INDEPENDENT BENEFITS COUNCIL

Plan of Action on Statewide Health Plan Initiatives

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January 15, 2003

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Independent Benefits Council
Project Overview

Statewide Action on School District Health Plans

The Council

The **Independent Benefits Council (IBC)** is a not-for-profit organization founded in March 2002 by the:

- Florida School Boards Association (FSBA),
- Florida Association of District School Superintendents (FADSS),
- Florida Association of School Administrators (FASA), and
- Florida Education Association (FEA).

The Florida Educational Risk Managers Association (FERMA) is an integral part of this project and holds a seat on the IBC Board of Directors. The Florida Community Colleges also has an interest in this project.

Issue

Florida School District health plan percentage increases have exceeded Florida budget percentage increases over the past several years. School districts have been forced to cut essential educational needs to pay for the health plan cost increases.

Goal

Take action by identifying and implementing statewide solutions that will improve the efficiency, effectiveness, cost, and quality of school district health plans.

Short Term Objectives

1. Increase awareness of elected officials, school boards, superintendents, employees and the general public of the impact of rising health care costs on school districts.
2. Include additional funding in the 2002-2003 State budget for school districts to help offset the increases in health plan premiums.
3. Secure matching State funds to assist in the operation of the IBC.

Long Term Objectives

1. Implement statewide solutions for school district health plans that improve upon plan efficiency, effectiveness, cost and quality.
2. Identify the administrative remedies that may exist to impact cost increases.
3. Reform school district health insurance funding.
4. Create and maintain a credible school district health plan database.

IBC Board of Directors

The IBC Board of Directors held its organizational meeting in March 2002. The Board is comprised of three (3) appointees from each of the founding organizations, one (1) appointee from FERMA, one (1) representative from the community colleges, and one (1) representative from the state universities. The Board meets on a regular basis and is governed by the IBC by-laws. Representatives from the Florida Governor's office and the Department of Insurance are invited to attend the IBC Board of Directors meetings.

The IBC Board of Directors is comprised of the following individuals:

Name	Organization
Tom Weightman	FADSS
David Miller	FADSS
William Montford	FADSS
Wayne Blanton	FSBA
Judith Conte	FSBA
Donna Enrico	FSBA
Doug Crawford	FASA
Bryan Kleiman	FASA
Steve Swartzel (Chairman)	FASA
Andy Ford	FEA
Bob Lee	FEA
Marshall Ogletree	FEA
Jay Wiggins	FERMA
Open	Community Colleges
Open	Universities

IBC Working Committees

Three (3) IBC Working Committees, comprised of nearly 40 individuals appointed by the founding organizations, developed recommendations on statewide solutions that were presented to the IBC Board of Directors in November 2002. The Working Committees met at least monthly and addressed the following:

Working Committee	Critical Areas Reviewed
Health Management	Regional and/or Statewide Plans Statewide Risk-sharing Pools Reporting Standards Personal Health Accountability Outcomes and Safety Standards Statewide/Regional Pharmacy Program

Working Committee	Critical Areas Reviewed
Retiree Benefits	Statewide Retiree Health Plans Retiree Subsidy Revisions Retiree Health Management Retiree Communication
Administration	Health Plan Survey IBC Website Statewide Administrative Functions

The IBC Working Committees are comprised of the following individuals:

Health Plan

Name	District	Appointing Entity	
Scott Clark	Dade	FADSS	
Linda Dekle	Leon	FADSS	
Craid Reed	NEFEC	FADSS	
Ronald Weintraub	Broward	FADSS	
Steve Henderson	Polk	FASA	
Bonnie Mozingo	Brevard	FASA	
Susan Strong	Lee	FASA	
Debbie Zimmerman	Polk	FASA	
Randy Acevedo	Monroe	FSBA	
Donna Enrico	Okeechobee	FSBA	
David Ford	Santa Rosa	FSBA	
David Hotary	Alachua	FSBA	Inactive
Julie Sessa	Martin	FSBA	
David Stone	Osceola	FSBA	
Dan Harmeling	Levy	FEA	
Jade Moore	Pinellas	FEA	Inactive
Gunnar Paulson	Alachua	FEA	
Bruce Proud	Lee	FEA	
Jan Bush	Consultant	IBC	
John Robinson	Consultant	IBC	

Retiree Benefits

Name	District	Appointing Entity	
BethAnne Newman	Seminole	FADSS	
Jay Wiggins	Wakulla	FADSS	
Joseph Bernard	Escambia	FASA	Inactive
Forrest Branscomb	Manatee	FASA	
Judy Conte	Volusia	FSBA	Inactive
John Radcliffe	Duval	FSBA	
Marion Cannon	Orange	FEA	
Sheila Olsen	Okaloosa	FEA	
Joan King	Retiree	FEA-R	
Mildred Dunlap	Retiree	FREA	
John Robinson	Consultant	IBC	

Administration

Name	District	Appointing Entity
Pat McDaniel	PAEC	FADSS
Linda Robertson	Indian River	FADSS
Frank Gibbs	Heartland	FASA
Nancy Haydon	Marion	FASA
Ken DeBord	Osceola	FSBA
Allun Hamblett	Collier	FSBA
Tony Donato	Osceola	FEA
Pat Siciliano	Dade	FEA
Jan Bush	Consultant	IBC

IBC Provider Council

The Provider Council was formed to give input to the IBC on statewide health plan issues, and assist the IBC in formulating recommendations. Provider Council membership is open to health insurance and health care related companies. Member organizations must:

1. Be committed to promoting the Goals of the IBC.
2. Have expertise in health plans, pharmacy and disease management, retiree benefits, or benefits administration.
3. Be willing to provide unbiased input and feedback to IBC committees.
4. Be committed to helping IBC committees reach objective and defensible positions.
5. Be fully aware that sponsorship will not result in special treatment.

IBC Communication

The IBC is an open, process-oriented organization with a goal to identify, develop and implement health plan solutions on a regional and statewide basis. The IBC has become visible to various educational stakeholders across the state via multiple communication strategies. First, in early 2002 health plan information was collected and distributed to all superintendents, benefit managers, union leaders and other interested parties which drew attention to the impact of health care costs on education budgets.

The IBC Board of Directors and Working Committees met regularly throughout 2002. Agendas and minutes were prepared as a record of each meeting. Minutes were submitted to board members after each meeting.

In addition, organizational meetings were conducted throughout the year to present the IBC project and solicit feedback. Feedback on the IBC and the various initiatives has been supportive and positive throughout the state. The meetings were held throughout the State at conferences of the following organizations:

- Florida Association of Community Colleges
- Florida Association of Community Colleges-Retirees
- Florida Association of District School Superintendents
- Florida Association of School Administrators
- Florida Association of School Personnel Administrators
- Florida Education Association
- Florida Education Association-Retirees
- Florida Educational Negotiators
- Florida Educational Risk Managers Association
- Florida Retired Education Association
- Florida School Boards Association
- Florida School Finance Officers Association
- Florida State University Systems

In addition, the IBC has provided briefings and solicited feedback from the following State Agencies:

- Department of Insurance
- Department of Management Services
- Division of State Group Insurance
- Executive Office of the Governor
- Florida Retirement System
- House and Senate Staff

On October 29, 2002 approximately 190 attendees participated in a health plan symposium held in Orlando. The purpose of the symposium was to present the preliminary recommendations of the IBC working committees and solicit feedback. Participants included health care providers, association members, benefit managers, community colleges and state university representatives and other interested parties.

IBC Timelines

IBC Board of Directors meetings are held on a regular basis. In addition the following timelines provide a guide to the project tasks:

Task	Time
Initial Board of Directors Meeting	March 5, 2002
Legislative Action on Short Term Goals	February-March
Working Committee Meetings	April-November
Joint Working Committees Meeting	June
Summer IBC Membership Workshops	June-July
Provider Council Membership Drive	August
Initial Provider Council Meeting	September 5
Advisory Board Input	September-November
Joint Committee Conference and Preliminary Recommendations	October 29
Committee Recommendations Report	November 18, 2002
Advisory Board Review	November-December
IBC Board Final Approval	January 15, 2003
Planning for 2003 Legislative Session	January 2003
Communicate Plan to IBC Membership	January 2003
Updated Health Plan Survey Results	March 31, 2003
Implementation of Action Items	Ongoing

Summary

The Independent Benefits Council is becoming a recognized leader for school district health plan improvement initiatives. The IBC has made significant progress in identifying critical areas to impact the cost of health care to the education community. The cooperation and participation of the various educational associations has been mutually beneficial to all interested parties.

The first step, collecting health plan data and defining the impact of health care costs to districts, has been accomplished. It is imperative to maintain an ongoing tool to measure and compare health care costs and issues across the education community.

In addition, the development of regional and statewide programs for employer paid services such as health plans, pharmacy benefits, life insurance and other administrative functions will provide cost containment opportunities given the critical mass within education.

The retiree population within school districts, and all FRS participating employers, continues to grow and impact health plan costs across the State. The current system for retirees needs to be studied and reformed.

In addition, the health of employees and dependents continues to decline at an alarming rate and should be addressed through healthy lifestyles initiatives.

By implementing the recommendations set forth by the IBC, the education community and the State have the potential to benefit significantly through identified cost containment initiatives.

Independent Benefits Council
Recommendations Summary For
Statewide Action on School District Health Plans

The Independent Benefits Council, following an extensive and process-oriented statewide school district health plan examination, has developed a plan of action summarized in the recommendations outlined below. The implementation of this comprehensive plan is expected to improve the efficiency, effectiveness, cost, and quality of school district health plans.

IBC Health Plan Information System

Recommendation:

Create a web-based survey tool that will be used to collect and update health plan information on each school district on an ongoing basis. The survey tool will utilize data portals and allow each district to self-report information on: health plan costs and funding by district; employee contributions; premium structures; plan participation; plan types offered and benefit designs; and eligibility criteria. In addition, history of plan costs from year to year will be available. Survey results and district comparisons will be available on the IBC website.

Action:

1. Develop and implement a web-based survey tool that will update the 2002 health plan survey information.
2. Request state funding during the 2003 legislative session to support the development and ongoing maintenance of the health plan information system.

Expected Outcome:

Develop a web-based survey tool that will provide ongoing and immediate health plan information for all 67 school districts.

Statewide Retiree Benefit Plan

Recommendation:

A State Health Program will be created to provide health insurance to retirees and their eligible dependents on a statewide basis. Comprehensive health plans would be designed to address the unique needs of retirees. Future retirees would have health plan coverage provided through the State Health Program. Other public sector groups will be encouraged to join. The Program will be funded by required contributions from FRS participating employers.

Action:

1. A request will be made to The Florida Legislature to fund an actuarial study to determine the feasibility of implementing a statewide retiree health program, based on the parameters outlined in the IBC recommendation.
2. FRS participating employers, in addition to the school district employers, will be asked to support the statewide retiree health program and the legislative funding request.

Expected Outcome:

A comprehensive, statewide retiree health program will be developed for all eligible FRS recipients that is cost neutral to the State and school districts. The Florida Retiree Health Plan will focus on the chronic health care and mobility needs of the retiree population.

Benefit Cooperatives

Recommendation:

School districts and community colleges will be encouraged to form coalitions, based on common interests, throughout the State to take action on health plan and other employee benefit issues. Benefit Cooperatives have the potential to: lower administrative costs; better stabilize the risk; increase competition; and implement targeted benefit and management programs.

Action:

1. Department of Insurance Review. A request will be made to the Florida Department of Insurance for a declaratory ruling to permit educational entities to join together and co-mingle risk for health and welfare benefits.
2. Florida Statute Modification. A change to FS 112.08 is being recommended that would allow all governmental employers, including local governmental units such as school districts and community colleges, to competitively bid and/or directly negotiate contracts for health insurance and related benefits. This change would expand the options available to local governmental units by permitting direct negotiations with health insurance carriers and providers.
3. Statewide Pharmacy Carve-out Program. The IBC will form a Cooperative for educational entities having a common interest in a statewide prescription drug carve-out program. A formal Request For Proposal will be developed following established procurement standards for educational entities.

Expected Outcome:

Development of large regional or statewide purchasing cooperatives that will reduce cost, stabilize risk, implement targeted health plan improvement programs and create efficiencies in the administration of employee benefits.

Healthy Lifestyle Improvement Program

Recommendation:

Employees will be encouraged and expected to become more accountable for their health. The IBC will develop and implement a comprehensive program with a concentration on: physical activity; overweight and obesity; tobacco use; and stress. Assistance will be given to employees to help change behavior. Integrated consumer communication components will also be developed.

Action:

1. Grant funding will be requested to support the recommendation to promote healthy lifestyles within the education community.

Expected Outcome:

Reduce health care costs by providing tools that will improve health status, increase productivity and set positive examples through healthy lifestyle behaviors.

Statewide Health Plan Standards

Recommendation:

Health plan reporting standards will be developed and utilized by all 67 school districts. The reporting standards will include information on: eligibility data; premiums; medical and pharmacy claims; administrative costs; and medical utilization data. Performance and quality standards will be implemented to measure and continuously improve health care value. Of particular interest is patient safety. The IBC will implement a patient safety initiative to raise the awareness of serious reportable medical events.

Action:

1. Funding will be requested from the Florida Legislature so that the IBC can establish consistent statewide standards for health plan reporting, performance, and quality for school district and community college health plans.
2. The IBC will collaborate with the Central Florida Health Care Coalition to expand patient safety awareness statewide, and to encourage hospitals in Florida to institute programs that will reduce preventable medical errors.

Expected Outcome:

Statewide health plan standards and patient safety initiatives will be developed that will improve quality and reduce cost.

Best Practices Initiatives

Recommendation:

A "Best Practices" program will be developed to highlight successful initiatives of school districts. Initiatives will be categorized by school district size and types of programs such as: Wellness/prevention programs; quality improvement initiatives; cost containment strategies; administrative functions; and communication/enrollment processes. The submitted practices will be published on the IBC website and will be available as a resource to districts wanting to implement programs with proven outcomes.

Action:

1. Funding will be requested from the Florida Legislature so that the IBC can establish a Best Practices clearinghouse as a resource to school districts.

Expected Outcome:

IBC will provide a web-based clearinghouse for successful Best Practice initiatives submitted by districts.

School District Funding

Recommendation:

State funding needs to recognize the health plan increases school districts are experiencing. Efforts will be made to educate the Florida Legislature about health plan issues. The Florida budget for school districts should include sufficient money to pay for the expected increases in health plan premiums.

Action:

1. Updated information from the 2003 school district health plan survey, including expected increases for 2003-2004, will be distributed to each legislator.
2. Presentations on the 2003 school district health plan survey will be given to each applicable Florida House and Senate committee. The presentations will include information on how health plan increases will impact school district services.

Expected Outcome:

The Florida budget for school districts will include sufficient dollars to pay for the expected increases in health plan premiums.

Malpractice Reform

Recommendation:

The malpractice crisis has significantly impacted all purchasers of health care services in the State of Florida.

Action:

1. Review the recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance.
2. Support activities that will stabilize the access to services and the cost of malpractice insurance.

Expected Outcome:

The IBC will support malpractice reform that will stabilize provider access and cost of services.

Recommendation
On
Health Plan Information System

Goal: To provide a single source of credible health plan information for all 67 school districts.

1. Health Plan Information System Parameters

A. The data collection method needs to be web-based, user-friendly, self-reportable, using portals to update database;
B. There needs to be a single recognized source to house benefit information and it needs to be communicated to all districts;
C. Correct contacts need to be updated at all districts on an ongoing basis and local boards and superintendents need to support the process;
D. The survey tool should not be used to report data on compensation, sick leave, workers compensation or liability insurance issues;
E. For self-funded programs, the transfer of general funds to the health plan and reserve requirements must be taken into consideration to determine total district cost;
F. Survey must have a save feature in the event user is interrupted prior to completion;
G. Drop down screens need to be utilized as much as possible to capture consistent information;
H. Logic should be put in the survey to ensure participation numbers for all plans equal the number of eligible employees reported;
I. Dialog boxes should be utilized to assist users with common areas that result in eligibility discrepancies;
J. Examples should be provided to assist users in answering questions accurately;
K. Major survey components should be identified and rolled-out based on established priority;
L. The health plan information system should capture information broken out in the following major components:
    1. Health Plans offered broken out by carrier, plan type, premium by tier, participation by tier, benefit design, include opt-out programs;
    2. Group Welfare Plans (life, disability, dental, vision, etc.)
    3. Section 125 (FSA, premium conversion)
    4. Employee demographics by age and gender
    5. Eligibility (waiting periods, minimum work hours)
    6. Health plan cost breakdowns (cost per member per month in major categories; utilization/1,000, etc.).
    7. Retiree benefits
    8. Administrative and Service Fees (stop loss limits and premium, claims administration, network access, utilization management, COBRA) including vendor names.

2. Initial Survey Priorities

A. Capture baseline financial information from school district finance officers. Survey will request budgeted per employee health plan cost and eligible employee count. Subsequent surveys will request actual health plan cost and eligible employee count for the previous plan year and budgeted numbers for current year. This will build an ongoing database and history of projected and actual health plan costs from year to year.
B. Survey benefit managers on plan changes and/or contribution changes that were necessary to impact rate increases, including the percent impact of any changes.
C. Initial web-based survey needs to focus on health plan component. The following draft has been developed as a template to capture initial health plan information:

3. Action Items

A. Update the 2002 health plan survey to determine the cost impact for use during the 2003 legislative session.
B. Request state funding during the 2003 legislative session to support the development and ongoing maintenance of the health plan information system.

DRAFT SURVEY QUESTIONS

1. Plan anniversary date (renewal date)

2. Total number of eligible employees (active, COBRA, LOA)

3. Total number of participating retirees

4. Total number participating (logic in system to sum questions 2 & 3 and will create logic for how participation is reported between all plans and opt outs)

5. Average age of participating employees

6. Gender breakdown: female___% male___% (logic will require equal to 100%)

7. Is the waiting period for benefits to begin the same for all employees? Y or N

8. If yes, please indicate benefits effective date (drop down screen with choices for 1st of month following 30, 60, 90, 120 days of employment, and other_____)

9. If no, please indicate job classification and related benefits effective date (use drop down screens)

10. List the name of each plan choice you offer to eligible employees and retirees. Must include all health plan options, alternative plans, opt-out benefits, Medicare Supplements, no coverage. (logic in system will require the sum of all participants reported equal answer provided in question 4 above)

    Based on the plan choices reported in question 10, the system will create a form for each plan name listed as follows:

	Plan A	**Plan B**	**Plan C**	**Plan D**
Plan Name (system will populate based on plans listed in question 10)				
Carrier/Claims Administrator (drop down screen with common carriers)				
Plan Type (drop down with HMO, PPO, POS, Opt Out, Med Supplement, No coverage)				
Indicate any benefit carve-outs (drop down with Rx, MH, other and field to list vendor)				
Funding (self-funded or fully insured)				
Participation and ANNUAL premium by tier for each Plan	(see Exhibit A for description)			
Benefit Design for each Plan	(see Exhibit B for description)			

Exhibit A – Participation and Annual Premium by Tier for Each Plan

Note: This screen needs to be broken out by active and retirees over/under age 65

Tier	Total Participating Employees/Retirees	Annual Board Cost Per Employee	Annual Employee Cost Per Employee	Annual Premium Per Employee
Single				(this column will auto sum board + employee cost)
Ee+Spouse				
Ee+Child(ren)				
Ee+1				
Ee + 2 or more				
Family				
Total	(sum of this field for all plans reported must equal question 4 total)	(auto sum)	(auto sum)	(auto sum)

(Note: Sum of total annual premium for all plans will be provided so a benefits manager can "spot-check" for accuracy).

Exhibit B – Benefit Design for Each Plan

Benefit	In-Network	Out of Network
Lifetime Maximum	(include drop downs)	(include drop downs)
Annual Deductible		
Coinsurance		
Out of Pocket Max (include deductible)		
Primary Care Physician Office Visit		
Specialist Office Visit		
Inpatient Hospital Stay		
Outpatient Surgery		
Emergency Room Visit		
Pharmacy <u>Retail</u> Generic Preferred Brand Non-Preferred <u>Mail</u> Generic Preferred Brand Non-Preferred		
Other Welfare Benefits Included in Health Plan	(drop down listing dental, vision, other)	
Benefit Alternative to Health Plan (opt-out). Describe in detail		

Additional feedback: Provide text areas for the following: 1) Wellness/prevention programs; 2) plan design changes to reduce premium

Recommendation
On
Statewide Retiree Health Plan

Goal: To develop and implement a stable and comprehensive statewide health program for retirees of the Florida Retirement System.

1. Statewide Health Plan Parameters

A. Current retirees and current vested employees will continue to be eligible for the Health Insurance Subsidy. Once implemented, employees retiring will only have the statewide health plan options for retirees and their eligible dependents under 65 and retirees and their eligible dependents over 65.
B. Current retirees/dependents will continue to have the option to remain a member of their school district health plan.
C. Current retirees/dependents on school district health plans will have the option to join the State Retiree Health Plan. This would be a one time option.
D. The State Retiree Health Plan(s) for Retirees Under 65 will be a PPO type of plan with emphasis on retiree health issues and the mobility of retirees. The plan will have all inclusive benefits and will include alternative care. The goal is to provide a comprehensive statewide and national provider network. HMO options will also be considered as a part of the State Retiree Health Plan.
E. Retirees not currently enrolled in their school district health plan, but who are receiving an FRS retirement check, will be eligible to enroll in the over 65 statewide health plan on a one time basis. They will apply their HIS payment toward the premium.
F. All FRS groups will be encouraged to join the State Retiree Health Plan.
G. The premiums will be established on a statewide basis, will be experience rated by co-mingling the under 65 retiree group with the active employee group, and will include several dependent tiers. A fully insured plan is the preference however self funding will be considered.
H. Local public employers will continue to offer health plan assistance and service to Retirees.
I. The Medicare Enhancement Plan (MEP) options will consider Medicare to be the primary coverage and will assume that enrollees have coverage under Medicare Part "B".
J. The MEP will include coverage for prescription drugs, wellness, and alternative care.
K. Retirees eligible for the MEP will be able to enroll any eligible family member under age 65 in the Under Age 65 Plan.
L. Timelines for implementation will include an extensive educational period.
M. Base plans will be developed first and several plan options will then be designed. The MEP may include an option with no supplemental pharmacy coverage. Restrictions would be included in the other MEP options to protect against adverse selection for pharmacy coverage.
N. The target date for implementation of the statewide retiree plans will be July 1, 2005.

O. Current Retirees selecting the new State Retiree Health Plan will have the option to discontinue coverage in the plan and will be eligible to receive the Health Insurance Subsidy. This will be permitted once. Current Retirees leaving a school district health plan for the State Retiree Health Plan will not be eligible to return to the school district health plan.

2. Health Plan Design

A. Under Age 65 State Retiree Health Plan (Base Plan)

Basic Plan Design	**Network**	**Out of Network**
Annual Deductible	$500	$500 (additional)
Office Visit Copayments		
Primary Care Physician	$15	60%/40%
Annual Physicals	$15	60%/40%
Specialist	$35	60%/40%
Emergency Room	$100 & 20%	60%/40%
Other Medical Services	80%/20%	60%/40%
Alternative Care	80%/20%	Network only
Out of Pocket (Annual)	$2,000 & $500	$4,000 & $500
Prescriptions		
Generic	$10	Network only
Preferred	$20 & 20%	Network only
Non-preferred	$40 & 20%	Network only
Out of Pocket (Annual)	$2,000	Network only

B. Over Age 65 State Retiree Health Plan (One of Several Options to be Developed)

Plan Design	**MEP**
Hospital Stay	$0
Outpatient Hospital Services*	0%
Other Medical Services*	0%
Office Visit*	0%
Preventive Services	0%
Alternative Care	0%
Prescriptions	
Generic	$10
Preferred	$20 & 20%
Non-preferred	$40 & 20%
Out of Pocket (Annual)	$2,000

**Note: Percentages are based on Medicare-approved amounts.*

3. State Retiree Health Plan Transition

A. Current retirees, current employees who are vested, and terminated employees who are vested will continue to be eligible for the Health Insurance Subsidy.

B. Current retirees, eligible for health plan coverage from the school district from which they retired, will be eligible to continue coverage with that school district.
C. Employees retiring from school districts after implementation of the State Retiree Health Plan, and eligible to continue health plan coverage, will only be offered the options established through the State Retiree Health Plan.
D. Employees who will be vested after the State Retiree Health Plan becomes effective will be eligible for health plan coverage in the State Retiree Health Plan upon retirement. These Employees/Retirees will not be eligible for the Health Insurance Subsidy.
E. Employees who retire and employees who vest will be eligible to participate in the Medicare Enhancement Plan even if they do not continue to participate in the Plan's under 65 health plan. These retirees would have their HIS payment applied toward the premiums.

4. Possible Statewide Insurance Health Program Funding

A. An FRS participating employer shall contribute 2.0 percent of gross compensation each pay period to the Statewide Health Insurance Program that will include the State Retiree Health Plan options and the Health Insurance Subsidy. The current Health Insurance Subsidy will be phased out over time and replaced with the new plan options.
B. Retirees and future vested employees who retire will be eligible for the State Retiree Health Plan. Upon retirement an eligible individual would be given a 2% credit for each year of actual service within the FRS system, up to a maximum of 35 years, which will be applied toward the single premium amount. This will be applied toward the blended premium for those under 65 and to the experience rated premium for those retirees over 65. Retirees with 35 years of experience would receive credit for 70%.
C. Credit for accumulated sick leave at retirement could also be transferred into the individual's pre-retirement health savings account to reduce future premiums.
D. Employees and retirees have been categorically placed into the following groups: Current Retirees; Vested Working Employees; Vested Terminated Employees; and Future Vested Employees.

	Current Retirees	**Vested Working**	**Vested Terminated**	**Future Vested**
District Plan	Option to continue	Not an option at retirement	Not an option	Not an option a retirement
HIS	Eligible to continue a one time option to return	Eligible	Eligible	Not eligible
State Plan instead of HIS				
Under 65	1 time option	Eligible at retirement from District	Not eligible	Eligible at retirement
Over 65	1 time option and at	Eligible at 65	Eligible at 65 to apply HIS	Eligible at 65 if vested

E. **Funding Example 2001 Data.** School districts are currently subsidizing the retiree health plan coverage by including the retiree claims experience with active employee claims experience. The recommendation would change the current practice. The Statewide Health Insurance Program would be responsible for setting the retiree premiums based on the co-mingling of experience of active employees and retirees. The assumption of $5,100 for the retiree Under 65 claims experience is a factor of 1.65 of the current active employee average of $3,100. If the Under 65 population represents 7% of the total, and the retiree under 65 is $5,100 then the actual active employee amount reduces to $2,950. Taking 100 covered individuals, 93 are active employees and 7 are retirees under 65. The 100 average cost is $310,000. 7 X $5,100= $35,700. $310,000-$35,700=$274,300. $274,300 divided by 93 equals $2,950. $5,100$2,950=$2,150. $2,150 X 7=$15,050. $15,050 divided by 93= $162 per active employee per year. If the average state salary is $31,000, the $162 equals about 0.52% of salary. The estimated Statewide Health Insurance Program contribution of 2% of gross compensation includes the current HIS contribution of 1.11% and the additional contribution for the transfer of retirees to the State Retiree Health Plan of 0.52% of gross compensation plus a margin of 0.37% of gross compensation.

The first year funding of this program is assumed to be cost neutral.

5. Statewide Health Insurance Program Eligibility at Retirement

A. To be vested in the Statewide Health Insurance Program, an individual will need to have a minimum of 10 years of FRS creditable service and meet a rule of 65. The creditable years of service and the individual's age must equal at least 65. Example: 10 years +age55=65. Eligible employees, with a minimum of 10 years of creditable experience, who become eligible for Medicare due to a disability, will not have an age restriction.

6. Retiree Plan Administration

A. **Governance Board**. The current Health Insurance Subsidy Trust would be expanded to include the administration of the State Retiree Health Plan and the Health Insurance Subsidy. The new Trust would have a Governance Board authorized to: set policy; hire staff; make disbursements; enter into contracts; set retiree health plan premiums; and administer the plans and HIS. The Governance Board will consist of seven (7) members as Trustees. The Governor will appoint one (1) member, the Chief Finance Officer will appoint one (1) member, the Speaker of the House will appoint one (1) member, and the Senate President will appoint one (1) member. The Retiree Benefits Advisory Committee (RBAC) Chairperson will be a member. Two (2) FRS retiree members will be elected for a three (3) year term by the retirees participating in the Statewide Health Insurance Program. The terms of office for appointed members will be staggered and will be for three (3) years. The RBAC Chairperson will be elected annually. Meetings will be advertised and open to the public. The health program would be administered within of the Florida Department of Management Services.

B. **Advisory Committee.** A Retiree Benefits Advisory Committee will be established to make recommendations to the Trust Governance Board on changes in the plan benefits and program administration. The Retiree Benefits Advisory Committee will consist of current retirees, active employees, and managers/administrators and will have fifteen (15) members. Terms will be for one (1) year and are renewable. The RBAC is to be representative of the participating employer groups with consideration given to employer size, geography, and organizational representation (unions, associations, employee or employer groups and retiree organizations). At least three (3) retirees will be appointed to the Committee. Appointments will be made by an Independent Selection Committee. The Independent Selection Committee will be appointed by the Governance Board. Appointees to the Retiree Benefits Advisory Committee must have a working knowledge of health plan benefits and program administration. The Independent Selection Committee will solicit members from FRS employers, organizational representatives, and retirees in the State Health Insurance Program.

5. Action Items

A. A request will be made to The Florida Legislature to fund an actuarial study to determine the feasibility of implementing a statewide retiree health program, based on the parameters outlined in the IBC recommendation.
B. FRS participating employers, in addition to the school district employers, will be asked to support the statewide retiree health program and the legislative funding request.

Recommendation
On
Benefit Cooperatives

Goal: To encourage the voluntary formation of educational entity health plan and other employee benefit cooperatives based on identified common interests.

1. Composition

Cooperatives would be comprised of public educational entities agreeing to join together within the state where a common interest is identified. Public educational entities include school districts, community colleges, and possibly state universities in the future. Educational entities would join together to form a Cooperative on a voluntary basis with a long term commitment.

2. Common Interest

The common interest may be identified as: contiguous counties; common hospital services and referral patterns; common provider referral patterns; economic hubs; employee residence patterns; school district informal cooperatives; statewide self funded groups; statewide pharmacy benefit carve-out groups; and area or rural coalitions. Cooperatives would more than likely develop around the larger cities within Florida, statewide carve-out initiatives, and coalitions of rural educational groups. Non-contiguous counties may also join together where a common interest exists.

3. Reasons for Formation

Cooperatives could be formally organized where the potential exists to:

A. Save costs on administrative services
B. Increase the population base to better stabilize risk
C. Provide targeted utilization/disease management services to a larger group
D. Increase the population base to encourage more competitive proposals
E. Increase the population base to negotiate improvements in provider contracts
F. Better coordinate health care programs within a specified portion of the state
G. Minimize the political influence on health plan selection and change
H. Implement health plan performance, quality, and patient safety standards
I. Standardize plan design within a Region
J. Provide other employee benefit plans on a regional basis
K. Provide statewide coverage for health plan and other employee benefit components such as: pharmacy benefit management; third party administration; behavioral health; term life insurance; catastrophic stop loss; and other voluntary benefit plans.

4. Cooperative Plan Components

Some Cooperatives may want to develop a single comprehensive health plan that would be offered to all employees. Cooperatives would be permitted to co-mingle claims experience. Some Cooperatives would only join together to purchase specific services such as: pharmacy benefit management; catastrophic stop loss coverage; healthy initiatives programs; benefit management and enrollment systems; COBRA and other administrative services; health plan claims, administrative, and utilization data; and/or implementation of health plan performance evaluation and quality improvement standards.

5. Cooperative Developmental Phases

Educational entities considering the formation of a Cooperative would be encouraged to consider the following phases of development:

A. Exploratory Phase
B. Feasibility Study
C. Organizational Commitment
D. Planning & Implementation
E. Evaluation

A. Exploratory Phase

The exploratory phase is intended to help the educational entities objectively focus on the following:

1. Expectations of Each Entity
2. Current Problems, Issues and Concerns
3. Common Interests
4. Commonalities and Common Services
5. Differences
6. Areas of Duplication of Effort
7. Identified Stakeholders and Their Interests
8. Resources (Time, Money, Personnel) Needed to Move Forward
9. Potential Value to the Entities
10. Issues Where Consensus will be Difficult to Achieve

This phase will be used to determine if: a common interest exists; and there is a benefit to proceeding. It will also help to identify the possible health plan components and/or other employee benefit plans where a positive cost/benefit potential may exist.

B. Feasibility Study

Educational entities, exploring the possibility of offering a comprehensive health plan or health plan components, would be encouraged to conduct a feasibility study prior to forming the Cooperative. Items to review would include:

1. Employees, retirees and dependents in each school district
2. Employee and retiree home ZIP codes
3. Hospital use
4. Outpatient facility use
5. Physician use
6. Pharmacy use
7. Health plan coverage comparison
8. Network contractual arrangements
9. Premium and funding comparisons
10. Contractual timelines and plan year issues
11. Collective bargaining agreements
12. Discussions with area health plan carriers and providers

If the Exploratory Phase identified the possibility of including other employee benefit plans within the Cooperative, additional information would be reviewed. The identified options could include plans such as: term life, dental, disability, and vision insurance; Section 125 Plan administration; annual enrollment; and other administrative services.

The study would be commissioned by the educational entities considering the formation of the Cooperative. The findings of the study would be used to determine the feasibility of continuing with the formation of the Cooperative, and would address the potential cost/benefit impact.

C. Organizational Commitment

Using the information from the Exploratory Meetings and Feasibility Study phases, and prior to forming the Cooperative, each educational entity would seek the commitment of their governing board and other identified stakeholders. Information would be presented on a defined course of action including stated commitments. This particular phase is intended to seek action to proceed with the formation of the Cooperative for the stated purpose. Educational entities considering the formation of a Cooperative need to commit to a long term arrangement.

D. Planning & Implementation

Specific plans would be developed based on the identified goals of the previous phases. Cooperatives agreeing to provide comprehensive health plan components would also need to establish a governance board to administer the program and to seek financial commitments from the impacted educational entities. An advisory committee may be formed to provide recommendations to the governance board.

E. Evaluation

An evaluation of the work accomplished by the Cooperative will be conducted annually by the governance board and included in a report back to the impacted educational entities. The evaluation will also include recommendations.

6. Action Items

A. Department of Insurance Review. The Florida Department of Insurance would need to be formally contacted to ask for a declaratory ruling to permit the formation of these Cooperatives. The issue of educational entities joining together and assuming health plan risk would need clarification.
B. Florida Statute Modification. A change to FS 112.08 is being recommended that would allow all governmental employers, including local governmental units such as school districts and community colleges, to competitively bid and/or directly negotiate contracts for health insurance and related benefits. This change would expand to options available to local governmental units by permitting direct negotiations with health insurance carriers and providers.
C. Statewide Pharmacy Carve-out Program. The IBC will form a Cooperative for educational entities having a common interest in a statewide prescription drug carve-out program. The formation of this Cooperative will follow the Cooperative Development Phases as outlined above. If there is interest in proceeding, a formal Request For Proposal will be developed following established procurement standards for educational entities.

Recommendation
On
Healthy Lifestyle Improvement Program

Goal: To provide resources to improve the health of school district employees, their dependents, and the students they serve.

1. Objectives:

A. To support targets set forth by Healthy People 2010 to achieve improvement in the leading health indicators listed below.
B. To develop statewide resources to bring health awareness issues to the attention of school district employees.
C. To develop a healthy lifestyles program where school district employees will serve as role models for students.
D. Promote nutritionally sound snacks and vending areas in all school district work sites.

2. Leading Health Indicators

A. Physical Activity
B. Obesity
C. Tobacco Use
D. Stress

3. Information on the Indicators

Physical Activity

A. Only 15% of the adult population engages in 30 minutes of moderate physical activity at least 5 days per week.
B. Approximately 40% of the adult population engages in no leisure-time activity at all.
C. People with lower than average physical activity include: women; people with lower income and education; African Americans and Hispanics; adults in the northeastern and southern States; and people over age 75.

Target: Provide resources that support HP2010 goal to increase the physical activity level of adults engaging in 30 minutes of moderate physical activity at least 5 days per week to 30%

Obesity

A. An estimated 31% of adults are considered obese (Body Mass Index greater than or equal to 30.0). The obesity rate was estimated to be 15% in 1980.
B. Populations with higher than average rates of being overweight and obese include: women with lower incomes; and African American and Mexican women.

Target: Provide resources that support HP2010 to reduce the proportion of adults who are considered obese (BMI 30+) to 15%

Tobacco Use

A. Nearly 24% of adults over age 18 are current cigarette smokers. 35% of adolescents (grades 9-12) have smoked 1 or more cigarettes in the past 30 days.
B. Populations with higher than average rates of smoking include: men slightly higher than women; lower income individuals; and adults with less than a high school education.

Target: Provide resources that support HP2010 goal to reduce adult cigarette smoking rate to 12% and the adolescent smoking rate to 16%

Stress

A. 80% of workers feel stress on the job, nearly half say they need help in learning how to manage stress and 42% say their coworkers need such help; (2000 Gallup Poll)
B. 62% routinely find that they end the day with work-related neck pain, 44% reported stressed-out eyes, 38% complained of hurting hands and 34% reported difficulty in sleeping because they were too stressed-out; (2000 Integra Survey)

Target: Provide tools to assist individuals in identifying stress and its causes, followed by stress reducing techniques

4. Other Considerations

A. Establish a statewide planning council.
   1. Purpose and Goals
   2. Who should lead the charge
   3. Identification of programs and outcomes

B. Work with the physician and provider community to establish the program.
   1. Florida Medical Association
   2. Local provider communities

C. Establish an implementation team in each school district.
   1. Determine best way to coordinate activities within each district
   2. Establish communication and program parameters

D. Behavior change theories and models
   1. Creating awareness
   2. Motivating individuals
   3. Tools to change
   4. Incentives

E. Best practices
   1. Identify successful programs and outcomes
   2. Set up district competitions (i.e., Walkathons)

F. Timeframes
   1. Establish Statewide Planning Council
   2. Implementation of program

G. Cost & Funding
   1. Grant applications
   2. Provider sponsorship
   3. Identification of potential funding sources available (i.e., tobacco) for preventive programs

5. Action Items

A. Funding will be requested from the Florida Legislature so that the IBC can establish a Best Practices clearinghouse as a resource to school districts.

Recommendation
On
Statewide Health Plan Standards

Goal: To develop and implement health plan reporting, performance, quality and patient safety standards that will be utilized by each Florida school district and community college.

1. Health Plan Reporting Standards

A. Data to be reported annually for each health plan offered would include:

1. Eligibility Data
    - a. Employees enrolled
    - b. Retirees enrolled
        - 1) Under 65
        - 2) Over 65
    - c. Covered Lives enrolled
        - 1) Employees
        - 2) Retirees
        - 3) Spouse & Domestic Partners
        - 4) Children
    - d. Bargaining Unit Breakdown
2. Premiums Paid
    - a. Employees
    - b. Retirees
    - c. Dependents
3. Medical Claims Data on a Per Member Per Month (PMPM) statue and by Covered Lives Status, Provider, & Bargaining Unit (HIPAA Compliant and Including Behavioral Health)
    - a. Average payments
    - b. Inpatient claims
        - 1) Payments
        - 2) Payments by Major Diagnostic Category (MDC)
    - c. Emergency room claims
    - d. Outpatient facility payments
    - e. Outpatient services payments
    - f. Professional fees paid
    - g. Claimants over $50,000 by MDC
    - h. Network Utilization
        - 1) In Network
        - 2) Out of Network

4. Administrative Costs (Medical)
    a. Claims and service charges
    b. Stop loss coverage
    c. Utilization Management
    d. Wellness Program Costs
    e. Network Access Fees
    f. Broker and consultant fees/commissions
    g. COBRA Administration
    h. Margin/profit
    i. Other (such as materials, actuarial)
5. Out of Pocket Expenses
    a. Deductibles
    b. Copays and coinsurance
6. Pharmacy Data by Member Status
    a. Pharmacy claims for retail and mail order
        1) Payments
            a. By Plan
            b. By member
        2) Top 50 drugs by cost
        3) Top 50 drugs by frequency
    b. Average claim cost
        1) Generic for retail and mail order
        2) Brand for retail and mail order
            a. Formulary/Preferred Drugs
            b. Non-formulary/ Non-preferred Drugs
    c. Prescriptions (per covered life per year)
    d. Generic prescription %
        1) Prescriptions dispensed
        2) Payments
    e. Administrative charges
    f. Rebates
7. Medical Utilization Data (per each 1,000 covered lives per year)
    a. Hospital admissions
    b. Hospital days
    c. Average length of inpatient stay
    d. Emergency room visits
    e. Surgeries
        1) Inpatient
        2) Outpatient
    f. Office visits
    g. Outpatient Diagnostic Services
        1) Radiology
        2) Laboratory

B. Reporting Standard Parameters

1. Health insurance carriers, health plan third party administrators, pharmacy benefit managers, and behavioral health administrators, doing business with Educational entities, will be evaluated on their ability to provide standardized data on claims, utilization, and administrative costs as outlined above annually.
2. The reporting standards will be discussed during annual renewal negotiations and will be included in future Request for Proposals (RFP). Implementation of these standards by all Educational entities is strongly encouraged. The reporting standards should be implemented for the next plan year. Educational entities may begin to use the proposed reporting standards for plan renewals as soon as they are adopted by the IBC.
3. Data for the annual reports will be for the plan year. The data will be on a claims paid/processed basis. Data is to be reported for each health plan offered. The reports are due within 60 days after the end of each plan year.
4. Definitions for the reporting categories will be included to ensure consistency of the data being reported.
5. Each Educational entity will post the following health plan information on the IBC Health Plan Annual Report section of the IBC website:

    a. Eligibility Data
    b. Medical Claims (PMPM) for Hospital stays, Outpatient facilities, Outpatient services, Professional services, and Pharmacy
    c. Administrative Fees
    d. Medical Utilization Data

    The Report will include data from each health plan offered. Initial health plan information will be requested in February 2004, and following the completion of each plan year thereafter.

2. Health Plan Performance, Quality, and Patient Safety Standards

The IBC recognizes the importance of quality medical care and supports the further investigation and implementation of statewide, consistent standards regarding measurable health plan performance and quality indicators. Evidence-based medical practices and relevant clinical practice guidelines for prevention, detection and management of disease and illness should be included in the standards. The safety of patients is a critical issue that also needs to be addressed. The outline below is intended to provide guidance in the ongoing review of appropriate nationally recognized health plan standards. The Standards may be used in RFPs and on an annual basis as a continuous quality improvement tool with health plan providers.

A. Performance Expectations

Health plan performance standards would be encouraged using the following indicators:

1. Provider access
2. Provider network attrition
3. Customer service
    a. Timely response
    b. Call abandonment rate
    c. Resolution of issue
4. Dispute resolution
    a. Objective and timely procedure
    b. Results
5. Claims processing
    a. Timely and accurate
    b. Administrative and auditing procedures
6. Member communications
    a. Timely distribution of documents
    b. Timely notification of plan changes
7. Health plan reports
8. Consumer satisfaction

B. Quality Expectations

Health plan quality standards would be established, taking into consideration the following:

1. Health plan accreditations
2. Network Provider Qualifications
3. Financial status
4. Integration of claims data
5. Member resources and internet access
6. Targeted disease management programs
7. Targeted chronic and acute case management
8. Evidence-based practice standards
9. Member education programs
10. Wellness and screening guidelines
11. Provider communication, education, and assistance

C. Patient Safety Expectations

The IBC is encouraging the statewide implementation of patient safety standards to raise the awareness of serious reportable medical events and to help reduce preventable medical mistakes. The IBC will study the feasibility of the implementation of a nationally recognized hospital initiative, such as The Leapfrog Group, using an approach that encourages systematic improvements. Participating hospitals need to see the value in reducing risk of patient mortality and serious medication prescribing errors. Purchasers of health care need to encourage hospitals to implement recognized standards, and educate consumers on patient safety issues.

3. Action Items

A. Funding will be requested from the Florida Legislature so that the IBC can establish consistent statewide standards for health plan reporting, performance, and quality for school district and community college health plans.
B. The IBC support the Central Florida Health Care Coalition in their patient safety initiative and assist the Coalition by raising the awareness of serious reportable medical events on a statewide basis.

Recommendation
On
Best Practices Initiative

Action Item: To establish a clearinghouse for school district health plan "Best Practices" and other health and quality related initiatives.

1. Program Overview

A. The "Best Practices" Initiative is being established to share the knowledge of health plan projects and other quality initiatives that have proven to be successful in school districts.
B. In addition to "Best Practices" that had positive and demonstrated outcomes, school districts will be encouraged to submit "Other Improvement Initiatives". These would include initiatives that were successful and also those that were tried and did not work, including the possible reasons for the less than expected result.
C. The Practice needs to be of interest to other school districts and have a demonstrated outcome. The Practice should be a program that was specifically implemented and working in the school district.
D. Health plan "Best Practices" will be divided into small, medium, and large school districts. Categories within each size division will include:

    1. Health plan initiatives
    2. Quality standards
    3. Wellness programs
    4. Communication and information
    5. Administration

2. Program Administration

A. The program will be administered by the IBC and published on the IBC website. The infrastructure needs to be in place to support this program.
B. The criteria to be used to determine the materials to be published will be consistent with the IBC goals.
C. Materials submitted for publication will be reviewed by a committee appointed by the IBC.
D. The "Best Practices" will be posted on the IBC website as they are received and approved.
E. The "Best Practices" portion of the IBC website will also include links to selected websites and updates on relevant health plan issues.

3. Submission of Articles

A. Benefit managers and union leaders will be notified of the program by e-mail and will be encouraged to participate. Categories of subject matter include but are not limited to:

1. Wellness & Prevention Programs
2. Quality Improvement Initiatives
3. Administrative Issues (i.e., procurement)
4. Ancillary Benefits
5. Communication & Enrollment
6. Cost Containment Strategies

B. The outline for a submission is to include:

1. Practice overview;
2. Relevant background including school district profile;
3. Health plan profile and resources needed to implement the Practice;
4. Practice goals;
5. Practice components;
6. Expected outcome and employee satisfaction;
7. References; and
8. Contact information for additional information.

4. Recognition

A. Special recognition will be given to the respondents who have their reports selected for publication on the IBC website. Individuals with published articles will be invited to present their "Best Practices" at an IBC or IBC member organization conference.
B. Special recognition will also be given to individuals with published articles at one of their district's school board meetings.

5. Action Items

A. Funding will be requested from the Florida Legislature so that the IBC can establish a Best Practices clearinghouse as a resource to school districts.

Independent Benefits Council

Best Practice Initiative
Submission Form

The Independent Benefits Council is soliciting Best Practice initiatives

Submission Date:_____

District:_____ # Employees_____

Submitted by:_____ Title:_____

Telephone:_____ Fax:_____ E-mail:_____

Name of Best Practice Initiative:_____

Describe Best Practice Initiative in detail including:

a. **General Overview Including Relevant Background**
b. **Goals & Objectives**
c. **Components of Program**
d. **Cost of Program**
e. **Time Period**
f. **Target Population**
g. **Communication Methods**
h. **Measurement Tools**
i. **Results/Outcome**
j. **Financial Impact**
k. **Lessons Learned**
l. **References**
m. **Contact for Additional Information**

Thank you for your submission.

Florida Public Education Survey

Health Plan Survey Results
May, 2002

Prepared by:

RobinsonBush, Inc.

John D. Robinson, CEBS
Janice S. Bush

www.robinsonbush.com

May 14, 2002

Survey Overview

The following pages represent the results of a health plan survey, conducted for the Independent Benefits Council and the Florida Education Association by RobinsonBush, Inc., of the 67 school districts, 28 community colleges and 11 public universities in the State of Florida.

The survey was initially commissioned by the Independent Benefits Council (IBC) to seek health plan information from the Florida school districts and later supplemented by the Florida Education Association (FEA) to include the community colleges and public universities. The IBC is a not-for-profit organization founded by the Florida School Boards Association (FSBA), the Florida Association of District School Superintendents (FADSS), the Florida Association of School Administrators (FASA), and the FEA.

The health plan survey was initially designed to gather basic information on public sector health plan carriers, types of plans, and cost of coverage. The survey also requested information on future health plan cost increases. The survey results were used effectively during the 2002 legislative session.

The IBC is currently conducting in-depth analysis on enhancements to the survey tool to include additional health plan information that impacts premium variation.

Florida Public Education
Combined Health Plan Survey Results

K-12	Community Colleges	State Universities

1. Eligibility and Participation Breakdown

Entity	Number Entities	Eligible Employees	Participating Employees	Avg Size
K-12	67	311,673	281,983	4,652
Colleges	28	18,411	17,212	658
Universities	11	35,594	31,740	3,236
Total	106	365,678	330,935	3,450

2. Fully Insured Versus Self-Insured

K-12	*Districts*		*Employees*	
	Number	**Percent**	**Number**	**Percent**
Fully Insured	44	66%	202,270	72%
Self-Insured	23	34%	79,713	28%
	67	100%	281,983	100%

Colleges	*Colleges*		*Employees*	
	Number	**Percent**	**Number**	**Percent**
Fully Insured	6	21%	5,735	33%
Self-Insured	22	79%	11,477	67%
	28	100%	17,212	100%

Universities – offered through Division of State Group Insurance

3. Health Plan Breakdown

	K-12		Colleges		Universities			
Provider	**#**	**Partic**	**#**	**Partic**	**#**	**Partic**	**Total Partic**	**Percent**
Blue Cross	36	52,244	23	12,444	11	20,746	85,434	24%
Self-Insured/TPA	16	61,081	1	832	0	0	61,913	17%
Cigna	4	45,956	2	1,737	0	0	47,693	13%
United	4	35,708	0	0	0	0	35,708	10%
Aetna	4	27,358	2	1,658	0	0	29,016	8%
Humana	4	26,608	0	0	0	0	26,608	7%
HIP/Vista	2	24,355	0	0	4	217	24,572	7%
Capital Health Plan	4	4,134	1	541	5	3,558	8,233	2%
Avmed	0	0	0	0	9	5,388	5,388	1%
Florida Health Care Plan	2	3,733	0	0	2	24	3,757	1%
Healthplan Southeast	2	806	0	0	6	1,361	2,167	1%
Misc. Fully Insured	0	0	0	0	9	446	446	0%
Not on Health Plan		29,690		1,199		3,854	34,743	9%
		311,673		18,411		35,594	365,678	100%

4. Health Plan Types Offered

	HMO	PPO	POS
K-12			
# Districts	29	57	15
Participation	175,081	93,292	13,610
Percent	62%	33%	5%
Colleges			
# Colleges	18	26	3
Participation	8,027	8,235	950
Percent	47%	48%	5%
Universities			
# Universities	11	11	0
Participation	10,994	20,746	0
Percent	35%	65%	0

5. Annual Renewal Dates

Entity	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jul*	*Aug*	*Sep*	*Oct*	*Total*
K-12	20	1	1	1	1	8	1	5	29	67
Colleges	21	-	-	-	-	5	-	1	1	28
Universities	11	-	-	-	-	-	-	-	-	11
Total	**52**	**1**	**1**	**1**	**1**	**13**	**1**	**6**	**30**	**106**

6. Health Insurance Funding and Premiums *(employee only coverage)*

	Average Premium Employee Only	Avg Employer Cost Per Employee
K-12	$3,088	$2,990
Colleges	**$**3,261	$3,383
Universities	$3,089	$4,094

7. Estimated Cost and Increases *(employer funding only)*

	Current Cost	Estimated Renewal	Total Increase	Percent
K-12	$903,434,517	$1,078,568,158	$175,133,641	19.4%
Colleges	$ 62,279,913	$ 71,621,900	$ 9,341,987	15%
Universities	$129,948,118	$ *149,440,336	$*19,492,718	*15%
Total	$1,095,662,448	$1,299,630,394	$203,968,346	18.6%

**Florida Division of State Group Insurance increase for 2002*

K-12 Health Plan Survey Results

1. Eligibility and Participation Breakdown

Eligible Employees/Retirees	Participating Employees/Retirees	Percent
311,673	281,983	90%

2. Fully Insured Versus Self-Insured

	Districts		*Employees*	
	Number	Percent	Number	Percent
Fully Insured	44	66%	202,270	72%
Self-Insured	23	34%	79,713	28%
	67	100%	281,983	100%

3. Health Plan Breakdown

Provider	# Districts	Participation	Percent
Self-Insured/TPA	10	58,417	21%
Blue Cross Blue Shield	36	52,244	18%
Cigna	4	45,956	16%
United Healthcare	4	35,708	13%
Aetna	4	27,358	10%
Humana	4	26,608	9%
HIP/Vista	2	24,355	9%
Fully Insured/Miscellaneous	8	8,673	3%
NEFEC	6	2,664	1%
		281,983	100%

4. Plan Types Offered

Plan Type	# Districts	Employee/Retiree Participation	Percent
HMO	29	175,081	62%
PPO	57	93,292	33%
POS	15	13,610	5%
		281,983	100%

5. Annual Renewal Dates

Jan	Feb	Mar	Apr	May	Jul	Aug	Sep	Oct	Total
20	1	1	1	1	8	1	5	29	67

6. Health Insurance Funding and Premiums

A. Employee Only Coverage Funded by District

	Employee Count	Average District Cost	Average Employee Premium	Average Employee Cost	Average District Size
Funding 100%	85,234	$2,976	$2,976	$0	6,556
Employee Only	30%				
Number Districts:	13				
At Least One Plan	150,540	$3,119	$3,194	$75	7,169
Funded at 100%	53%				
Number Districts:	21				
No Plan at 100%	46,209	$2,528	$2,970	$442	1,400
	17%				
Number Districts:	33				
Total	281,983	$2,990	$3,088	$ 98	4,209

B. Fully Insured Versus Self-Insured

	Employee Count	Average District Cost	Average Employee Premium	Average Employee Cost	Average District Size
Fully Insured	202,270	$2,925	$3,007	$82	4,597
Self-Insured	79,713	$3,156	$3,295	$139	3,466
Total	281,983	$2,990	$3,088	$ 98	4,209

7. Estimated Cost Increase to Districts

*Current Cost	Estimated Renewal	Total Increase	Percent Increase
$903,434,517	$1,078,568,158	$175,133,641	19.4%

**current cost includes funding for dependent coverage and/or flex benefits.*

Community Colleges Health Plan Survey Results

1. Eligibility and Participation Breakdown

Total Eligible Employees	Employees Participating in Health Plan	Percent	Employees Not in Health Plan	Percent
18,411	17,212	93%	1,199	7%

2. Age/Sex Breakdown

Average Age	# Male	# Female	Total
51.2	7,519	10,892	18,411
	41%	59%	100%

3. Fully Insured Versus Self-Insured

	Colleges		*Employees*	
	Number	Percent	Number	Percent
Fully Insured	6	21%	5,735	31%
Self-Insured	22	79%	12,676	69%
	28	100%	18,411	100%

4. Health Plan Breakdown

Provider	# Districts	Participation	Percent
Blue Cross Blue Shield	23	12,444	68%
Cigna	2	1,737	9%
Aetna	2	1,658	9%
Health Partnership Plan	1	832	5%
Capital Health Plan	1	541	3%
Alternative to Health Plan	20	747	4%
No Coverage	6	452	2%
		18,411	100%

5. Health Plan Types Offered

Plan Type	# Districts	Employee/Retiree Participation	Percent
PPO	26 (93%)	8,235	48%
HMO	18 (64%)	8,027	47%
POS	3 (11%)	950	5%
		17,212	100%

6. Annual Renewal Dates

January	July	September	October	Total
21	5	1	1	28

7. Health Insurance Funding and Premiums

Employer Cost	**# Employees**	**Avg Employer Cost/EE**
$62,279,913	18,411	$3,383

Employee Only Premium Cost	**# Employees**	**Avg Single Premium**
$44,428,824	13,624	$3,261

Total Premium	**# Employees**	**Avg Total Premium/EE**
$77,529,442	18,411	$4,211

Tier Type	**# Employees**	**Percent**
Single Coverage	12,425	67.5%
Family Coverage	4,787	26%
Alternative/Opt Out	1,199	6.5%

8. Current Cost and Estimated Increase to Colleges

Health coverage portion funded by college

Current Employer Cost	**Estimated Renewal**	**Total Increase**	**Percent Increase**
$62,279,913	$71,621,900	$9,341,987	15%

Total premium including employee contributions

Current Total Premium	**Estimated Renewal**	**Total Increase**	**Percent Increase**
$77,529,442	$89,158,858	11,629,416	15%

Universities Health Plan Survey Results

1. Eligibility and Participation Breakdown

Eligible Employees	Participating Employees	Percent
35,594	31,740	89%

2. Age/Sex Breakdown

Average Age	# Male	# Female	Total
46.2	17,314	18,280	35,594
	49%	51%	100%

3. Health Plan Breakdown (Division of State Group Insurance)

Provider	# Universities	Participation	Percent
Blue Cross Blue Shield PPC	11	20,746	65%
Avmed Health Plan	9	5,388	17%
Capital Health Plan	5	3,558	11%
Healthplan Southeast	6	1,361	4%
Prudential Health Care	7	408	1%
HIP Health Plan	4	217	1%
JMH Health Plan	2	38	<1%
Florida Health Care Plan	2	24	<1%
Total		31,740	100%

4. Plan Types Offered

Plan Type	# Universities	Employee Participation	Percent
HMO	11	10,994	35%
PPO	11	20,746	65%
		31,740	100%

5. Monthly Insurance Premiums *(Effective November 1, 2001)*

Tier	University	Enrollee	Total
Single	$220.24	$37.14	$257.38
Family	$450.34	$133.62	$583.96
Subscriber Spouse	$291.98	$0	$291.98

6. Annual Cost Breakdown

Tier	# Enrollees	Percent	University Cost	Enrollee Cost	Total Cost	Average Cost Per Tier
Single	12,267	38%	$32,420,209	$5,396,293	$37,887,336	**$3,089**
Family	15,346	48%	$82,931,012	$24,606,390	$107,537,402	**$7,008**
Sub. Spouse	4,286	14%	$15,017,115	$0	$15,017,115	**$3,504**
Total	**31,740**	**100%**	**$129,948,118**	**$30,002,683**	**$159,950,802**	**$5,039**
Average			$4,094	$945	$5,039	
Percentage			81%	19%	100%	