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Special Review

March 2001 Report No. 01-21

Options to Re-Design State Employee Health Insurance Benefits Presented

at a glance

The State Employees' Group Health Insurance Program has experienced growth in health care costs resulting in projected program deficits beginning in Fiscal Year 2001-02. Expenses are projected to exceed revenues by $28.8 million in Fiscal Year 2000-01 and are projected to exceed revenues by $121.3 million in 2001-02 and $225.1 million in 2002-03. The Legislature should consider options in four areas to better control costs, provide enrollees more choices for their health insurance benefits, and address contribution rate inequities:

- **modifying the health insurance plan design;**
- **modifying the contribution rate design;**
- **increasing medical claims cost controls; and**
- **increasing prescription drug cost controls.**

Purpose

In February 2001, Senate and House appropriations and substantive committee staff requested that OPPAGA identify options for the Legislature to consider for providing a health insurance benefit to state employees and retirees. Our review focuses on answering two questions.

- What employee health insurance design options are available?
- What strategies could be used to better control costs?

Due to the limited timeframe for this review, we did not determine the potential fiscal impact of the options identified. Some of the options would require an actuarial analysis to fully determine their potential cost effects.

We wish to acknowledge the assistance of Department of Management Services managers and staff in providing information for our review.

Background

The Department of Management Services (DMS) Division of State Group Insurance is responsible for administering the State Employees' Group Health Self-Insurance Trust Fund and providing state employee health insurance benefits. For Fiscal Year 1999-2000, the department spent $700.3 million to provide health insurance benefits to both active and retired state employees.

Current state employee health insurance design

The state gives employees and retirees a choice of two types of health plans: a Preferred Provider Organization (PPO) plan and Health Maintenance Organizations (HMOs) where available. HMO coverage is available only to those employees who live or work in an HMO service area.

Preferred Provider Organization Plan. A Preferred Provider Organization (PPO) is a network of physicians and medical facilities that have agreed to provide health care at discounted prices. Enrollees pay lower out-of-pocket expenses for using the network to obtain health care services. However, they have the option to obtain services outside of the network at higher out-of-pocket charges.

The state's PPO plan is self-insured. The state pays for claims using funds from the State Employees' Group Health Self-Insurance Trust Fund. Contributions made by state agencies and enrollees are deposited into the trust fund. By self-insuring, the state avoids insurance risk charges and has more control over cost containment decisions than if the state purchased coverage from a private sector insurer. The state contracts with a third-party administrator, Blue Cross and Blue Shield of Florida, Inc., to process medical claims for the PPO plan and to provide cost control services such as case management review and coordination of benefits with other insurance plans. The state contracts with a pharmacy benefits manager, Caremark, Inc., to process prescription drug claims and provide cost control services such as drug utilization review and pharmacy audits.

Health Maintenance Organizations. Health Maintenance Organizations (HMOs) are a type of managed care health plan. HMOs control costs by only allowing enrollees to obtain services from the HMO's provider network (except in emergency situations), requiring prior approval by primary care physicians for visits to specialists and other services, and strict pricing of reimbursement to physicians and facilities.

The HMO option is fully insured. The state pays premiums to the HMOs, which in turn bear the risk that these premiums will be sufficient to cover the cost of enrollees' health care benefits.

Premiums and Contribution Rates. DMS makes recommendations to the Governor and Legislature for employee health insurance premium levels and contribution rates. Premiums are established for single enrollees and enrollees who wish to have health insurance coverage for their spouses and/or eligible family members. The Legislature annually approves premium levels and contribution rates through the appropriations process.

Contribution rates for active employees are the same for the HMO and PPO plan options. Currently, the state contributes 86% of the active employee single rate premium and 77% of the active employee family rate premium.

Retirees contribute the full premium for their health insurance coverage.[1] Premiums for retirees who are Medicare-eligible are adjusted to reflect the degree to which Medicare will be responsible for paying their health care costs.[2]

The state's current employee health insurance contribution rates are shown in Exhibit 1.

Exhibit 1
Health Insurance Contribution Rates Vary for Single, Family, and Retiree Coverage

Category[1] Coverage Type	Monthly Contribution[2] State	Enrollee	Total Premium
Active Full-Time Employees			
Single	$191.52	$ 32.30	$223.82
Family	391.60	116.20	507.80
Early Retirees			
Single	$0	$223.82	$223.82
Family	0	507.80	507.80
Medicare-Eligible Retirees			
One Medicare-eligible individual	$0	$119.03	$119.03
Family with one person eligible for Medicare	0	342.86	342.86
Family with two persons eligible for Medicare	0	238.05	238.05

[1] COBRA participants pay contributions equaling the total premium for active employees plus a 2% administrative charge.
[2] The actual contribution rate for some retirees participating in an HMO may differ from the rates presented.
Source: DMS Division of State Group Insurance.

Escalating state health care costs

Florida's employee health insurance program is experiencing escalating health care costs. Rising health care costs are of national concern. Nationwide, employer-sponsored health insurance plans experienced a 7.1% annual cost increase in 1999 compared to average annual increases of less than 2.5% during the early 1990s. As shown in Exhibit 2, Florida's employee health insurance plan experienced a 7.6% cost increase

[1] The state provides a health insurance subsidy through the Florida Retirement System to help offset the cost of retirees' health insurance.

[2] Medicare is considered the primary insurer for retirees who are Medicare-eligible. The State Employee Group Health Insurance Program covers eligible health care expenses that are not covered by Medicare.

per enrollee in Fiscal Year 1999-2000 and is projected to incur a 12.7% increase in 2000-01.

Exhibit 2
State Employee Health Insurance Costs Per Enrollee Increase 7.6% in 1999-2000; Expected to Reach 12.7% in 2000-01

	Actual	Projected	
	1999-2000	2000-01	2001-02
Program Cost[1]	$680,200,000	$772,500,000	$863,400,000
Number of Enrollees	162,964	164,251	165,395
Average Cost	$4,174	$4,703	$5,220
Percentage Increase per Enrollee	7.6%	12.7%	11.0%

[1] Excludes internal administrative costs and other incidental expenses such as patient auditor refunds.
Source: DMS Division of State Group Insurance.

As shown in Exhibit 3, the State Employees' Group Health Self-Insurance Trust Fund is projected to have a deficit balance by the end of Fiscal Year 2001-02.[3] Expenses are projected to exceed revenues by $28.8 million in Fiscal Year 2000-01 and are projected to exceed revenues by $121.3 million in 2001-02 and $225.1 million in 2002-03.

Exhibit 3
The State Employees' Group Health Self-Insurance Trust Fund Is Projected to Have a Deficit Balance by Fiscal Year 2001-02 [1]

	2000-01	2001-02 (in millions)	2002-03
Beginning Balance	$115.2	$ 86.4	$00.0 [2]
Revenues	761.1	759.5	764.2
Expenses	789.9	880.8	989.3
Gain/loss	(28.8)	(121.3)	(225.1)
Ending Balance	$ 86.4	$ (34.9)	$(225.1)

[1] These are preliminary figures based on March 2001 figures prepared for the State Employees' Group Health Self-Insurance Trust Fund Estimating Conference.

[2] The projected beginning balance for Fiscal Year 2002-03 assumes that $34.9 million would be appropriated to cover the ending trust fund balance deficit from Fiscal Year 2001-02.
Source: DMS Division of State Group Insurance.

The cost increases in the state's employee health insurance program are attributed to a variety of factors, including:

- increased prescription drug costs, particularly due to new, high-cost drugs, increased direct-to-consumer prescription drug marketing campaigns, and an aging employee and retiree population which tends to use more prescription drugs;
- increased utilization of inpatient and outpatient medical services;
- new technologies;
- price inflation; and
- increased HMO premiums.[4]

Florida has already implemented numerous cost control strategies

Florida is using prevailing cost containment methods in providing employee health insurance benefits. These include self-insuring, using a PPO, offering employees use of HMOs, and establishing a wide variety of cost control mechanisms for medical and prescription drug benefits. For example, the state controls PPO plan medical claims cost by using case management, coordination of benefits, pre-admission certification and concurrent review of inpatient health care, claims processing edits, and hospital audits. Another cost control for PPO plan medical claims is requiring enrollees to pay a portion of their health care costs through deductibles, coinsurance, and co-pays (intended to share costs with enrollees and control utilization).

The program also has prescription drug cost control strategies, including obtaining rebates from drug manufacturers and price discounts from pharmacies, conducting concurrent and retrospective drug utilization reviews, and instituting co-pay schedules that help control utilization, share costs with enrollees, and encourage generic drug substitution. In January 2001, the program implemented a three-tier prescription drug co-pay schedule for the PPO plan and HMOs, as approved by the Florida Legislature.[5] The three-tier schedule is based on a preferred drug formulary to better align enrollee

[3] In recent years, deficits in the trust fund have been covered by temporary loans from other trust funds, cash infusions by the Legislature, or increases in contribution rates.

[4] HMOs have been experiencing cost increases for reasons similar to those affecting the PPO plan, as well as consumer pressure to increase access to services and increasing government-mandated benefits.

[5] Enrollees pay $7 for generic drugs, $20 for brand name drugs on a preferred drug list, and $35 for non-preferred brand name drugs. For the PPO plan mail order pharmacy, enrollees pay $10.50 for generic drugs, $30 for brand name drugs on the preferred drug list, and $52.50 for non-preferred brand name drugs.

costs with actual drug costs and encourage the use of generic and brand name drugs as determined by a pharmacy and therapeutic committee composed of physicians and clinical pharmacists.

Employee Health Insurance Benefit Options

To identify additional steps that the Legislature could take to better manage employee health insurance costs, we researched employee health insurance benefit design and cost control strategies used by other states and the private sector. To further identify options, we also reviewed current literature and interviewed DMS administrators, consultants familiar with Florida's employee health insurance program, and representatives of the PPO plan's third-party administrator and prescription benefits manager.

We believe that the Legislature should consider a combination of options to better control costs, offer employees more choices for their health insurance benefits, and address contribution rate inequities. We have identified options for consideration in four areas.

Health insurance plan design options

- Provide a continuum of self-insured plan options with a standard state contribution rate;
- implement a point-of-service plan;
- implement a high deductible health insurance plan option and encourage use of Flexible Spending Accounts;
- offer an array of fully-insured health insurance plans to Medicare-eligible retirees;
- implement Medical Savings Accounts;
- discontinue self-insuring the PPO plan and contract with providers for fully-insured group plans; and
- give employees a set amount for health insurance to obtain coverage in the private market.

Contribution rate design options

- Establish multi-tiered contribution rates that reflect the number of persons receiving coverage;
- adjust contribution rates for retirees to better reflect their health care costs;
- incrementally increase state and enrollee contribution rates to reflect annual medical cost increases;
- adjust employee contribution rates to align premiums with the costs of the PPO plan and HMOs; and
- require all employees to contribute toward their health insurance coverage.

Medical claims cost control options

- Increase deductible, coinsurance, and co-pay schedules;
- increase utilization review; and
- expand disease management.

Prescription drug cost control options

- Increase prescription drug co-pay schedules;
- establish a prescription drug deductible;
- establish prescription drug coinsurance;
- increase enrollee cost share for brand name drugs with generic drug substitutes;
- require prior authorization for certain drugs;
- implement physician profiling;
- limit the pharmacy networks that can participate in the state program;
- establish lower dispensing fees;
- implement performance-based pharmacy networks with pharmacist incentives;
- negotiate larger rebates and/or price discounts by grouping with other large government health insurance programs; and
- implement mandatory price controls if manufacturers do not significantly lower prices.

Each of these options have advantages and disadvantages, which are presented in Appendices A, B, C, and D. For comparison purposes, we have listed the current design or cost control strategies as the first item in each appendix. To the extent possible, we have arrayed the options in order of their feasibility and/or dissonance.

Appendix A

State Employee Health Insurance Benefit Design Options

Florida offers a comprehensive employee benefits program, which provides health insurance benefits for active and retired state employees, their families, and surviving spouses. Enrollees may choose between two types of health plans: a self-insured Preferred Provider Organization (PPO) Plan or a fully-insured Health Maintenance Organization (HMO) plan (where available). This appendix lists options for other ways to provide a health insurance benefit, and the advantages and disadvantages associated with each of these options. For comparison purposes, we have first listed the current benefit design.

Benefit Design Option	Advantages	Disadvantages
Current benefit design The state offers health insurance to its employees and retirees through a self-insured Preferred Provider Organization (PPO) plan and fully-insured Health Maintenance Organization (HMOs) where available. The state contracts with a third-party administer to process claims for the PPO plan and provide cost control services. The third-party administrator also provides the PPO network, which is a group of physicians and medical facilities that have agreed to participate in the network at discounted prices. Enrollees pay lower out-of-pocket expenses for using the network to obtain health care services. However, they have the option to obtain services outside of the network at higher out-of-pocket charges. Employees and retirees living in counties with an HMO available may elect to use an HMO for their health insurance coverage. Coverage under an HMO is not self-insured. Traditionally, HMOs have controlled cost through managed care mechanisms such as only allowing enrollees to obtain services from the HMO's provider network (except in emergency situations), requiring prior approval by primary care physicians for visits to specialists and other services, and strict pricing of reimbursement to physicians and facilities.	▪ The stability and simplicity of the state's employee health insurance options may make it easier for some enrollees to make annual enrollment decisions. ▪ By self-insuring the PPO plan, the state avoids insurance risk charges and has more control over cost containment strategies than if the state purchased coverage from a private sector insurer. ▪ PPOs provide a discounted rate on medical services. ▪ PPOs allow enrollees more freedom of choice than HMOs for physicians and medical facilities. ▪ HMOs generally provide enrollees access to health care services at lower out-of-pocket expenses than PPO plans or traditional fee-for-service plans.	▪ The current benefit design allows only limited flexibility to enrollees for selecting a health insurance plan that fits their financial, health, or geographic situations. Enrollees living in counties without an HMO or who live out-of-state have only one option for health insurance coverage. ▪ The state pays risk charges to the HMOs for fully insuring the enrollees who select this option.
Provide a continuum of self-insured plan options with a standard state contribution rate Under this option, enrollees would be given the choice of several self-insured plan benefit packages with different benefits, contribution rates, deductibles, and coinsurance and/or co-pay structures. The state's contribution toward employee health insurance premiums would be set at the level needed to cover a basic package of benefits. Enrollees could choose to obtain the basic package, or opt for lesser or greater benefits, and their contribution toward premiums would vary depending on the option chosen.	▪ The state's contribution toward health insurance costs would be limited to a set amount, regardless of the health insurance package chosen by employees. Enrollees, rather than the state, would pay the cost difference for their health plan choices. ▪ Enrollees would have more options for choosing a health plan that fits their financial, geographic, and health situations than under the current plan structure. ▪ Unlike the current design, premiums would reflect the costs of the services offered. ▪ The state would still realize cost benefits from self-insuring. Nationally, premiums increased more rapidly for fully-insured plans (9.6%) than self-insured plans (7.1%). ▪ The state's third-party administrator for the PPO plan is currently developing a product to provide this type of benefit package. The administrator is anticipating that the product	▪ Enrollees would need to be educated about the new plan structure. ▪ Some enrollees may have difficulty affording the health insurance coverage they want. ▪ The state's third-party administrator does not expect to have this type of product available statewide until the end of 2002.

Benefit Design Option	Advantages	Disadvantages
	will include a more cost-effective network structure than the state's current PPO network and thus the state's medical costs may be reduced.	
Point-of-service plan (POS) A POS plan combines the managed care mechanism of an HMO with a PPO plan. When the enrollee uses the plan's provider network and a primary care physician for referrals to specialists (also called a "gatekeeper" requirement), the enrollee pays lower out-of-pocket expenses, such as deductibles, coinsurance, co-pays, and calendar year maximums. The enrollee has the option of going outside the network or to specialists without prior approval, but must pay higher out-of-pocket expenses. Currently, the PPO plan allows enrollees to visit specialists within the plan's network without receiving referrals from a primary care physician.	▪ Health care costs might be reduced due to better control of enrollees' access to services. ▪ POS plans give enrollees more freedom of choice than an HMO while incorporating some of the cost control mechanisms of a managed care plan. ▪ Benefits could still be self-insured. ▪ Although not used frequently, some other government employers use POS plans. According to a published survey, 13% of state and local government health plans offer a POS option. (HMO and PPO plans are offered more frequently—37% and 47% respectively).	▪ Managed care health insurance plans have been experiencing significant cost increases nationwide. As a result, the cost of a POS plan may not be significantly different from that of Florida's current PPO plan. ▪ Nationally, POS plan participation is declining because PPO plans have similar costs without the administrative burden of a gatekeeper function. Some plan vendors have recognized this market preference by dropping the gatekeeper requirement, in effect converting the POS product to a PPO.
Implement a high deductible health insurance plan option and encourage use of Flexible Spending Accounts (FSAs) A FSA is a type of cafeteria plan authorized under Section 125 of the Internal Revenue Code. FSAs allow employees to purchase qualified health benefits on a pre-tax basis. FSA funds not used by the end of the year become the property of the employer. The state already has a FSA option that allows employees to set aside money to pay for medical expenses, including those not covered by their health plan such as vision care. However, under this option, the FSA would serve as the enrollee's primary method of paying for health care expenses up to the amount of a high deductible, at which point the health insurance plan would cover medical costs. The deductible would be set at a higher level than under the current design, such as $1,500 or $2,000 for single coverage, as compared to the current PPO plan deductibles of $150 network and $300 non-network. The state's contribution toward health care premiums would be limited to the amount needed to fund coverage for the high deductible plan.	▪ Enrollee medical expenses would be paid for with pre-tax money. ▪ The state may save money on lower premiums, depending on the extent to which adverse selection occurs. (Note: Adverse selection occurs when a change shifts the health and age distribution of enrollees among health insurance plans to the extent that cost reductions in one plan are offset by cost increases in another plan.) ▪ When salaries are reduced through pre-tax deductions, the state retains additional monies for health insurance expenses. The state deposits savings from the employer portion of Social Security (currently 7.65% of each dollar of salary reduction) into the trust fund for pre-tax monies. These funds are transferred to the State Employees' Group Health Insurance Trust Fund to help fund health insurance benefits. ▪ The state retains FSA funds not used by employees by the end of the year, thereby increasing the state's cost savings. ▪ This option might encourage employees who have not used their FSA funds by the end of the year to spend funds on preventative care, such as physical exams.	▪ This option has the potential to increase overall state employee health insurance costs. A recent Blue Cross study of the feasibility of a similar option (giving employees the option of choosing a high deductible plan at no cost to state employees) estimated a high rate of movement away from the PPO plan and subsequent net cost increase to the state. Another factor leading to the projection of an overall net cost increase was an assumption that many employees who do not currently elect to have state employee health insurance benefits would do so if offered such an option (approximately 20,000 employees). The state would need to start contributing toward coverage for these employees, whereas currently there is no need for a state contribution on their behalf. ▪ Employees must accurately estimate their medical expenses or lose their FSA contributions. ▪ We did not identify any other states that use FSAs as the primary method of setting aside health care funds for employees. ▪ If faced with significant health care expenses, employees who have not elected to set aside sufficient funds in their FSAs would have to come up with funds to cover the high deductible. ▪ Enrollees who are not affluent and healthy are not likely to benefit from this type of program because they are more likely to need medical care and have limited ability to cover high deductibles. ▪ Currently, state regulations limit employees to contributing $2,400 to FSAs. These regulations would need to be reviewed for possible revision. The rationale for the limitation is that federal regulations allow an employee to withdraw the full amount of a year's FSA contributions at any point

Benefit Design Option	Advantages	Disadvantages
		during the year. The state has capped the contribution amount to limit the state's exposure to a loss should an employee withdraw more than contributed and then leave state employment. However, DMS administrators stated that the state's gain from forfeiture of employee contributions may more than offset the state's losses, and thus the $2,400 limit may be set too low. ▪ FSA funds used for typical health care expenses would limit the amount enrollees have left for medical expenses not covered by health insurance.
Offer an array of fully-insured health insurance plans to Medicare-eligible retirees This option would involve the state discontinuing offering retirees coverage as part of the self-insured PPO plan. Instead, the state would offer retirees an array of fully-insured group plan types, including traditional fee-for-service, PPO, POS, HMO, and Medicare Supplement plans. Each option would be priced to the retirees at a level equal to the premium cost charged by the private insurers.	▪ Currently, retirees' medical and prescription drug claim costs for the PPO plan are greater than their premiums. During Fiscal Year 1999-2000, the PPO plan's costs for retirees exceeded their premiums by approximately $41 million. This option would ensure that retiree premiums are set at a level that equals their cost, resulting in greater cost control and predictability for the state. ▪ This option would provide retirees with additional health care choices to meet their financial and health situations.	▪ The market for providing health insurance coverage only to the retiree population may be limited. ▪ Retirees would lose the cost advantage of obtaining health insurance priced for a more widely dispersed age group. Although the cost impact for retirees is unknown without further study, it is likely that their health insurance costs would increase. ▪ Some retirees might not be able to afford sufficient health care.
Medical Savings Accounts (MSAs) MSAs pair a savings account with a high-deductible insurance policy. Employers contribute toward their employees' savings accounts and also purchase the high-deductible insurance policies (such as a policy with a deductible between $1,650 to $2,400 for single coverage). Employees use money in their accounts to pay their medical expenses up to the amount of the deductibles. Any money remaining in the accounts at the end of the year generally rolls over to the next year to cover future medical costs. Currently under federal law, only self-employed individuals and small employer groups of 50 or fewer employees are eligible to use MSAs at a tax advantage (i.e., the employer contributions are not considered taxable income to the employee for federal purposes). The federal government is still studying the tax implications of expanding the MSA tax shelter to large group insurance plans. Arizona has implemented the MSA concept as an option for state employees to choose for their health insurance coverage. Contributions are considered taxable income for federal tax purposes but are not subject to state income taxes.	▪ Proponents of MSAs state that they reduce health care costs for enrollees because enrollees are encouraged to shop around for the best price for prescription drugs and medical care. ▪ Some enrollees may be able to recoup money from their accounts that they do not use for medical expenses. ▪ The state may save money on lower premiums, depending on the extent to which adverse selection occurs.	▪ Under current federal law, Florida's group plan is too large participate in a tax-advantaged MSA. ▪ This option has the potential to increase overall state employee health insurance costs. A recent Blue Cross study of the feasibility of a similar option (giving employees the option of choosing a high deductible plan at no cost to state employees) estimated a high rate of movement away from the PPO plan and subsequent net cost increase to the state. Another factor leading to the overall net cost increase was an assumption that many employees who do not currently elect to have state employee health insurance benefits would do so if offered such an option (approximately 20,000 employees). The state would need to start contributing toward coverage for these employees, whereas currently there is no need for a state contribution on their behalf. ▪ MSAs may encourage enrollees to avoid preventative health care to save money, which may result in higher future health care costs. ▪ Enrollees who are not affluent and healthy are not likely to benefit from this type of program because they are more likely to need medical care and have limited ability to cover high deductibles. ▪ Jersey City, NJ, experimented with this concept for three years, but found it was too costly and complicated to continue.

Benefit Design Option	Advantages	Disadvantages
Discontinue self-insuring the PPO plan and contract with providers for fully-insured group plans This option would involve the state contracting with multiple private insurance companies to provide group health insurance coverage. The state would contribute a set amount toward health insurance premiums and enrollees would pay any cost differential for the provider and benefits package they choose.	▪ The state's contribution toward premiums would be limited to a set amount and may be more predictable, depending on the extent to which the state wants to let enrollees bear the burden of health insurance cost increases. ▪ Enrollees may have more opportunities to choose health insurance plans and benefit packages that fit their financial, health, and geographic situations.	▪ This option divides up enrollee risk pools among the various plans that would be offered by the private insurers. One result of dividing up the risk pools is that insurers would not have a predictable set of enrollees on which to base their cost bids. This may add to insurers' cost bids and/or lead to a reduction in the number of insurers willing to participate in the state's employee health insurance program. As a result, this option may increase health insurance costs over that of the current benefit design. ▪ The state would lose any cost advantage from self-insuring. Insurers would need to establish premiums sufficient to cover costs such as premium taxes, insurance risk charges, and claim reserves. ▪ State administrators would need to be involved in periodic rate negotiations for multiple products with multiple vendors, which may result in faster increases in health insurance costs and less stability and predictability in state and enrollee costs and enrollee plan choices.
Give employees a set amount for health insurance to obtain coverage in the private market * This option would involve eliminating the state's group health plans and instead providing enrollees with a fixed dollar amount to search for health insurance in the open market. The payment from the state to its employees could be in various forms, such as cash, vouchers, reimbursement of premiums, or payments to insurers. *Note: This is a "defined contribution" approach in its strictest form. Some of the other options also have a defined contribution element in that the state would limit its contribution to a set amount, but these options would not involve the state removing itself from the business of establishing group health insurance plans.	▪ The state's contribution toward health insurance costs would be limited to a set amount and may be more predictable, depending on the extent to which the state wants to let enrollees bear the burden of health insurance cost increases. ▪ Health care decisions would be solely in the hands of enrollees and no longer the state's responsibility. ▪ Enrollees may have more choice of health insurance plans and benefit packages than under the current state plan design.	▪ Although frequently discussed in recent literature, this approach is not widely implemented. It is seen as needing further testing. ▪ Depending on how this option is implemented, the tax implications for enrollees could be detrimental. If an employer gives an employee cash to buy his or her own individual health benefits, the employer is seen as giving the employee a "raise." The federal government currently considers this money taxable income. ▪ Enrollees would lose the benefit of obtaining health insurance using a group plan's increased purchasing power. Some enrollees might find it very difficult to find affordable coverage due to their financial, health, or geographic situations. There is a small market available for individual insurance coverage. ▪ Enrollees may need significant guidance and education to be able to independently make sound health insurance decisions. ▪ Retirees would no longer be able to benefit from being included in the state's employee group health insurance program. Retirees with significant health problems may not be able to find and/or afford sufficient health care.

Source: OPPAGA analysis.

Appendix B

State Employee Health Insurance Contribution Rate Design Options

This appendix describes options for the Legislature to consider in establishing the annual contribution amounts paid by the state and enrollees toward health insurance premiums, and the various advantages and disadvantages of each of these options. For comparison purposes, we have first described the state's current contribution rate design.

Contribution Rate Design Option	Advantages	Disadvantages
Current contribution rate design DMS makes recommendations to the Governor and Legislature for employee health insurance premium levels and contribution rates. Premiums are established for single enrollees and enrollees who wish to have health insurance coverage for their spouses and/or eligible family members. The Legislature annually approves premium levels and contribution rates through the appropriations process. State and employee contribution rates toward health insurance premiums are the same for the Preferred Provider Organization (PPO) plan and Health Maintenance Organization (HMO) plan options. Currently, the state contributes 86% of the active employee single rate premium and 77% of the active employee family rate premium. However, employees in certain positions receive free health insurance coverage as a job benefit. Retirees pay the full premium for their health insurance coverage.	▪ Enrollee contributions have remained fairly stable in recent years and are thus predictable to employees and retirees.	▪ Contribution rates have not been incrementally adjusted to keep pace with rising medical costs. DMS has projected a $35 million deficit in the program's trust fund for Fiscal Year 2001-02 and a $225 million deficit for Fiscal Year 2002-03. ▪ Retiree premium rates do not reflect the real cost of providing their health insurance coverage. During Fiscal Year 1999-2000, the PPO plan's claims cost for retirees exceeded their premiums by approximately $41 million. ▪ Contribution rates do not reflect the number of persons receiving coverage. For example, an employee receiving coverage for his or her spouse and three children pays the same amount as an employee receiving coverage for one child.
Establish multi-tiered contribution rates that reflect the number of persons receiving coverage This option would establish additional tiers to the single and family coverage premiums currently in effect. For example, the state could continue offering a premium for single employees and add a premium for an employee and spouse, a premium for an employee and one dependent, and a family coverage premium for an employee and two or more other persons.	▪ This option provides for a more equitable contribution rate structure. Enrollee contributions would better reflect their consumption of health care services. ▪ Other employers often use this type of premium structure.	▪ This option would result in a mixture of enrollee satisfaction and dissatisfaction depending on whether the enrollee's contribution rate goes up or down. For example, the employee contribution rate for employees providing coverage for just two persons (the employee and one other person) would go down, whereas the contribution rate for employees insuring multiple family members would go up. Reasons for the change would need to be clearly communicated. ▪ This option would not directly address funding deficits or reduce state costs unless contribution rates are set at a level to better cover projected cost increases.
Adjust contribution rates for retirees to better reflect their health care costs Data provided by DMS shows that retiree premiums are being subsidized by the premiums paid by and on behalf of active employees with family coverage. During Fiscal Year 1999-2000, the PPO plan's costs for the coverage provided to retirees (approximately 21,000) exceeded their premiums by $41 million. This option would eliminate the subsidy by raising the premiums for retirees to reflect their consumption of health care services.	▪ This option provides for a more equitable contribution rate structure. Enrollee contributions would better reflect their consumption of health care services. ▪ Surveys indicate a growing trend toward employers raising retiree premiums to better reflect their consumption of health care services, or discontinuing retiree coverage altogether. Utilization of health care services, including high cost prescription drugs, tends to increase with age.	▪ Although retirees receive a health insurance subsidy through the Florida Retirement System, it is possible that some retirees would have difficulty affording their health insurance coverage if their premiums were significantly raised.

Contribution Rate Design Option	Advantages	Disadvantages
Incrementally increase state and enrollee contribution rates to reflect annual medical cost increases This option would result in incremental increases in both state and enrollee premiums each year. One approach would be to index contribution rates to medical consumer price indices. Another would be to use actual plan experience and actuarial analyses to annually establish premiums. Under the current contribution rate design, the state does not regularly adjust contribution rates on an annual basis and may address program deficits with infusions of cash.	▪ This option would reduce the occurrence of annual funding shortfalls as revenues would increase annually, and may result in the accumulation of trust fund reserves. ▪ Incremental nominal adjustments to contribution rates would be more predictable for the state and enrollees than less frequent, larger adjustments.	▪ The Legislature would lose some of its current control over establishing contribution rate levels. ▪ Enrollees would likely be dissatisfied since the state has not traditionally passed on cost increases to enrollees every year. Some dissatisfaction may be avoided if the reasons for the change are clearly communicated.
Adjust employee contribution rates to align premiums with the costs of the PPO plan and HMOs Currently, state and employee contribution rates are the same regardless of whether an employee chooses an HMO or the PPO plan. The state has historically used excess contributions toward HMO premiums to pay for PPO plan claim costs. However, average 2001 HMO premiums exceed current contribution rates. This option would involve establishing employee contribution rates for the PPO plan and for each HMO that would reflect the cost differences among these options. The state would contribute a set amount toward health insurance premiums and employees would pay any cost differential for the health plan option they choose.	▪ This option provides for a more equitable contribution rate structure. Enrollee contributions would better reflect the cost of the health plan they choose.	▪ This option would result in a mixture of enrollee satisfaction and dissatisfaction depending on whether the enrollee's contribution rate goes up or down. Reasons for the change would need to be clearly communicated.
Require all employees to contribute toward their health insurance coverage Currently, some state employees receive free health insurance coverage as a job benefit. The state agencies that employ them pay the full cost of their health insurance premiums. These employees include those in the Senior Management Service and Select Exempt Service personnel classifications, legislative employees, and employees whose spouses also work for the state. (The latter is known as the "Spouse Program"). Under this option, all employees would be expected to contribute toward their health insurance coverage.	▪ This option provides for a more equitable contribution rate structure in that all employees would contribute toward their coverage. ▪ State agency payroll costs would be reduced. For example, if the approximately 10,000 persons currently receiving free health insurance as a job benefit and the approximately 9,000 married couples receiving free health insurance under the Spouse Program were instead contributing toward their health insurance premiums, the effect on the state's payroll would be a reduction of $23.1 million annually. However, this cost impact could be reduced to the extent that state agencies choose to increase employee salaries to offset the loss of job benefits.	▪ This option would not affect deficit problems in the State Employees' Group Health Insurance Trust Fund. Contributions to the trust fund would be the same as under the current system. ▪ This option may make it more difficult for the state to recruit and retain employees for the affected positions. ▪ Implementing this option may require revisions to Florida Statutes.

Source: OPPAGA analysis.

Appendix C

State Employee Health Insurance Medical Claims Cost Control Options

The state is currently using several cost containment methods to control the medical claims cost of the Preferred Provider Organization (PPO) plan. This appendix lists options for the Legislature to consider for other medical claims cost containment strategies, and the various advantages and disadvantages of each of these options. For comparison purposes, we have first listed the PPO plan's current medical claims cost control strategies.

Medical Claims Cost Control Options	Advantages	Disadvantages
Current PPO plan medical claims cost control strategies The state controls PPO plan medical claims cost by self-insuring, using a PPO network to obtain discounted prices for physicians and facilities, case management, coordination of benefits, pre-admission certification and concurrent review of inpatient health care, and requiring enrollees to pay deductibles, coinsurance, and co-pays.	▪ The current cost controls are typical of those used in the health insurance field. ▪ Enrollees have limited out-of-pocket expenses for medical care within the PPO network, keeping access to health care affordable.	▪ Despite implementing a number of cost controls, the state is facing a deficit situation for state employee health insurance benefits. ▪ According to Blue Cross, the PPO plan's deductibles and coinsurance amounts need to be re-evaluated and possibly raised to improve cost control.
Increase deductible, coinsurance, and co-pay schedules Deductibles, coinsurance, and co-pays are intended to help control costs through cost sharing and reduced utilization. Deductibles require enrollees to pay claim costs out-of-pocket before the plan begins to assume responsibility for the claim. Coinsurance requires enrollees to pay a percentage of the total cost of a claim. Co-pays require enrollees to pay a flat dollar amount for each claim, regardless of claim cost. As a short-term cost control strategy, the state could increase the amount of health care costs enrollees pay out-of-pocket.	▪ This option would increase the portion of medical cost borne by enrollees and may help decrease utilization of medical services.	▪ Some enrollees might not be able to afford access to needed medical services. ▪ This option does not control the prices charged by providers. ▪ A March 2001 actuarial review showed that raising deductibles, coinsurance, and co-pays would not be sufficient to fully address the program's deficit situation.
Increase Utilization Review The PPO plan could more aggressively review benefits for chronic patients or complex cases and offer case management to help patients navigate the system and reduce duplication of health care services.	▪ Cost savings may be achieved due to reduced medical costs.	▪ Administrative costs would be increased. DMS would have to continue to carefully balance the extent to which utilization review is practiced to ensure that administrative costs do not outweigh the benefit of reduced medical costs.
Expand Disease Management Disease management programs manage patient care in specific disease categories through patient education, drug therapy compliance, and physician communication. DMS has contracted with its prescription benefits manager (PBM) to provide disease management services for adult asthma patients. The PBM provides nurses who council patients one-on-one to encourage self-care and help them identify (and avoid) asthma triggers in their environment. Other disease management modules are available for diseases such as pediatric asthma, congestive heart failure, other heart disease, diabetes, and peptic ulcers.	▪ Some early studies have found that disease management programs can result in overall cost reductions for medical claims due to reductions in more expensive health care such as hospital admissions. ▪ DMS contracts for a guaranteed cost savings from its provider for disease management services.	▪ More long-term studies are needed before drawing conclusions about the cost effectiveness of disease management. For example, the cost benefit of disease management for conditions such as diabetes may be long-term and more difficult to quantify than for asthma. (OPPAGA is currently reviewing the cost effectiveness of the Medicaid Program's disease management initiative, with the final report to be published in April 2001.) ▪ Administrative costs would be increased. DMS will need to continue to balance the extent to which disease management is practiced to ensure that administrative costs do not outweigh the benefit of reduced medical costs.

Source: OPPAGA analysis.

Appendix D

State Employee Health Insurance Prescription Drug Cost Control Options

The state is currently using several cost containment methods to control prescription drug costs for the Preferred Provider Organization (PPO) plan. The state has also established a co-pay schedule to help control prescription drug costs for both the PPO plan and HMOs. This appendix lists options for the Legislature to consider for other prescription drug cost containment strategies, and the various advantages and disadvantages of each of these options. For comparison purposes, we have first listed the state's current prescription drug cost control strategies.

Prescription Drug Cost Control Option	Advantages	Disadvantages
Current prescription drug cost controls The Department of Management Services (DMS) contracts with a Pharmacy Benefits Manger (PBM) to administer prescription drug benefits for the PPO plan, which includes providing prescription drug rebates and cost discounts. The PBM provides a number of other prescription drug cost control strategies including concurrent and retrospective drug utilization review, case management, disease management, geriatric management, a preferred drug list, pharmacist profiling, pharmacy audits, and therapeutic interchange. HMOs include prescription drug benefits as part of their contracts with the department. However, both the PPO plan and HMOs use the same prescription drug co-pay schedule for purchases at retail pharmacies. Effective January 1, 2001, enrollees pay $7 for generic drugs, $20 for brand name drugs on a preferred drug list, and $35 for non-preferred brand name drugs. The PPO plan also has a mail order pharmacy benefit. The mail order pharmacy provides the state with higher discount rates than purchases at retail pharmacies. Enrollees who utilize the mail order pharmacy (mainly for maintenance drugs) can obtain a 90-day supply of drugs. Enrollees pay co-pays of $10.50 for generic drugs, $30 for brand name drugs on the preferred drug list, and $52.50 for non-preferred brand name drugs when using the mail-order pharmacy.	▪ The state obtains prescription drug rebates and price discounts using the combined purchasing power of employees and retirees. ▪ The newly implemented three-tier co-pay structure (lowest co-pay for generic drugs, middle tier co-pay for preferred brand name drugs, and highest tier co-pay for non-preferred brand name drugs) is projected to help reduce program prescription drug costs. DMS has estimated savings attributable to the new three-tier co-pay structure at $5 million for Fiscal Year 2000-01 and $10.1 million for Fiscal Year 2001-02. ▪ The PBM uses numerous management tools to promote the quality and cost effectiveness of the PPO plan's prescription drug benefit.	▪ The new co-pay structure took effect January 1, 2001. As a result, there has not been sufficient time to determine whether projected claims cost reductions have actually been achieved. ▪ The PBM assumed administration of the PPO plan's prescription drug benefit as of January 1, 2001. It is too early to draw conclusions about the effectiveness of its management controls on the quality and cost effectiveness of care. More time is needed with careful monitoring of desired outcomes.
Increase prescription drug co-pay schedules The state could establish higher co-pays or a more dramatic differential between generic and brand name drug co-pays. For example, the generic drug co-pay could be increased to $10, the preferred brand name drug co-pay to $30, and the non-preferred brand drug co-pay to $50.	▪ Higher co-pays may result in decreased utilization as enrollees' exposure to actual costs increase. ▪ Enrollees would be contributing more toward the cost of their prescription drugs. ▪ A larger cost differential between generic and brand name drugs might increase generic drug substitution rates. ▪ This option is not likely to increase administrative costs because a co-pay system is already in place.	▪ The state's three-tier co-pay system has not been in place long enough to fully assess cost effectiveness before further modifications are implemented. ▪ Flat dollar co-pays need to be reevaluated periodically to adjust for drug cost increases. ▪ Enrollees who cannot afford higher drug prices may not comply with medically prescribed drug therapies. Any option that increases enrollees' out-of-pocket expenses for prescription drugs includes a risk of increased medical claim costs. ▪ This option would likely cause enrollee dissatisfaction.

Prescription Drug Cost Control Option	Advantages	Disadvantages
Establish a prescription drug deductible The state could establish a prescription drug deductible. Enrollees would be responsible for their prescription drug costs up to the amount of the deductible, at which point they would be able to purchase prescription drugs using their health plan benefits. For example, enrollees could be responsible for the first $100 of their prescription drug costs before their health plan benefits take effect.	▪ Deductibles for prescription drugs may result in decreased drug utilization. ▪ Enrollees would be contributing more toward the cost of their prescription drugs. ▪ Additional administrative costs may be minimal compared to other options because the program's Pharmacy Benefits Manager has other customers using deductibles.	▪ The exact amount of potential cost savings is unknown without further study. Any option that increases enrollees' out-of-pocket expenses for prescription drugs includes a risk of increased medical claim costs. ▪ Enrollees who cannot afford higher drug prices may not comply with medically prescribed drug therapies. ▪ This option would likely cause enrollee dissatisfaction.
Establish prescription drug coinsurance requirements Coinsurance would require enrollees to pay a percentage of the cost of their prescription drugs rather than flat dollar co-pays. For example, enrollees could pay 10% coinsurance for generic drugs, 20% for brand name drugs, and 30% for non-preferred brand name drugs. This option could be implemented with a limit on the coinsurance requirement for certain high-cost drugs to maintain enrollee affordability.	▪ Coinsurance rates for prescription drugs may result in decreased drug utilization as enrollee's exposure to actual cost increases. ▪ Coinsurance maintains the same enrollee cost share level as drug costs increase over time thereby stabilizing the state's contribution share as well. ▪ Additional administrative costs may be minimal compared to other options because a co-pay system is already in place.	▪ The cost impact of this option is unknown without further study. ▪ Enrollees who cannot afford higher drug prices may not comply with medically prescribed drug therapies. ▪ This option would likely cause enrollee dissatisfaction. ▪ Exceptions for life sustaining high-cost drugs would likely be necessary.
Increase enrollee cost share for brand name drugs with generic drug substitutes Florida statutes currently require the substitution of generic drugs for brand name drugs, but make an exception for drugs for which the doctor indicates that the brand drug is "medically necessary" or the generic drug poses a threat to the health of patients. Under this option, if the enrollee is prescribed a brand name drug that has a generic substitute, the state would require the enrollee to pay the brand co-pay and the difference in cost between the brand and generic drug, regardless of whether the physician deemed the drug "medically necessary." However, this option would make exceptions for generic drugs on a negative formulary list (generic drugs deemed to be inferior to their brand name equivalents).	▪ This option may improve the program's generic drug dispensing rate by encouraging physicians to prescribe lower-cost generic drugs and enrollees to request generics. ▪ This option allows the program to recover more of the cost of expensive brand name drugs.	▪ Cost savings from this option may not be significant, as the program's generic substitution rates are already high (95%). ▪ This option may result in enrollee dissatisfaction.
Require prior authorization for certain drugs This option would restrict prescription drugs that would be covered by the health insurance plan. Prior authorization requires a doctor to convince the prescription drug benefit administrator that the drug is medically necessary. Otherwise, the plan administrator may choose not to cover the cost of the prescription drug. Plans using this option establish a prior approval list of certain high-cost drugs with lesser-cost therapeutic equivalents. Another approach to this option would be to establish a one-year moratorium on new, high-cost drugs requiring the patient to pay the full cost of a new drug during the first year. Or, if new drugs are not shown to be cost effective, require that the drug be priced equal to or less than the existing products. Note: Currently, the PPO plan only requires prior authorization for three drugs to ensure that they are being used in a manner consistent with PPO plan benefit exclusions.	▪ Prior authorization encourages physicians to first try lower-cost, most conservative therapies, resulting in reduced drug claims costs. ▪ This type of cost control is used by other employee health insurance plans (e.g., Maine's employee health insurance program).	▪ The exact amount of cost savings is unknown without further study. ▪ Prior authorization would likely add administrative cost to claims processing. Physicians must be allowed to override the formulary when medically appropriate. ▪ A previous program effort to establish a prior authorization system was prohibited by the Legislature. (Chapter 99-255, *Laws of Florida,* revised s. 110.12315, *F.S.,* to prohibit a prior authorization program. However, this restriction no longer exists in statute.) ▪ This option is likely to result in enrollee dissatisfaction. ▪ Drug companies oppose this type of proposal, stating that any restriction on access to drug therapies could potentially raise medical costs.

Prescription Drug Cost Control Option	Advantages	Disadvantages
		▪ Formulary development is not subject to a private accreditation program. Information used by pharmacy and therapeutics (formulary) committees in the formulary decision-making process is often supplied by manufacturers. ▪ On-call physicians may not have access to formulary information applicable to a specific patient. ▪ Restrictions on the physician's drug choice have the potential to result in patient injuries that are considered negligent and create liability issues.
Physician profiling This option is a management tool that involves comparison of physicians' drug prescribing patterns to those of peers providing services to comparable populations. Significant deviations may indicate prescribing habits above the norm, e.g., prescribing more brand name versus generic drugs. The Pharmacy Benefits Manager (PBM) would then educate the physician on how he/she is deviating from other local providers to encourage the physician to adjust prescribing patterns accordingly.	▪ Profiling would give physicians information so that they have a better perspective on their behavior compared to their peers. ▪ Profiling would provide information to the PBM to help identify physicians who tend to prescribe high-cost drugs. The PBM can use this information to better target education and compliance efforts. ▪ This information can be used to identify potentially fraudulent and abusive practices. ▪ The Medicaid Program has been profiling physician practices for two years.	▪ Cost savings are not certain and would require further study. ▪ Physicians would likely oppose this option and may elect not to participate in the PPO plan. ▪ Tracking information to continuously profile physicians can be time-consuming and may be administratively costly.
Limit pharmacy networks that can participate in the state program Under this option, the program would contract with a small group of pharmacies that agree to follow program prescription drug dispensing polices in exchange for exclusivity. These pharmacies may also agree to give a discount on dispensing fees.	▪ This option may result in drug claims cost savings to the extent that lower dispensing fees can be negotiated and policies are established to maximize cost-effective dispensing (e.g., encouraging generic drug substitution). ▪ Administrative costs may be less than other options due to the limited nature of the network.	▪ Cost savings are not certain and would require further study. ▪ Pharmacy lobbyists and enrollees have opposed past efforts to limit pharmacies participating in the program. ▪ Due to the restricted access to pharmacies, enrollees may have increased transportation costs. ▪ This option would require revision to s. 110.12315(1), *F.S.*
Establish lower dispensing fees The total cost of a prescription is divided between a dispensing fee and the discounted ingredient cost. The program pays a dispensing fee of $4.28 for retail or $4.22 for mail order each time a pharmacist fills a prescription.	▪ This option directly addresses prescription drug prices.	▪ The feasibility of this option is not certain. According to DMS administrators, the program has a high dispensing fee in comparison to those of other state employee health insurance programs, but the program's price discounts are also high. They maintain that the dispensing fees and discount rates in conjunction with each other provide optimal pricing. ▪ The Pharmacy Benefits Manager would need to renegotiate discount arrangements with pharmacies, which may not result in overall lower prices. ▪ Pricing methodologies applied to large pharmacies may not be feasible for smaller, independent pharmacists. ▪ This option may require revision to s. 110.12315(2)(c), *F.S.,* which states that the current pharmacy dispensing fee "…remains in effect."

Prescription Drug Cost Control Option	Advantages	Disadvantages
Performance-based networks with pharmacist incentives Using performance-based incentives, pharmacists could earn higher dispensing fees as a result of dispensing drugs that mirror a particular drug policy. Bonus incentives, shared savings, or basing dispensing fees on achievement of performance targets such as generic drug substitution rates, could be used to encourage cost-effective dispensing and more pharmacist counseling services to enrollees.	▪ This option may result in retail prescription drug cost savings from more cost-effective formulary dispensing.	▪ Cost savings are not certain and would require further study. ▪ This option requires well-defined and proactive network management by the Pharmacy Benefits Manager. ▪ This option may cause some enrollee disruption when prescriptions are delayed due to intervention by the pharmacist. ▪ Good communication of the formulary process to enrollees and pharmacists is required to facilitate compliance. ▪ This option would require revision to s. 110.12315, *F.S.*
Negotiate larger rebates and/or price discounts by grouping with other large government health insurance programs (e.g., the Medicaid Program, other state or local government employee health insurance programs, etc.) Some smaller state health insurance plans have grouped together in an attempt to negotiate larger rebates and/or price discounts for drugs. Another approach is to attempt to join with a state Medicaid program to benefit from Medicaid's federally mandated price discounts. In some cases, this option has taken the form of using the same Pharmacy Benefits Manager (PBM) to at least lower administrative costs.	▪ Negotiated purchasing agreements may reduce prescription drug costs. ▪ Multi-state buying pools could include Medicaid patients, state employees, low-income seniors, and the uninsured. ▪ Some states are experimenting with variations on this option. For example, Maine, Massachusetts, Florida, California, and Vermont provide Medicare beneficiaries Medicaid drug prices. (A pharmacy association is challenging Vermont's program in court). Maine, New Hampshire, and Vermont are forming a three-state buying pool.	▪ Grouping with the Medicaid Program for price discounts would require federal approval of waivers. It may also require using similar preferred drug lists. ▪ Cost savings are not certain because Florida's state employee health insurance program is already considered large and receives the benefits of its PBM's negotiating leverage. The PBM negotiates based on the membership size of health plans in its customer base. This membership size exceeds 20 million persons. The extent to which further rebates or discounts may be negotiated is unknown. ▪ Manufacturers will assert that larger rebates will reduce funds available for research and development of new drugs.
Implement mandatory price controls if manufacturers do not significantly lower prices One state (Maine) is attempting to regulate the price of prescription drugs by passing laws authorizing bulk-purchasing programs and limiting prices that manufacturers may charge in the state. If bulk-purchasing negotiations fail to significantly lower the price of prescription drugs by 2003, Maine's human services commissioner is to set the maximum prices that manufacturers may charge in the state.	▪ According to the National Conference of State Legislatures, similar legislation is being considered in 16 other states. ▪ Canada and Mexico already have price controls.	▪ A pharmacy association has challenged Maine's law in court. The case is not yet decided, but the court's preliminary findings suggest the state's action is unconstitutional. ▪ The state may experience litigation costs. ▪ Opponents of price controls contend that they would limit new drug research.

Source: OPPAGA analysis.

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