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State could save by axing HMOs

By Christine Jordan Sexton
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Florida could save more than \$118 million if it removed HMOs as one of the health care options offered to state employees, according to a consultant's report commissioned by the state agency that oversees health insurance for state workers and their families.

The state could save another \$143.6 million if it required employees to purchase a high-deductible, self-insured plan administered by Blue Cross and Blue Shield of Florida, says the report by Buck Consultants.

The report, commissioned by the Division of State Group Insurance, comes out amid growing calls by state legislators to retool the state's health insurance program, which this current year is expected to cost \$1.8 billion.

One of the changes that legislative leaders have already discussed is whether to require all state workers to start paying part of the price of their health-insurance premiums. Roughly 27,000 state workers -- including legislators, the governor and the Cabinet -- do not pay any premiums.

Currently, state employees have access to one of four plans: a standard HMO, a standard PPO, a high deductible HMO or a high deductible PPO. The PPO options are self insured, which means the state pays a third party to administer the plan. Blue Cross and Blue Shield of Florida is the administrator of the state's self-funded plan.

For 2009-10, it's estimated that more than 80,000 state employees will enroll in the traditional HMO plan and almost 95,000 will enroll in the PPO plan. While there are more people enrolled in the PPO now, state economists predict that HMO enrollment will surpass PPO enrollment by 2012.

HMOs available to state employees include Capital Health Plan (CHP), AvMed Health Plan, Florida Health Care Plan, United Health Care Plan and Vista Health Plan.

Eliminating some HMOs may not disrupt patient physician relationships because providers can contract with more than one managed care network. But it would be wrenching for those in Capital Health Plan because it is a staff-model HMO based in Tallahassee; its doctors work only for CHP.

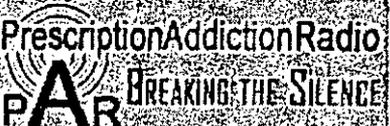
"(A)ny HMO network that has a 'staff model' (such as CHP) will result in provider disruption as those providers are exclusively contracted with that HMO and will not be available to treat members once they change vendors," the report says.

CHP is one of the highest-ranked managed care organizations in the country and commands great loyalty among its customers. A decision to eliminate HMOs from state workers' health opinions would therefore roil the home of state



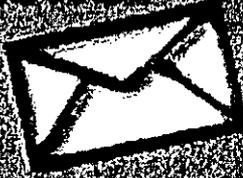
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government.

To determine the potential savings, Buck Consulting assumed that workers' premium contributions toward the plan would remain the same. But Senate leaders have suggested re-examining that policy, saying it's "out of touch."

--Christine Jordan Sexton is co-founder of TallahasseeReporters.com.

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State of Florida
Program Modification Study –
All Participants

December 22, 2009

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State of Florida
Program Modification Study – All Participants
Summary of Analysis and Considerations

As requested by the State of Florida, Division of State Group Insurance, Buck Consultants (Buck) performed a comprehensive financial analysis of the State's projected health plan costs for fiscal year 2010 – 2011, under various alternative scenarios. The analysis includes all categories of participants covered by the State's health plan including actives, COBRA, early retirees and Medicare-eligible retirees. Contained herein is an overview of the analysis that was conducted, a summary of the financial results, assumptions used in the analyses, as well as some preliminary transition and implementation issues to be considered. Detailed financial exhibits are included under separate cover.

Overview of Current Health Plan Program

The State of Florida State Employees Group Insurance Program currently consists of the following options:

Active Employees, COBRA Participants, Early Retirees	Medicare-Eligible Retirees
1. Standard PPO	1. Standard PPO
2. Standard HMO	2. Standard HMO
3. Health Investor Health Plan (HIHP) PPO	3. Health Investor Health Plan (HIHP) PPO *
4. Health Investor Health Plan (HIHP) HMO	4. Health Investor Health Plan (HIHP) HMO *

**Note – these plans are available to Medicare-eligible retirees with no State funding of the Health Savings Account. There are currently no Medicare-eligible retirees enrolled in these plans.*

The PPO options (Standard and HIHP) are self funded, with the medical benefits administered by the third party administrator, Blue Cross Blue Shield of Florida

(BCBSF), and the pharmacy benefits administered by the Pharmacy Benefit Management (PBM) vendor, CVS Caremark.

The HMO options (Standard and HIHP) are fully insured and administered by the following carriers, with pharmacy benefits integrated with medical benefits for each vendor:

1. AvMed Health Plan (AvMed)
2. Capital Health Plan (CHP) (does not currently offer HIHP option)
3. Florida Health Care Plans (FHCP)
4. United Health Care (UHC)
5. Vista Health Plan (Vista)

Alternative Scenarios Analyzed

As requested by the State of Florida, Division of State Group Insurance, a financial analysis of the following four scenarios was conducted:

Scenario 1 - Conversion of all current plans to self funded

Scenario 2 - Elimination of the HMOs

Scenario 3 - Elimination of all plans except for the HIHP options

Scenario 4 - Elimination of all plans except for the HIHP PPO option

For all scenarios in the analysis, active employee contributions are assumed to remain at the May 2010 amounts (by plan option and coverage tier) for all studies. Contributions for COBRA participants, early retirees and Medicare-eligible retirees remain as currently structured.

For all applicable plan option changes, when the current vendor has a remaining plan option to offer, members are assumed to remain with the vendor with which they are currently enrolled.

Summary of Results

The chart below summarizes for each scenario, the total projected cost savings, revenue impact, and resulting net savings to the Trust Fund on a cash basis, for fiscal year 2010 – 2011, and assumes the changes for each scenario are implemented at the beginning of the fiscal year. If changes are effective later in the fiscal year, the projected cost savings would be reduced.

Total Projected Impact for Fiscal Year 2010-2011

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Scenario Description	Conversion of all current plans to self funded	Elimination of the HMOs	Elimination of all plans except for the HIHP options	Elimination of all plans except for the HIHP PPO option
Projected Cost Savings	\$ 9,878,732	\$ 118,595,621	\$ 245,838,669	\$ 295,035,238
Projected Premium Contribution/ Revenue Impact	\$ 0	\$ 0	(\$151,990,796)	(\$151,378,229)
Total Net Trust Fund Savings	\$ 9,878,732	\$ 118,595,621	\$ 93,847,873	\$ 143,657,009

The following is a summary describing the changes reflected in each scenario, assumptions used in the analyses, total projected cost savings to the health insurance program and an overview of potential transition, implementation, and other issues for consideration.

Scenario 1 - Conversion of all current plans to self funded

Changes: All current fully insured plans (Standard and HIHP HMOs) convert to self funded plans. All HMOs were re-underwritten, based on the claims and retention detail data provided, to reflect the applicable claims experience as well as an expected HMO-specific retention level based on the retention information provided by each HMO vendor.

Assumptions: All vendors and plan options remain in place. HMO-specific retention amounts are based on information provided by each HMO vendor detailing the current retention components, and removing items that are not applicable to self funding (i.e., pooling charge, margin, etc.). All benefits administered by the respective vendors continue to be administered by the same vendor.

Total Projected Cost Savings: \$ 9,878,732

The financial impact of this scenario is driven primarily by the reduction of administrative expenses. When changing to self funding, the retention portion of the current fully insured HMOs is reduced by the components that do not apply to self funded plans including risk charge, margin, pooling charges and premium tax. The charges for these components as outlined by each HMO vendor, were removed from the projections to determine the remaining administrative fees which would range from \$43 - \$51 PEPM. No further adjustment was made to these fees to account for further reductions that could be realized resulting from competitive pressures among the HMOs and comparisons to the current self funded PPO plan fees.

Minimum guaranteed pharmacy pricing terms and rebates are not included as part of the current fully insured HMO contracts. It should be noted, however, that additional savings may be realized from negotiation of these terms as part of a self funded agreement with the respective HMO vendors. Alternatively, the State could choose to consolidate all of the pharmacy benefit administration under its current PBM vendor, CVS Caremark, and have each incumbent HMO administer only the medical benefits. Increasing the number of members for whom CVS Caremark administers pharmacy benefits, to include all of

the plans' participants, would trigger improved overall pharmacy pricing terms as negotiated in the recent renewal agreement.

Transition and Implementation Issues to be Considered

Vendors

Conversion of all current plans to self funded does not directly result in the termination of any of the current vendor relationships. All plan options could remain as is with the fully insured Standard and HIHP HMOs now being self funded, like the Standard and HIHP PPO options currently administered by BCBSF (medical) and CVS Caremark (pharmacy). As noted above, alternatively the State may choose to consolidate all of its pharmacy benefit management and administration under its current PBM vendor and have each incumbent HMO vendor administer only medical benefits. Under a self funded arrangement HMOs may be referred to as EPO (Exclusive Provider Organization) but in most cases, it is a change in plan name only.

Benefits

Since no plan options or vendors are being eliminated, no change in benefits results.

Provider Disruption

Since no plan options or vendors are being eliminated, there is no change in provider networks, therefore no provider disruption for participants.

Transition of Care

There would be no transition of care issues under this scenario.

Administrative

Since no plan or vendors are being eliminated, no re-enrollment is required. Some administrative changes may be necessary due to vendor requirements so new ID cards may be needed for example.

Premium Contributions

No premium contribution changes are required as a result of this change.

Communications

Converting all the current plans to self funded results in a relatively seamless transition for plan participants however, any benefit program change requires communication. Some effort will be required to educate members on the reason for the change, how they may be impacted, and what they need to do. This message however, does not carry the sensitivity that some of the other scenarios include, and should be a simpler effort.

Data Analysis

The ability to perform more accurate, data-driven analyses is significantly enhanced because the data available to self funded plans is generally much more robust than that available to fully insured plans. Aggregating all of the self funded data into a data warehousing system will enable the State to:

- analyze its historical data and trends;
- implement targeted changes and/or program initiatives to improve plan performance;
- monitor the impact of the changes; and
- conduct outcomes analyses to validate the results.

Identified changes or program initiatives that support an employer's goal of shared responsibility and accountability for employees' health and well-being can be implemented much more easily under a self funded arrangement than under the current fractured financial risk pool. Some of these initiatives may include the implementation of:

- health risk appraisals to identify areas of health risk within the State's population, the results of which can be used to raise awareness of health issues and encourage behavior change among participants with unhealthy lifestyles;
- targeted disease management programs to help participants identify and address health risk factors associated with chronic conditions, to improve health status through compliance with evidence-based protocols, knowledge and health coaching;
- on site services such as medical screenings, medical care or pharmacy services, to manage costs through early detection, reduce absenteeism through convenient acute care services, or dispensing commonly used prescription drugs;

- coordinated wellness programs to address facets of health for living such as preventive care, fitness, exercise, weight management, nutrition, tobacco cessation, stress, safety, substance abuse, and healthy aging; and
- incentives to encourage or motivate specific behaviors such as making appropriate health care decisions to control cost or utilization, selecting providers with better outcomes or higher quality ratings, and making personal lifestyle choices that reduce the risk of future chronic disease or injury.

Some of these types of initiatives will require more of the State's administrative resources than others, due to the multiple-vendor structure. Specifically, implementation of programs, communication to participants and program monitoring are less efficient when programs are administered by multiple vendors. However, if the data is aggregated into a warehousing program, program evaluation and outcomes analyses can be conducted, similarly to as if the vendors were consolidated.

Other

The outcome of this change as outlined under this scenario is six self funded plan administrators (seven including CVS Caremark), five of whom administer identical benefit options (Standard and HIHP HMOs/EPOs). Among the five that administer identical benefit options, some are offered in the same geographic area and likely have significant provider network overlap. With the financial competition from fully insured rates eliminated, and the entire financial risk now on the State, there is little advantage to the State in offering multiple vendors for the same plan in the same geographic areas. Consolidation of EPO vendors would streamline the administration of the program and allow the State to more efficiently undertake and manage strategic, plan-wide initiatives. Consolidation of EPO vendors could be undertaken with the change to self funding, or as a second phase after the initial transition.

Scenario 2 - Elimination of the HMOs

Changes: The Standard and HIHP HMO plans, currently fully-insured and administered by the five HMO vendors (AvMed, CHP, FHCP, UHC and Vista), are eliminated. All participants are offered a choice of the Standard or HIHP PPO plans administered by BCBSF (medical) and CVS Caremark (pharmacy).

Assumptions: All participants are covered by BCBSF self funded Standard or HIHP PPO plans. There is no change to BCBSF plan designs or employer/employee contributions.

Medicare-eligible retirees: Since the only options left under this scenario would be the Standard PPO and the Standard HIHP, and current Medicare eligible retirees do not have Health Savings Accounts from which to draw funds, for purposes of this analysis all HMO Medicare-eligible retirees are assumed to move to the Standard PPO.

Total Projected Cost Savings: \$ 118,595,621

Transition and Implementation Issues to be Considered

Vendors

Elimination of the HMO plan options results in the termination of the current five HMO vendor relationships. The plan options remaining would be the self funded Standard and HIHP PPO options currently administered by BCBSF (medical) and CVS Caremark (pharmacy). Consolidation of vendors and the resultant transition of the entire State plan to self funding facilitates strategic plan management opportunities that were not previously readily available.

Benefits

Elimination of the HMO plans results in a reduction of the higher "value" benefit options resulting in reduction of benefits to participants which would be considered a benefit "takeaway" by most participants currently enrolled in an HMO plan.

Provider Disruption

Some currently-utilized providers in the HMO plans may not be contracted with BCBSF's network. The elimination of the five HMO vendors may result in some disruption of provider relationships for in network benefits due to the change in contracted networks, requiring members to seek the services of a different provider in order to receive in network benefits. However, because the PPO plan option includes out of network benefits, members will be able to maintain their current provider relationship if that provider is not contracted in BCBSF's network, but members will receive the lower, out of network benefits and incur additional out of pocket expenses. Any HMO network that has a "staff model" (such as CHP) will result in provider disruption as those providers are exclusively contracted with that HMO and will not be available to treat members once they change vendors. To help mitigate provider disruption, in advance of the transition an analysis should be conducted to identify the specific providers that members are currently utilizing that would be out of network for the BCBSF plan. These providers could be targeted by BCBSF's provider contracting representatives for possible contracting review and negotiations. Due to the breadth of BCBSF's PPO network in Florida, it is anticipated that the level of provider disruption would not be significant, with the possible exception of CHP's staff providers.

Transition of Care

Medical management transition issues will likely exist due to the elimination of the HMO vendors. Examples would include members in catastrophic or large case management, maternity and disease management programs. Transition of care plans from the HMOs to BCBSF would need to be arranged for those members so their treatment regimens are not interrupted.

Administrative

Re-enrollment for new plan selection will be required for all affected members. This can be accomplished through an open enrollment process for all members, or a default plan designation can be made for affected members, with optional re-enrollment offered. Members will have some administrative changes including new ID cards, contact numbers and websites. Access to online claims history and other information that may have been hosted by the HMOs for their members will be terminated either at the date of

termination or some date thereafter (to allow members to access information on run-out claims). A transfer of this data history to BCBSF should be explored to help minimize the loss of historical data for participants.

Premium Contributions

The State and members currently contribute the same amount for the Standard PPO and HMO plans, and for the HIHP PPO and HMO plans. Elimination of the Standard and HIHP HMO plans will therefore not require a change in the State or the participant contributions due specifically to this change. For various strategic reasons however, the State may want to consider evaluating its premium contribution approach at the time of this change.

Communications

Any benefit program change requires communication to participants. Elimination of HMO plans and vendors is a significant change that impacts members in numerous areas. A communications campaign to members including the reason for the change, how they may be impacted, and what they need to do, should be conducted. A well-executed communication effort will assist the State and members with the transition, minimize member anxiety and complaints.

Data Analysis

As noted in the "vendor" consideration section, consolidation of vendors and plan participants into one self funded risk pool facilitates strategic plan management opportunities that were not previously readily available. The ability to perform more accurate, data-driven analyses is significantly enhanced because the data available to self funded plans is generally much more robust than that available to fully insured plans. Through the use of comprehensive, aggregated data the State will be able to:

- analyze its historical data and trends;
- implement targeted changes and/or program initiatives to improve plan performance;
- monitor the impact of the changes; and
- conduct outcomes analyses to validate the results.

Identified changes or program initiatives can be implemented much more easily under this consolidated structure than under the current fractured risk pool and vendor

arrangements. For example, initiatives that support an employer's goal of shared responsibility and accountability for employees' health and well-being may include the implementation of:

- health risk appraisals to identify areas of health risk within the State's population, the results of which can be used to raise awareness of health issues and encourage behavior change among participants with unhealthy lifestyles;
- targeted disease management programs to help participants identify and address health risk factors associated with chronic conditions, to improve health status through compliance with evidence-based protocols, knowledge and health coaching;
- on site services such as medical screenings, medical care or pharmacy services, to manage costs through early detection, reduce absenteeism through convenient acute care services, or dispensing commonly used prescription drugs;
- coordinated wellness programs to address facets of health living such as preventive care, fitness, exercise, weight management, nutrition, tobacco cessation, stress, safety, substance abuse, and healthy aging; and
- incentives to encourage or motivate specific behaviors such as making appropriate health care decisions to control cost or utilization, selecting providers with better outcomes or higher quality ratings, and making personal lifestyle choices that reduce the risk of future chronic disease or injury.

While it is possible to implement these or other program performance-enhancing initiatives under the State's current multiple-vendor, varied-funding structure, communication to participants, tracking of participation and performance monitoring are more difficult and less efficient to conduct when data is disaggregated and programs are managed by multiple vendors and are not structured consistently.

Scenario 3 - Elimination of all plans except for the HIHP options

Changes: Under this scenario the Standard PPO and HMO options would be eliminated, resulting in all participants enrolling in either the HIHP PPO or HIHP HMO option.

Assumptions: Because this scenario eliminates the Standard plan options and does not assume the elimination of any vendor, for purposes of this analysis, participants are assumed to remain with the vendor they are currently enrolled with under the remaining plan option. Employee contributions for the HIHP plans are assumed to remain at the May 2010 level.

Medicare-eligible retirees: Since current Medicare eligible retirees do not have Health Savings Accounts from which to draw funds, for purposes of this analysis all Medicare-eligible retirees are assumed to be in the Standard plan with current vendor.

Total Projected Cost Savings: \$ 245,838,669

Transition and Implementation Issues to be Considered

Vendors

Elimination of the Standard PPO and HMO plan options does not involve the termination of any of the current vendor relationships.

Benefits

Elimination of the Standard PPO and HMO plan options results in a reduction of two of the higher "value" benefit options resulting in reduction of benefits to participants which would be considered a benefit "takeaway" by most participants. Since most of the State's current participants are not currently enrolled in one of the HIHP plans, many participants would experience a reduction in the value of their benefits and many may incur higher out of pocket expenses. All participants would be enrolled in the HIHP plans which are considered Consumer Driven Health Plans (CDHPs) and include a high deductible health plan (as defined by the IRS) and a fund (Health Savings Account). Under this scenario the State is assumed to continue it's funding of HIHP participants' accounts at the current annual levels of \$500 single and \$1000 family. Participants can

also contribute to their HSAs on a tax deferred basis, the accounts accrue interest on a tax-free basis, and withdrawals from the accounts are tax-free when used for qualified health care expenses.

Although it is still relatively early since the introduction of these types of plans, some studies have reported metrics for CDHPs that support the implementation of these plans as an integral part of a comprehensive program management initiative. Some of these supportive metrics include:

- Reduced utilization of elective services
- Increased utilization of preventive care services
- Increased use of generic and/or lower cost rx alternatives

Provider Disruption

Since no vendors are being eliminated, there is no change in provider networks, therefore no provider disruption for participants.

Transition of Care

There would be no transition of care issues under this scenario since all vendors are remaining and all participants are assumed to remain with their current vendor.

Administrative

Since no vendors are being eliminated, re-enrollment is not a requirement however annual open enrollment will allow participants to choose between the remaining HIHP PPO and HIHP HMO options. Some administrative changes may be necessary due to vendor requirements. New ID cards will be needed for example.

Premium Contributions

Premium contributions for the HIHP PPO and HIHP HMO plans are currently the same, but they are lower than the current Standard PPO and Standard HMO plan contributions. With all participants moving into the HIHP options, and premium contributions remaining the same for these options, participants that are currently enrolled in one of the Standard plans (which includes the majority of current health plan participants), and are required

to contribute towards their health plan, will receive a reduction in their per paycheck contributions.

Communications

Any benefit program change requires communication to participants. Elimination of the Standard Plans resulting in a total replacement with HIHP options requires an extensive communication campaign. Eliminating the Standard plans is a significant benefit design change for members enrolled in these plans, however the change to offering only the HIHP plans has additional implications for participants. As noted previously, the HIHP options are considered to be Consumer Driven Health Plans (CDHPs) and they operate differently than what most of the Standard plan participants are accustomed to. These types of plans encourage proactive "consumerism" behaviors, such as comparing costs of services, comparing the quality of providers, and the use of preventive care services which are not currently incentivized in the design of the Standard plans, particularly the Standard HMOs. The desired outcome of these "consumerism" behaviors is more "appropriate" utilization of required services, reduction of non-required services, and increases preventive care services to promote the maintenance of health and early detection of illness or disease. In order to do this, participants need extensive education on how the plan works, where to find the needed information, and how to use the available tools. Communication support for these plans is not a one-time event. It should include ongoing support to ensure participants understand how to navigate their benefit program. A well-executed communication effort will assist the State and members with the transition, minimize member anxiety and complaints, and assist the State in implementing a program that has the potential to reduce the State's long term trend rate.

Other

With the significant movement of participants from the Standard HMO to the HIHP HMO plans, the HMO vendors may significantly change how they underwrite these plan options.

Scenario 4 - Elimination of all plans except for the HIHP PPO option

Changes: The Standard PPO plan currently administered by BCBSF and CVS Caremark, and the Standard HMO and HIHP HMOs plans currently fully-insured and administered by the five HMO vendors (AvMed, CHP, FHCP, UHC and Vista) are eliminated. All participants are enrolled in the HIHP PPO plan administered by BCBSF (medical) and CVS Caremark (pharmacy).

Assumptions: All participants are covered by BCBSF self funded HIHP PPO plan. There is no change to BCBSF HIHP PPO plan design or employee contributions.

Medicare-eligible retirees: Since the only option left under this scenario would be the HIHP PPO, and current Medicare eligible retirees do not have Health Savings Accounts from which to draw funds, for purposes of this analysis all Medicare-eligible retirees are assumed to move to the Standard PPO.

Total Projected Savings: \$ 295,035,238

Transition and Implementation Issues to be Considered

Vendors

Elimination of all plans except the HIHP PPO option results in the termination of the current five HMO vendor relationships. The plan option remaining would be the self funded HIHP PPO option currently administered by BCBSF (medical) and CVS Caremark (pharmacy). Consolidation of vendors and the resultant transition of the entire State plan to self funding facilitates strategic plan management opportunities that were not previously readily available.

Benefits

Elimination of the Standard PPO and HMO plan options results in a reduction of two of the higher "value" benefit options resulting in reduction of benefits to participants which would be considered a benefit "takeaway" by most participants. For the current HIHP HMO participants, the benefit change to the HIHP PPO plan would not be as significant. Since most of the State's current participants are not currently enrolled in one of the

HIHP plans, many participants would experience a reduction in the value of their benefits and many may incur higher out of pocket expenses. All participants would be enrolled in the HIHP PPO plan which is considered a Consumer Driven Health Plan and includes a high deductible health plan (as defined by the IRS) and a fund (Health Savings Account). Under this scenario the State is assumed to continue its funding of HIHP participants' accounts at the current annual levels of \$500 single and \$1000 family. Participants can also contribute to their HSAs on a tax deferred basis, the accounts accrue interest on a tax-free basis, and withdrawals from the accounts are tax-free when used for qualified health care expenses.

Provider Disruption

Some currently-utilized providers in the HMO plans may not be contracted with BCBSF's network. The elimination of the five HMO vendors may result in some disruption of provider relationships for in network benefits due to the change in contracted networks, requiring members to seek the services of a different provider in order to receive in network benefits. However, because the HIHP PPO plan option includes out of network benefits, members will be able to maintain their current provider relationship if that provider is not contracted in BCBSF's network, but members will receive the lower, out of network benefits and incur additional out of pocket expenses. Any HMO network that has a "staff model" (such as CHP) will result in provider disruption as those providers are exclusively contracted with that HMO and will not be available to treat members once they change vendors. To help mitigate provider disruption, in advance of the transition an analysis should be conducted to identify the specific providers that members are currently utilizing that would be out of network for the BCBSF plan. These providers could be targeted by BCBSF's provider contracting representatives for possible contracting review and negotiations. Due to the breadth of BCBSF's PPO network in Florida, it is anticipated that the level of provider disruption would not be significant, with the possible exception of CHP's staff providers.

Transition of Care

Medical management transition issues will likely exist due to the elimination of the HMO vendors. Examples would include members in catastrophic or large case management, maternity and disease management programs. Transition of care plans from the HMOs to BCBSF would need to be arranged for those members so their treatment regimens are not interrupted.

Administrative

Re-enrollment for the new plan will be required for all members however this can be accomplished through a default plan designation since only one plan option remains. Members will have some administrative changes including new ID cards, contact numbers and websites. Access to online claims history and other information that may have been hosted by the HMOs for their members will be terminated either at the date of termination or some date thereafter (to allow members to access information on run-out claims). A transfer of this data history to BCBSF should be explored to help minimize the loss of historical data for participants.

Premium Contributions

Premium contributions for the HIHP PPO are the same as the current HIHP HMO plans, but they are lower than the current Standard PPO and Standard HMO plan contributions. With all participants moving into the HIHP PPO option, and contributions remaining the same for this option, participants that are currently enrolled in one of the Standard plans (which includes the majority of current health plan participants), and are required to contribute towards their health plan, will receive a reduction in their per paycheck contributions.

Communications

Any benefit program change requires communication to participants. For participants changing from the HIHP HMO plan to the HIHP PPO plan, the change is not significant. However, for Standard plan participants, elimination of these options resulting in a total replacement with the HIHP PPO option requires an extensive communication campaign. Eliminating the Standard plans is a significant change however the change to the HIHP plans has additional implications for participants. As noted previously, the HIHP PPO

option is considered to be a Consumer Driven Health Plan and it operates differently than what most of the Standard plan participants are accustomed to. These types of plans encourage proactive "consumerism" behaviors, such as comparing costs of services, comparing the quality of providers, and the use of preventive care services which are not currently incentivized in the design of the Standard plans, particularly the Standard HMOs. In order to do this, participants need extensive education on how the plan works, where to find the needed information, and how to use the available tools. Communication support for these plans is not a one-time event. It should include ongoing support to ensure participants understand how to navigate their benefit program. A well-executed communication effort will assist the State and members with the transition, minimize member anxiety and complaints, and assist the State in implementing a program that has the potential to reduce the State's long term trend rate.