HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHSC 11-09 State Group Insurance Program
SPONSOR(S): Health & Human Services Committee; Schenck
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 include health, life, dental, vision, disability, and other supplemental insurance benefits. The bill makes changes to the program in each of the next three plan years.

For the 2012 plan year, the Department of Management Services (DMS) is directed to establish a single risk pool for the program and to contract with HMOs for a self-insured plan design. DMS is also directed to contract with an independent benefits manger that will analyze the program and develop a plan to convert the state group insurance program to a defined contribution plan. 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 suit the employee's individual needs. The plan will be submitted to the Legislature for consideration by January 1, 2013.

For the 2013 plan year, the program will offer four levels of benefits to employees: Platinum, Gold, Silver, and Bronze. Each level will offer a different benefit package and the premium will be priced accordingly. Employees who chose a lower cost level will share the savings with the state through a proportional pay increase.

In the 2013 plan year, the independent benefits manger will transition into the day-to-day administrative management of the state group insurance program. DMS will phase out its day-to-day operation and management program but will manage the contract with the independent benefits manager and be responsible for the financial management of the program.

During the 2013 session, the Legislature will review the plan submitted by the independent benefits manager to convert the state group insurance program to a defined contribution plan. The Legislature may approve or modify the plan. If the plan is approved, the independent benefits manager will implement the plan in the 2014 or 2015 plan year.

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

The bill has an effective date of July 1, 2011.

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 (DGIS) 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 $1.45 billion out of total premium of $1.61 billion for FY 2010-11[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. The HMOs assume all financial responsibility for the health benefit cost.

Additionally, the program offers two high-deductable health plans with health savings accounts. The Health Investor PPO Plan[2] is the statewide, high deductable health plan with an integrated health saving account.[3] 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[4] in which the state has contracted with multiple state and regional HMOs.

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 state program qualifies as a cafeteria plan.

[1] Fiscal information provided by DGIS.
[2] Each HMO is a self-administered, pre-paid health plan that provides health services to people who live or work within the HMO's service area. Five HMOs provide coverage in various geographic regions. The standard HMO plan providers are VISTA, Capital Health Plan, AvMed, United Health Care, and Florida Health Care Plan. The Health Investor HMO plan providers are VISTA, AvMed, and United.
[3] 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. These contributions are not subject to federal income tax on the employee's income.
[4] Id.

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 employee pays a set monthly premium for either a single or family plan. The state pays the reminder of the cost of the premium.

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

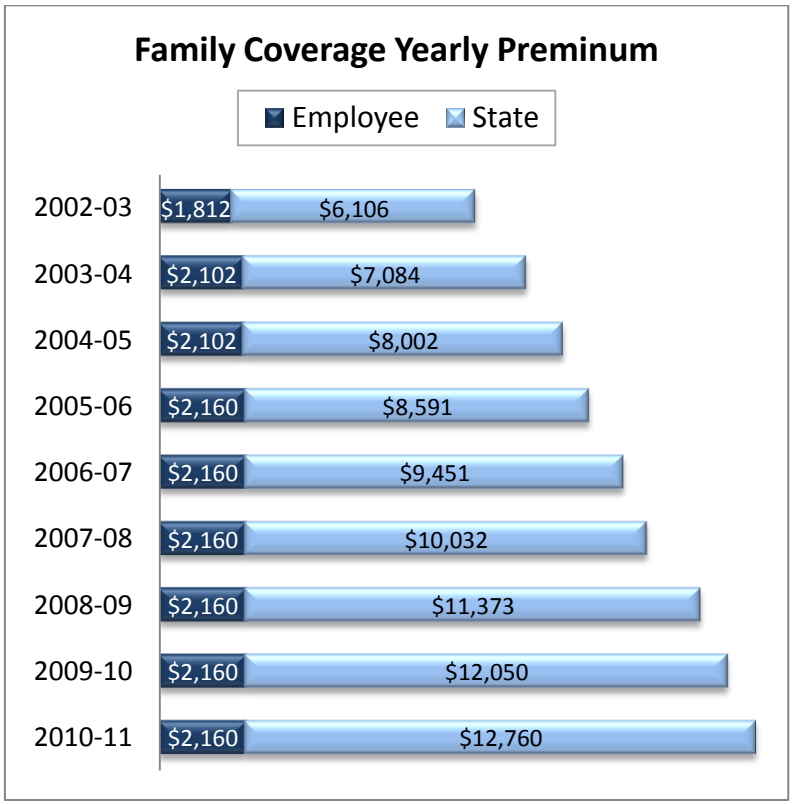
		Standard Plan PPO/HMO			Health Investor Health Plan PPO/HMO		
Category	**Coverage**	**Employer**	**Enrollee**	**Total**	**Employer***	**Enrollee**	**Total**
Career Service	Single	499.80	50.00	549.80	499.80	15.00	514.80
	Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
	Spouse	1,243.32	30.00	1,273.32	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.

Cost and Trends

The state program is estimated to spend $2 billion in FY 2011-12 in health benefit costs.[5] Spending has been growing on average 8.4% per year.[6] The state has absorbed most of the cost of the increase and employee contributions have remained relatively flat as illustrated by the following chart.

[5] Presentation on January 27, 2011, to the Health and Human Services Committee by the Department of Management Services, Division of Group Insurance.
[6] Id.



Financial Impact of Self-Funding HMO 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[7] to HMOs for contracts for plans years beginning January 1, 2012. The department has selected HMOs to negotiate with, but has not completed negotiations or entered into contracts for the 2012 plan year.

The Legislature also directed the department to, no later than February 1, 2011, submit a report recommending whether it is in the best interest of the state to offer a fully insured or a self funded HMO financial arrangement. The department contracted with Gabriel, Roeder Smith & Company (GRS) to analyze the responses by the HMOs to the invitation to negotiate and make recommendations based on their analysis. GRS submitted its report on January 28, 2011, and concluded that a self-funded arrangement could result in overall savings to the program of approximately 4.3% to 5.2%. This potential savings would be between $91 million and $109 million over the two-year period.

Employer-sponsored Insurance Trends

DGIS contracted with Mercer Consulting to prepare the Benchmarking Report[8] (report) for the state group insurance program. The report compares Florida's state group insurance program to the programs of other large employers[9], 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%.

[7] ITN NO.: DMS 10/11-011
[8] Mercer Consulting, State of Florida Benchmarking Report (February 15, 2011), on file with the Health and Human Services Committee.
[9] For the purpose of the report, "large employers" had 500 or more employees.

- 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.

Effect of the bill:

The bill makes changes to the state employee group insurance program in each of the next three plan years. Prior to the 2013, the Legislature will be presented with a plan to convert the current state group insurance program into a defined contribution plan. If the Legislature approves the plan, the conversion will take place in the 2014 or 2015 plan year. 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 suit the employee's individual needs.

The 2012 Plan Year

The bill creates s. 110.12305, F.S., which directs DMS to establish a single health insurance risk pool for the 2012 plan year and thereafter. Section 110.12302, F.S., is amended to direct the department to contract with HMOs for a self-insured plan design. The department must contract with no fewer HMOs than the number that participated in each service area for the 2011 plan year. The PPO plan will continue to operate without any changes in the 2012 plan year.

The bill also directs DMS to competitively procure an independent benefits manager. DMS shall initiate the procurement no later than August 1, 2011. The independent benefits manager must not be or have a financial relationship in any HMO or insurer. Additionally, the independent benefits manager must have substantial experience in designing and administering benefit plans for large employers and public employers.

The ongoing duties of the independent benefits manager 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 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.

During the 2012 plan year, the independent benefits manager 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. If the independent manager concludes the conversion should not occur for the 2014 plan year, the manager must provide an explanation of the factors that prevent

implementation by 2014 and a timeline for conversion in the 2015 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 report must recommend a new plan design of either an employment-based benefits exchange or a full cafeteria plan which provides a variety of plan and benefit options.

The 2013 Plan Year

For the 2013 the program will offer four levels of benefits: Platinum, Gold, Silver, and Bronze. Each level will offer a different benefit package and the premium will be priced accordingly. The Platinum Level benefits will be actuarially equivalent to 90 percent of the benefits covered in the 2012 plan year. Gold Level benefits will be actuarially equivalent to 80 percent. Silver Level benefits will be actuarially equivalent to 70 percent. Bronze Level benefits will be actuarially equivalent to 60.

The state will contribute a different percent of premium depending on the level chosen. If the employee chooses less costly option than Platinum, the employee will get 60 percent of the difference between the cost of the chosen plan and the amount the state would have contributed to the Platinum plan. The following chart illustrates the different options for employees.

Benefit Level	Percentage of 2012 Benefit	State Contribution	Employee Pay Enhancement
Platinum	90%	90% Individual 86% Family	None
Gold	80%	85%	60% of the difference between the Gold and Platinum premium
Silver	70%	80%	60% of the difference between the Silver and Platinum premium
Bronze	60%	75%	60% of the difference between the Bronze and Platinum premium

The following chart is an illustration based on a hypothetical Platinum Level premium.

Coverage Options

Family	Platinum	Gold	Silver	Bronze
	90% Current	**New 80%**	**New 70%**	**New 60%**
Total Premium	**1,243.34**	**1,119.01**	**870.34**	**746.00**
Employer Share	86%	85%	80%	75%
Employee Share	14%	15%	20%	25%
Employer Cost	1,063.34	951.16	696.27	559.50
Employee Cost	180.00	167.85	174.07	186.50
Change in employee cost		(12.15)	(5.93)	6.50
Savings		**124.33**	**373.00**	**497.34**
60/40				
To Employee (*Gross*)		74.60	223.80	298.40
To Employee (*After Taxes*)		55.95	166.37	225.43
To Employee (*Net*)		68.10	160.15	212.99
To State		49.73	149.20	198.93

In the 2013 plan year, the independent benefits manger will transition into the day-to-day administrative management of the state group insurance program including negotiation and supervision of contracts. The independent benefits manager will develop and implement wellness initiatives. Enrollee education and decision support tools, including an online interface, to assist enrollees in choosing benefit plans will be developed and operated by the independent benefits manager. The independent benefits manager will assume the duty of assuring compliance with federal and state regulations.

The department will phase out its day-to-day operation and management of the state group insurance program but will manage the contract with the independent benefits manager. Additionally, the department will maintain 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 2014 and 2015 Plan Years

During the 2013 session, the Legislature will review the plan submitted by the independent benefits manager a plan to convert the state group insurance program to a defined contribution plan. The plan will be detailed and the Legislature may either approve the plan as submitted or make modifications. If the Legislature approves the plan, the independent benefits manger will implement the plan as directed in either the 2014 or 2015 plan year. If the Legislature authorizes the creation of a state employee benefits exchange, the independent benefits manger will certify health insurance plans, health maintenance organizations, and other providers eligible to participate. If the Legislature authorizes the implementation of a full cafeteria plan, the independent benefits manger will supervise the procurement

process and conduct contract negotiations with providers necessary for these entities to participate in defined service areas.

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 management of the program from DMS to the independent benefits manager. 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 insurance plan" is amended to reflect that HMOs in the program will no longer be self-funded.
- "State contracted HMO" is repealed since the term is not used in the section.
- "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.
- Direction is given for employer contributions for plan years beginning before and after 2013.
- Obsolete duties for the department are repealed such as contracting with a specialty psychiatric hospital for mental health services.
- Specific duties are created for the department relating to contracting with HMOs in the 2012 plan year.
- Benefit levels for the 2013 plan year are specified.

Subsection (5) – Department Powers and Duties:

- Obsolete duties for the department are repealed.
- The subsection is repealed effective January 1, 2014, when the independent benefits manager assumes the day-to-day management of the program.

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: Amends s. 110.12302, F.S., relating to costing options for plan designs required for contract solicitation; best value recommendations; required plan design.
Section 3: Creates s. 110.12303, F.S., relating to independent benefits manager.
Section 4: Creates s. 110.12304, F.S., relating to state and employee contributions toward health plan premium cost.
Section 5: Creates s. 110.12305, F.S., relating to health insurance risk pool.
Section 6: Provides an effective date of July 1, 2011.

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 state may experience savings in the 2011-2012 fiscal year from contracting HMOs in accordance with a self-funding plan design.

The state may experience some programming costs to the payroll system in the 2012-2013 fiscal year for calculating differing state contributions to employee.

The bill has a significant, but indeterminate fiscal impact as a result of the contract with the independent benefits manager. These costs may be offset to some extent by reductions in FTE and other costs for the Division of State Group Insurance.

For the 2012-2013 fiscal year and beyond, employees will be given a choice of benefit packages. If employees chose the Gold, Silver, or Bronze Level plans, the state will experience a saving that will be shared with employees in increased earnings. 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.

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