The Florida Senate

Interim Project Report 2004-140 *January 2004*

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STATE EMPLOYEES' HEALTH INSURANCE

SUMMARY

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

BACKGROUND

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

State employees in established positions[1] may select from either a universally accessible self-insured indemnity plan or one of several area-specific managed care providers Both plans also include a prescription drug benefit with tiers of employee co-payments based upon drug type and dispensing means. The employer provides premium-free health insurance coverage for dually employed spouses, exempt and managerial employees, and state officers. Retirees are permitted to maintain their state health insurance benefits at full cost less a separately funded health insurance premium subsidy allowance set by statute.[2] Participants in the Deferred Retirement Option Program (DROP) receive the lower premium exposure of active employees until their termination of employment. Florida law[3] also permits designated units of local government to apply for plan membership under similar financial terms and conditions.

The Division of State Group Insurance in the Department of Management Services is responsible for plan administration. That entity contracts with Blue Cross and Blue Shield of Florida for third party administrator services for the self-insured indemnity plan. The administrator provides the physician and hospital network and operates the medical cost control systems. The division negotiates separately with the multiple managed care providers and retains a pharmaceutical benefits manager. The general parameters of coverage are established in s. 110.1234, F.S., with the components of plan benefits established in the contract. A conference process for the development of consensus funding estimates is provided by s. 216.136(11), F.S.[4]

The health insurance estimating conference reported operating deficits in the state employee health insurance program exceeding $120 million in FY 2002,

[1] Section 110.123, F.S., excludes health insurance coverage for persons performing casual labor.

[2] Section 112.363, F.S.

[3] Section 110.1228, F.S.

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

and $94 million by June 30, 2003, net of FY 2002 premium increases. Under the financial outlook prepared on November 13, 2003, the negative cash flow continues but a positive ending cash balance of $40 million in June 2004 turns negative again the following year. An earlier financial collapse was averted in fiscal years 1997-99 only through a combination of cash infusions by the Legislature, three separate emergency loans from the state treasury, and additional increases in employer, employee and retiree contributions. In only two of the past several plan years since FY 96 was there *not* an estimated cash balance deficit. The durability of the changes made in 2003 will be short-lived as additional revenue from premium increases, benefit redesign, and higher co-payments effective in January 2004 will be insufficient by 2005. Total program enrollment, inclusive of indemnity and managed care options, is increasing by only about one percent per year but retiree enrollment is averaging five times that growth rate.[5]

METHODOLOGY

The report gathered materials from the Division of State Group Insurance, the legislative estimating conference process, and statutory directives for study initiatives given by the 2001 Legislature. Staff has also assembled and analyzed source materials from employee benefit consulting firms that review the cost and deployment of workplace benefits.[6] Lastly, the staff has reviewed materials from the State's third party administrator (TPA) discussing alternative approaches to benefit expense payment and administration.

FINDINGS

Cost Controls

The indemnity plan employs multiple design and management cost control features. The principal ones are higher out-of-pocket expense for use of out-of-network care, co-payments and deductibles for approved care, lower cost generic drug availability including mail-order multiple refills, utilization review, and pharmaceutical benefits management. A recently issued legislative report outlined the possible changes within each of these categories.[7] Cost controls alone contain inherent limitations. *First*, they accept the delivery structure and philosophy of coverage as a constant, varying only the incidence of burden; they do not address the difficult but more powerful issues of wellness and proactive disease management. Active disease management programs are available through Medicaid, thus creating the unusual policy imbalance of having proactive health controls for the unemployed and simply reactive ones for the employed. *Second*, front-end cost controls alone are not terribly powerful unless they are substantial. Significant increases in office visit co-payments produce relatively insignificant results. *Third*, higher financial barriers to primary care may act as a disincentive to seek care. This could risk greater employee and plan exposure to deferred, more costly events.

The financial experience with prescription drugs – its costs doubling every 4 years - is illustrative of just such a dilemma. Employee co-payments have risen to meet cost increases while the plan attempts to secure longer-term solutions for expanded purchasing discounts. The ability to secure such discounts is itself embroiled in a larger national debate about pricing, distribution rights, and allocation of research costs over which the State of Florida can exercise little, immediate impact, short of negotiating direct agreements with manufacturers, testing the limits of litigious choices, or making choices that separate price discounts from quality assurance.

Incidence of Cost and True Cost

The Preferred Provider Organization (PPO) apportions premium expense on a shared basis. About 9,000 dually employed spouses in the Career Service receive insurance coverage without employee premium expense, and a premium forgiveness feature is also provided to exempt and managerial employees and state officers. A civil service reform initiative of the 2001 Legislature expanded this premium benefit feature to a larger category of exempt workers, expanding beneficiaries from 19,000 to 35,000.

Philosophy of Coverage

Inherent to the PPO plan is a philosophy of first day coverage to the employee and all immediate family members. But changing national demographics of household formation and child rearing are witnessing

[5] Department of Management Services, *State Employees' Group Health Insurance Trust Fund*, Report on the Financial Outlook for the Fiscal Years Ending June 30, 2004 & 2005, November 13, 2003.

[6] Mercer Human Resource Consulting, *State of Florida Employees' Group Health Insurance Program*: Report on Program Design and Funding Alternatives for Calendar Year 2005, November 21, 2003.

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

more single-parent families as well as grandparents raising their grandchildren. About one in every nine participants in the family plan is a single parent with one or more children. The state plan provides a single premium structure regardless of family size, thus providing a subsidy to larger households and a greater relative cost to smaller ones. Many large plans that permit dependent coverage permit spouse, dependent, and other benefit eligibility with different coverage and eligibility assumptions for their workforces.

The 1997 Legislature's enactment of DROP has also affected the premium cost structure. The DROP program permits participating employees to enjoy the deferred receipt of pension benefits in an interest-bearing account while staying as salaried employees for up to five years. In that capacity DROP participants are not exposed to the full insurance premium less the subsidy payment. They receive the same premium-sharing arrangement, or full forgiveness, as active employees. This subsidy phenomenon is not unique to the DROP participants. As the below table indicates there are parallels embedded elsewhere in the PPO:

PPO Costs and Enrollment Subsidies, FY 2001, Per Subscriber

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

Single and family coverage for active employees now are priced close to cost. Eligible retiree groups received coverage at a per-enrollee premium deficit ranging from $135 to $310 a month in 2001. But too abrupt a change could pose significant intergenerational inequities and undermine the concept of group coverage.[8,9] As discussed below, equally significant though subtle changes have been occurring concurrently with their own cost consequences.

Privatization, Outsourcing, and Demographics

The Legislature first established a statutory preference for contracted over directly provided public services with the 1975 reorganization of the then Department of Health and Rehabilitative Services and the creation of a Department of Corrections.[10] In the ensuing years the use of contracted providers has grown many fold. Today, some 40% of the state budget is directly vendor delivered. Over time this has suppressed on-budget position growth and shifted benefit responsibility from the treasury to the vendors themselves.[11] Accompanying this suppression has been the natural retirement of the children of World War II-era parents, the ones who populated the expansion of government services in the 1960s and 1970s. Technology has permitted replacement of their labor-intensive activities with ones emphasizing force multiplier, process-based improvements. These events have exacted two costs: *first*, the insurance plan is losing the replenishment factor of new workers, especially single males, who pay premiums but make few claims. S*econd*, the residual workforce has aged as positions are eliminated, employees terminate, and benefit claims increase. In its most recent annual report the Division of Retirement documented the decline in active members of the state pension plan and the 30% increase in the ratio of annuitants to retired plan members since 1998.[12] Some state contract vendors are beginning to experience similar insurance difficulties.[13]

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[8] The Division of State Group Insurance asked the TPA to evaluate a proposal to pay employees $100 a month not to enroll in the state PPO. Such an alternative, while saving money in the short term, could result in adverse selection as healthy subscribers depart and may create a public policy of paying employees to sign up for public assistance. The TPA recommended against this concept in February 2001 and suggested consideration of several alternative benefit platforms with greater employee selectivity on cost exposure. Section 8 of the General Appropriations Act for FY 2002, ch. 2001-253, Laws of Florida, required a review of this option along with an independent actuarial review of many of the other issues discussed in the March 2001 OPPAGA report (fn. 6, above) for delivery by January 1, 2002.

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

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

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

[12] State of Florida, Department of Management Services, Division of Retirement, *Annual Report*, July 1, 2001-June 30, 2002, Tallahassee, FL.

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

How the State of Florida manages its benefit base produces its own stresses. The more than $570 million in vested leave benefits for state employees are unfunded. Their payment is accommodated in agency budgets through a combination of position lapse, salary rate, and unfilled position decisions that manage the financial exposure but at some compromise to agency mission. Potential changes in the funding of postretirement benefits advanced by the Governmental Accounting Standards Board may accelerate the recognition and funding of these liabilities.[14] Any significant shift from the current "pay-as-you-go" approach to an actuarial funding method could pose unrecognized employer funding burdens as early as 2006.

The transfer of the public post-secondary education system to "non-state agency" status has effectively altered the federal tax-exempt status of the plan requiring it to requalify as a multi-employer plan. Furthermore, the Department of Education indicated in 2003 that it would like to solicit health coverage for its member state universities separate from the state plans although a specific contract was not executed.

Technology, Expectations, and Economics

Advances in medical technology produce improvements in diagnosis and treatment permitting a productive return to the active workforce following illness or injury. Yet the innovations themselves are expensive and produce uncomfortable and imprecise compromises between better or cheaper. Is the employee who stays out a shorter amount of time because of a more expensive but successful intervention a hero, or is the employee who stays out longer but costs less the one to be celebrated? In spite of the advancement of public sector performance measurement, a decision on whether the quality of the effort and its effectiveness is better than the quantity of its volume and its expense is still far from settled. As governments continue to examine the durability of the silent employment contract – "we will always take care of you" – mixed policy and financial signals will endure.

In early 2002 the Legislature received an actuarial report on financial and structural alternatives for the plan.[15] That report presented fifteen ideas for the distribution of risk, equitable apportionment of contributions, and subscriber coverage choices that would lessen the recurring negative cash flows. Subsequently, in 2003 two additional reports were received by the plan consultants who argued a more comprehensive restructuring of its component parts. Among the changes noted in the most recent report received from the plan consultants were the emergent changes at the federal and large private employer level expanding the use of wellness and consumer-choice[16] driven health care models specifically tailored to individual participant values. That report suggested a multi-faceted and multi-year engagement by policymakers in reformatting the health insurance choices for its state government agencies and employees.

RECOMMENDATIONS

It is unlikely that any single change will durably address the multiple factors at work in the state employee health insurance plans. At a time when there was sustained growth in the state workforce, many of the imperfections were tolerable when addressed on an incremental basis. But state employee health insurance finds itself at a demographic and financial crossroads. Its active membership is beginning a sustained overall decline as it finds itself with a maturing and departing workforce. The effects have been incremental but unmistakable: systemic reengineering of plan design and funding is required. Several levels of recommended alternatives are offered based upon scope of intervention and depth of change.

The lessons that can be learned from two previous benefit reengineering exercises are illustrative of the challenges and the opportunities that present themselves. Deferred promises without funding led to the collapse of the former Teachers' Retirement System in the late 1960s but led ultimately to the creation of a well-funded FRS successor. The 2000 Legislature created an alternative pension choice in FRS that

[14] Governmental Accounting Standards Board, *Accounting and Financial Reporting by Employers for Postretirement Benefits Other than Pensions*, Exposure Draft, February 14, 2003.

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

[16] A "consumer choice" model can take many forms but refers generally to a plan in which the employer negotiates a benefit package but gives the employee some equity ownership in the premium payments. The employee may use or roll over the unused amounts to subsequent plan years. Such plans usually have a stop loss feature in which the employer provides catastrophic coverage for unusual or chronic events.

permitted the complementary co-existence of two differing pension ethics. These two events suggest that systemic change can be effected without jeopardizing anyone's financial security, one that contains elements of choice and relevance for changing circumstances, in changing times, and in changing markets.

1. The Legislature should consider significantly amending chs. 110 and 112, F.S., to establish a health insurance plan for state employees, retirees, and their dependents that achieves overall state health goals on a generational basis and is not simply reactive to recurring cash flow crises.
2. The Legislature should consider rechartering the plan to permit federal compliance as a multiple employer entity. While this will ensure nominal compliance for state and former state agencies, the larger question must be debated as to how open the plan should be to new, non-state entities that are dealing with the difficult choices of affordability and access in their own benefit plans.
3. This public policy revision should take advantage of the wellness efforts being pioneered through the Department of Health, the Agency for Health Care Administration and other private and public sector employers but now defined principally to the unemployed and the un- and underinsured.
4. The Legislature should consider funding for the Department of Management Services to use its underused disease management and epidemiological data base to focus on the significant cost drivers of plan expenses. The wealth of data that can be mined from this resource would exceed its nominal cost.
5. The Legislature should consider using three structural elements at its disposal to influence a revision in this benefit system.

First, a policy statute should be crafted that does not focus on specific benefit components but sets overall design and expectation. The current use of indemnity and managed care providers with an overlay of external administrators has served the state well and should continue to be featured in future designs.

Second, Once a durable structure is created its implementation should be executed through the appropriations process. This uses the powerful and short-range tools of the appropriations and implementing bills to provide the necessary cost discipline but still retains the longer term objectives of general law.

Third, the Legislature should provide for a disciplined reprocurement of employment-based health care services. Considerable lessons have been learned about the acquisition of government services over the past several years. A revised procurement which uses the best assets of a business case analysis, service level agreements, and arrays the costs and benefits in a manner that provides individual choice and employer stability will meet the needs of active and retired employees for years to come.