Group self-insurance, premium cost

Number: INFORMAL

Date: July 11, 2018

Mr. Roman Gastesi
County Administrator
County of Monroe
1111 12th Street, Suite 408
Key West, Florida 33040

Dear Mr. Gastesi:

The Monroe County Board of County Commissioners has authorized an opinion request seeking clarification of the meaning of the term "premium cost" as used in section 112.0801, Florida Statutes (2017), and applied to an employer's self-insured health plan.[1] Attorney General Bondi has asked that I respond to your letter.

In pertinent part, section 112.0801(1) ("Group insurance; participation by retired employees") provides:

"Any…county…that provides…health…insurance…for its officers and employees and their dependents upon a…self-insurance plan shall allow all former personnel who retired before October 1, 1987, as well as those who retire on or after such date, and their eligible dependents, the option of continuing to participate in the…self-insurance plan. *Retirees and their eligible dependents* shall be offered the same health and hospitalization insurance coverage as is offered to active employees at a *premium cost* of no more than the *premium cost applicable to active employees*. For retired employees and their eligible dependents, the cost of continued participation may be paid by the employer or by the retired employees. To *determine health and hospitalization plan costs, the employer shall commingle the claims experience of the retiree group with the claims experience of the active employees…. Retirees covered under Medicare may be experience-rated separately from the retirees not covered by Medicare and from active employees if the total premium does not exceed that of the active group and coverage is basically the same as for the active group*."

(Emphasis added.)

"One of the most fundamental tenets of statutory construction requires that we give statutory language its plain and ordinary meaning, unless the words are defined in the statute or by the clear intent of the legislature."[2] But, "in considering the meaning of particular words and phrases, courts must also distinguish between terms of art that may have specialized meanings and other words that are ordinarily given a dictionary definition."[3] Therefore, "[w]ords, particularly technical ones, must be interpreted in the specific context in which they are used."[4]

What Is "Premium Cost"?
As applied here, the term "premium cost" has both ordinary and industry-specific meanings. To the insured under a contract of insurance, the ordinary meaning of "premium" is the "price of

insurance protection for a specified risk for a specified period of time;"[5] the "consideration paid or to be paid to an insurer for the issuance and delivery of any binder or policy of insurance[;]"[6] the "money charged for…insurance coverage reflecting expectation of loss."[7] In other words, it is "the consideration for insurance, by whatever name called."[8] Thus, in a contact between insurer and insured, the insured's payment, or "premium," equals the insured's cost to obtain coverage for a specified period of time.

The relationship between an employer and its employees (or retirees) in providing and receiving health care, however, is not identical to the one which exists between an insurance company and its insured. In the employer/employee context, "premium cost" and the contribution of the insured employee/ retiree[9] are not synonymous; instead, the employee/retiree health plan contribution (if any) plus the employer health plan contribution (if any) together comprise the "premium cost."

This is true regardless of whether the employer provides its employees and retirees (and their dependents) health and hospitalization benefits through a self-insured fund, or by obtaining third-party insurance coverage. In a fully insured health plan, the premium cost is the *pro rata* insurance premium calculated and charged by the *insurer*, reflecting the total cost of coverage for the applicable period to the identified class of insureds, within the tiers of coverage provided, and including both the employer and employee portions. In a self-insured plan, similarly, although the *employer* must calculate the cost of providing coverage, the premium cost reflects the *pro rata* actuarially-determined total contribution towards the cost of health plan coverage for the applicable period to the identified class of insureds, within the tiers of coverage provided. Again, this cost will be paid by combining the employer's *and* the employees'/retirees' contributions.

As thus defined, the "premium cost" and the "cost of continued participation," under section 112.0801(1), should be the same. Under the statute, retirees' coverage may be wholly funded by the retirees, or may be funded in whole or in part by the employer. And there is no requirement under the statute that an active employee's contribution towards the premium cost be the same as the retiree's contribution for identical coverage, in all offered tiers. But, within the various levels of coverage, the premium cost for all insureds—except retirees covered by Medicare[10]—will be the same for retirees (and their dependents) as it is for employees (and their dependents).

How Is the "Premium Cost" Calculated?

In section 112.0801(1), the Legislature has not described in detail a specific method to be used in calculating the "premium cost." That calculus—which appears both to require actuarial expertise,[11] and to be dependent on the fixed and changing factors applicable to a particular employer's plan[12]—is beyond the purview of this analysis.[13]

There is one aspect of the process which the Legislature has specified, however: in providing the same health and hospitalization coverage to active members (and their dependents) and retirees (and their dependents), plan costs *shall* be determined by commingling "the claims experience of the retiree group with the claims experience of the active employees[.]"[14] Only one exception is provided to this rule: retirees covered under Medicare may be experience-rated separately from

retirees not covered by Medicare and from active employees “if the total premium does not exceed that of the active group and coverage is basically the same as for the active group.”[15] Given this statutory identification of “similarly situated” insureds (*i.e.*, that the claims experiences of active employees and their dependents must be commingled with those of retirees and their dependents), an actuary belonging to the Society of Actuaries or the American Academy of Actuaries,[16] by following accepted professional actuarial practices and methods consistent with Office of Insurance Regulation guidance,[17] will be able to calculate the “premium cost” contemplated in section 112.0801(1).

In sum, under section 112.0801(1), the “premium cost” and the “cost of continued participation,” as applied to a self-insured health plan, refer to the *pro rata* actuarially-determined total contributions (employee/retiree plus employer) towards the cost of providing health plan coverage for the applicable period to the identified class of insureds, within the tiers of coverage provided. I trust that these informal comments will be helpful.

Sincerely,

Teresa L. Mussetto
Senior Assistant Attorney General

TLM/tsh

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[1] *See* Board of County Commissioners Regular Meeting Agenda, July 19, 2017, Agenda Item Number: N.6, Agenda Item Summary #3190.

[2] *Green v. State*, 604 So. 2d 471, 473 (Fla. 1992).

[3] *OB/GYN Specialists of Palm Beaches, P.A. v. Mejia*, 134 So. 3d 1084, 1088 (Fla. 4th DCA 2014); *see also Crews v. Fla. Pub. Emp'rs Council 79, AFSCME*, 113 So. 3d 1063, 1069 (Fla. 1st DCA 2013) (“[C]ourts should give words in a statute their ordinary and everyday meaning unless the context reveals that a technical meaning applies.”).

[4] *Variety Children's Hosp., Inc. v. Perkins*, 382 So. 2d 331, 337 (Fla. 3d DCA 1980) (citing *Alsop v. Pierce*, 155 Fla. 185, 19 So. 2d 799, 803 (1944)).

[5] Glossary of Insurance Terms 207 (BISYS Education Services 6th ed. 2000).

[6] § 627.041, Fla. Stat. (2017).

[7] Glossary of Insurance Terms, National Association of Insurance Commissioners (NAIC) (available at http://www.naic.org/consumer_glossary.htm) (last visited February 8, 2018). The National Association of Insurance Commissioners describes its role as follows:

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance

regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

[8] § 627.403, Fla. Stat. (2017).

[9] An employee's "contribution" is defined as "the amount of premium for group insurance or a pension plan paid by the employee." Glossary of Insurance Terms 57 (BISYS Education Services 6th ed. 2000).

[10] § 112.0801(1), Fla. Stat. (2017). However, the total premium for retirees covered by Medicare cannot exceed that of the active group, and their health care coverage must be basically the same as for the active group. *Id.*

[11] *See generally* § 112.08(2)(b), Fla. Stat. (2017) ("[T]o obtain approval from the Office of Insurance Regulation of any self-insured plan for health, accident, and hospitalization coverage, each local governmental unit…shall submit its plan along with a certification as to the actuarial soundness of the plan, which certification is prepared by an actuary who is a member of the Society of Actuaries or the American Academy of Actuaries.").

[12] *See Self-Insurance Institute of America, Inc., Industry White Paper, A Model Self-Funded Health Plan*, at 11 (May 2009) (available at https://www.google.com/search?q=Self-Insurance+Institute+of+America%2C+Inc.%2C+Industry+White+Paper%2C+A+Model+Self-Funded+Health+Plan&rlz=1C1QJDB_enUS721US721&oq=Self-Insurance+Institute+of+America%2C+Inc.%2C+Industry+White+Paper%2C+A+Model+Self-Funded+Health+Plan&aqs=chrome..69i57.585j0j8&sourceid=chrome&ie=UTF-8) (last visited April 30, 2018) ("The cost of health care benefits is dependent on plan design, because design dictates to a great extent the cost of claims and the impact of trend. Other factors that contribute to the overall plan expense include: administrative fees, health care management fees,…excess loss premiums, network access fees, advisory services, and the change in appropriate reserves.").

[13] *See* Department of Legal Affairs Statement Concerning Attorney General Opinions (available at http:// myfloridalegal.com/pages.nsf/Main/dd177569f8fb0f1a85256cc6007b70ad#nature, last visited April 30, 2018) ("Frequently Asked Questions About Attorney General Opinions").

[14] § 112.0801(1)(a), Fla. Stat. (2017).

[15] *Id.*

[16] *See* § 112.08(2)(b), Fla. Stat. (2017).

[17] *See, e.g.*, Fla.Admin.Code R. 69O-149.052 ("Establishing a Self-Funded Health Benefit Plan"); Fla.Admin.Code R. 69O-149.053 ("On-Going Review of the Self-Funded Health Benefit Plan").