Lakeland's Health Insurance Program

Four years ago, Lakeland, Florida, a city of 75,000 residents located midway between Tampa and Orlando, self-funded its employee health insurance program. This action was the direct result of the largest health maintenance organization (HMO) which city employees were utilizing, going bankrupt. Prior to self-funding, city employees were involved in three different programs: two HMOs and one traditional program. The majority of employees (75 to 80 percent) were involved in the HMO that folded.

In 1988, using approximately $1 million in reserve funds that became available when the city withdrew from its traditional indemnity program and the HMOs, the city created a new self-insurance reserve fund. A third party claims administrator (TPA), selected via bid process, was hired to administer the program and to process claims. Employees were allowed to go to any medical doctor they chose, with the city paying 80 percent of the costs and the employee paying 20 percent, after a $200 deductible was met. Due to the impending closing of the HMO, no attempt was made at that time to negotiate a more cost effective health insurance program.

All comparisons from this point on will be between the largest HMO program and the self-funded program.

Cost Considerations

One major problem that developed with the change to the self-funded program was significant employee dissatisfaction over the program's cost. Dependent premiums would have risen from approximately $144 per month plus the $10 co-pay per visit in the HMO program, to approximately $245 ($200 deductible) in monthly premiums for the self-funded program. To assist implementation and reduce dissatisfaction, the city commission voted to subsidize family or dependent coverage by 25 percent, thereby reducing family coverage to $184 per month. The city maintained its existing rate structure in which the total premium for each employee is born by the city. Today, even with the 25 percent dependent subsidy, many employees remain discontented with the cost of the program.

Since implementation of this program, a number of changes have been made. Prior to initiation of any changes, however, members of the city's Employees Association Insurance Committee are provided with background information and submit their input after discussing the proposed changes with fellow employees. This process has greatly assisted in decreasing the uncertainty and fear of change that is exhibited when employees do not understand why a change is made or that change is necessary. Major changes made during the past four years are:

- Initiated more aggressive utilization review, hospice and home care options, and other cost control measures.
- Rebid (1989 and 1992) claims handling (TPA) services, which resulted in significant declines in administrative costs. Also, rebid and adjusted other insurance coverages (aggregate, conversion, etc.) to reduce costs. Excess or reinsurance coverage (the point at which a contracted insurance company takes over a health claim) has been maintained at $100,000, a level that is cost-effective for Lakeland.
- Provided pretax payroll deduction for health insurance premium payments under Section 125 Internal Revenue Code, thereby reducing tax liability and increasing take-home pay.
- Started regular review of TPA administrative costs by an accounting firm to insure that annual renewal costs are kept in line.
- Established a new health claims administrator position to assist employees and coordinate between the city and the TPA.
- Retooled the wellness program to focus on awareness of health issues through seminars presented

in the workplace by local doctors, developed articles for the employee newsletters, and reinstituted the Employee Health Fair.

- Implemented a prescription card service for employees as a service to them and their families, recognizing that this would increase city costs significantly. The co-pay was established at $6 per 30-day prescription, with employees mandated to accept generic drugs, unless a written explanation is provided by the physician (1990).
- Raised deductibles from $200 to $300 per individual and from $300 to $500 per family. Maximum out-of-pocket limits were raised to $1,800/individual and $3,500/family. These changes were necessary to maintain adequate reserves for claims payments.

PPO Established

In 1992, a City of Lakeland Preferred Provider Organization (PPO) was established with the local hospital, the Lakeland Regional Medical Center (LRMC) and area physicians. LRMC is owned by the city but privately managed. A substantial negotiated discount based on reasonable and customary fees at the 68 percentile of the medical index was established for both the hospital and the physicians. The discount rate was recommended by a consultant hired by the city.

The consultant determined the feasibility of establishing a city PPO, particularly when the only hospital in the city was getting approximately 99 percent of the city's employees at a retail rate. In other words, there was no incentive for a rate reduction. LRMC is the most advanced hospital locally, and it would have been impractical to try to channel employees to a less specialized facility. An additional factor that could have hampered negotiations is the lease fee payments of greater than $3 million annually that the hospital provides to the city. A substantial number of city employees also were under the care of physicians of a local specialty diagnostic clinic, Watson Clinic, which is similar to the Mayo Clinic in Minnesota. Employees were paying premium rates but wanted to continue to utilize the services of the Watson Clinic. Again, there was little incentive to offer a rate reduction. Further, this was an extremely sensitive political situation, since the local medical community wields considerable political strength in the community. The consultant was able to negotiate an acceptable basis for determining the discount and establish an audit trail that insured that actual dollars would be saved at the projected level.

To implement the PPO, the reimbursement schedule was modified, with the city paying 80 percent of "in-network" costs for hospital and physician claims and 60 percent of costs for employees using out-of-network providers (If the employee is referred out-of-network or experiences an emergency situation, reimbursement is 80 percent.) One example is a referral to Tampa's burn unit where to ensure quality, only board certified or board eligible physicians are invited to join the city's PPO network. Certified chiropractors also are included in the network.

This year, in response to increasing mental health costs, which were doubling annually, the city implemented a preferred provider organization. The major component of this system is the "gatekeeper," a local psychologist who reviews diagnoses and treatment programs, places employees and/or family members in the appropriate treatment facility, and monitors the treatment program. The gatekeeper maintains an independent and impartial point-of-view, and does not accept city of Lakeland employees as patients. Through a bid process, the city has contractual arrangements with local providers for its Employee Assistance Program (EAP). As customary, the first three visits to the EAP are paid by the city. Also, mental-nervous services and substance abuse services for both adults and adolescents who are either outpatients and inpatients were selected on a bid basis. Again, quality of care was a major issue, and each facility was carefully checked and visited to insure that city officials had a level of confidence in the institution, the care provided, and its financial viability.

The rate structure was revised to encourage use of the Mental Health PPO. Employees using the contracted counseling and treatment services and facilities are reimbursed on an 80 percent basis (deductibles apply). Those using a non-contract facility or counselor, but going through the gatekeeper are reimbursed on a 60 percent basis up to the maximum discounted level that the city pays for "in-network" PPO participants. Employees who do not use the city's gatekeeper are not reimbursed for their mental health costs.

Since the city became self-insured, two changes in employee premiums were made after three years without a premium rate increase. Both became effective in October 1992. A $10 per month premium increase for employees was implemented; family coverage was increased by $8 and now totals $192 per month. These are the first changes made to the premium rates since the initiation of the self-funding program four years ago. The city's proportionate contribution toward employee and family health

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care has continued at the same level of the self-funding program and family subsidized rates as when they were first initiated.

Future Plans

Future plans are to link the city's 1,800 employees with other area governmental entities to establish appropriate purchasing coalitions, which hopefully will drive costs down even further for the participants. Pharmaceutical purchases appear to be a good place to initiate such a coalition. Additionally, the city is considering the addition of a "gatekeeper" for its regular health insurance program. The use of an existing medical clinic or physician network to provide primary care for employees on a per capita (negotiated rate per person) basis is under consideration. Although this change would limit physician choices, it is anticipated to reduce the program's costs significantly. There now is concern that employees are overusing the services of medical specialists, rather than using family or general practitioners who would refer to specialists where necessary. Input from the employees would be solicited prior to moving in this direction. An expansion of the Section 125 program to cover various medical expenses and dependent care currently is planned for implementation in January 1994 to coincide with the new tax year.

In conclusion, the city is particularly proud that costs have been controlled by taking back its health program and implementing a self-funded system. Medical inflation has been held to approximately 14 to 15 percent annually since the initiation of the self-funded concept, as well as the other changes to the program. According to various publications, other organizations have been experiencing and continue to experience 20 to 25 percent medical inflation. While costs have been controlled, medical benefits have not been sacrificed. In fact, the benefits have been enhanced. Not only has the benefit package remained intact, but the quality of the participating doctors, hospitals and clinics and treatment programs has not diminished.

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