Office of Superintendent of School
Board Meeting of October 11, 2000

October 9, 2000

Personnel Management and Services
Nelson E. Diaz, Deputy Superintendent

SUBJECT: RESTRUCTURING OF HEALTH PLANS FOR CALENDAR YEAR 2002

At the Board meeting of June 21, 2000, Agenda Item A-3, the Board approved the rates for calendar year 2001, the fifth year of its five-year health plan contract, which was approved at the Board meeting of August 28, 1996, pursuant to the terms of Request For Proposal (RFP) # 173-SS-10.

Over the past five years, a number of factors affecting the health insurance industry have resulted in changes to plans currently offered by the Board, which necessitate a thorough review of the Board's fringe benefits program. At the June 21, 2000 Board meeting, the Board also authorized staff to analyze different approaches to providing benefits for 2002, with recommendations to come back to the Board at its meeting of October 11, 2000. This agenda item is an effort to identify changes which have occurred in the healthcare industry, and their affect on the Board's current program. With this as a foundation, staff is recommending implementation of an initiative to review different benefit design and funding approaches which could be utilized in 2002, and beyond, to ensure that School Board employees and dependents continue to have access to quality health care. This coupled with the realization that because of the tight labor market, the creation of a comprehensive benefit program will further the Board's ability to attract and retain quality employees.

Among the forces which have negatively affected the health plans under contract to the Board since 1997 are:

- Health care inflation averaging15% per year over the past three years;
- Companies offering health care coverage to employers declining due to mergers, financial insolvencies and companies choosing to get out of the healthcare business completely;
- Pharmaceutical inflation of 20+% per year over the past three years;
- State mandates requiring specific coverages with lower or no cost share and direct access to identified specialists;
- Hospitals continued revenue shortfalls resulting in re-negotiations with health plans at higher reimbursement rates;
- Change in Federal Law no longer requiring HMO's to enroll one non-Medicare enrollee for each Medicare contract; and

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- ❑ Federal Health Care Financing Administration's (HCFA) continued diminishment of monthly payments to managed care providers participating in medicare risk contracts, resulting in higher costs to retirees and significant restrictions in access.

Last year, 41 Florida HMO's lost $175.7 million, more than triple the industry's shortfall for 1998. These factors have directly affected the Board's ability to offer its employees a full spectrum of quality, affordable health care. The direct impact to the Board's plans and employees over the past five years include:

- ❑ Humana's decision to not provide a preferred provider option (PPO) for 2001 and a 97% rate increase on its point of service (POS) option, resulting in the Board's cancellation of Humana's contract for 2001;

- ❑ HIP HEALTH PLAN OF FLORIDA's financial problems and resultant administrative supervision from the State of Florida Department of Insurance, with a pending buyout from Dr. Steven Scott who purchased Beacon Health Plan last year;

- ❑ Medicare risk contracts with providers who have begun charging monthly premiums and reducing benefits for medicare-eligible retirees who have enrolled in what used to be "no cost plans";

- ❑ Double digit increases in employee and dependent rates; and

- ❑ Significant lack of available options for M-DCPS retirees who do not reside in Palm Beach, Broward, or Miami- Dade counties.

The approach the Board took in structuring its health plan programs, which have been in place since 1997, provided a broad selection of coverage options with competitive rates. However, because of changes which have significantly changed the healthcare industry and its affect on Florida, it is now more important than ever to properly re-evaluate the Board's objectives for 2002 and beyond.

To re-structure the Board's health plan, it will be necessary that a Request For Proposal (RFP) be developed and issued to seek competitive proposals. The Board's benefits consultant, William M. Mercer, and M-DCPS staff will begin preparing a comprehensive RFP which will attempt to incorporate a number of different approaches, including benefits design and financing alternatives. Specifically, the goal of the RFP will be to get as many local, state and national healthcare companies to provide proposals as possible. To accomplish this, it is recommended that an RFP be constructed to seek proposals which will include various innovative approaches to providing healthcare. Proposals will be sought from insurance companies, HMOs ,and other healthcare providers, which will focus on a variety of choices offered by one or more healthcare provider incorporating the following options and requirements:

- ❑ Financing alternatives which include both fully insured options (currently used), as well as self-insurance alternatives wherein the Board would self-fund health claims and purchase excess insurance for catastrophic claims;

- ❑ Access to comprehensive provider networks including hospitals, physicians and other medical providers on a local, state-wide, and national basis;

- ❑ Pricing options which include pharmacy benefits and those which exclude them, in order to evaluate the cost/benefits of a comprehensive stand alone pharmacy program; and

- ❑ Benefit options including HMOs which have primary care physicians and require referrals for specialists; open access HMOs which require seeking care within a defined network, but not requiring referrals to specialists; in and out of network PPOs where employees decide at the time they access care whether to use a participating physician and receive a higher percentage of the cost of the care or to go out of network to any licensed provider requiring a larger cost share to the employee.

Kathryn Swartz, Ph.D., Harvard School of Public Health, recently spoke at the Florida Governor's Summit on Health Care, held on Miami Beach September 21-22, 2000, regarding the development of national proposals to increase access of health care for employers and employees. Among her insights was the fact that the result of managed care has been that health care is now viewed as an entitlement with first dollar coverage. This phenomena has lead to significantly higher costs due to overutilization of medical care by employees and providers.

To stem the tide of this healthcare cost spiral, Dr. Swartz suggests that plan designs need to move away from first dollar coverage, including low co-payments for physician office visits and pharmaceutical, and return to the days when health insurance companies would pay a percentage towards services which were rendered, after an annual deductible or cost borne by the user. These two elements alone could significantly reduce both the utilization and cost of providing health care coverage. A look at the dramatic increase in premiums paid by employers who offer managed care plans, as well as the employees who participate in that cost for themselves and their dependents, proves that the current situation must change.

The following timeline is recommended to re-market the Board's health plans for 2002:

October 11, 2000 - Seek authority from Board to research and create an RFP, including outlined options

October, November, December, 2000 - Board staff and Mercer create RFP, while working with Board's Compensatory Fringe Benefits Counsel to specifically outline benefit and financing options

January 17, 2001 - Board authority sought to issue RFP

March 1, 2001 - Proposals received by the Board for review

March, April, 2001 - Proposals analyzed by Board staff and Mercer, recommendations received by the Board in Executive Session and then with Board's Compensatory Fringe Benefits Counsel

May or June, 2001 - Final recommendations for health plans for 2002 come to the Board

July - August, 2001 - implementation schedule of plan begins including meetings to establish technology requirements, financial arrangements, etc.

September - November, 2001 - Open enrollment for 2002 Fringe Benefits Program

January 1, 2002 - Coverage becomes effective

The Miami-Dade County School Board has traditionally been on the cutting edge of healthcare offerings, offering the first PPO in the state, as well as offering cost-effective HMOs before they became the mainstay of healthcare in the 1990s. It is now time for new approaches which will continue the commitment of the School Board to provide its employees, dependents, and retirees with accessible, affordable, quality healthcare in 2002 and beyond.

The Board's benefits consultant, William M. Mercer, Inc., has provided staff with an outline of anticipated costs associated with designing and re-marketing the health program. Mercer's input will include meeting with members of the Board's Compensatory Fringe Benefits Council, structuring the technical aspects of the RFP, meeting with prospective proposers in a pre-bidders conference, working with staff on the analysis of received proposals, and technical work in the implementation of a recommended program. The cost associated with the restructuring is $275,000. Staff is recommending that the Board's existing contract with William M. Mercer, Inc. be amended to include the authorization of expenditures not to exceed $275,000 as part of the Office of Risk and Benefit Management's Professional and Technical Budget, with funding to be provided from the Board's contingency fund.

RECOMMENDED: That The School Board of Miami-Dade County, Florida:

1. authorize staff to begin work on a comprehensive Request For Proposal (RFP) incorporating different approaches towards benefits design and financing alternatives for health plan offerings for calendar year 2002, with the request to issue an RFP for health plans coming to the Board meeting of January 17, 2001;

2. authorize an increase in the Office of Risk and Benefit Management's Professional and Technical Budget (0100,5310,9112,7760,7790) for consulting expenses incurred for the restructuring of its health plans for 2002, in the amount of $275,000, with funding to be provided from the Board's contingency fund; and

3. amend the Board's current contract with William M. Mercer, Inc. to include the additional provision of providing consulting services to the Board for restructuring of its health plans for 2002, with expenses for such consulting not to exceed $275,000.

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