An act relating to the state group health insurance program and the state employees' prescription drug program; providing legislative intent; authorizing the Department of Management Services to contract for an actuarial study for certain purposes; providing criteria; requiring the department to request a private letter ruling from the Internal Revenue Service; providing definitions; amending s. 110.123, F.S.; requiring solicitations or contracts for a state group dental program to include a comprehensive indemnity dental plan providing unrestricted enrollee access to dentists; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. (1) It is the intent of the Legislature to consider legislation at the 2001 Regular Session to expand the eligibility of the state group health insurance program and the state employees' prescription drug coverage program to include small municipalities, small counties, and district school boards of small counties. It is the intent of the Legislature that any costs or savings to the state group health insurance program or the state employees' prescription drug coverage program resulting from such expansion shall be passed on to the local government participants and their employees.

(2) The Department of Management Services shall contract with a third party to conduct an actuarial study to

determine the cost of allowing small counties, small municipalities, or eligible district school boards to participate in the state group health insurance program and the state employees' prescription drug program offering such coverage to officers, employees, dependents, and retirees of such entities. Such costs shall be delineated based on the impact to the state, state officers and employees, and local government employers and their employees. The department shall issue its report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2000.

(3) For purposes of conducting the actuarial study, criteria to be considered for eligibility to enroll include, but are not limited to:

(a) A minimum enrollment or contractual period of 3 years.

(b) A requirement that written notice to withdraw from the program must be given at least 12 months prior to the termination date.

(4) The Department of Management Services shall request from the Internal Revenue Service, by October 1, 2000, a written determination letter and a favorable private letter ruling, stating that the State Group Self-Insurance Program is a facially qualified plan. The department shall notify the President of the Senate and the Speaker of the House of Representatives within 30 days after the receipt of the favorable or unfavorable letters.

(5) For the purposes of this section "small county" means any county that has a population of 100,000 or less according to the most recent decennial census and "small city"

means any incorporated municipality that has a population of 12,500 or less according to the most recent decennial census.

Section 2. Paragraph (g) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.--

(3) STATE GROUP INSURANCE PROGRAM.--

(g)1. A person eligible to participate in the state group insurance program may be authorized by rules adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The department shall contract with health maintenance organizations seeking to participate in the state group insurance program through a request for proposal or other procurement process, as developed by the Department of Management Services and determined to be appropriate.

a. The department shall establish a schedule of minimum benefits for health maintenance organization coverage, and that schedule shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription

drugs; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO.

b. The department may establish uniform deductibles, copayments, or coinsurance schedules for all participating HMO plans.

c. The department may require detailed information from each health maintenance organization participating in the procurement process, including information pertaining to organizational status, experience in providing prepaid health benefits, accessibility of services, financial stability of the plan, quality of management services, accreditation status, quality of medical services, network access and adequacy, performance measurement, ability to meet the department's reporting requirements, and the actuarial basis of the proposed rates and other data determined by the director to be necessary for the evaluation and selection of health maintenance organization plans and negotiation of appropriate rates for these plans. Upon receipt of proposals by health maintenance organization plans and the evaluation of those proposals, the department may enter into negotiations with all of the plans or a subset of the plans, as the department determines appropriate. Nothing shall preclude the department from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the department determines that the plan offers high value to enrollees.

d. The department may limit the number of HMOs that it contracts with in each service area based on the nature of the bids the department receives, the number of state employees in the service area, or any unique geographical characteristics

of the service area. The department shall establish by rule service areas throughout the state.

e. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

3. The division is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The division may establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the department shall enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25 percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a. through d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal process described in subparagraph 2.

5. All enrollees in the state group health insurance plan or any health maintenance organization plan shall have the option of changing to any other health plan which is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year.

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 months after termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not

prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

7. Any HMO participating in the state group insurance program shall submit health care utilization and cost data to the department, in such form and in such manner as the division shall require, as a condition of participating in the program. The department shall enter into negotiations with its contracting HMOs to determine the nature and scope of the data submission and the final requirements, format, penalties associated with noncompliance, and timetables for submission. These determinations shall be adopted by rule.

8. The department may establish and direct, with respect to collective bargaining issues, a comprehensive package of insurance benefits that may include supplemental health and life coverage, dental care, long-term care, vision care, and other benefits it determines necessary to enable state employees to select from among benefit options that best suit their individual and family needs.

a. Based upon a desired benefit package, the department shall issue a request for proposal for health insurance providers interested in participating in the state group insurance program, and the division shall issue a request for proposal for insurance providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the department may enter into contract negotiations with

insurance providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans. With respect to dental coverage, the division shall include in any solicitation or contract for any state group dental program made after July 1, 2001, a comprehensive indemnity dental plan option which offers enrollees a completely unrestricted choice of dentists. If a dental plan is endorsed, or in some manner recognized as the preferred product, such plan shall include a comprehensive indemnity dental plan option which provides enrollees with a completely unrestricted choice of dentists.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the department shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental insurance benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or

offer supplemental benefit coverage to state employees as provided under existing agency plans.

Section 3. This act shall take effect upon becoming a law except that section 1 shall take effect July 1, 2001.