# RECOMMENDATIONS OF HEALTH CARE PLAN STUDY COMMITTEE FOR SHORT-TERM CHANGES TO THE HILLSBOROUGH COUNTY HEALTH CARE PROGRAM

**September, 2009**

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# SPECIAL TRIBUTE

## Phyllis Busansky

This report is dedicated to the memory of Phyllis Busansky, who died unexpectedly on June 23, 2009. Phyllis, as she was known throughout the community, was a unique person who served the residents of Hillsborough County with boundless energy, imagination, and good will. We in the Department of Health & Social Services will remember Phyllis best for her role in creating the Hillsborough County Health Care Program, which she did with dedication and determination in 1991. Phyllis believed that the County could save money by creating a system of primary care centers that would improve access to health services for the working poor and uninsured. Her idea resulted in the creation of the Hillsborough Health Care Program, which this year will provide health care for over 30,000 low-income, uninsured residents of Hillsborough County. This unique program is as special as its creator – Phyllis Busansky. For us, Phyllis will be remembered for her warmth and exuberance, her caring and commitment – a woman whose passion for life was evident in all she did and said. She will be missed.

# EXECUTIVE SUMMARY

## Background and Study Committee Charge

At a February 25, 2009 Budget Workshop, Health & Social Services (HSS) staff presented a report to the Hillsborough County Board of County Commissioners (BOCC) indicating that, while the Hillsborough County Health Care Program (HCHCP) currently is in sound financial status, its financial viability is being threatened by the poor economy. In response to this report, the BOCC re-convened its Health Care Study Committee (Study Committee) on March 18, 2009.

The BOCC charged the Study Committee with two tasks:

1. To identify by September 2009 short-term actions to be implemented beginning in October 2009 that extend the risk of being at/or below the actuarial- identified Trust Fund balance minimum threshold to the end of September 2011.

2. To identify by April 2010 longer term, multi-year actions that would assure the long-term viability of the HCHCP, including the possible transitioning of the HCHCP to an interface with a national health plan, if approved.

This report presents short-term recommendations – the first of the above tasks.

## Process

The Study Committee held eight meetings over the period of May 29, 2009 through September 25, 2009. The committee's meetings were posted as required by Florida law. Meeting agendas, summaries, materials, and recordings were posted on the Study Committee's webpage. Every meeting of the Study Committee ended with the opportunity for public comment; other opportunities for input were provided as well.

The Study Committee identified, discussed, and formulated recommendations relating to possible changes in services, eligibility, reimbursement, and policy that could impact the program's financial short-term viability with the goal of achieving a reduction of at least $20,000,000 for Fiscal Year 2010.

The value of the changes were estimated by an independent actuary who ran models to confirm that the recommended changes would result in the HCHCP remaining at or over the minimum actuarial recommended threshold for the Trust Fund balance (three and one-half months of claims) in September 2011.

## Recommendations

The recommendations were addressed in the following priority.

## 1. Reductions with Same Level of Service

Initially, efforts were made to achieve the desired reduction while maintaining the same level of service. To accomplish reductions in this way, changes are made primarily to the way that services are delivered as opposed to the actual services themselves. As a result of these changes, service is not reduced. Rather, delivery is enhanced, becoming more streamlined and efficient with some costs shifted to other providers where appropriate. The recommendations result in first-year reductions in Trust Fund expenditures of $10,100,000. The specific recommendations are:

Increased coordination with other health care programs

- In lieu of HCHCP membership, pay the employee's portion (35%) of the cost of COBRA for eligible individuals under the new ARRA COBRA program for nine months; this should be less than the cost of HCHCP membership.[1]
- Increase enrollment in, and recovery of costs from, Medicaid and Medicaid's Medically Needy Share-of-Cost Program by sharing with the State Department of Children & Families the cost of a dedicated worker to obtain needed information; this should result in reduced expense to the HCHCP.
- Facilitate enrollment of medically disabled HCHCP members into the Social Security Disability Program, which should reduce the expense to the HCHCP while increasing the number of available providers to the disabled individual.

Changes in services currently provided

- Utilize intermediate care rather than a skilled nursing facility, where appropriate.
- Continue to implement improvements to the HCHCP eligibility determination and review process, and to seek additional gains through adoption of an electronic verification of income/assets program.
- Fully implement the new retail pharmacy contract, which provides deeper discounts to the HCHCP in paying for prescription drugs.
- Require HCHCP members to participate in the Patient Assistance Program (PAP) and to cooperate with our third party PAP vendor.[2]

Decreased use of specialists

- Expand the role of the Utilization Review/Utilization Management provider to assure that independent, objective medical criteria are applied uniformly to all specialty care requests.
- Select specific procedures for prior authorization by the Utilization Review/Utilization Management provider; randomly audit certain procedures to assure appropriate physician practices.
- Limit referrals to specialists to no more than three visits[3] (initial evaluation and not more than two follow-up visits for a single problem-based referral)

[1] This recommendation has already been approved by the BOCC.
[2] PAP provides brand name prescriptions to low income individuals at no charge from the drug manufacturer.
[3] Additional treatment, if necessary, would require re-referral and re-authorization.

and, in addition, require that referrals to certain specialties, such as but not limited to speech, occupational and physical therapy, be fully evaluated by a participating physician and authorized prior to commencing the initial course of treatment.[4]

- Establish a single evidence-based "center of excellence" for pain management, with strict protocols employed by the Utilization Review/Utilization Management provider prior to the initiation of therapy, procedures, or pharmaceutical agents.
- Redeploy HCHCP staff currently performing utilization review and utilization management functions to assist with other areas, such as securing disability benefits.

Reductions in staff compensation

- The Fiscal Year 2010 budget includes reductions in staff compensation and benefits, which also apply to staff positions partially paid for by the Trust Fund.

## 2. Changes in Eligibility

Another way to meet the required expenditure reduction is to decrease the number of people eligible for the program. Rather than an artificial "first come-first served" cap, it was recommended that a three-track model be used that emphasizes working with individuals in obtaining self-sufficiency or, if an individual cannot work due to health reasons, a quicker approval of their disability status so that their health care is paid for by State or Federal dollars. The recommendations result in first-year reductions in Trust Fund expenditures of $11,100,000, including $10,500,000 from adoption of the self-sufficiency model (below). The specific recommendations are:

- Change "grandfathering" provision that was implemented in 2005 so that all members with income above 100% of the Federal Poverty Guideline are transitioned from the HCHCP full benefit plan.[5]
- Adopt the "Self-Sufficiency Model" limiting HCHCP members to 24 months of uninterrupted eligibility and providing self-sufficiency case management to assist them to either find employment or obtain Social Security/Veteran's benefits before being transitioned off program.[6] Implementation of the self-sufficiency model will occur over two years, allowing for refinement of the model during the first year. The actuarial analysis conservatively projects a $10,500,000 reduction in Trust Fund expenditures in FY 2010 as a result of the model's adoption, which will be continued into the following year for an additional reduction of $10,500,000. This allows flexibility to determine how

[4] Certain courses of treatment, such as chemotherapy, would be exempt from the three-visit limit but would be monitored for appropriateness.

[5] At least six months of notice will be provided prior to transition from the full benefit plan. In addition, members may be eligible to be enrolled in a 90-day limited benefit plan during which they will be provided an information packet with a list of alternative medical options.

[6] Ibid.

transitions should occur. The HCAB will monitor implementation of the model, particularly as it applies to the resultant savings and report back to the BOCC at the start of the 2011 fiscal year.

- The above sets out the proposed plan to implement an enhanced program eligibility process. However, HSS will work with the County Attorney's Office to ensure that implementation will meet any legal requirements.

3. **Changes in Reimbursement**

A third and final way to reduce expenditures is to change the reimbursement structure. The reimbursement structure can be changed in a number of ways. Reimbursements, for example, can be capped by event, time period, or type of service. Or, reimbursements could be reduced by capitating payment per individual and by lowering or exercising the provider cap.

The specific recommendation is to change hospital outpatient reimbursement from 20% of billed charges to 80% of Medicare outpatient reimbursement for applicable encounter codes regardless of where the outpatient services are provided. The recommendation results in a first-year reduction in Trust Fund expenditures of $1,200,000.

## Actuarial Analysis

The actuarial analysis indicates that the opportunity exists to realize significant reductions in expenses by utilizing other payers and modifying certain methods of obtaining care, such as the Patient Assistance Program. An independent actuarial firm, Milliman, was hired to work with staff and the Study Committee to project the impact of these short-term changes.

Approval of all recommendations results in a projected first-year reduction in Trust Fund expenditures of $22,400,000. The changes will provide additional time to develop and implement longer term strategies that will be coordinated with Federal and State health care reforms, if approved. The actuarial projection, if the recommendations are approved, is that the Trust Fund balance will be $27,545,000 at the end of September 2011. The desired minimum Trust Fund balance at that date is projected at $25,193,000.

## Next Steps

The Study Committee considered and tabled for the time being the adoption of a number of policies that would cap/reduce eligibility, benefits, or reimbursements. In particular, the Study Committee also deferred action on a proposal that would "withhold" certain network reimbursements, which in turn would serve as a reserve fund in the event that some savings projected by the actuary fail to materialize. (If implemented, the networks would be provided an incentive payment in the amount of the reserve funds withheld from their network if all of the savings were realized.)

Based on the actuary's projections, while a "withhold" is not essential at this point in time, it should continue to be discussed by the Study Committee as a contingency and long-term strategy

to help the HCHCP achieve fiscal sufficiency. (The projections do show the likely need to make adjustments in anticipation of the Trust Fund balance falling below the actuarial level at the beginning of Fiscal Year 2012 and, as such, the committee is recommending that this strategy be fully evaluated and discussed with the potentially affected providers in Phase 2).

The Study Committee believes that HCHCP members should be encouraged to take responsibility for their own health and the attainment of increased self-sufficiency. Consistent with this belief, it supports adoption of the self-sufficiency model and the required use of the Pharmacy Assistance Program. Implementation of both of these recommendations will result in the enrollees assuming a greater level of responsibility.

With this report, Phase 1 draws to an end. The Study Committee will now address multi-year actions that can be taken to assure the long-term viability of the HCHCP, including the interface of the HCHCP with a national health plan in 2013, if one is approved by Congress. Between now and April, the committee will continue to meet to discuss and formulate its recommendations with respect to this important issue as well others identified during the course of preparing this report

# BACKGROUND

## The Challenge

As outlined in a report presented to the BOCC at a February 25, 2009 Budget Workshop (Attachment 1), the HCHCP currently is in sound financial status and is controlling its unit cost of coverage, as measured by the average per member per month cost. However, the financial viability of the HCHCP is being threatened by the poor economy, which has resulted in historic and continued projections for lower sales tax collection as well as increases in the number of people needing assistance.

The key indicator of the financial viability of the HCHCP is the Trust Fund balance.[7] As described in the February 2009 report referenced above, an independent actuary recommends that the minimum Trust Fund balance represent the equivalent of three to four months of expenses. (For planning purposes, the mid-point of three and one-half months was used.) This recommendation assumes only that the minimum balance is defined as the level necessary to meet liabilities if the program is discontinued, such as outstanding claims.

The recommendation represents a change in logic from previous assumptions regarding the minimum Trust Fund balance, which included more than the dollars necessary to meet liabilities if the program was discontinued. Previously, the recommended balance included contingency funds for emergencies such as a localized storm or another strong negative economic event resulting in the HCHCP becoming the payer for health care for a significantly higher number of Hillsborough residents. The new recommendation assumes that the poor economy has dipped into this contingency.

The actuary projected that without intervention the HCHCP Trust Fund balance will drop below the minimum three and one-half months reserve for expenses between November 2010 and March 2011, depending upon which of three revenue[8] projections is used. Therefore, we will simplify these projections by saying that without intervention the HCHCP will drop below the minimum recommended Trust Fund Balance by the end of calendar year 2010.

## Reconvening the Study Committee

In response to this report and faced with a deepening economic recession, the BOCC re-convened its Health Care Study Committee (Study Committee) on March 18, 2009. Appointed three years ago to re-evaluate the structure of the HCHCP Managed Health Care Program, the re-convened committee was charged with developing recommendations to maintain the economic stability of the HCHCP. Its membership included seven members of the original committee, four

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[7] The HCHCP is set up in a way that revenue from sales tax, recoveries, and investments flows into a Trust Fund from which all HCHCP expenditures are paid.

[8] Revenues estimates are provided by the State Revenue Estimating Conference to the Hillsborough County Office of Management and Budget.

new members selected by commissioners elected since 2005, and one representative of current HCHCP providers. The members of the committee were:

Commissioner Mark Sharpe, Chair (Board of County Commissioners)
John Curran M.D., Vice-Chair (USF College of Medicine, Health Care Advisory Board))
Joe Chillura (Former County Commissioner, Architect)
Jim Davison, D.O. (Emergency Room Physician)
Edi Erb (Social Services Administrator, Health Care Advisory Board)
Anthony Escobio (Provider Representative, Tampa General Hospital)
Steve Freedman Ph.D. (Retired Health Policy Professor, Health Care Advisory Board)
Mary Ellen Gillette R.N. (Retired School Administrator, Health Care Advisory Board)
Dee Jeffers (Faculty Member/Administrator, University of South Florida)
Steven J. Mason (Non-Profit Human Services Executive, Health Care Advisory Board)
Bob Parrado R. Ph. (Pharmacist, State Board of Pharmacy) [9]
Maria Russ. Ph. D. (School System Health Administrator, Nurse Practitioner, Health Care Advisory Board)

## Charge to Study Committee

The BOCC charged the reconvened Study Committee with developing recommendations to address both short- and long-term interventions. The specific charge was as follows:

**Phase 1. Short-Term Recommendations:** In order to be positioned to transition the HCHCP to respond to Federal changes in health care policy, including a possible national health plan, identify actions to be implemented beginning in October 2009 that extend the timing of the risk of being at/or below the actuarial- identified Trust Fund balance minimum threshold to the end of September 2011. These recommendations will be made to the BOCC by September 2009.

**Phase 2. Long-Term Recommendations:** Identify longer term, multi-year actions that assure the long-term viability of the HCHCP. These may include transitioning of the HCHCP to an interface with a national health plan, if approved. Assuming the direction of Federal health policy is available by the fall of 2009, these recommendations will be made to the BOCC by April 2010.

## Methodology

Based on the charge to the Study Committee, this report focuses on Short-Term Recommendations to be implemented beginning in October 2009. The recommendations were identified based on achieving a reduction of at least $20,000,000 for Fiscal Year 2010. Strategies also were identified for implementation if additional changes are needed at the end of FY 2010. The recommendations were developed in the following order:

1. Changes that result in no or minimal service change and no change in eligibility. These changes are typically operational and several already have been implemented or are in the

[9] Resignation effective August 7, 2009.

process of being implemented. However, there are some changes that will require BOCC review and approval of policy changes.

2. Changes that represent a higher degree of difficulty in implementation. For example, changes that require provider or patient behavior change.

3. Changes that require major policy changes or have a high degree of difficulty in implementation. These include reduction of who is eligible, capping of benefits, and reduction in provider reimbursement.

The recommendations were discussed and agreed to by the Study Committee in this order to maximize agreement on the reductions before looking at service reduction and reimbursement reduction. For each recommendation, the annual cost impact was identified as a range from low to high, as well as the assumed impact on patients and providers being identified.

After the short-term recommendations were identified, they were re-grouped into: Services; Eligibility; and Reimbursement. The following section discusses each of the recommendations.

# RECOMMENDATIONS

This report identifies specific recommended changes and the magnitude of the impacts those changes make when taken together as a whole.

Ideally, the reductions would be made by reducing the cost per person without reducing the number of people served nor their level of service. However, it is not possible to achieve this level of reduction by just reducing the cost per person.

The Reductions with Same Level of Service lower the average cost per person for delivery of health care services, but that reduction is not sufficient to effectively slow the erosion of the Trust Fund to the level needed.

Ultimately, the number of covered individuals must be reduced to maintain program viability. This is accomplished primarily through recommended Changes in Eligibility, which essentially removes individuals from the program previously "grandfathered" in and limits enrollment to 24 months.

## Reductions with Same Level of Service

## Increased Coordination with Other Health Care Programs

The potential savings for each item, when presented initially to the Study Committee, had a range of three values: "Low", which assumed sub-optimal participation/significantly delayed implementation, "Assumed" which included assumptions of moderate issues in implementation and adequate participation, and "High", which assumed all went as planned – the best case scenario. The estimated savings results shown below represent the midpoint between "Low" and "Assumed" to reflect a realistic, conservative portrayal of reluctance to change and other implementation issues.

**Pay cost of COBRA for eligible individuals.** [10] Under the American Recovery and Reinvestment Act of 2009 (ARRA), unemployed persons who elect to participate in COBRA are required to pay only 35% of the monthly COBRA premium for their first nine months of coverage. It is cost effective for HCHCP enrollment staff to have the option of using Trust Fund dollars to pay the 35% COBRA payment for up to nine months rather than directly enroll the individual in the HCHCP because (1) the overall cost to the Trust Fund should be less; (2) the individual retains his or her established physician relationship under their prior health program, and (3) any medical course of treatment currently underway is not interrupted.

The ARRA COBRA program is only scheduled at this time to enroll participants through December 31, 2009. Individuals who are enrolled may receive no more than nine months of COBRA subsidy from the date of their enrollment. However, if the Federal

[10] This recommendation has already been approved by the BOCC.

Government extends program enrollment beyond that date, or provides for longer than nine months of subsidy, HSS would be authorized to continue such payments for individuals meeting the HCHCP eligibility criteria. In either event, after the end of the ARRA COBRA eligibility period, the individual would be enrolled directly in the HCHCP if he or she still meets the program's eligibility guidelines.

Attachment 3 provides the method of calculating savings. Based upon an initial survey of new HCHCP members, a midpoint of 20 per month in this option would save approximately $200,000.

**Increase enrollment in and recovery of costs from Medicaid and its Medically Needy Share-of Cost Program.** In Florida, Medicaid is administered by the Agency for Health Care Administration (AHCA) and DCF determines eligibility. The records of both agencies are protected by Federal law. It is difficult for local government to access their records. Currently, a time-consuming, labor-intensive telephonic and paper process must be undergone to determine 1) whether someone applying for the HCHCP can be or is covered by Medicaid or Medicaid's Share-of-Cost program; (2) if the person is in Medicaid or the Share-of-Cost program, the person's financial responsibility; and (3) the amount of money paid by the HCHCP that should have been paid by Medicaid. The HCHCP is in the process of contracting, through one of the HCHCP hospital providers, to utilize a DCF program whereby the cost of an HCHCP-dedicated DCF worker is split between DCF and the HCHCP to obtain this information.

If the percentage of those enrolled jointly in the HCHCP and the Medicaid Share-of-Cost program were increased to represent 12.5% of the program, an achievable objective in a climate of increased unemployment, there would be a projected savings of $800,000. Historically, when DCF data were available to staff, the percentage enrolled in Share-of-Cost program was higher than what is seen at the present.

**Facilitate enrollment of HCHCP members into Social Security Disability Program as is appropriate.** Moving HCHCP members who are medically disabled (physically, mentally, or both) on to Social Security is a priority for FY10 and beyond. These individuals would also obtain Social Security disability payments in addition to having their medical needs paid for by Medicaid, thus not only saving the HCHCP and County General Assistance fund payments, but permitting greater provider choice as there are many providers accepting Medicaid who do not participate in the HCHCP. Staff who will be freed up from some current duties will be redeployed in assisting these Hillsborough County residents in obtaining their rightful Federal disability payments. In addition, the HCHCP may contract with outside entities to expedite the Social Security Disability process.

A dollar savings figure has not been assigned to this as it is integrated with the self-sufficiency model.

## Changes in Services Currently Provided

**Utilize Intermediate Medical Care.** When someone is discharged from a hospital, the individual may not be capable of going directly to their home for any number of reasons, including the need for follow-up medical care in a more intensive setting or that the member is homeless or has an unstable home environment. The HCHCP provides coverage for skilled nursing facility (SNF) admissions, which offers the next level of care below inpatient hospitalization. Examples of appropriate SNF use include rehabilitation immediately following joint replacement, post-stroke care, open wound care, etc.

The unique population served by the HCHCP has resulted in instances where a SNF admission may have occurred when a less intensive site of care would have sufficed. Indeed, a review of historic SNF use and patient history indicates that the HCHCP can avoid the premium of a SNF and not compromise patient safety with the use of Assisted Living Facility with Limited Nursing Services (ALF-LNS) upon completion of a thorough assessment by an HSS case manager. As a next step, the HCHCP should pursue a pilot program with the Agency for Health Care Administration (AHCA) to create a hybrid service delivery model that falls somewhere between ALF-LNS and SNF; at present, no such licensure is available within the State of Florida.

Estimated savings for this modification are $150,000.

**Improve eligibility determination and review process.** During the past year, several changes have been adopted enhancing the HCHCP eligibility determination and review process. These changes are listed and briefly described below:

- Medifax – Staff now can access web-based Medifax to verify Medicaid status prior to enrollment in HCHCP.
- Medically Needy – Individuals who are potentially eligible for Medicaid's Medically Needy Program are asked to apply for Medicaid and are enrolled for two months in HCHCP. Future HCHCP eligibility requires verification of share-of-cost amount or proof of reasonable denial.
- Returned Mail – When returned mail is received, HCHCP eligibility is terminated since eligibility cannot be determined.
- Notices – Automated printing of reenrollment forms and Notices of Decision replaced a manual process previously performed by the Certification Unit.
- Mail – HSS has partnered with the Tax Collector's Office. All mail addressed to or received from HCHCP members is processed through the Tax Collector's mail room, replacing a very labor intensive manual process previously performed by the Certification Unit.
- Customer Service – Calls from HCHCP members are directed to Client Relations staff for timely resolution
- Income/Assets Verification – Staff complete property, business, and marital status inquiries to verify eligibility for HCHCP enrollment.

The estimated savings is $450,000. Additional gains might be made through electronic verification of income/assets. The committee recommends adoption of such a system.

**Fully implement new retail pharmacy contract.** The HCHCP provides payment for prescription drugs for its members at one of the contracted network pharmacies. In 2009, the retail pharmacy contract was placed out for public bid. Kash N' Karry (dba Sweetbay Supermarkets) was the successful respondent. In its proposal, the vendor reduced its compensation in all areas. In addition, prior to the retail contract becoming effective, the Maximum Allowable Charge (MAC) by which the HCHCP reimburses generic drugs was significantly reduced as a result of another bidding process. Prescription drugs are also obtained at three other entities under contract to the HCHCP – Tampa General, Suncoast Community Health Centers and Tampa Family Health Centers. The reimbursement levels for these three organizations are being reduced to mirror the Kash N' Karry contract, and to reflect the new MAC drug pricing.

Savings, based upon historic utilization patterns and the revised pricing, are estimated to be $2,200,000.

**Require full participation in Patient Assistance Program as is appropriate.** In response to the concern over affordability of brand name non-generic prescription drugs for low-income Americans, most of the pharmaceutical manufacturers have established programs, called "Patient Assistance Programs" (PAP) which enable these individuals to obtain prescription medications, at no cost, directly from the manufacturer.

Drugs are available when an individual meets income guidelines and has no other public or private insurance that provides drug coverage. The HCHCP is not insurance, and as such our members qualify in many instances for these free drugs.

Enrolling in a PAP may be complicated by the fact that each manufacturer has different guidelines as to what information it requires to qualify for the free drugs. Recognizing this, the HCHCP has contracted with a third-party vendor to work with our members and their physicians to facilitate obtaining these free PAP drugs. This vendor has the expertise and software necessary to assist our members and is reimbursed only when a PAP application is successful.

As of December, 2009, all brand name drugs eligible for a PAP will be provided only through the PAP when practical to do so. A member may obtain the first 60 days prescription through a contracted retail pharmacy, but thereafter the drug will be sent from the manufacturer.

Member cooperation with the PAP process is mandatory. Non-compliance with providing the information necessary to complete a PAP application will result in the member's drug no longer being available through the HCHCP for a small co-pay; rather, the member will be responsible for the entire cost of the drug.

The PAP process can be more convenient for the member, as receiving the drugs via the mail is simpler than trips to the pharmacy.

The savings estimate is $5,200,000 dollars.

## Decreased Use of Specialists

**Expand role of Utilization Review/Utilization Management (UR/UM) Vendor.** The HCHCP utilizes a third party to provide utilization review and utilization management services. The vendor uses established, published criteria (Interqual® and others) to evaluate the necessity of certain services requested by a medical provider, and while focusing on quality and appropriate medical care delivery, the HCHCP also saves money by avoiding certain expenses as well as making certain members receive their care in an appropriate setting.

At present, while most services are reviewed by this vendor, some services are reviewed and authorized by staff. After extensive review, the decision has been made to move all authorizations and reviews to the third party vendor.

Because the vendor utilizes independently published criteria as to medical necessity and best practices, uniform criteria (Interqual® and others) will be utilized in all reviews. The HCHCP staff currently performing these services will be redeployed to assist with other areas, such as securing disability benefits.

The savings estimate is $250,000 for implementing this administrative change.

**Limit specific specialties.** Physician specialty care services represent one of the fastest growing components of the expenditures for medical services. Specific areas have been identified for intervention in the 2010 Fiscal Year and these steps are already underway.

Select procedures will now require the use of a UR/UM firm to request authorization prior to the procedure being performed with industry accepted criteria (Interqual® and others) utilized for determinations. A detailed review of historic practices indicates that these additional controls should result in cost savings and appropriate utilization.

Evidence-based pain management is an issue facing all medical programs, not just the HCHCP. We will pursue the establishment of a "center of excellence" for pain management, with strict protocols employed by the third party UR/UM vendor for oversight and the authorization for these services.

A 10 % random audit of certain procedures will be implemented as an additional control to assure appropriate physician practices related to the quality, utilization, and provision of services and referrals.

Referrals to specialists will now be limited to no more than three visits for a single disease process or principal diagnosis group in order to ensure that the primary care

provider continues to be involved in the treatment regiment and aftercare. Payment for therapies, such as speech, occupational, and physical therapy, will now require a referral and authorization prior to the initiation of a course of treatment. (Historically, patients were automatically authorized 12 visits without the need for an authorization from the UR/UM vendor.)

Savings estimates are $300,000.

### Reductions in Staff Compensation

**Adopt BOCC approved salary reductions.** The BOCC approved several actions to reduce the FY10 budget deficit for the county, including two actions, which impacted the HSS Budget and reduced staff compensation by $550,000. The HR actions included:

- Instituting a mandatory furlough of five days for all County employees without pay initiative.
- Reducing the County contribution to employee deferred compensation of 3.5% to 1.5%.

## Changes in Eligibility

### Enhanced Program Eligibility Process

**Change "grandfathering" provisions.** The intent is to transition all previously "grandfathered" Medical Crisis Intervention (MCI) members[11] off of the full HCHCP benefit plan. At least six months of notice will be provided, although exceptions may be considered for members experiencing extreme hardship or for continuity-of-care concerns. HSS staff will conduct medical reviews of all MCI members. Written notification of the transition will be provided along with a packet of information that includes a listing of alternative medical providers.

- Members who are employed or employable may be covered for 90 days through Community Services Block Grant funding.
- Members who are not able to work may be enrolled in an HCHCP limited benefit plan for 90 days. Options for the 90-day limited benefit plan may include a combination of primary care, pharmacy with mandatory Patient Assistance Program participation, limited diagnostic and limited specialty consultations. (This is currently under evaluation.)

Savings estimate is $650,000.

**Adopt self-sufficiency model.** Over the past two years, HSS has experienced a dramatic increase in demand for services due to the economic downturn. To meet this demand in the face of a declining property tax revenue stream, HSS has changed its focus from crisis intervention to helping clients return to self-sufficiency and move out of poverty. Case

[11] Members of the HCHCP with household income above 100% of the Federal Poverty Guidelines.

managers now measure and track a client's movement towards self-sufficiency by deploying a Results Oriented Management and Accountability (ROMA) self-sufficiency scale.

As sales tax revenues have similarly declined, HSS management decided to expand its utilization of the results-oriented self-sufficiency model to clients enrolled in the HCHCP. Clients should be active and committed to raising their level of self-sufficiency and the provision of quality health care should be viewed as a building block for self-sufficiency as opposed to a stand-alone entitlement earned and maintained by remaining below the poverty income guideline.

In this model, HCHCP members will have 24 months of eligibility during which they will be case managed towards self-sufficiency. Whether they are unemployed, underemployed, or disabled, members will be expected to work closely with their case manager to either find new or more substantial employment or to aggressively pursue Social Security or Veteran's disability benefits. Exceptions to the 24-month time limits may be considered for members experiencing extreme hardship or for continuity-of-care concerns.

Upon adoption of the self-sufficiency model by the BOCC, HCHCP members who have been enrolled for 24 months or more will receive written notice of their transition date. At least six months of notice will be provided. In addition, these members may be eligible to be enrolled in a 90-day transitional HCHCP limited benefit plan[12] that may include a combination of primary care, pharmacy with mandatory Patient Assistance Program participation, limited diagnostic and limited specialty consultations. Prior to transition from the limited benefit plan, all HCHCP members will receive a packet containing a listing of alternative medical providers. Those members who are not placed on the limited eligibility plan will receive a listing of alternative medical providers.

The self-sufficiency model will be implemented over two years. This should allow for refinements to be introduced during the first year. The actuary conservatively projects a $10,500,000 reduction in Trust Fund expenditures in FY 2010 for adoption of this model and an additional reduction of $10,500,000 in FY 2011.This allows flexibility to determine how transitions should occur. The HCAB will monitor implementation of the model, particularly as the resultant savings and report back to the BOCC at the start of the 2011 fiscal year.

Meet Any Applicable Legal Requirements. The above sets out the proposed plan to implement an enhanced program eligibility process. However, HSS will work with the County Attorney's Office to ensure that implementation will meet any legal requirements.

[12] The specifics of this plan currently are under discussion.

## Changes in Reimbursement

### Hospital Outpatient Reimbursement

**Change hospital outpatient reimbursement to 80% of Medicare.** – Hospital outpatient reimbursement is one of the few remaining services reimbursed based on a discount from full charges. Therefore, the Study Committee is recommending approval of a change to reimbursement for hospital outpatient services from 20% of billed charges to 80% of Medicare allowable for outpatient services regardless of where the outpatient services are provided consistent with all other outpatient reimbursements. These actions will yield approximately $1,200,000 in savings.

# ACTUARIAL ANALYSIS

The HCHCP relies solely upon the ½ cent sales tax for its operations. During the past few years, prior to the economic downturn, management adopted a strategy to accumulate sufficient reserves to weather an economic downturn. Unfortunately, the current downturn is greater than anyone would have predicted three to five years ago. Although Trust Fund reserves are sufficient to carry the program through fiscal year 2010, unless immediate action is taken to reduce expenses while enrollment continues to grow, the program will be faced with the possibility of closing enrollment to new members or some other means to remain financially viable. The Trust Fund reserve balance has been decreasing by approximately $2,000,000 per month during FY 2009, which can only be supported for a limited time.

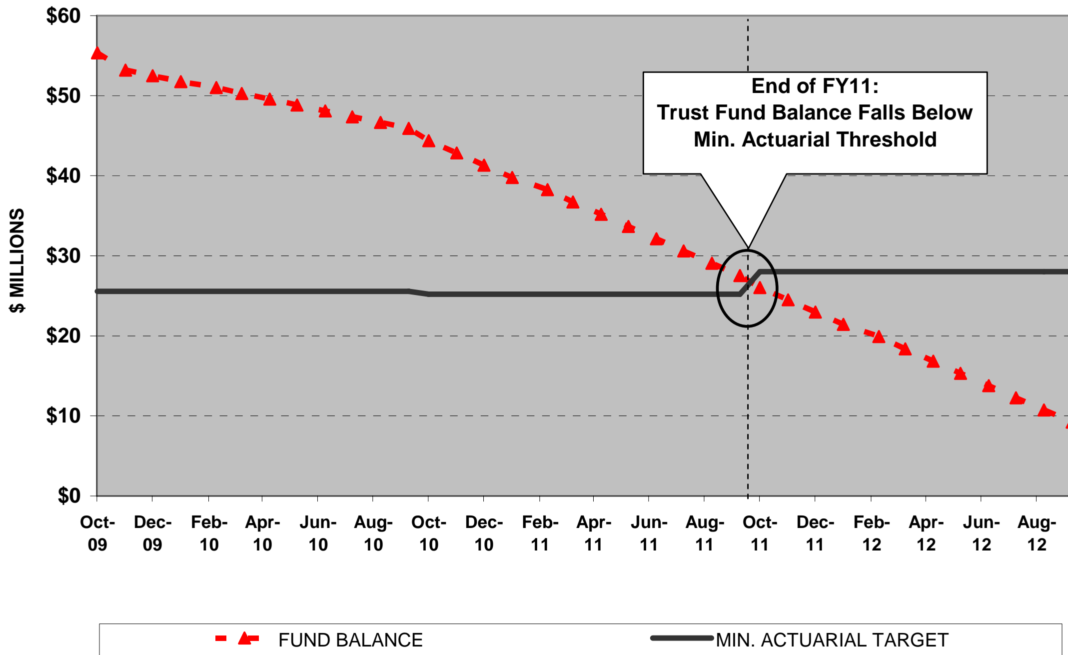
HSS secured the services of an independent actuarial firm to work with staff on developing and validating financial projections in concert with potential changes to HCHCP service delivery and eligibility to protect the financial integrity of the Trust Fund, and to determine what actions must be taken to remain financially sound through 2012. The actuarial firm, working with staff, looked at the impact of changes to various program components and validated projections. Ultimately, financial forecast models were developed to reflect the impact of changes recommended by the Study Committee to the HCHCP Trust Fund balance.

The recommended option includes all of the above items, and forecasts that the Trust Fund balance will be slightly above the recommended reserve level (approximately three and one-half months of claims) by the end of September 2011 and significantly below the recommended reserve level but still be "in the black" at the end of September 2012. It is important to note that forecasting three years into the future produces a significant margin for error, and that the models assume no additional significant economic downturn or other geopolitical/economic events which might impact either or both our sales tax revenues or enrollment levels.

The first table on the next page reflects the actuarial evaluation of the impact of the recommendations, while the second table is a reprint of the original evaluation presented to the BOCC in February 2009 presenting the actuarial projections, if no changes were made.

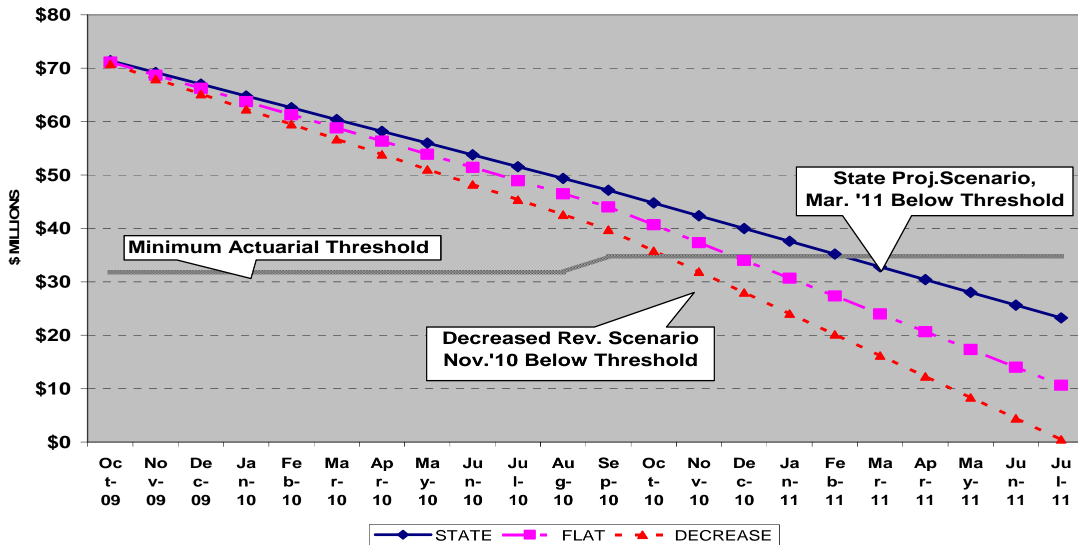
(Note: The sales tax revenue forecast was provided by Florida's State Revenue Estimating Conference and adjusted to reflect the Hillsborough County fiscal year by the County's Department of Management & Budget.)

**TRUST FUND BALANCE PROJECTIONS AFTER IMPLEMENTATION OF SHORT-TERM COMPARED TO MINIMUM ACTUARIAL THRESHOLD BALANCE**
**(Source: Milliman Projections, Sept. 2009)**




## Initial Actuarial Report 2/25/09

**COMPARISON OF TRUST FUND BALANCE PROJECTIONS TO MINIMUM ACTUARIAL THRESHOLD**



# NEXT STEPS

The Study Committee tabled, at least for the time being, the adoption of policies that would cap eligibility by number of members, income, types of services, length of residency, or other demographic criteria; increase the level of client financial participation; or reduce/cap benefits. In addition, the Study Committee deferred discussion of capitating payments to providers for individual members; increased bundling of payments; and lowering and exercising provider caps.

In particular, the Study Committee looked at lowering certain network reimbursements by approximately 10% in the form of a "withhold," which would serve as a reserve fund in the event some of the savings projected by the Actuarial Analysis fail to materialize. If all of the savings were realized, the networks would have been provided an incentive payment not to exceed the amount of the reserve funds withheld from their network.

Based on the actuary's projections, the Study Committee believes that implementation of a withhold is not necessary as a short-term recommendation but should be actively considered as a long-term strategy to be evaluated in the next phase of the committee's deliberations since the projections do show the likely need to make adjustments in anticipation of the Trust Fund balance falling below the actuarial level at the beginning of Fiscal Year 2012.

As noted earlier, forecasting three years into the future does intrinsically incorporate a significant margin of uncertainty. The models used assume no additional significant economic downturn or other geopolitical/economic events that might impact either or both HCHCP sales tax revenues or enrollment levels. While it is impossible to totally guard against the unexpected, the Study Committee has tried to recognize and protect against uncertainty by basing its recommendations on what it believes to be reasonable, conservative, and cautious assumptions. However, if these recommendations fail to achieve the desired reductions, additional adjustments may need to be made.

This report draws to an end Phase 1, thus leaving the Study Committee free to address multi-year actions that can be taken to assure the long-term viability of the HCHCP, including the possible transitioning of the HCHCP to interface with a national health plan in 2013, if one is approved by Congress. Between now and April, the Study Committee will continue to meet, discuss, and formulate its further recommendations to sustain the fiscal viability of the HCHCP. In addition to the issues identified above, the committee will examine such long-term issues as prevention, wellness, and disease management; the use of options to emergency room care including mini-clinics; the applicability of "navigators" to the program; and the concept of "Play or Co-Pay" and how this concept could implemented.

# ATTACHMENTS

Attachment 1: Initial Actuarial Report 2/25/09
Attachment 2: Savings Assumptions if all Recommendations Adopted
Attachment 3: COBRA/ARRA Assumptions

Attachment 1

BOARD OF COUNTY COMMISSIONERS
Kevin Beckner
Rose V. Ferlita
Ken Hagan
Al Higginbotham
Jim Norman
Mark Sharpe
Kevin White

Hillsborough County
Florida
Office of the County Administrator
Patricia G. Bean

ADMINISTRATORS
Lucia E. Garsys
Carl S. Harness
Eric R. Johnson
Michael S. Merrill
Manus J. O' Donnell
Edith M. Stewart

**MEMORANDUM**

**DATE:** February 5, 2009

**TO:** Eric R. Johnson
Management Services Administrator / Director, Management and Budget

**FROM:** David P. Rogoff
Director, Health and Social Services

**SUBJECT:** Update on the HCHCP Trust Fund Balance Report

The following report addresses three questions regarding the Hillsborough County Health Care Plan's (HCHCP) Trust Fund:

- Information regarding the ability to swap or "loan" funds from the Indigent Healthcare Sales Tax fund to the General Fund to return funds that were previously supplemented by the General Fund.
- Perform a financial analysis to see if it is feasible to reduce the Indigent Healthcare Sales Tax from ½ percent to ¼ percent and determine the steps needed to do this, if necessary.
- Determine at what point in time the Trust Fund balance falls below the actuarial recommended balance.

This report is an update to the initial report to the Board provided on June 5, 2008, in response to a request made at the April 23, 2008 Budget Workshop.

The attached report provides the specific information. In summary:

1) The 2002 BOCC-approved HCHCP financial plan resulted in $20.1M of General Funds being used for the HCHCP between 2002 and 2007. At the end of FY09, the Trust Fund will have expended $20.2M for expenses that the 2002 financial plan identified would have been paid out of the General Fund.

2) The reduction in the sales tax rate from ½ cent to ¼ cent, at a time in which expenses are already exceeding revenues, will cause the Trust Fund to be at a zero balance by September 2010, assuming that a change in sales tax rates can only commence as of October 2009 (FY10).

3) Utilizing three revenue scenarios 1) the State Revenue Forecast, 2) a Flat Revenue Forecast, and 3) a Revenue Decrease Forecast, financial models were utilized to project when the Trust Fund balance would fall below the actuarial recommended balance. The range, depending upon the scenario, is between November 2010 and March 2011.

As has been discussed, we continue to closely monitor our financial status. The Trust Fund balance is predicted to fall below the actuarial recommended levels during FY11 utilizing the state's optimistic revenue forecast and assuming no additional unfunded mandates become the Trust Fund's responsibility. If the state's forecast is incorrect, and/or additional mandates are passed down, this timetable is accelerated significantly.

We can provide any additional back up documentation requested as to either the source or development of the figures herein. The projections were reviewed by our actuary as to reasonableness.

Attachment

cc: Patricia G. Bean, County Administrator
Manus J. O'Donnell, Human Services Administrator

## INTRODUCTION:

The following report addresses three questions regarding the Hillsborough County Health Care Plan's (HCHCP) Trust Fund:

- Information regarding the ability to swap or "loan" funds from the Indigent Healthcare Sales Tax fund to the General Fund to return funds that were previously supplemented by the General Fund.

- Perform a financial analysis to see if it is feasible to reduce the Indigent Healthcare Sales Tax from ½ percent to ¼ percent and determine the steps needed to do this, if necessary.

- Determine at what point in time the Trust Fund balance falls below the actuarial recommended minimum balance.

This report is an update to the initial report to the Board provided on June 5, 2008, in response to a request made at the April 23, 2008 Budget Workshop.

## SUMMARY OF FINDINGS:

- Since the HCHCP is now reliant only upon the Sales Tax, the key indicator of its financial status is the Trust Fund Balance, because all Sales Tax revenue flows into the Trust Fund, and HCHCP expenses are paid out of the Trust Fund. The poor economy negatively impacts the Trust Fund Balance, therefore it negatively affects the viability of the HCHCP by reducing sales tax collection and increasing the number of people needing assistance.

- A revised actuary report (from Milliman USA) identifies that the minimum Trust Fund Balance should be between 3 and 4 months of claims expense – at 3 ½ months this is equivalent to $31.8M in FY10 and $34.8M in FY11.

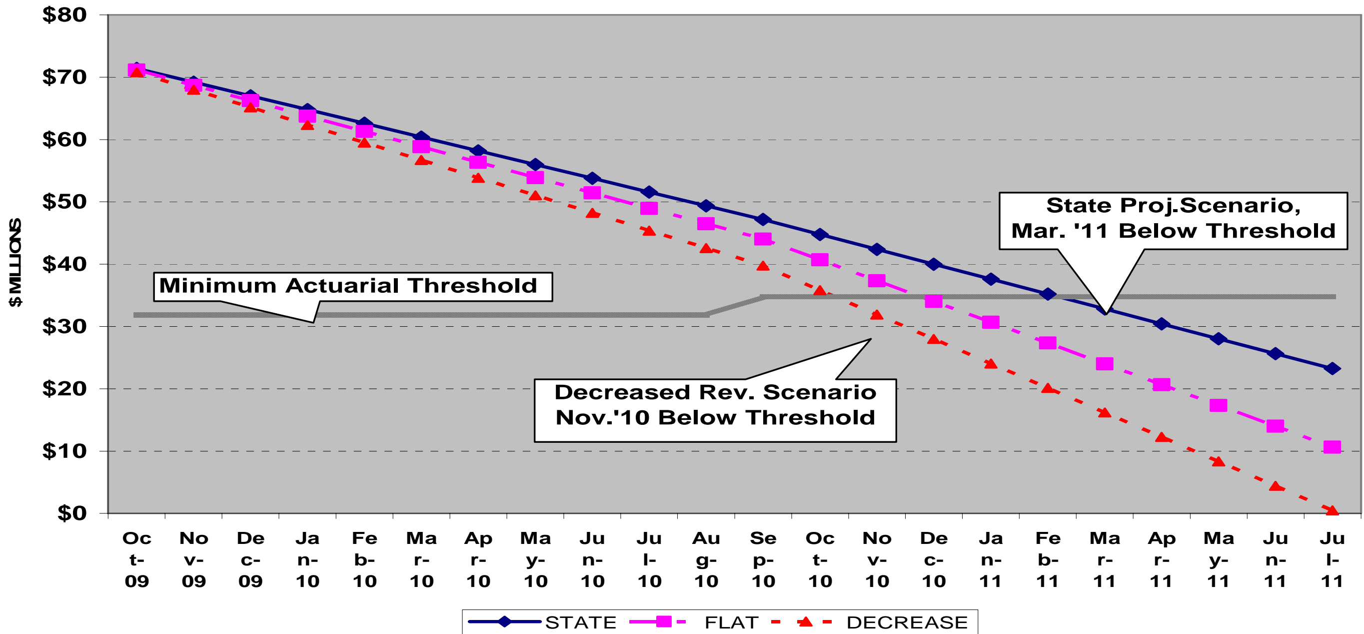
- Revised projections for the Trust Fund Balance reflect three scenarios – 1) the State Revenue Forecast, 2) a Flat Revenue Forecast, and 3) a Revenue Decrease Forecast. While the County must use the State Forecast for budgeting, its Sales Tax projection has been overly optimistic in the last two years, therefore a more pessimistic revenue decrease that is more consistent with recent history has been used to establish a range. The flat revenue projection is in the middle. These revenue projections, coupled with a projection of a moderate enrollment increase of 75 members per month, yields the following:

DRAFT

- The Trust Fund Balance, depending upon the scenario, will be below the actuary's recommended threshold between November 2010 and March 2011 (see chart below).

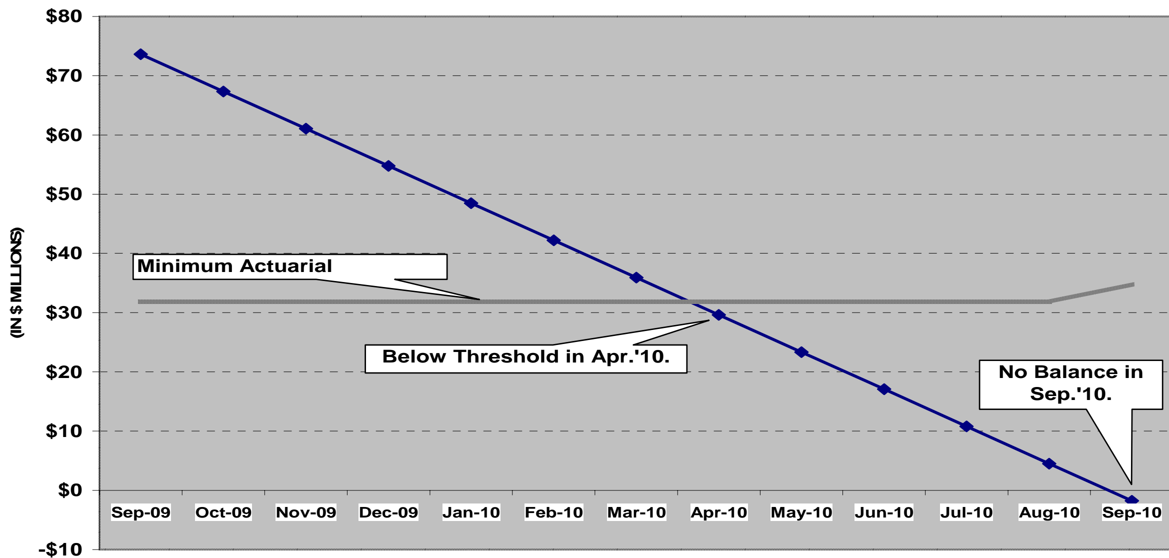
○

**COMPARISON OF TRUST FUND BALANCE PROJECTIONS TO MINIMUM ACTUARIAL THRESHOLD**




- A reduction in the sales tax collection from ½ percent to ¼ percent would result in a zero or negative Trust Fund Balance within one year of its implementation, which can only be done in October.

**COMPARISON OF STATE PROJECTION FOR 1/4 PERCENT TAX TO MINIMUM ACTUARIAL THRESHOLD**



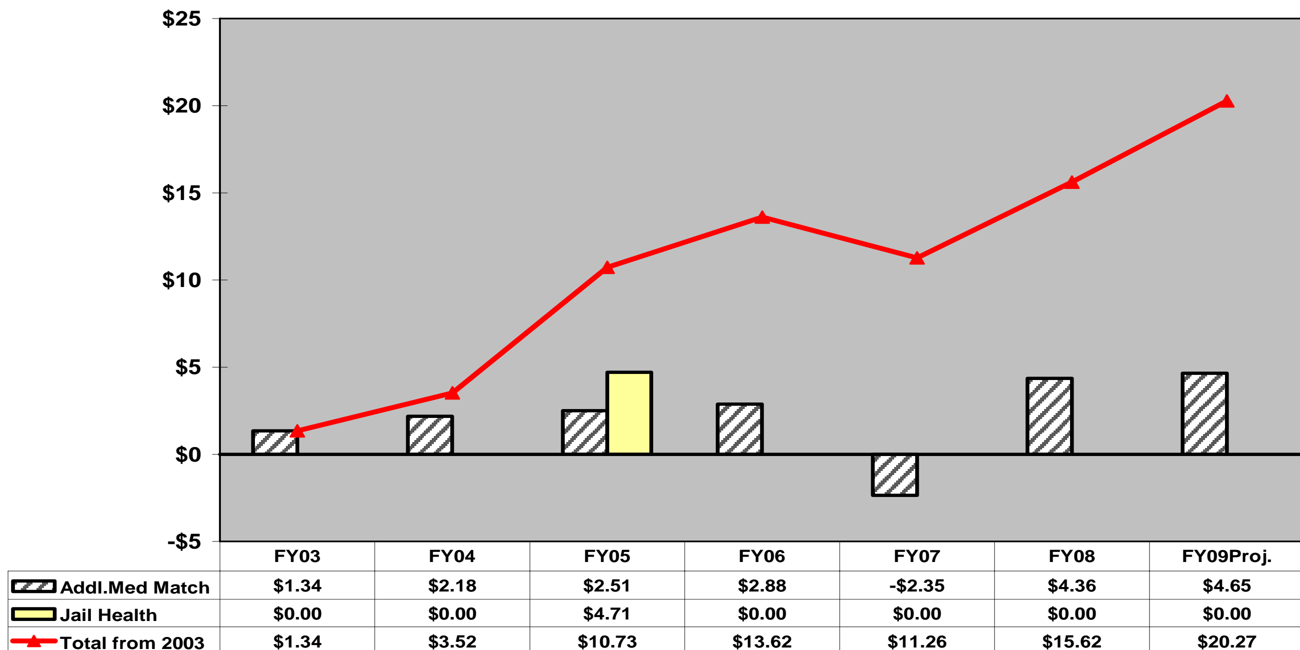
- There are several factors that will occur in the next year and beyond that will affect decisions on action to maintain HCHCP viability. They include:

  - Negative factors:
    - Worst than expected economy.
    - Implementation of State policy that would increase the County's Medicaid Match which is paid for out of the HCHCP. Proposals are being considered that could increase the annual match by close to $5M.
    - Negative changes in State Medicaid coverage (such as elimination of the Share of Cost Program would have a negative $3M plus annual impact on the HCHCP).

  - Positive factors:
    - Better than expected economy.
    - Increased assistance for the uninsured by the State (the "Cover Florida" initiative) or federal policy change.

- The 2002 BOCC-approved HCHCP financial plan resulted in $20.1M of general fund being used for the HCHCP between 2002 and 2007. At the end of FY09, the Trust Fund will have expended $20.2M for expenses that the 2002 financial plan identified would have been paid out of general fund.

**HCHCP SALES TAX EXPENDITURES IN LIEU OF GENERAL FUND**
**(IN $ MILLIONS)**




| | FY03 | FY04 | FY05 | FY06 | FY07 | FY08 | FY09Proj. |
|---|---|---|---|---|---|---|---|
| Addl.Med Match | $1.34 | $2.18 | $2.51 | $2.88 | -$2.35 | $4.36 | $4.65 |
| Jail Health | $0.00 | $0.00 | $4.71 | $0.00 | $0.00 | $0.00 | $0.00 |
| Total from 2003 | $1.34 | $3.52 | $10.73 | $13.62 | $11.26 | $15.62 | $20.27 |

- While it is clear that the poor economy will be a major contributor to the erosion of the HCHCP financial viability, it appears prudent to take the next year to identify rational changes necessary to continue the program's viability. The HCHCP is critical to the economic recovery and stability of the County's low income population.

**BACKGROUND:**

The financial status of the HCHCP is highly dependent upon the rate of enrollment in the program. With the current economic situation we have observed several phenomena which make forecasting more complex due to changing underlying variables, such as less stable residences (many HCHCP members are not at the address they were just six months earlier, thus difficult to contact), and while more residents are enrolling in the HCHCP, more are dropping off the HCHCP as well. First-time members typically may enroll at a time of medical crisis, and by these members not remaining on the program as long by not re-enrolling, the opportunity is lost to provide less costly primary care rather than respond to a more costly medical crisis.

Sales tax revenues for FY07 (actual), FY08 (actual), and FY09 (forecast) are over $50 million dollars less than what was projected for the three fiscal years in April 2007, while demand is increasing (See Attachment A).

The HCHCP is now utilizing the actuarial firm of Milliman USA to assist with its financial projections and other forecasting as we move through this period of economic uncertainty. The HSS contract with the prior actuary, Aon Consulting has expired.

The HCHCP Trust Fund had referenced two "target" amounts in the prior report. The first is the upper and lower range for program viability, which reflected that the HCHCP would become a financial resource in the event of a significant event or combination of events that would disrupt the area, such as a significant economic downturn or other event such as a hurricane. Given that we are currently experiencing a significant economic downturn such as for which the $50 - $60 million dollar reserve estimate was contemplated, we recognize that it is not feasible to maintain that target in FY10 and FY11, given our increased demand for services coupled with our decreased revenues.

The second target is the Reserve Level to cover outstanding liabilities – which is akin to the amount the HCHCP would need if it were a commercial health plan under State regulation. Milliman USA has revised the estimate previously calculated and indicated that a conservative amount to reserve is in the range of three to four months of annual claims expense, which, assuming moderate enrollment increases, yields a range average, at 3.5 months of forecast claims expense, of $31.8 M in FY10 to $34.8 M in FY11.

The State of Florida has forecast that sales tax revenues will be 3.32% higher in FY10, and 8.32% higher in FY11, which may conflict with other economic forecasts. As such, we have provided three revenue scenarios within this document to illustrate just how sensitive the Trust Fund balance is to minor changes.

We have looked at three revenue scenarios: 1) the State Revenue Forecast, 2) a Flat Revenue Forecast, and 3) a Revenue Decrease Forecast assuming on the expense side a 5% annual increase in administration costs, many of which are outsourced, and a 5% increase in medical trend. Unfortunately, all scenarios, including the State's revenue forecast, place the Trust Fund balance below the actuarially sound Reserve Level to cover outstanding liabilities in FY11 – and the modest revenue decrease model produces a negative Trust Fund balance by the end of FY11.

The above projections do not include over $8M per year added expenditures in the future if the State enacts cuts and additional mandates being discussed (if the Trust Fund is to pay for them) and other possible changes due to economic uncertainties. These additions would result in a zero Trust Fund balance prior to the end of FY11 in all models except the optimistic State revenue forecast.

While the decision to use a general fund infusion to the Trust Fund to raise the balance is known, the BOCC-approved 2002 Financial Plan for the Trust Fund included ongoing Trust Fund expenditures for expenses previously paid for out of the general fund, principally paying for the increases in the Medicaid Match and for services previously paid for by General Fund. It is projected that at the end of FY09, there will be $20,270,683 paid for out of the Trust Fund for previously General Fund budgeted expenditures that are in excess of the assumptions in the 2002 financial plan. Thus the entire General Fund amount would be matched in Trust Fund payments by the end of FY09.

By comparison, between FY02 and FY07, the General Fund infusion to the Trust Fund equaled $20,170,000. The General Fund infusion has been discontinued but Trust Fund expenditures previously paid out of General Fund continues.

In addition, when the HCHCP was started in 1991, there was a requirement that the General Fund would continue to provide a $26.8 M "Maintenance of Effort". The maintenance of effort was discontinued in FY98.

A change from a ½ percent sales tax to a ¼ percent tax would further compound the threats to the Trust Fund Balance by halving the tax collection. For example, using the optimistic State forecast, a change from ½ percent to ¼ percent in FY10 would change the projected sales tax collection from $96.9 Million to $48.45 Million. This would result in a projection of a zero or negative Trust Fund balance by October, 2010, the first month of FY11.

Revised Projection for Trust Fund Balance:

As detailed in Attachment A, the downward revision of the projected Trust Fund balance is the result of:

- Revised sales tax revenues (actual and projections) for the HCHCP indicate an aggregate of $50,656,585 less sales tax revenue in FY07, FY08, and FY09, compared to previous projections.

- FY 09's budget included expenditures of $302,809 per year for mandated Baker Act activities that previously were paid for by the general fund.

Based upon a recommendation from the 2005 HCHCP Study Committee, indirect costs and costs for information service development are now being fully allocated to the Trust Fund rather than the General Fund. This will add close to $2,200,000 in recurring indirect costs each year, and $3,900,000 in dedicated one-time IT project charges over a three year period.

- The projections over the last two years have included a projection of an increase in volume. We have seen a volume projection consistent with the projected increases; therefore we are not adding additional costs due to revised volume projections.

However, there are several uncertainties that could cause further impact on the Trust Fund balance, such as:

- The State legislature is evaluating a change in the Medicaid match formula. If the new formula was in place last year, Hillsborough would have paid approximate $4.5 million more for the local Medicaid nursing home match. Additionally, the federal stimulus package under consideration allows states to place unemployed residents in the state's Medicaid program, thus potentially increasing our Medicaid HMO match an undetermined amount.

- It is unclear whether the State legislature will renew the Medicaid Medically Needy Program for adults after the next fiscal year. The program was discontinued in the recent legislative session but funded by state trust fund dollars.

    - To continue the Medically Needy Program, next year's legislature will need to decide to continue to use State trust fund dollars or agree to again fund the program out of State tax dollars.

- In the last few years, the HCHCP has attempted to maximize adult enrollment in the Medically Needy Program and pay the individual's share of cost, in lieu of the HCHCP. The average cost to the County for paying the Medicaid share of cost (then the State payments will kick in) versus full HCHCP coverage is $172 per month (or $2,064 annualized). As of January 31, 2008, 1,434 (or 9.2% of all enrollees) of our HCHCP enrollees are in the Share of Cost program. Therefore, if the Share of Cost Program was eliminated, it would cost us an additional $ 2,959,776 per year based upon the current enrollment level.

Projected Trust Fund Balance Compared to Actuarial Targets:

Utilizing the State's revenue forecast, it is projected that there will be a Trust Fund balance of $25.8 million at the end of Fiscal Year 2011 (September 30, 2011). However, if any revenue forecasts are erroneous, the implication is significant.

Trust Fund Balance (Millions) as of September 30, 2011:

| | **State Forecast** (FY10 = + 3.32%, FY11 = + 8.32%) | **"Flat" Revenue -** (FY10 and FY11 same as FY09) | **Revenue Decrease** (FY10 = - 4.5%, FY11 = -3.0%) |
|---|---|---|---|
| Minimal Enrollment Increase of 50/month | $25.28 | $10.78 | ($0.54) |
| Moderate Enrollment Increase of 75/month | $18.47 | $3.97 | ($7.35) |

With regard to other actuarial targets:

The HCHCP's prior actuarial firm, Aon Consulting, recommended the following targets in a January 2005 report.

- A range from $50,000,000 to $60,000,000 for the recommended Trust Fund Balance was the result of the actuary looking at the industry recommended reserve levels needed for a commercial insurance program ($32,000,000), coupled with the unique challenges of a program such as the HCHCP.

- because of the geography of the program (in a single County), in the event of a localized event (storm or other strong negative economic event) that additional reserves are required since the programs roles would swell, and the program would in the short-run become the payer for many citizens' care.

- Unlike a commercial insurance program, where premiums can be raised to reflect (and even reduce) risk, the HCHCP is limited to sales tax revenue and must allow additional reserves to reflect the fact that revenues cannot be increased at will.

We recognize that maintaining a reserve level of this amount, although prudent, is no longer feasible under the current economic situation.

- The then actuary had indicated that even if there were not the uncertainty of enrollment and economic factors, an insurance plan of this size would need a Trust Fund balance of $32,000,000. Another way to look at this level is that $32,000,000 is necessary to meet liabilities if the program is discontinued, such as outstanding claims and liabilities.

- Our current actuary has estimated that, based upon the nature of the HCHCP and its unique program attributes, that 3 to 4 months of claims expense would be required. This results in numbers that are congruent with the figure previously provided when we look at 3½ months of claims expense: $31.9 M in FY10, and $34.3 M in FY11.

Based upon current projections, the Trust Fund Balance targets will reduce to the above level in the following time frames:

Month in which minimum recommended Trust Fund balance is breached:

| | **State Forecast**<br>(FY10 = + 3.32%, FY11 = + 8.32%) | **"Flat" Revenue -**<br>(FY10 and FY11 same as FY09) | **Revenue Decrease**<br>(FY10 = - 4.5%, FY11 = -3.0%) |
|---|---|---|---|
| Minimal Enrollment Increase of 50/month | June 2011 | March 2011 | January 2011 |
| Moderate Enrollment Increase of 75/month | March 2011 | January 2011 | November 2010 |

<u>Need for Ongoing Monitoring and Possible Action:</u>

The BOCC decision to have the HCHCP reliant on its sales tax means a need to recognize that there are good years and bad years. Therefore, the roller coaster of the balance is to be expected. The sales tax increase of the years when the

economy is good is needed to be saved for the years when the sales tax collection is not good and due to economic times, the enrollment increases. We are now at that time.

In the next year, the Trust Fund balance should be monitored in the context of negative and positive factors that may result in a change of the Trust Fund balance. The factors to monitor include:

- Negative factors:
  - Worse than projected economy resulting in higher than projected enrollment and further decreasing of sales tax collection.
  - Implementation of State policy that further increases local expenditure from the HCHCP sales tax such as increases in the Medicaid match and decreases in the number of people covered by Medicaid.
- Potential positive factors:
  - As the State implements the Governor's plan to reduce uninsurance, there may be some local savings through coordinated planning.
  - A better than projected economy that improves the situation by increasing aggregate sales tax revenue and, through greater employment opportunities reduces our roles.

<u>Other Issues for Consideration</u>

As the Trust Fund balance will decline significantly in the next two year budget cycle, it is time sensitive to begin exploring ways to preserve the financial viability of the HCHCP.

It is to early to predict what healthcare will look like in FY10 or FY11, and one must operate under the assumption of status quo. At present, the federal stimulus package has not been approved, and the impact on Medicaid, health care providers, and others cannot be opined.

A healthy workforce is an integral part of economic recovery. The HCHCP pumps millions of dollars annually into the local healthcare provider community, and these dollars are then utilized to further purchase goods and services, and pay wages, in the local economy.

The largest recipients of HCHCP payments are Tampa General Hospital (4,921 employees), St. Joseph's (4,340 employees), Brandon Hospital (1,592 employees), University Community Hospital (2,064 employees) [(1)], several other Hillsborough County hospitals as well as over 2,000 Hillsborough County physicians and their office staff, in addition to Hillsborough County-based claims administration, utilization review, and ancillary medical service providers and pharmacists. (1) Source: Book of Lists, Tampa Bay Business Journal, 2009 Ed.

We recognize that most of the recipients of healthcare under the HCHCP may not ever rise to high-paying jobs within Hillsborough County. However, keeping these residents healthy allows them to pursue employment in many areas, such as the local healthcare industry itself, which has an ongoing demand for CNAs, medical technicians, etc.

Changes in Funding Mix between Sales Tax and General Fund:

When the HCHCP first started in the early 1990's, there was a requirement to maintain a general fund contribution of $26,800,000 for Medicaid (referred to as the "maintenance of effort".) This was eliminated in FY98.

In 2002, there were concerns over the dwindling Trust Fund balance and an HCHCP financial plan was approved by the BOCC at a workshop on October 23, 2002. The emphasis of this financial plan was to set strategies for the building and maintaining the Trust Fund. This work plan included more than a decision to reinstitute a general fund contribution to the Trust Fund for a finite number of years. It included the following statement (Concept 2 on the first page):

> *"Trust Fund Revenues will exclusively pay for the following expenditures and be limited to only paying for those expenditures:*
>
> - *All Hillsborough County Health Care Plan medical, administrative and case management expenses.*
> - *Entire Medicaid payment beginning in FY 04 (estimated annual expenditure of $7.1 million). If the future percentage increase in the Medicaid payment exceeds the annual percentage increase in sales tax revenues, the HCAB and County Administrator will jointly develop a funding strategy to fund the difference that will preserve the Health Care Plan and the Trust Fund.*
> - *Special payment to Tampa General Hospital (currently [referring to October 23, 2002 but still] $3.5 million)."*

Later at its November 11, 2005, meeting, the BOCC reaffirmed that the Medicaid match would be paid for out of Trust Funds not general fund.

It is projected that at the end of FY09, $20,270,683 will have been paid out of the Trust Fund for previously General Fund budgeted expenditures that are in excess of the assumptions in the 2002 financial plan. This includes $15,565,683 for excess Medicaid match since 2002, and indirect costs and information services replacement costs previously assumed under the General Fund ($2,990,000 budgeted for FY08).

By comparison, between FY02 and FY07, the General Fund infusion to the Trust Fund equaled $20,170,000. The General Fund infusion has been discontinued but the Medicaid match is higher than the 2002 Financial Plan and the paying of indirect cost out of the Trust Fund will continue.

Changing from a ½ Percent Tax to ¼ Percent Tax:

A change from a ½ percent sales tax to a ¼ percent tax would further compound the threats to the Trust Fund Balance by halving the tax collection. For example, using the optimistic State forecast, a change from ½ percent to ¼ percent in FY10 would change the projected sales tax collection from $96.9 Million to $48.45 Million. This would result in a projection of a zero or negative Trust Fund balance by October, 2010, the first month of FY11.

**Attachment A**

**Revenue Projections, April 2007 vs. January 2009**

*Source: Hillsborough County Office of Management and Budget*

| HCHCP ½ Cent Sales Tax Revenue Estimate | April 2007 Projection | January 2008 Actual *(A)* Or Projection *(P)* | Change FY over prior FY | Difference |
|---|---|---|---|---|
| FY07 | $110,251,577 | $104,881,571 *(A)* | N/A | ($5,370,006) |
| FY08 | $115,223,923 | $98,346,084 *(A)* | -6.2% | ($16,877,839) |
| FY09 | $122,206,493 | $93,797,753 *(P)* | -4.7% | ($28,408,740) |
| **Aggregate Lower Revenue Projection:** | | | | **($50,656,585)** |

**Attachment B**

**Revenue Projections, FY10 and FY11**

*Source: Hillsborough County Office of Management and Budget*

| HCHCP ½ Cent Sales Tax Revenue Estimate | Projection *(P)* | Change FY over prior FY |
|---|---|---|
| FY10 | $96,911,838 *(P)* | +3.32% |
| FY11 | $104,497,903 *(P)* | +8.32% |

Attachment 2

**Savings Assumptions If All Recommendations Adopted**

| POTENTIAL ACTION | | | IMPACT ($M) Low | Assumed | Hi |
|---|---|---|---|---|---|
| **I. CHANGE IN SERVICES - MODERATE DIFFICULTY** | | | | | |
| **A.** | **Coordination with other programs:** | | | | |
| | 1 | Increased use of COBRA for newly unemployed (County pays 35% that ARRA does not cover) | $0.1 | $0.3 | $0.7 |
| | 2 | Increase use of Medicaid | $0.5 | *$1.2* | $1.9 |
| | 3 | Get people on disability earlier (Expedite Medicare) | | *TBD* | |
| **B** | **Service changes:** | | | | |
| | 1 | Use of "Intermediate medical Care" rather than skilled nursing beds | $0.1 | $0.2 | $0.3 |
| | 2 | Eligibility enhancement without electronic support | $0.4 | $0.5 | $0.5 |
| | 3 | New retail pharmacy contract | $2.2 | $2.2 | $2.2 |
| | 4 | Mandatory patient assistance program (PAP) | $4.4 | $5.9 | $7.6 |
| | 5 | Staff compensation reductions | $0.5 | $0.5 | $0.5 |
| | **Aggregate of impacts (may be lessened due to cross-impact of changes between categories)** | | **$8.2** | **$10.8** | **$13.8** |
| **II. CHANGE IN SERVICES - HIGHER DEGREE OF DIFFICULTY** | | | | | |
| **A.** | **Enhance program eligibility process** | | | | |
| | 1 | Change "grandfathering" provisions | $0.3 | $1.0 | $1.7 |
| | 2. | Move to Self-Sufficiency Model | $7.0 | $14.0 | $21.1 |
| **B** | **Decrease use of specialists.** | | | | |
| | 1 | UR / UM vendor expanded role | $0.2 | $0.3 | $0.4 |
| | 2 | Limit specific specialties | $0.3 | $0.3 | $0.7 |
| | **Aggregate of impacts (may be lessened due to cross-impact of changes between categories)** | | **$7.8** | **$15.7** | **$23.8** |

**NOTE: Detailed worksheets for each line are available but not included in this report.**

**Attachment 3**

**COBRA/ARRA Assumptions**

Background
The following figures were utilized in the development of the estimated savings below:

- Hillsborough County Health Care Plan average medical benefit expense per member, per month, year-to-date June: **$474**

- Average single premium, all benefit plan types for Tampa Bay and Southeastern US: **$487.50**

  *(Source: Milliman 2008 Benefit Survey and Kaiser Foundation 2008 benefit survey of employer premium rates, trended forward to 2009 showing an estimated benefit cost range of $475 - $500 for employer premium rates)*

- Estimated average ARRA COBRA expense to be paid by HCHCP Trust Funds per individual = **$170.63** (35% of $487.50)

Estimated Savings

- The estimated average savings resulting from paying ARRA COBRA 35% per individual, per month in lieu of enrollment in the HCHCP:

  **$303.37 ($474-$170.63)**

- The estimated savings to the HCHCP assuming ten (10) persons per month, who would otherwise qualify for the HCHCP, are enrolled in the ARRA COBRA premium payment option from August through December, and remain for the entire nine month eligibility period: **$136,517**

- The estimated savings assuming thirty (30) persons per month, who would otherwise qualify for the HCHCP, are enrolled in the ARRA COBRA premium payment option from August through December, and remain for the entire nine month eligibility period: **$409,550**

The total amount of actual savings to the HCHCP will be determined by the actual number of individuals who are enrolled in the ARRA COBRA rather than in the HCHCP.