By the Committee on Budget

576-03598-11 20112102__

A bill to be entitled

An act relating to health insurance benefits for state employees; amending s. 110.123, F.S.; deleting references to TRICARE supplemental insurance plans; deleting the definition of the term "state-contracted HMO"; deleting the Department of Management Services' authorization to contract with health maintenance organizations for participation in the state group insurance program; authorizing the Department of Management Services to establish health maintenance incentive programs; providing for state contributions to health insurance coverage for employees and their families for the 2011-2012 fiscal year; repealing s. 110.12302, F.S., relating to the costing options for plan designs required for contract solicitations for health maintenance contracts and the requirement of the department to make recommendations to the Legislature regarding a procurement of services; creating s. 110.12303, F.S.; requiring the Department of Management Services to establish a health insurance risk pool for certain employees and retirees; amending s. 110.12315, F.S.; revising the conditions under which pharmacies are provided reimbursement for prescription medicines that are dispensed to members of the state group health insurance plan under the state employees' prescription drug program; amending s. 112.0801, F.S.; deleting the authority of state agencies to allow certain former personnel and their eligible dependents the option of continuing to

participate in certain group insurance plans or self-insurance plans; specifying the parameters for the health insurance plans and their funding for the state group insurance program administered by the Department of Management Services; providing the premiums to be charged under the state group insurance program to employees and retirees for specified periods; providing an effective date.

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

Section 1. Subsections (1), (2), and (3), paragraph (e) of subsection (5), and subsection (12) of section 110.123, Florida Statutes, are amended to read:

110.123 State group insurance program.—

(1) TITLE.—Sections 110.123—110.12315 ~~This section~~ may be cited as the "State Group Insurance Program Law."

(2) DEFINITIONS.—As used in ss. 110.123—110.12315 ~~this section~~, the term:

(a) "Department" means the Department of Management Services.

(b) "Enrollee" means all state officers and employees, retired state officers and employees, surviving spouses of deceased state officers and employees, and terminated employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program. "Enrollee" includes all state university officers and employees, retired state university officers and employees, surviving spouses of deceased state university officers and employees, and

terminated state university employees or individuals with continuation coverage who are enrolled in an insurance plan offered by the state group insurance program.

(c) "Full-time state employees" includes all full-time employees of all branches or agencies of state government holding salaried positions and paid by state warrant or from agency funds, and employees paid from regular salary appropriations for 8 months' employment, including university personnel on academic contracts, but in no case shall "state employee" or "salaried position" include persons paid from other-personal-services (OPS) funds. "Full-time employees" includes all full-time employees of the state universities.

(d) "Health maintenance organization" or "HMO" means an entity certified under part I of chapter 641.

(e) "Health plan member" means any person participating in a state group health insurance plan~~, a TRICARE supplemental insurance plan,~~ or a health maintenance organization plan under the state group insurance program, including enrollees and covered dependents thereof.

(f) "Part-time state employee" means any employee of any branch or agency of state government paid by state warrant from salary appropriations or from agency funds, and who is employed for less than the normal full-time workweek established by the department or, if on academic contract or seasonal or other type of employment which is less than year-round, is employed for less than 8 months during any 12-month period, but in no case shall "part-time" employee include a person paid from other-personal-services (OPS) funds. "Part-time state employee" includes any part-time employee of the state universities.

(g) "Retired state officer or employee" or "retiree" means any state or state university officer or employee who retires under a state retirement system or a state optional annuity or retirement program or is placed on disability retirement, and who was insured under the state group insurance program at the time of retirement, and who begins receiving retirement benefits immediately after retirement from state or state university office or employment. In addition to these requirements, any state officer or state employee who retires under the Public Employee Optional Retirement Program established under part II of chapter 121 shall be considered a "retired state officer or employee" or "retiree" as used in this section if he or she:

1. Meets the age and service requirements to qualify for normal retirement as set forth in s. 121.021(29); or

2. Has attained the age specified by s. 72(t)(2)(A)(i) of the Internal Revenue Code and has 6 years of creditable service.

(h) "State agency" or "agency" means any branch, department, or agency of state government. "State agency" or "agency" includes any state university for purposes of this section only.

(i) "State group health insurance plan or plans" or "state plan or plans" mean the state self-insured health insurance plan or plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section.

~~(j) "State-contracted HMO" means any health maintenance organization under contract with the department to participate in the state group insurance program.~~

(j)~~(k)~~ "State group insurance program" or "programs" means

the package of insurance plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section, including the state group health insurance plan or plans, health maintenance organization plans, ~~TRICARE supplemental insurance plans,~~ and other plans required or authorized by law.

(k) ~~(l)~~ "State officer" means any constitutional state officer, any elected state officer paid by state warrant, or any appointed state officer who is commissioned by the Governor and who is paid by state warrant.

(l) ~~(m)~~ "Surviving spouse" means the widow or widower of a deceased state officer, full-time state employee, part-time state employee, or retiree if such widow or widower was covered as a dependent under the state group health insurance plan~~, a TRICARE supplemental insurance plan,~~ or a health maintenance organization plan established pursuant to this section at the time of the death of the deceased officer, employee, or retiree. "Surviving spouse" also means any widow or widower who is receiving or eligible to receive a monthly state warrant from a state retirement system as the beneficiary of a state officer, full-time state employee, or retiree who died prior to July 1, 1979. For the purposes of this section, any such widow or widower shall cease to be a surviving spouse upon his or her remarriage.

~~(n) "TRICARE supplemental insurance plan" means the Department of Defense Health Insurance Program for eligible members of the uniformed services authorized by 10 U.S.C. s. 1097.~~

(3) STATE GROUP INSURANCE PROGRAM.—

(a) The Division of State Group Insurance is created within the Department of Management Services.

(b) It is the intent of the Legislature to offer a comprehensive package of health insurance and retirement benefits and a personnel system for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans which best suit their individual needs. Therefore, the state group insurance program is established which may include the state group health insurance plan or plans, health maintenance organization plans, group life insurance plans, ~~TRICARE supplemental insurance plans,~~ group accidental death and dismemberment plans, and group disability insurance plans. Furthermore, the department is additionally authorized to establish and provide as part of the state group insurance program any other group insurance plans or coverage choices that are consistent with the provisions of this section.

(c) Notwithstanding any provision in this section to the contrary, it is the intent of the Legislature that the department shall be responsible for all aspects of the purchase of health care for state employees under the state group health insurance plan or plans~~, TRICARE supplemental insurance plans,~~ and the health maintenance organization plans. Responsibilities shall include, but not be limited to, the development of requests for proposals or invitations to negotiate for state employee health services, the determination of health care benefits to be provided, and the negotiation of contracts for health care and health care administrative services. Prior to

the negotiation of contracts for health care services, the Legislature intends that the department shall develop, with respect to state collective bargaining issues, the health benefits and terms to be included in the state group health insurance program. The department shall adopt rules necessary to perform its responsibilities pursuant to this section. It is the intent of the Legislature that the department shall be responsible for the contract management and day-to-day management of the state employee health insurance program, including, but not limited to, employee enrollment, premium collection, payment to health care providers, and other administrative functions related to the program.

(d)1. Notwithstanding the provisions of chapter 287 and the authority of the department, for the purpose of protecting the health of, and providing medical services to, state employees participating in the state group insurance program, the department may contract to retain the services of professional administrators for the state group insurance program. The agency shall follow good purchasing practices of state procurement to the extent practicable under the circumstances.

2. Each vendor in a major procurement, and any other vendor if the department deems it necessary to protect the state's financial interests, shall, at the time of executing any contract with the department, post an appropriate bond with the department in an amount determined by the department to be adequate to protect the state's interests but not higher than the full amount estimated to be paid annually to the vendor under the contract.

3. Each major contract entered into by the department

pursuant to this section shall contain a provision for payment of liquidated damages to the department for material noncompliance by a vendor with a contract provision. The department may require a liquidated damages provision in any contract if the department deems it necessary to protect the state's financial interests.

4. The provisions of s. 120.57(3) apply to the department's contracting process, except:

a. A formal written protest of any decision, intended decision, or other action subject to protest shall be filed within 72 hours after receipt of notice of the decision, intended decision, or other action.

b. As an alternative to any provision of s. 120.57(3), the department may proceed with the bid selection or contract award process if the director of the department sets forth, in writing, particular facts and circumstances which demonstrate the necessity of continuing the procurement process or the contract award process in order to avoid a substantial disruption to the provision of any scheduled insurance services.

(e) The Department of Management Services and the Division of State Group Insurance may not prohibit or limit any properly licensed insurer, health maintenance organization, prepaid limited health services organization, or insurance agent from competing for any insurance product or plan purchased, provided, or endorsed by the department or the division on the basis of the compensation arrangement used by the insurer or organization for its agents.

(f) Except as provided for in subparagraph (h)2., the state contribution toward the cost of any plan in the state group

insurance program shall be uniform with respect to all state employees in a state collective bargaining unit participating in the same coverage tier in the same plan. This section does not prohibit the development of separate benefit plans for officers and employees exempt from the career service or the development of separate benefit plans for each collective bargaining unit.

(g) Participation by individuals in the program is available to all state officers, full-time state employees, and part-time state employees; and such participation in the program or any plan is voluntary. Participation in the program is also available to retired state officers and employees, as defined in paragraph (2)(g), who elect at the time of retirement to continue coverage under the program, but they may elect to continue all or only part of the coverage they had at the time of retirement. A surviving spouse may elect to continue coverage only under a state group health insurance plan~~, a TRICARE supplemental insurance plan,~~ or a health maintenance organization plan.

(h)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; age-based and gender-based wellness benefits; 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. As used in this paragraph, the term "age-based and gender-based wellness benefits" includes aerobic exercise, education in alcohol and substance abuse prevention, blood cholesterol screening, health risk appraisals, blood pressure screening and education, nutrition education, program planning, safety belt education, smoking cessation, stress management, weight management, and women's health education.

b. The department may establish uniform deductibles, copayments, coverage tiers, 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, the 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 administrative fees or 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.~~

3.~~e.~~ All persons participating in the state group insurance program may be required to contribute toward ~~towards~~ a total state group health premium that may vary depending upon the plan and coverage tier selected by the enrollee and the level of state contribution authorized by the Legislature.

4.~~3.~~ The department may ~~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 department 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 may 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.-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 or invitation to negotiate process described in subparagraph 2.~~

5. All enrollees in a state group health insurance plan~~, a TRICARE supplemental insurance plan,~~ or any health maintenance organization plan have the option of changing to any other health plan that 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 department 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 or invitation to negotiate for health insurance providers interested in participating in the state group insurance program, and the department shall issue a request for proposal or invitation to negotiate 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.

(i) The benefits of the insurance authorized by this

section shall not be in lieu of any benefits payable under chapter 440, the Workers' Compensation Law. The insurance authorized by this law shall not be deemed to constitute insurance to secure workers' compensation benefits as required by chapter 440.

(j) Notwithstanding the provisions of paragraph (f) requiring uniform contributions, and for the 2010-2011 fiscal year only, the state contribution toward the cost of any plan in the state group insurance plan shall be the difference between the overall premium and the employee contribution. This subsection expires June 30, 2011.

(5) DEPARTMENT POWERS AND DUTIES.—The department is responsible for the administration of the state group insurance program. The department shall initiate and supervise the program as established by this section and shall adopt such rules as are necessary to perform its responsibilities. To implement this program, the department shall, with prior approval by the Legislature:

(e) Have authority to establish incentive programs for ~~a voluntary program for~~ comprehensive health maintenance, which may include lifestyle choices, individual health goals, participation in health promotion and compliance programs, ~~health educational components~~ and health appraisals. Contributions established pursuant to paragraph (a) may differ based on participation in such programs by the enrollee or health plan member.

Final decisions concerning enrollment, the existence of coverage, or covered benefits under the state group insurance

program shall not be delegated or deemed to have been delegated by the department.

(12) HEALTH SAVINGS ACCOUNTS.—The department may ~~is authorized to~~ establish health savings accounts for full-time and part-time state employees in association with a health insurance plan option authorized by the Legislature and conforming to the requirements and limitations of federal provisions relating to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(a)1. A member participating in this health insurance plan option shall be eligible to receive an employer contribution into the employee's health savings account from the State Employees Health Insurance Trust Fund in an amount to be determined by the Legislature. A member is not eligible for an employer contribution upon termination of employment. For the 2011-2012 ~~2010-2011~~ fiscal year, the state's monthly contribution for employees having individual coverage shall be $41.66 and the monthly contribution for employees having family coverage shall be $83.33.

2. A member participating in this health insurance plan option shall be eligible to deposit the member's own funds into a health savings account.

(b) The monthly premiums paid by the employer for a member participating in this health insurance plan option shall include an amount equal to the monthly employer contribution authorized by the Legislature for that fiscal year.

(c) The health savings accounts shall be administered in accordance with the requirements and limitations of federal provisions relating to the Medicare Prescription Drug,

Improvement, and Modernization Act of 2003.

Section 2. Section 110.12302, Florida Statutes, is repealed.

Section 3. Section 110.12303, Florida Statutes, is created to read:

110.12303 Health insurance risk pool.—

(1) For the 2012 plan year, the department shall establish a single health insurance risk pool for the state group insurance plans. Contribution determinations made pursuant to s. 110.123(5)(a) shall consider relative plan values; however, such determinations may encourage enrollment in consumer-directed plans.

(2) For the 2012 plan year and for each plan year thereafter, the department shall establish a single health insurance risk pool for each of the following groups participating in the state group insurance plans:

(a) Active employees;

(b) Retirees not eligible for Medicare; and

(c) Retirees eligible for Medicare.

Contribution determinations made pursuant to s. 110.123(5)(a) shall consider relative plan values; however, such determinations may encourage enrollment in consumer-directed plans.

Section 4. Subsections (1), (2), and (3) of section 110.12315, Florida Statutes, are amended to read:

110.12315 Prescription drug program.—The state employees' prescription drug program is established. This program shall be administered by the Department of Management Services, according

to the terms and conditions of the plan as established by the relevant provisions of the annual General Appropriations Act and implementing legislation, subject to the following conditions:

(1) ~~The Department of Management Services shall allow prescriptions written by health care providers under the plan to be filled by any licensed pharmacy pursuant to contractual claims-processing provisions. Nothing in~~ This section does not prohibit ~~may be construed as prohibiting~~ a mail order prescription drug program distinct from the service provided by retail pharmacies.

(2) In providing for reimbursement of pharmacies for prescription medicines dispensed to members of the state group health insurance plan and their dependents under the state employees' prescription drug program:

(a) Retail pharmacies participating in the program must be reimbursed ~~at a uniform rate and subject to uniform conditions,~~ according to applicable network agreements and the terms and conditions of the plan.

(b) There shall be a 30-day supply limit for prescription card purchases and 90-day supply limit for mail order or mail order prescription drug purchases. The Department of Management Services may implement a 90-day supply limit program at select retail pharmacies if the department finds that it is in the best financial interest of the program.

(c) The ~~current~~ pharmacy dispensing fee shall be negotiated in accordance with best industry practices ~~remains in effect~~.

(3) The Department of Management Services shall establish the reimbursement schedule for prescription pharmaceuticals dispensed under the program. Reimbursement rates for a

prescription pharmaceutical must be based on the cost of the generic equivalent drug if a generic equivalent exists, unless the physician prescribing the pharmaceutical clearly states on the prescription that the brand name drug is medically necessary or that the drug product is included on the formulary of drug products that may not be interchanged as provided in chapter 465, in which case reimbursement must be based on the cost of the brand name drug as specified in the reimbursement schedule adopted by the Department of Management Services. Notwithstanding any other provision of this subsection, the department may require that a generic or formulary brand prescription be filled before dispensing an alternative within any therapeutic class.

Section 5. Subsection (1) of section 112.0801, Florida Statutes, is amended to read:

112.0801 Group insurance; participation by retired employees.—

(1) Any ~~state agency,~~ county, municipality, special district, community college, or district school board which provides life, health, accident, hospitalization, or annuity insurance, or all of any kinds of such insurance, for its officers and employees and their dependents upon a group insurance plan or self-insurance plan shall allow all former personnel who have retired prior to 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 such group insurance plan or 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 the retired employees and their eligible dependents, the cost of any such continued participation in any type of plan or any of the cost thereof 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; and, for other types of coverage, the employer may commingle the claims experience of the retiree group with the claims experience of active employees. Retirees covered under Medicare may be experience-rated separately from the retirees not covered by Medicare and from active employees, provided that the total premium does not exceed that of the active group and coverage is basically the same as for the active group.

Section 6. (1) For the period July 1, 2011, through December 31, 2012, the Department of Management Services shall administer the plans and benefits provided under the state group insurance program consistent with the following parameters:

(a) The state group insurance program shall include a health insurance standard plan, a state group health insurance high-deductible plan, a state-contracted health maintenance organization standard plan, and a state-contracted health maintenance organization high-deductible plan. Beginning January 1, 2012, the health insurance portion of the state group insurance program shall be self-insured for active employees and retirees not eligible for Medicare, and may be self-insured for retirees eligible for Medicare.

(b) The benefits provided under each of the plans shall be

those benefits as provided in the current State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefit Document, current health maintenance organization contracts, and other health insurance benefits that are approved by the Legislature.

(c) The high-deductible plans shall continue to include an integrated health savings account. Such plans and accounts shall be administered in accordance with the requirements and limitations of federal provisions relating to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The state shall make a monthly contribution to an employee's health savings account to the extent authorized in s. 110.123(12), Florida Statutes.

(2) For the 2012 plan year and each plan year thereafter, the Department of Management Services shall develop a program of health insurance options and enrollee contribution requirements consistent with s. 110.123(5), Florida Statutes. Options shall encourage and promote enrollee health plan choices and positive behavior to promote the health and well-being of health plan members and to encourage appropriate plan utilization. The division shall determine the level of premiums necessary to fully fund the state group health insurance program for the next fiscal year. The Legislature shall provide in the General Appropriations Act a premium schedule.

Section 7. The premiums charged under the state group insurance program for health insurance authorized in s. 110.123, Florida Statutes, shall be as follows:

(1) STATE CONTRIBUTION.—

(a) Effective July 1, 2011, for the coverage period beginning August 1, 2011, the state contribution toward the cost

of any plan in the state group health insurance program which is paid by the executive, legislative, and judicial branches on behalf of participating employees, shall be, for individual coverage, the total actuarial cost for the lowest cost plan offered by the department for individual coverage and shall be, for family coverage, the total actuarial cost for the lowest cost plan offered by the department for family coverage, less the employee contribution in paragraphs (2)(a) and (b).

(b) Effective July 1, 2011, for the coverage period beginning August 1, 2011, the state contribution toward the cost of any plan in the state group health insurance program which is paid by the executive, legislative, and judicial branches on behalf of each employee enrolled in the spouse program shall be one-half the total actuarial cost for the lowest cost plan offered by the department for family coverage, less the employee contribution in paragraphs (2)(a) and (b).

(2) EMPLOYEE CONTRIBUTION.—

(a) For employees not participating in the spouse program, effective July 1, 2011, for the coverage period beginning August 1, 2011, the employee contribution toward the cost of a standard plan in the state group health insurance program shall be $50 per month for individual coverage, and $200 per month for family coverage, plus the difference between the cost of the lowest cost plan and the cost of the plan selected.

(b) For employees participating in the spouse program in accordance with section 60P-2.0036, Florida Administrative Code, effective July 1, 2011, for the coverage period beginning August 1, 2011, the employee contribution toward the cost of a standard plan in the state group health insurance program shall be $100

per month for family coverage, plus the difference between the cost of the lowest cost plan and the cost of the plan selected.

(3) STATE RETIREE ELIGIBLE FOR MEDICARE.—Effective July 1, 2011, for the coverage period beginning August 1, 2011, a Medicare participant who participates in the state group insurance program shall pay a monthly premium set in the General Appropriations Act.

(4) STATE RETIREE NOT ELIGIBLE FOR MEDICARE.—Effective July 1, 2011, for the coverage period beginning August 1, 2011, the monthly premium for a retiree who is not eligible for Medicare but who participates in any plan offered through the state group insurance program shall be set in the General Appropriations Act.

(5) COBRA PARTICIPANTS.—An individual who is covered under a continuation plan as a result of the purchase of insurance coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987 (COBRA) shall continue to pay a monthly premium equal to 102 percent of the total premium charged, including state and employee contributions, for an active employee who participates in the standard plan.

Section 8. This act shall take effect July 1, 2011.