HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHSC 12-02 State Employee Group Insurance Program
SPONSOR(S): Health & Human Services Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee		Shaw	Gormley

SUMMARY ANALYSIS

The State Group Insurance Program (program) is an optional benefit for employees that includes health, life, dental, vision, disability, and other supplemental insurance benefits. The current program is a defined benefit program in which the state selects the health benefits, sets the premium level for employees, and pays the difference between the premium paid by the employee and the cost of the health plan.

The bill converts the program from defined benefit to defined contribution as of 2014. With a defined contribution plan, the employer contributes a defined amount toward benefits on behalf of the employee and the employee is given a variety of options to purchase. Instead of the employer choosing the benefit package, the employee is given discretion to choose benefits that best suits the employee's individual needs.

The bill sets a minimum amount for the defined contribution. That minimum is based on the current level of the employer contribution and the actuarial value of the current plan. The state's currently pays approximately 90% of the cost of an individual health plan and 85% of the cost of a family health plan. The bill authorizes an enhanced contribution for non-tobacco users. If the employee selects a health plan that costs more than the state's contribution, the employee will have to pay the balance. However, if the employee selects a health plan that costs less than the state's contribution, the employee may use the balance to fund a Flexible Spending Arrangement, to fund a Health Savings Account, or to increase the employee's salary.

The bill also directs DMS to competitively procure an independent benefits consultant (IBC). The IBC will assist DMS with aspects of the administrative management of the state group insurance program. DMS will manage the contract with the IBC and be responsible enrollment activities and the financial management of the program.

The IBC will develop a plan to convert the state program to a defined contribution program. The plan shall include recommendations for timelines, contribution polices, incentives for health lifestyle choices, and program design and structure.

During the 2013 session, the Legislature will review the plan submitted by the IBC. The Legislature may approve or modify the plan. If the plan is approved, the independent benefits consultant will assist DMS to implement the transition in 2014.

The state may experience both costs and savings. See fiscal comments.

The bill has an effective date of upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

State Group Insurance Program

Overview

The State Group Insurance Program (program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS).

The program is an optional benefit for all state employees including all state agencies, state universities, the court system, and the Legislature. The program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

The health insurance benefit for active employees has premium rates for single, spouse, or family coverage regardless of plan selection. The state contributes approximately 90% toward the total annual premium for active employees for a total of $1.40 billion out of total premium of $1.57 billion for FY 2011-12[1]. Approximately 67% of the state's total annual contribution is general revenue. The general revenue contribution was $971.5 million in FY 2010-11. The remaining $478.5 million was from state trust funds.

The program provides several options for employees to choose as their health plans. The preferred provider organization (PPO) plan is the statewide, self-insured health plan administered by Blue Cross Blue Shield of Florida. The administrator is responsible for processing health claims, providing access to a Preferred Provider Care Network, and managing customer service, utilization review, and case management functions. The standard health maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs.

Prior to the 2011 plan year, the participating HMOs were fully insured; in other words, the HMOs assumed all financial risk for the covered benefits. During the 2010 session, the Legislature enacted s. 110.12302, F.S., which directed the Department of Management Services to require costing options for both fully insured and self-insured plan designs as part of the department's solicitation for health maintenance organization contracts for the 2012 plan year and beyond. The department included these costing options in its Invitation to Negotiate[2] to HMOs for contracts for plans years beginning January 1, 2012. The department entered into contracts for the 2012 and 2013 plan years with two HMOs with a fully insured plan design and four with a self-insured plan design.

High Deductable Health Plans (HDHP) with Health Savings Accounts (HAS)

Additionally, the program offers two high-deductable health plans (HDHP) with health savings accounts[3]. To qualify as a high-deductable plan, the annual deductible must be at least $1,200 for single plans and $2,400 for family coverage. The Health Investor PPO Plan is the statewide, high deductable health plan with an integrated health saving account. It is also administered by Blue Cross Blue Shield of Florida. The Health Investor HMO Plan is a high deductable health plan with an integrated health saving account in which the state has contracted with multiple state and regional HMOs. The state makes a $500 per year contribution to the health savings account for single coverage and a $1,000 per year contribution for family coverage. The employee may make additional annual contributions[4] to a limit of $5,950 for single coverage and $11,900 for family coverage. Both the employer and employee contributions are not subject to federal income tax on the employee's income.

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[1] Fiscal information provided by DSGI.
[2] ITN NO.: DMS 10/11-011
[3] Sec. 223 I.R.C.
[4] The IRS annually sets the contribution limit as adjusted by inflation.

Unused funds roll over automatically every year. A health savings account is owned by the employee and is portable.

Flexible Spending Accounts

Currently, the state program offers flexible spending accounts (FSA)[5] as an optional benefit for employees. The FSA is funded though pre-tax payroll deductions from the employee's salary[6]. The funds can be used to pay for medical expenses that are not covered by the employees' health plan. Presently, there is no limit on the contribution to a FSA; however, beginning in 2013 the contribution will be limited to $2,500 and subsequently adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement. If the employee does not annually use the contributions to the FSA, the contributions are forfeited.

Cafeteria Plans

A cafeteria plan is a plan that offers flexible benefits under the Internal Revenue Code Section 125. Employees choose from a "menu" of benefits. The plan can provide a number of selections, including medical, accident, disability, vision, dental and group term life insurance. It can reimburse actual medical expenses or pay children's day care expenses.

A cafeteria plan reduces both the employer's and employee's tax burden. Contributions by the employer are not subject to the employer social security contribution. Contributions made by the employee are not subject to federal income or social security taxes.

The employer chooses the range of benefits it wishes to offer in a cafeteria plan. The plan can be a simple premium only plan where the only health insurance is offered. Full flex plans, which offer a wide variety of benefits and choices, are more often offered by large employers and allow for more consumer directed consumption of benefits. In some full flex plans, the employee is offered the choice between receiving additional compensation in lieu of benefits.

The state program qualifies as a cafeteria plan.[7]

Employer and Employee Contributions

The state program is considered employer-sponsored since the state contracts with providers and contributes a substantial amount on behalf of the employee toward the cost of the insurance premium. The state's employer contribution is part of a state employee's overall compensation. The state program is a defined-benefit program. The employee pays a set monthly premium for either a single or family plan. The state pays the reminder of the cost of the premium. In a defined-contribution program, the employer pays a set amount toward the monthly premium and the employee pays the reminder.

[5] Sec. 125 I.R.C.; see IRS Publication 969 (2011).

[6] Employers are also allowed to contribute to FSAs.

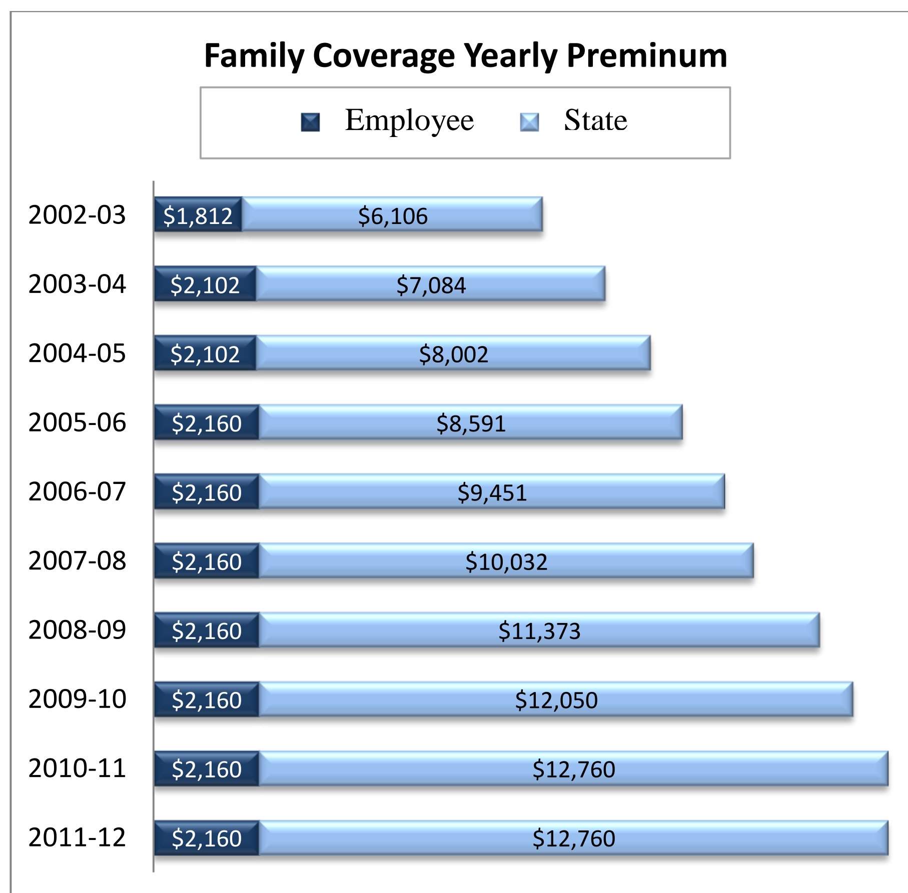
[7] Sec. 125 I.R.C. requires that a cafeteria plan allow its members to choose between two or more benefits "consisting of cash and qualified benefits." The proposed regulations define "cash" to include a "salary reduction arrangement" whereby salary is deducted pre-tax to pay the employee's share of the insurance premium. Since the state program allows a "salary reduction arrangement", the program qualifies as a cafeteria plan. 26 C.F.R. ss. 1.125-1, et seq.

The following chart shows the monthly contributions[8] for the state and the employee to employee health insurance premiums.

Category	Coverage	Standard Plan PPO/HMO			Health Investor Health Plan PPO/HMO		
		Employer	Enrollee	Total	Employer*	Enrollee	Total
Career Service	Single	499.80	50.00	549.80	499.80	15.00	514.80
	Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
	Spouse	1,243.32	30.00	1,273.32	1,097.64	30.00	1,127.64
SES/SMS/EOG/ LEG/Lottery	Single	541.46	8.34	549.80	506.46	8.34	514.80
	Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64

*Includes employer tax-free HSA contribution - $500 per year for single coverage and $1,000 per year for family coverage.

The state program is estimated to spend $1.9 billion in FY 2011-12 in health benefit costs.[9] Spending is projected to increase on average 9.2% per year through FY 2015-16.[10] The state has absorbed most of the cost of the increase and employee contributions have remained relatively flat as illustrated by the following chart.[11]



[8] State Employees' Group Health Self-Insurance Trust Fund, Report on the Financial Outlook, January 4, 2012.
[9] Id.
[10] Id.
[11] Fiscal information provided by DSGI.

Employer-sponsored Insurance Trends

DGIS contracted with Mercer Consulting to prepare the Benchmarking Report[12] (report) for the state group insurance program. The report compares Florida's state group insurance program to the programs of other large employers[13], both in the public and in the private sectors. Specific findings in the report include:

- From 2005 through 2009, cost increases for health benefits per employee averaged 6%.
- In 2010, the average cost increase for health benefits per employee for all employers was 7%, but costs for large employers increased 8.5% with the average premium cost exceeding $10,000 per employee for the first time.
- To hold down costs, employers are continuing to shift costs to employees through higher deductibles, co-insurance, and other cost-sharing provisions.

The report also found that State of Florida contributes a higher percentage of the premium to employee health benefits than other states and private employers. For example, Florida pays 84% of the monthly premium for a family PPO plan, but the average for large national employers is 69%. This results in Florida state employees paying less in monthly premiums than other states' employees and private employees. For example, the monthly premium for a family PPO plan for a Florida state employee is $180 and the average premium for large national employers is $361.

Plan Options

The FY 11-12 General Appropriations Act directed DMS to develop a report of plan alternatives and options for the state program. DMS contracted with Buck Consultants who released its report[14] on September 29, 2011. The report concludes:

> 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.

Employer Sponsored Insurance Exchanges

A health insurance exchange is intended to create organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to

[12] Mercer Consulting, State of Florida Benchmarking Report (March 24, 2011), available at: http://www.dms.myflorida.com/index.php/content/download/81470/468862/version/1/file/2010+Benchmarking+Report+for+State+of+Florida.pdf
[13] For the purpose of the report, "large employers" had 500 or more employees.
[14] Buck Consultants, Strategic Health Plan Options for the State of Florida (September 29, 2011), available at: http://www.dms.myflorida.com/index.php/content/download/81468/468856/version/1/file/Strategic+Health+Plan+Options+for+the+State+of+Florida+9-30-11+-+Final.pdf

them.[15] An insurance exchange can be either public or private. Currently, there is a growing market in private employer-sponsored exchanges.[16]

A private exchange can be structured to have a variety of insurance products offered by one company or it can be structured to offer a variety of products from multiple insurance companies. The employer provides a defined contribution to the employee to use to purchase insurance through the private exchange. The private exchange allows the employee to have multiple and diverse health insurance options to choose from. Additionally, using a private exchange allows the employer to transfer much of the administration of the health benefit program to a third party.

Effect of the bill:

Defined Contribution

The bill converts the state employee group insurance program from a defined benefit to a defined contribution program. Beginning with the 2014 plan year, subject to appropriations, the state shall make a defined contribution for each employee[17] that is actuarially equivalent to no less than 90 percent of the benefits covered in the 2012 plan year for an individual plan 85 percent for a family plan. Since the state currently pays 90 percent of the employee's premium for an individual plan and 85 percent for a family plan, the defined contribution in 2014 would be approximately the same contribution as current year. For example, the state now pays $12,760 per year for a family plan for a Career Service employee. Accordingly, the states defined contribution for the 2014 plan year would be $12,760[18] for this employee.

The bill also directs that the program have more health plan options[19] either by being a full flex cafeteria plan or by adding an employee-sponsored multi-carrier exchange. Under the state's current program, the employee only has a choice between a standard plan or a high deductible plan. The monthly premium for a Career Service employee with a family plan is either $180 or $64.30 per month respectively. In 2014, the employee will have sustainably more choices of health plans at differing price points to choose from.

When the state moves to the defined compensation plan, employees will have the following options:

- Use the entire employer contribution to pay for health insurance and pay any additional premium if the cost of the plan exceeds the employer contribution.
- Use part of the employer contribution to pay for health insurance and have the balance credited to a Flexible Spending Arrangement.
- Use part of the employer contribution to pay for health insurance and have the balance credited to a Health Savings Account.
- Use part of the employer contribution to pay for health insurance and have the balance used to increase the employees pay[20].

[15] The Kaiser Foundation, What Are Health Insurance Exchanges? (May 2009); available at www.kff.org/healthreform/upload/7908.pdf

[16] American Medical News, Private Insurers Forming Their Own Exchanges (January 4, 2012); available at: http://www.ama-assn.org/amednews/2012/01/02/bisf0104.htm

[17] The state pays differing amounts for employees depending upon their service class (Career Service/SES/Senior Management, etc.) Also the state pays differing amounts for employee only and family plans. Under the bill, the state may continue to pay differing amounts based on these same criteria.

[18] This assumes no changes in the actuarial value of health benefits.

[19] See the discussion of the Independent Benefits Consultant below.

[20] The employee must use part of the employer contribution to purchase health insurance. The employee may not receive pay in lieu of benefits.

The following chart illustrates a hypothetical[21] example for a Career Service employee with a family plan:

Family Coverage	Same Coverage as 2012	80% AV Coverage	70% AV Coverage	60% AV Coverage
State Defined Contribution	$12,760	$12,760	$12,760	$12,760
Plan Cost	$14,920	$11,936	$10,444	$8,953
Employee Contribution	$2,160	$0	$0	$0
Employee Receives	$0	$824	$2,316	$3,807

The bill allows for non-tobacco users to receive an enhanced contribution.

Independent Benefits Consultant

The bill also directs DMS to competitively procure an independent benefits consultant (IBC). DMS may initiate the procurement upon the bill becoming a law. The IBC must not be or have a financial relationship in any HMO or insurer. Additionally, the IBC must have substantial experience in designing and administering benefit plans for large employers and public employers.

The ongoing duties of the IBC include:

- Providing assessments of trends in benefits and employer sponsored insurance that affect the state group insurance program.
- Conducting comprehensive analysis of the state group insurance program including available benefits, coverage options, and claims experience.
- Evaluating designs for the state group insurance program including a full flex cafeteria plan, an employer-sponsored multi-carrier exchange plan, and alternatives to and variations of these designs.
- Identifying and establishing appropriate adjustment procedures necessary to respond to any risk segmentation that may occur when increased choices are offered to employees.
- Submitting recommendations for any modifications to the state group insurance program no later than January 1 of each year.

The IBC will develop a plan to convert the state group insurance program to a defined contribution plan. The plan will be submitted to the Legislature for consideration by January 1, 2013. The plan must include an implementation timeline for conversion of the state group insurance program from a defined benefit to a defined contribution program as of the 2014 plan year. The plan must also include recommendations for employer and employee contribution policies including provisions that reward and incentivize nonsmoking and other healthy lifestyle choices. In order to avoid reducing overall compensation to the employees, the report must recommend steps for maintaining or improving total employee compensation levels when a transition to a defined contribution plan is initiated. The IBC must recommend a new plan design of either an employment-based benefits exchange or a full flex cafeteria plan which provides a variety of plan and benefit options. The Legislature may approve or modify the plan submitted by the IBC. Upon approval by the Legislature, the IBC will begin working with DMS to implement the transition plan.

In the 2013 plan year, the independent benefits consultant will begin assisting DMS with administrative oversight of the state group insurance program. The IBC with assist with the negotiation and supervision of contracts and the monitoring of the funding and reserves of the state self-insured plan. The IBC will develop and help to implement wellness initiatives. Enrollee education and decision support tools, including an online interface, to assist enrollees in choosing benefit plans will be

[21] All examples must be hypothetical since the 2014 benefit structure and plan actuarial values cannot be known at this time.

developed and operated in cooperation with DMS. The IBC will assist DMS in complying with federal and state regulations.

The department will utilize the IBC as a single, consistent source of advice and assistance for management of the state group insurance program. DMS will manage the contract with the independent benefits consultant. Additionally, the department will maintain exclusive responsibility for the following functions: financial management of the program including financial and budget oversight of program operations; management of vendor payments and premium administration; analyzing and forecasting program revenues and expenditures; monitoring of financial compliance of contractors; and auditing. The department will retain responsibility for employee enrollment and premium collection and administration.

Section 110.123, F.S.—State Group Insurance Program

The bill amends s. 110.123, F.S., to make conforming changes to the program related to transitioning aspects of the management of the program from DMS to the independent benefits consultant. The bill also revises the section to improve clarity and repeal obsolete language. Specific changes are described below.

Subsection (2) – Definitions:
- “Plan year” is added to reflect that a plan year is a calendar year.
- “State group health insurance plan”, “State contracted HMO”, and “State group insurance program” are repealed since the definitions are circular and redundant.
- “TRICARE supplemental insurance plan” is repealed since the program does not offer these supplemental plans.

Subsection (3) – State Group Insurance Program:
- The language creating the Division of State Group Insurance is removed since the division is also created by s. 20.22(2)(h), F.S.
- Obsolete legislative intent language is repealed.
- Redundant duties of the department are repealed and current duties are clarified.
- Obsolete duties for the department are repealed such as contracting with a specialty psychiatric hospital for mental health services.

Subsection (4) – Payment of Premiums; Contribution by States:
- Directs the state to make a defined contribution to employees beginning in 2014.

Subsection (5) – Department Powers and Duties:
- Obsolete duties for the department are repealed and current duties are clarified.

Subsection (13) – Florida State Employee Wellness Council
- The council is repealed since it is inactive.

B. SECTION DIRECTORY:

Section 1: Amends s. 110.123, F.S., relating to the state group insurance program.
Section 2: Creates s. 110.12303, F.S., relating to independent benefits consultant.
Section 3: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may provide additional opportunities for private companies to contract to provide services to the state or to state employees.

D. FISCAL COMMENTS:

The bill has indeterminate fiscal impact as a result of the contract with the independent benefits consultant. DMS will have costs associated with contracting with the independent benefits consultant, but may experience overall saving by contracting with a single consultant for multiple tasks.

Beginning in FY 13-14, employees will be given a choice of benefit packages. Consequently, the state may experience an overall savings. The state may experience savings due to the changes in plan design to the state group insurance program if the changes result in lower overall program costs or a lower rate of cost increase for the program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Department of Management Services has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES