FL 32399

City

State

Zip

Job Title Director

State Group Insurance

Speaking: For Against Information

Appearing at request of Chair

Subject Health Plan Options

Representing Dept of Management Services

Lobbyist registered with Legislature: Yes No

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If designated employee: Time: from .m. to .m.

S-001 (04/14/10)

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

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10/20/2011

Date

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REPORT PAGES 21-27

Bill Number

Barcode

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Speaking: For Against Information

Appearing at request of Chair

Subject PHARMACY BENEFIT MANAGEMENT FOR STATE GROUP HEALTH INSURANCE PLAN

Representing FLORIDA PHARMACY ASSOCIATION

Lobbyist registered with Legislature: Yes No

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S-001 (04/14/10)

CourtSmart Tag Report

Room: KN 412
Caption: Senate Budget Committee

Case:
Judge:

Type:

Started: 10/20/2011 2:06:20 PM
Ends: 10/20/2011 3:33:31 PM Length: 01:27:12

2:06:22 PM Sen. Alexander (Chair)
2:09:20 PM TAB 1 - Estimating Conference Revisions
2:09:36 PM Amy Baker, Coordinator, Office of Economic & Demographic Research
2:29:03 PM Sen. Alexander
2:30:08 PM A. Baker
2:33:23 PM Sen. Rich
2:33:47 PM Sen. Alexander
2:33:57 PM A. Baker
2:35:13 PM Sen. Rich
2:35:29 PM Sen. Alexander
2:37:40 PM Sen. Simmons
2:39:03 PM A. Baker
2:40:50 PM Sen. Simmons
2:41:05 PM Sen. Alexander
2:41:23 PM Sen. Gaetz
2:41:58 PM A. Baker
2:42:36 PM Sen. Alexander
2:43:01 PM A. Baker
2:43:19 PM Sen. Simmons
2:43:32 PM Sen. Alexander
2:43:38 PM A. Baker
2:43:52 PM Sen. Alexander
2:47:33 PM A. Baker
2:50:00 PM Sen. Alexander
2:51:28 PM TAB 2 - Dept. of Management Services Report - Strategic Health Plan Options for the State of Florida
2:52:29 PM Michelle Robleto, Director, Division of State Group Insurance, Dept. of Management Services
2:59:36 PM Sen. Montford
2:59:57 PM M. Robleto
3:00:16 PM Sen. Montford
3:00:35 PM M. Robleto
3:01:06 PM Sen. Montford
3:01:20 PM M. Robleto
3:01:34 PM Sen. Alexander
3:02:08 PM M. Robleto
3:02:49 PM Sen. Alexander
3:03:51 PM Sen. Gaetz
3:05:42 PM M. Robleto
3:06:36 PM Sen. Alexander
3:07:07 PM M. Robleto
3:17:34 PM Sen. Gaetz
3:18:27 PM M. Robleto
3:19:33 PM Sen. Gaetz
3:20:47 PM M. Robleto
3:21:24 PM Sen. Gaetz
3:22:47 PM Sen. Sobel
3:23:25 PM M. Robleto
3:24:28 PM Sen. Sobel
3:24:37 PM Sen. Montford
3:26:47 PM M. Robleto
3:27:15 PM Sen. Montford
3:27:28 PM Sen. Lynn
3:27:55 PM Sen. Alexander

3:27:58 PM	Sen. Lynn
3:28:09 PM	Sen. Alexander
3:28:17 PM	Sen. Rich
3:29:35 PM	M. Robleto
3:30:26 PM	Sen. Rich
3:30:51 PM	Sen. Alexander
3:31:36 PM	M. Robleto
3:32:29 PM	Sen. Alexander



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

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Rules

SENATOR ANITERE FLORES

Majority Whip
38th District

OK JD
9/7/11

September 1, 2011

The Honorable JD Alexander
Chair of Committee on Budget
201 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Alexander:

I respectfully request to be excused from the Committee on Budget during the months of September, October and November. I have been informed by my doctor that I should refrain from travel until after I have given birth which is expected to be at the end of October.

Please do not hesitate to contact me should you have any questions.

Sincerely,

Anitere Flores

CC: Ms. Terry Rhodes, Staff Director, Committee on Budget

REPLY TO:

- 10691 North Kendall Drive, Suite 309, Miami, Florida 33176 (305) 270-6550
- 316 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5130

Senate's Website: www.flsenate.gov

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Budget - Subcommittee on Transportation, Tourism,
and Economic Development Appropriations,
Vice Chair
Reapportionment, *Vice Chair*
Banking and Insurance
Budget
Budget - Subcommittee on Finance and Tax
Communications, Energy, and Public Utilities
Criminal Justice
Governmental Oversight and Accountability
Rules

SENATOR GWEN MARGOLIS
35th District

October 17, 2011

President Haridopolos,

On Monday, October 24, 2011, I am schedule to undergo surgery for a hip replacement. During this week, I will be having the necessary "pre-ops" that are require pre-surgery. At this time, I am requesting approval of my absence from the current committee week and the committee week of October 31st.

My Legislative staff will be in Tallahassee in my absence and should you need anything, please do not hesitate to contact them.

Thank you again for your continued support and understanding.

Sincerely,

Gwen Margolis
State Senator

ok
JM

- cc: Chair Alexander
- cc: Chair Benacquisto
- cc: Chair Gaetz
- cc: Chair Richter
- cc: Chair Bogdanoff
- cc: Chair Gardiner
- cc: Chair Evers
- cc: Chair Ring
- cc: Chair Thrasher

SENATE APPROPRIATIONS
11 OCT 17 AM 10:15
STAFF DIR. _____ STAFF _____

REPLY TO:

- 3050 Biscayne Boulevard, Suite 600, Miami, Florida 33137 (305) 571-5777
- 414 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5121

Senate's Website: www.flsenate.gov

MIKE HARIDOPOLOS
President of the Senate

MICHAEL S. "MIKE" BENNETT
President Pro Tempore