State of Florida
DEPARTMENT OF MANAGEMENT
Services

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Governor Rick Scott

Secretary John P. Miles

February 1, 2011

The Honorable Dean Cannon, Speaker
Florida House of Representatives
420 The Capitol
402 South Monroe Street
Tallahassee, FL 32399-1300

Dear Speaker Cannon:

I look forward to working with you in our new roles and am pleased to provide you with an opportunity to better manage costs for state employee health insurance.

Pursuant to the authority provided by the Florida Legislature in s. 110.12302, Florida Statutes, the Department collected procurement responses for Health Maintenance Organization (HMO) plans and required bidders to provide both fully-insured and self-funded pricing. The analysis, supported by a white paper from Buck Consultants and a review by Gabriel Roeder Smith & Company (GRS), indicates there is considerable opportunity if the State of Florida shifts to a self-funded HMO program from the fully insured program now in place.

The State Group Insurance Program insures a large and stable workforce with relatively predictable expenses. As such, self-insuring appears to be a sensible solution to manage the cost of providing healthcare to our employees. The state has successfully used this approach with the State Group's Preferred Provider Organization plan, which began in 1978.

Attached, please find the above referenced documents that support this best-value recommendation. The HMO funding analysis, performed by GRS, uses the initial competitive bids from the HMO plans. The HMO funding whitepaper, produced by Buck Consultants, provides comparative information of both fully-insured and self-funded models.

Please note that the actual costs and benefits will not be known until the sourcing process is completed. In order to advance to that point, we will need to work closely and quickly with the Legislature to provide DMS the authority necessary to complete our HMO procurement. I am eager to begin working with you and your staff on this and other opportunities.

Sincerely,

John P. Miles
Secretary

Attachments

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Secretary John P. Miles

February 1, 2011

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

Dear President Haridopolos:

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John P. Miles
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January 28, 2011

Michelle Robleto
Director, Division of State Group Insurance
4050 Esplanade Way, Suite 215A
Tallahassee, FL 32399-0950

Re: HMO Funding Analysis

Dear Ms. Robleto:

At the request of the State of Florida Department of Management Services, Division of State Group Insurance (the Department), Gabriel, Roeder Smith & Company (GRS) is pleased to submit this analysis of the potential financial impact of self-funding Health Maintenance Organization (HMO) benefits for active and retired state employees and their eligible family members. Our analysis is based on responses to ITN No.: DMS 10/11-011 inviting HMOs to submit proposals for the administration of medical and pharmacy benefits on both a fully insured and a self funded basis. As stated in the ITN, the Department wishes to determine whether it is in the best interest of the state to offer a fully insured or a self funded HMO financial arrangement.

METHODOLOGY

GRS based this analysis on the initial financial proposals submitted in response to ITN No.: DMS 10/11-011. Responses were received from the following HMOs:

- Aetna
- AvMed Health Plans
- Capital Health Plan
- Coventry Health Care of Florida
- Florida Health Care Plan
- United Healthcare

For the purposes of calculating an aggregate cost, January 2011 enrollment and plan selection (Standard HMO and High Deductible Health Plan HMO) was assumed. With the exception of Aetna, each of the responding HMOs currently provides services for the State. As a result, Aetna was not included in the analysis. GRS has assumed that each of the State's current HMOs will continue to offer coverage for calendar years 2012 and 2013 in the counties in which they currently provide services. For comparison purposes, aggregate costs were calculated for the current benefits, including prescription drug coverage.

Fully Insured Premiums

Fully insured premiums on a per employee per month basis (PEPM) were submitted by each incumbent HMO in Attachment B-5 of the ITN. Aggregate costs for calendar years 2012 and 2013 were developed by multiplying the county-specific PEPM premium by the enrollment in each county. The resulting product was then annualized by multiplying by 12.

Self Funded Fees and Incurred Claims

Self funded Administrative Services Only (ASO) fees (PEPM) were provided by each incumbent HMO in Attachment B-7 of the ITN. Aggregate fees for calendar years 2012 and 2013 were developed by multiplying the PEPM by enrollment; the resulting product was annualized by multiplying by 12. Because 2012 administrative fees were quoted on an immature[1] basis, an additional administrative fee to cover the costs incurred by a vendor to administer claims incurred prior to but processed after contract termination, known as runout claims, has been applied. The Runout Administration Amount (RAA) was calculated by multiplying the per employee per year (PEPY) fee by plan enrollment.

Expected incurred claims by county and tier were estimated by multiplying each HMOs target loss ratio by the corresponding fully insured premium found in Attachment B-5 of the ITN. Each incumbent HMO submitted a premium development worksheet for 2012-2013 fully insured premiums in addition to guaranteed loss ratios for 2014-2015. GRS used this data to develop a set of loss ratio assumptions by HMO for the analysis, producing a range of expected claims for each HMO. These amounts were then multiplied by the enrollment and annualized. Aggregate costs for 2012 and 2013 were calculated as the sum of ASO fees, RAA fees and expected incurred claims.

ANALYSIS OF AGGREGATE COSTS

A comparison of the expected two year costs for each incumbent HMO under both a fully insured and self funded arrangement resulted in an overall savings of approximately 4.3% to 5.2%. This represents potential savings between $91 million and $109 million over the two-year period. GRS also evaluated the financial proposals submitted by Aetna and determined that, similar to the incumbent HMOs, self funding would produce a savings for the State. Savings resulting from self funding the HMO plans will continue beyond the two year period covered by this analysis.

RATIONALE FOR SELF FUNDING

Self funding the HMO benefit plans represents a viable option for large plans such as the State of Florida Employee Group Health Insurance Program. Benefits of self funding include:

- Elimination of charges for risk, margin and profit, which are components of fully insured premiums;
- Additional interest earned on funds retained until benefit payments are due;
- Additional interest earned on IBNR reserves typically held by the HMO in a fully insured plan;
- Greater flexibility in plan design and underwriting guidelines;
- Greater flexibility in determining contribution levels; and
- Control of adverse selection between the HMO and PPO plans and vendors.

[1] "Immature" refers to the fact that in the first contract year claims processing activity will be less than that of subsequent years due to the lag between the time between when a claim is incurred and when it is processed. Under a self funded arrangement, vendors will not be responsible for process claims incurred prior to the contract effective date.

CONCLUSION

Based upon the above rationale for self funding and the potential plan savings demonstrated by the initial financial proposals, GRS views the adoption of a self funded approach for the administration of the HMO benefits as a viable alternative for the Department's consideration. If the State elects to self fund any or all of the HMO plans in calendar year 2012, the need for additional internal resources should be evaluated and put in place prior to the end of 2011. The cost of additional resources would be significantly less than projected savings from self funding HMO benefits.

Respectfully submitted,
Gabriel, Roeder, Smith & Company

William J. Hickman
Senior Health Care Consultant

Amy E. Cohen, ASA, MAAA
Senior Health Care Analyst

State of Florida
Employee Group Health Insurance Program; HMO Funding Whitepaper

January 26, 2011

A Xerox Company

buckconsultants

State of Florida Employee Group Health Insurance Program;
HMO Funding Whitepaper

January 26, 2011

Introduction

As requested by the State of Florida, Division of State Group Insurance (the State), Buck Consultants (Buck) has drafted the following HMO Funding Whitepaper pertaining to the State of Florida Employee Group Health Insurance Program (Employee Health Program). The objective of the whitepaper is to assist the State with its decision to continue its fully insured HMO arrangement(s) or to change the financial arrangement to self-funded. The discussion provides an overview of these areas:

- Fully insured vs. self-funded contracts: financial and administrative comparisons and the impact of PPACA
- Survey information from other state governments and large employers
- Opportunities provided by self-funding

This whitepaper is intended to provide the target audience with comparative information that is pertinent to the decision-making process, rather than address every comparative nuance of insured and self-funded contracts, self-funded program management requirements, or potential opportunities of self-funding.

Background on the State Program

The State of Florida Employee Group Health Insurance Program currently consists of the following plans and vendors, which include self-funded PPO and fully insured HMO plans and financial arrangements. The current funding arrangement of each plan option is also noted.

Plan Options	Medical Vendor(s)	Pharmacy Vendor(s)	Current Funding
• Standard PPO and • Health Investor Health Plan (HIHP) PPO	Blue Cross Blue Shield of Florida (BCBSF)	CVS Caremark	Self-funded
• Standard HMO and • Health Investor Health Plan (HIHP) HMO	• AvMed Health Plan (AvMed) • Capital Health Plan (CHP – Standard HMO only, no HIHP HMO available) • Florida Health Care Plans (FHCP) • UnitedHealthcare (UHC) • Coventry Health Care of Florida (Coventry)	Same as medical *	Fully insured

* For all HMO plans, pharmacy benefits are integrated with the respective medical vendor

The State offers these plan options to all eligible groups of the State of Florida Employee Group Health Insurance Program including active employees, COBRA participants, early retirees and Medicare-eligible retirees. Medicare-eligible retirees are eligible for the HIHP plan options with no State funding of the Health Savings Account.

The State has recently issued an Invitation to Negotiate (ITN) for HMO services that includes both fully insured and self-funded options.

Fully Insured vs. Self-funded Contracts

Financial & Administrative Considerations
Dividing an employer risk pool into separate fully insured and self-funded arrangements creates the potential to produce adverse selection against one of the plans, which is a situation where higher risk individuals migrate increasingly over time to a certain plan because its pricing structure or benefit coverage favors or is more attractive to those in poorer health. Over time this can induce disproportionate cost increases in that plan, rendering it unsustainable.

For background on insured versus self-funded plans, the charts on the following pages provide a comparison of financial and administrative considerations. While there are pros and cons of each funding arrangement, the reasons self-funded plans are generally more attractive to many larger employers than fully insured plan are as follows:

- *Risk Charge, Pooling Charge, Administrative Fees, State Premium Taxes* – Insured plans consolidate these components into a "Retention Factor," which may or may not be fully disclosed as part of the renewal rating process. At minimum the components of the Retention Factor are not generally disclosed in detail. This lack of transparency may result in overall uncompetitive components, especially the adminstrative fees as compared to those for self-funded plans.
    - *Risk Charge* – Fully insured plans charge a fee to transfer the risk of loss from the employer to the insurer. This charge may range from 2 – 5% and would be eliminated under self-funding.

    - *Pooling charge* – Pooling charges are included in fully insured plans as reinsurance against the losses from large claimants. Unless the State were to purchase stop loss coverage, this charge would be eliminated in a self-funded plan. Given the size of the State's covered population, the State's claims are statistically valid and predictable and the State can readily self insure this risk as it does with its current PPO program.

    - *Administrative fees* – in fully insured plans the retention factor is often shown as a percentage of total rate, e.g. 10%. When that rate is converted into actual dollars per employee per month (as is the basis for most self-funded plan adminstrative fees) and divided into the components noted above, the resultant administrative fees may be higher than those for self-funded plans for the same services and programs.

- *State Premium Taxes* – Fully insured plans are generally subject to state taxes. Florida state premium tax is currently 2%. However, as the current plans do not include premium taxes, self-funding would not provide any savings in this area.

- *Administrative Ease* – with a self-funded plan, an employer generally has more control over plan design. For multi-state employers, or as is the case with the State, employers with retirees in other states, self-funding allows them to offer one plan design to all employees regardless of location, enabling more consistent benefit provisions, coverage and procedure policies.

- *Cash Flow* – Under a self-insured plan, the employer pays claims as they are incurred rather than pre-funding based on insured premiums. As medical claims are typically paid a month or more after the date of service, the employer retains use of the funds prior to drafts clearing the bank.

- *Reserves* – Under a self-funded plan, the employer retains the reserves for Incurred But Not Reported (IBNR) claims and unknown claims. While this is a financial liability an employer must record, the employer retains the funds and associated accruing interest instead of the insurer holding the funds.

Charts 1 and 2 below outline common Financial and Administrative Considerations between fully insured and self-funded arrangements.

Chart 1 - Financial Considerations

	Insured	Self-funded
Employer Risk	None. Insurance carrier takes the risk.	Up to a defined "attachment point" on medical if there is stop loss insurance. If not, there is unlimited risk.
Cash Flow Advantages	Predictable, steady monthly cost is payable during contract period (usually 12 months).	Claims are funded on a "cleared" basis. Bank account may be a "zero balance" account, similar to current PPO arrangement.
Retention/Administration	All retention (administrative expense) costs are set at the beginning of each year as part of the insured rates and are not adjusted until the rates are renewed.	All retention (administrative expense) costs are set at the beginning of each year and are not adjusted until the annual renewal. Additional direct charges and extra-contractual charges may apply if services are beyond contractual scope.
Premium Taxes	State of Florida premium tax is 2%; however, this tax is not applicable to the State's plans.	No premium taxes apply.
Reserves for Incurred But Not Reported (IBNR) Claims	Held by insurance company. Reserves are built into premium rates as the insurance company uses a portion of the current premiums to pay claims after the plan terminates.	Liability of the employer. Employer must calculate reserves and estimate the liability for financial reporting. Employer earns interest on funds rather than insurer.

Guaranteed Liability if the Contract/Plan is terminated	The employer's liability is capped or limited to premiums due; the insurance company is responsible for paying run-out claims after plan termination.	Employer must pay claims incurred prior to plan termination (using reserves). Stop Loss insurance (individual and aggregate) reduces the employer's liability but does not completely eliminate risk.
Fiduciary Responsibility	Insurance company takes fiduciary responsibility for claim payments and determining covered services.	Employer may retain ultimate fiduciary responsibility or pay vendor to assume fiduciary liability for claims payment and covered services
Margin/Risk Charge	Insurance company includes margin to protect the plan against unknown claims costs.	Self-funded rates may or may not include margin to protect against unknown claims costs.

Chart 2 - Administrative Considerations

	Insured	Self-funded
Flexibility	Employer must take insurance company state-filed plan. Limited changes/customization to plan design under insured arrangements.	Employer can select plan design (subject to vendor's administrative restrictions or capability constraints).
Pricing/Financials	Rates are determined by the insurer.	Vendor may assist with plan pricing; however, generally an actuary is retained to provide funding rates, reserve estimates, and contribution options.
Contributions	Insurer generally requires minimum employer funding contribution of 75% to protect it against adverse selection.	Employer can choose its funding level and strategy based on its budget and business needs. Actuary is generally retained to model options to protect employer against adverse plan selection in multi-option plans.
Auditing	Since the insurer is at risk for the claims liability, audits by the employer are generally not allowed.	Employer should regularly audit plan to ensure it is being administered in accordance with plan and contractual provisions.
Documentation/SPDs	Insurer provides a Certificate of Coverage (COC). Different COCs may be required for members (e.g. retirees) outside the state.	One all-encompassing document may be provided because of consistent plan design. Employer is responsible for providing Summary Plan Description (SPD) but vendor may assist in drafting and maintaining.
Communications	Insurer is generally responsible for communication materials, ID cards, etc.	Employer may be responsible for communications or pay vendor to do communications.
State Mandates	Insured plans are subject to state mandates on benefit design.	Although it is possible to opt out of some state mandates, the State plan tends to follow state mandates.
Privacy/HIPAA	Insurer has primary responsibility for all Protected Health Information; employer may receive limited reporting on plan experience.	Plan sponsor (employer) has the right to information regarding the plan; plan sponsor must have adequate controls on information to be HIPAA compliant.

The Impact of PPACA

In considering any change in benefit strategy and delivery, the State needs to carefully consider the impact of the Patient Protection and Affordable Care Act (PPACA). For the State there are two primary advantages of self-funding HMOs under PPACA. First, starting in 2014 there will be a health insurance industry tax that will help fund health reform. While additional guidance and regulation is required to fully review the impact of this new tax, it appears to only apply to insured plans. Self-funding could help avoid this tax.

Second, self-funding the HMOs provides the State with greater flexibility in plan design and underwriting guidelines that will allow additional flexibility for complying with the PPACA requirements. For example, under the Early Retiree Reinsurance Program (ERRP), the State may need to share the reinsurance payments with HMO enrollees. With self-funded HMOs, the State will have more flexible approaches to share those funds with HMO enrollees, such as sharing ERRP funds with HMO enrollees through reduced copayments. With self-funded HMOs, this can be done without renegotiating the insured rate.

Survey Information

The Kaiser Family Foundation Health Research & Education Trust 2010 Annual Employer Health Benefits Survey found that 66% of covered workers in state and local government employee health plans are in plans that are partially or completely self-funded.

As outlined in the chart below, for companies (public or private) with 5,000 or more employees, the survey found that 65% of covered workers enrolled in HMOs are in a partially or completely self-funded HMO plan. Overall, 93% of covered workers in firms with 5,000 or more workers were in self-funded plans in 2010.

Percentage of Covered Workers in Partially or Completely Self-funded Plans, by Plan Type, for Employers with 5,000 or More Workers, 2010

HMO	PPO	POS	HDHP	All Plan Types
Health Maintenance Organization	Preferred Provider Organization	Point-of-Service	High Deductible Health Plan	
65%	96%	85%	99%	93%

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

Mercer's 2009 National Survey of Employer-Sponsored Health Plans shows the following:

HMO funding and administration
The use of self-funding among HMO sponsors has grown over the past decade as employers seek to have more control over their HMO costs. In 2000, just 7% of HMO plans offered by large employers were self-funded; in 2009, sponsors reported that 24% were self-funded.

State of Florida, Division of State Group Insurance, SALGBA Survey
Since the readily published survey data that specifically addresses state employee health programs was limited in scope, the Division of State Group Insurance surveyed other state employee health programs through the State and Local Governments Benefit Association (SALGBA). The questions asked were targeted to the following areas: types of plans offered (PPO, HMO, HDHP, etc.); funding of each option; whether Rx is bundled or carved out; savings from self-funding; pros and cons experienced by self-funding.

The following 12 states provided responses:

- Colorado
- Kansas
- Maryland
- Oregon
- Delaware
- Louisiana
- Nebraska
- Vermont
- Georgia
- Maine
- New York
- West Virginia

Of the 12 state responses:

- 11 of the 12 states currently offer one or more self-funded health plan options
- 6 of the 12 states self fund all their employee health plan options
- 9 of the 12 states offer an HMO-type plan
- of the 9 states that offer an HMO type plan, 4 states self fund their HMOs
- of the 4 states that self fund their HMO-type plans, 3 states carve out pharmacy administration to a separate pharmacy benefit administrator (PBM)

All respondents with self-funded programs provided positive feedback regarding their preference for and experience with self-funded vs. fully insured plans, citing plan design flexibility and cost savings as consistent advantages to self-funding.

Some noteworthy comments provided by the survey respondents regarding savings and advantages experienced as a result of self-funding are included below:

Question: What savings (or added costs) have there been as a result of self-funding (vs. being fully insured)?

Answer: State of Maine – Based on a comparison with previous fully insured rates, we estimate that the plan has saved between 2-4% annually; in the first several years of self-funding the plan built excess reserves of over $35 million which were used to reduce the general fund budget gap.

Note – Maine does not currently offer an HMO-type plan but does self fund PPO and POS options.

Answer: State of Maryland – Typically we see about 15% overall cost savings. With the recent switch to self-funding the EPO (in July 2009), we had first year savings of $23 million.

Question: Please describe any other pros and cons your plan experienced as a result of self-funding (vs. being fully insured).

Answer: State of Georgia – Pros – flexibility; no real cons as opposed to fully insured.

Answer: State of Maine – A primary advantage has been the ability to implement benefit design features that have not been offered by fully insured plans. It afforded us the opportunity to introduce tiered benefits for primary care and hospitals and value-based benefits for selected chronic conditions.

Answer: State of Maryland – All pros – as a large employer (75,000 employees with 40,000 retirees), our actual claims experience is credible and typically runs below national averages that are typically developed with a conservative eye by the fully insured carriers.

Answer: State of Vermont – Totally positive. You need good people in leadership who know how to run a self-funded plan, but other than that, we vastly prefer to be self-funded. Not subject to carrier whims, mergers, premium rate increases which include carrier overhead, etc. Stability in non-reliance on insurers.

Note- the State of Vermont does not currently offer an HMO-type plan but does self fund the PPO and POS options it offers.

Opportunities Provided by Self-Funding

Historically many large employers have offered one or more fully insured HMOs as an option alongside a self-funded PPO (or POS) program, much like the current plans offered by the State. The typical HMO design included copayments for various services, while the PPO design, in addition to office and prescription drug copayments, would often include additional employee cost sharing through deductibles and coinsurance. Because of their fixed copayment structure, typical HMO plan designs require annual "tweaking" in order for employee cost sharing to keep pace with trend. The copayments structure isolates participants from the true cost of the services and does not encourage participants to make wise purchasing decisions or otherwise "shop" for care. The behavior that often results from this plan does not align well with many employer initiatives of wellness and encouraging positive behavior changes that will improve the health and well-being of participants and help manage plan costs.

Over the past several years, we have seen many employers move away from this strategy towards a more common funding and design approach. These new strategies have focused on more consistent employee cost sharing through plan designs, increased employee cost sharing (in part to support "consumerism" efforts) and consolidation of the population into a single risk pool. Actions employers have taken include:

- **Incorporating more employee cost sharing into HMO designs** – this includes moving away from the fixed copayment design for all HMO services and adding deductibles and coinsurance for medical services and prescription drugs. In a fully insured environment, changing the HMO design from a copayment structure to a deductible/coinsurance arrangement may not be available due to vendor contractual, administrative or operational constraints.

- **Self-funding HMOs** – by self-funding HMOs (usually then referred to as an EPO or Exclusive Provider Option) employers can reduce risk and profit charges by HMO vendors and also manage the self-funded costs more consistently with the non-HMO plans. While there may still be multiple vendors providing the non-HMO and HMO benefits, the employer would have one self-funded program.

- **Eliminating some or all of the HMO options and consolidating health coverage with one vendor** – By eliminating some or all HMOs, the employer is further consolidating the risk pool into a single, larger self-funded pool. This enables the employer to focus on the management of the risk in that one pool. Employers who still want to provide choice to the employees under this approach typically do so by expanding the plan offerings with the primary vendor.

A combination of some or all of the above approaches is not uncommon for large employers. Often the desire to change from a copayment design that insulates the members from the true cost of services to a deductible/coinsurance design is a primary driver of the change from a fully insured HMO to a self-funded EPO, providing more plan design flexibility. Once an HMO is self-funded, if network provider access is adequate and that vendor has competitive discounts, vendor consolidation may take place to eliminate unnecessary duplication of plan management efforts, streamline plan administration and simplify member communications efforts.

Access to Data for More Effective Population Health Management
With self-funded EPOs, whether vendors are consolidated or not, the experience data becomes more readily available to the employer and can be used for plan management purposes. Access to the group's experience data is of paramount importance to an employer's ability to effectively manage the performance of a health program. If more than one vendor is used, a third party data aggregation vendor can easily consolidate the data into one database, allowing for detailed analyses of plan and vendor program performance.

Using aggregated data, a population-level data analysis can provide metrics to help employers maximize the return on investment of their health programs by identifying the most prevalent conditions and highest health risks among their covered participants. Once identified, employers can focus their program management efforts and resources in these targeted areas, resulting in more effective population health management (disease management, wellness, etc.). Consolidation of one or more vendors would further the effectiveness of population health management efforts by providing greater opportunities for coordination of care.

Through the use of aggregated data, an employer's focus turns from vendor negotiation and contract management to population health management including vendor performance management, program evaluation and outcomes analyses. This change in focus to population health management, provided other important components of a strategically designed program are in place (including supportive infrastructure, properly aligned incentives, and access to information for education and decision-making purposes), should assist the State in delivering longer-term savings opportunities through trend reduction.

Conclusion

For a group the size of the State of Florida Employee Group Health Insurance Plan, there is no compelling financial advantage to maintaining fully insured HMO plans. In addition to the immediate financial advantage that should be realized by moving to self-funding, the administrative advantages of self-funding are numerous, including flexibility in plan design and access to population-level data for more effective population health management. Access to and analysis of this aggregated data would allow the State to make smarter, more informed strategic decisions based on better information and would provide the State the ability to measure outcomes in various ways.

Program management efforts under a self-funded program will shift from vendor negotiation and contract management to vendor performance management, program evaluation and outcomes analyses. Consolidating vendors in addition to self-funding the HMOs would provide greater and more consistent coordination of care, furthering the effectiveness of population health management efforts.

When self-funded, every dollar saved through health improvement goes back to the State, not the insurer. Assuming the State would take advantage of the opportunities afforded by self-funding and focus its efforts on population health management initiatives, self-funding would position the State to more directly benefit from its efforts to improve the health of its population and assist the State in delivering longer-term savings opportunities through trend reduction.