HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7157 PCB HHSC 14-01 State Group Insurance Program
SPONSOR(S): Appropriations Committee, Health & Human Services Committee, Brodeur
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	16 Y, 1 N	Shaw	Calamas
1) Appropriations Committee	17 Y, 10 N, As CS	Delaney	Leznoff

SUMMARY ANALYSIS

The State Group Insurance Program (program), administered by the Department of Management Services (DMS), is an optional benefit for employees that includes health, life, dental, vision, disability, and other supplemental insurance benefits. The program offers employees a choice among a health maintenance organization (HMO) plan, preferred provider organization plan (PPO) plan, and a high-deductible health plan (HDHP) with a health saving account (HSA). The employee's premium for the HMO and PPO are the same.

Current law requires DMS to keep a list of maintenance drugs that must be filled by mail order for a 90-day supply by PPO plan participants after initially being filled three times at a retail pharmacy.

The bill directs DMS to develop premium alternatives that reflect the cost to the program for medical and prescription drug benefits under several scenarios. DMS shall report on the alternatives to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2014.

The bill provides DMS broad authority to contract for a variety of additional products and services. Employees will be able to purchase these new products as optional benefits. DMS is directed to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other types of medical procedures.

Beginning in 2015, DMS is directed to implement a 3-year price transparency pilot project in at least one, but no more than three areas of the state. The purpose of the pilot is to reward value-based pricing by publishing the prices of certain diagnostic and surgical procedures and sharing any savings generated by the enrollee's choice of providers. Participation in the project will be voluntary for state employees.

Beginning in the 2017 plan year, the bill provides that state employees will have health plan choices at four different benefit levels. If the state's contribution towards the premium is more than the cost of the plan selected by the employee the remainder may be used in a variety of ways.

The bill directs DMS to hire an independent benefits consultant (IBC). The IBC will assist DMS in developing a plan for the implementation of the new benefit levels in the state program. The plan shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives no later than January 1, 2016. The IBC will also provide ongoing assessments and analysis for the program.

The bill also allows the Department of Management Services to negotiate dispensing fees and authorizes 90-day maintenance prescription refills to be filled at retail.

$151,216 in recurring trust funds and $507,546 in nonrecurring trust funds, and two full-time equivalent positions are appropriated to the Department of Management Services to implement the administrative provisions of the act. Expanding the 90-day refill of maintenance drug prescriptions has an indeterminate fiscal impact on the state. See fiscal comments.

The bill has an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

State Group Insurance Program

Overview

The State Group Insurance Program (program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS or department).

The program is an optional benefit for all state employees including all state agencies, state universities, the court system, and the Legislature. The program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

The health insurance benefit for active employees has premium rates for single, spouse program[1], or family coverage regardless of plan selection. The state contributes approximately 90% toward the total annual premium for active employees for a total of $1.55 billion out of total premium of $2 billion for FY 2013-14[2]. The enrollees contribute $393 million and remaining $89 million is from other sources such as interest, refunds, and rebates.

Cafeteria Plans

A cafeteria plan is a plan that offers flexible benefits under the Internal Revenue Code Section 125. Employees choose from a "menu" of benefits. A cafeteria plan can offer a number of options, including medical, accident, disability, vision, dental and group term life insurance. A cafeteria plan can also reimburse actual medical expenses or pay children's day care expenses.

A cafeteria plan reduces both the employer's and employee's tax burden. Contributions by the employer are not subject to the employer social security contribution. Contributions made by the employee are not subject to federal income or social security taxes.

The employer chooses the range of benefits it wishes to offer in a cafeteria plan. The plan can be a simple premium only plan where the only health insurance is offered. Full flex plans, which offer a wide variety of benefits and choices, are more often offered by large employers and allow for more consumer-directed consumption of benefits. In some full flex plans, the employee is offered the choice between receiving additional compensation in lieu of benefits.

The state program qualifies as a cafeteria plan[3] even though the program offers relatively narrow health plan options compared to other cafeteria plans.

Health Plan Options

The program provides limited options for employees to choose as their health plans. The preferred provider organization (PPO) plan is the statewide, self-insured health plan administered by Florida Blue, whose current contract runs through plan year 2014 and has been renewed for the 2015 through 2018 plan years. The administrator is responsible for processing health claims, providing access to a

[1] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.
[2] Fiscal information provided by DSGI.
[3] 26 USC sec. 125 requires that a cafeteria plan allow its members to choose between two or more benefits "consisting of cash and qualified benefits." The proposed regulations define "cash" to include a "salary reduction arrangement" whereby salary is deducted pre-tax to pay the employee's share of the insurance premium. Since the state program allows a "salary reduction arrangement", the program qualifies as a cafeteria plan. 26 C.F.R. ss. 1.125-1, et seq.

Preferred Provider Care Network, and managing customer service, utilization review, and case management functions. The standard health maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs[4].

Prior to the 2012 plan year, the participating HMOs were fully insured; in other words, the HMOs assumed all financial risk for the covered benefits. During the 2010 session, the Legislature enacted s. 110.12302, F.S., which directed DMS to require costing options for both fully insured and self-insured plan designs as part of the department's solicitation for health maintenance organization contracts for the 2012 plan year and beyond. The department included these costing options in its Invitation to Negotiate[5] to HMOs for contracts for plans years beginning January 1, 2012. The department entered into contracts for the 2012 and 2013 plan years with two HMOs with a fully insured plan design and four with a self-insured plan design. The contracts with the HMOs have been renewed for the 2014 and 2015 plan years.

Additionally, the program offers two high-deductible health plans (HDHP[6]) with health savings accounts[7]. The Health Investor PPO Plan is the statewide, high deductible health plan and includes an integrated health saving account. It is also administered by Florida Blue. The Health Investor HMO Plan is a high deductible health plan with an integrated health saving account in which the state has contracted with multiple state and regional HMOs. Both have a deductible of $1,250 for individual coverage and $2,500 for family coverage for network providers. The state makes a $500 per year contribution to the health savings account for participants with individual coverage and a $1,000 per year contribution for those with family coverage. The employee may make additional annual contributions[8] to a limit of $3,330 for individual coverage and $6,550 for family coverage. Both the employer and employee contributions are not subject to federal income tax. Unused funds roll over automatically every year. A health savings account is owned by the employee and is portable.

The following charts illustrate the benefit design of each of the plan choices:

	HMO Standard	PPO Standard	
	In Network Only	In Network	Out-of-Network
Deductible	None	$250 | $500 Individual | Family	$750 | $1,500 Individual | Family
Primary Care	$20 copayment	$15 copayment	40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist	$40 copayment	$25 copayment	
Urgent Care	$25 copayment	$25 copayment	
Emergency Room	$100 copayment	$100 copayment	
Hospital Stay	$250 copayment	20% after $250 copayment	40% after $500 copayment plus the difference between the charge and the allowance
Generic | Preferred |	$7 | $30 | $50 Retail	$7 | $30 | $50 Retail	Pay in full, file claim

[4]The HMOs include Aetna, AvMed, Capital Health Plan, Coventry Health Care of Florida, and UnitedHealthcare.
[5] ITN NO.: DMS 10/11-011
[6] High-deductible health plans with linked health savings accounts are also called consumer-directed health plans (CDHP) because costs of health care are more visible to the enrollee.
[7] 26 USC sec. 223. To qualify as a high-deductible plan, the annual deductible must be at least $1,250 for individual plans and $2,500 for family coverage, but annual out-of-pocket expenses cannot exceed $6,350 for individual and $12,700 for family coverage. These amounts are adjusted annually by the IRS.
[8] The IRS annually sets the contribution limit as adjusted by inflation.

Non-Preferred Prescriptions	$14 | $60 | $100 Mail Order	$14 | $60 | $100 Mail Order	
Out-of-Pocket Maximum	$1,500 | $3,000 Individual | Family	$2,500 | $5,000 (coinsurance only) Single | Family	

	PPO and HMO Health Investor	
	In Network	Out-of-Network (PPO Only)
Deductible	$1,250 | $2,500 Individual | Family	$2,500 | $5,000 Individual | Family
Primary Care	After meeting deductible, 20% of network allowed amount	After meeting deductible, 40% of out-of-network allowance plus the difference between the charge and the allowance
Specialist		
Urgent Care		
Emergency Room		
Hospital Stay		After meeting deductible, 40% after $1,000 copayment plus the difference between the charge and the allowance
Generic | Preferred | Non-Preferred Prescriptions	After meeting deductible , 30% | 30% | 50% Retail and Mail Order	Pay in full, file claim
Out-of-Pocket Maximum	$3,000 | $6,000 (coinsurance only) Individual | Family	$7,500 | $15,000 (coinsurance only) Individual | Family

Prescription Drug Program

Section 110.12315, F.S., establishes the state employees' prescription drug program which is administered by the department. In addition to the requirements of s. 110.12315, F.S., the Legislature annually sets forth additional terms and conditions for the prescription drug program in the General Appropriations Act and related implementing legislation.[9]

The department contracts with a single pharmaceutical benefit manager, Express Scripts, Inc.[10] The department is not a party to the private business contracts between the PBM and its retail pharmacies.[11]

Section 110.12315, F.S., states: "The Department may implement a 90-day supply limit program for certain maintenance drugs as determined by the department at retail pharmacies participating in the program if the department determines it to be in the best financial interest of the state." Additionally,

[9] See for example, Ch. 2013-41, S. 54 and Ch. 2013-40, s. 96.
[10] Department of Management Services, 2014 Bill Legislative Bill Analysis for SB 1266, on file with the committee.
[11] Id.

the statute imposes a 90-day supply limit through mail order and specialty pharmacies and a 30-day supply limit through retail pharmacies.

The 2013 General Appropriations Act required that PPO Plan members be limited to three retail pharmacy fills of certain maintenance drugs after which the prescription must be filled through mail order. Members of the HMO Plans are not required to use mail order for maintenance drug prescriptions but may choose to do so.

Section 110.12315, F.S., sets out the prescription copayments. The member receives a 30-day supply limit for retail purchases and a 90-day supply limit for mail order purchases. These copayments are described below:[12]

	Standard PPO and Standard HMOs		Health Investor HMO and PPO
	Retail (up to a 30-day supply)	Mail Order Program (up to a 90-day supply)	Retail and Mail Order
Generic	$7	$14	30%
Preferred Brand-Name	$30	$60	30%
Nonpreferred Brand-Name	$50	$100	50%

The 2013 General Appropriations Act required the department to maintain a list of maintenance drugs that are required to be filled by mail order for PPO Plan members. Maintenance drugs are typically used to treat chronic conditions, such as high blood pressure, asthma, and high cholesterol, which require regular or on-going use of medicines. The current Maintenance Drug List[13] includes, in part, the following prescription drugs:

- Avapro;[14]
- Boniva;[15]
- Celexa;[16]
- Depakote;[17]
- Enlyte;[18]
- Lamictal;[19]
- Paxil;[20]
- Simvastatin;[21]
- Topamax;[22] and
- Wellbutrin.[23]

The dispensing fees for prescriptions filled at mail order and for prescriptions filled at retail pharmacies, $4.22 and $4.28 respectively, are specified in the contract with Express Scripts.[24] The contract with Express Scripts contains pricing provisions for discounts off AWP (average wholesale pricing) and

[12] Information available at www.myflorida.com/mybenefits/Health/Prescription_Drugs/Prescription_Drug.htm (last viewed on March 25, 2014).
[13] Express Scripts, *Express Scripts Maintenance Drug List-Effective January 1, 2014*, available at www.myflorida.com/mybenefits/pdf/MaintenanceDrugList_EY.pdf (last viewed on March 30, 2014).
[14] Used to treat high blood pressure and kidney problems caused by diabetes.
[15] Used to treat osteoporosis in postmenapausal women.
[16] Used to treat depression and other mood disorders.
[17] Used to treat various types of seizure disorders, as a mood-stabilizer, and to prevent migraine headaches.
[18] A prescription vitamin used to increase the level of vitamin B12.
[19] Used to treat epileptic seizures and to delay mood episodes in people with bipolar disorder.
[20] Used to treat depression.
[21] Used to reduce "bad" cholesterol" and increase "good" cholesterol.
[22] Used to treat seizures in children and adults and to prevent migraine headaches.
[23] Used to treat depression and to aid in smoking cessation.
[24] Department of Management Services, 2014 Bill Legislative Bill Analysis for SB 1266, on file with the committee.

quarterly minimum guarantee payments of earned rebates.[25] Such pricing provisions are for current Plan designs (PPO and HMO) and include pricing adjustments for plan design changes.[26]

Chapter 2013-41, Laws of Florida, was the Implementing Bill for the General Appropriations Act for Fiscal Year 2013-14. Section 54(1), ch. 2013-41, provides:

> "[t]he amendment to s. 110.12315(2)(b), Florida Statutes, as carried forward by this act from chapter 2012-119, Laws of Florida, expires July 1, 2014, and the text of that paragraph shall revert to that in existence on June 30, 2012, except that any amendments to such text enacted other than by this act shall be preserved and continue to operate to the extent that such amendments are not dependent upon the portions of text which expire pursuant to this section."

Effective July 1, 2014, s. 110.12315(2)(b), F.S., will read:

(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.

Flexible Spending Accounts

Currently, the state program offers flexible spending accounts (FSAs)[27] as an optional benefit for employees. The FSA is funded though pre-tax payroll deductions from the employee's salary[28]. The funds can be used to pay for medical expenses that are not covered by the employees' health plan. Prior to 2013, there was no limit on the contribution to a FSA; however, the contribution is now limited to $2,500 and is subsequently adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement.[29] If the employee does not annually use the contributions to the FSA, the contributions are forfeited.

Employer and Employee Contributions

The state program is considered employer-sponsored since the state contracts with providers and contributes a substantial amount on behalf of the employee toward the cost of the insurance premium. The state program is a defined-benefit program. The employee pays a set monthly premium for either a single or family plan. The state pays the reminder of the cost of the premium. In a defined-contribution program, the employer pays a set amount toward the monthly premium and the employee pays the reminder.

The following chart shows the monthly contributions[30] for the state and the employee to employee health insurance premiums.

Subscriber Category	Coverage Type	PPO and HMO Standard			PPO and HMO Health Investor		
		Employer	Enrollee	Total	Employer*	Enrollee	Total
Career	Individual	591.52	50.00	641.52	591.52	15.00	606.52

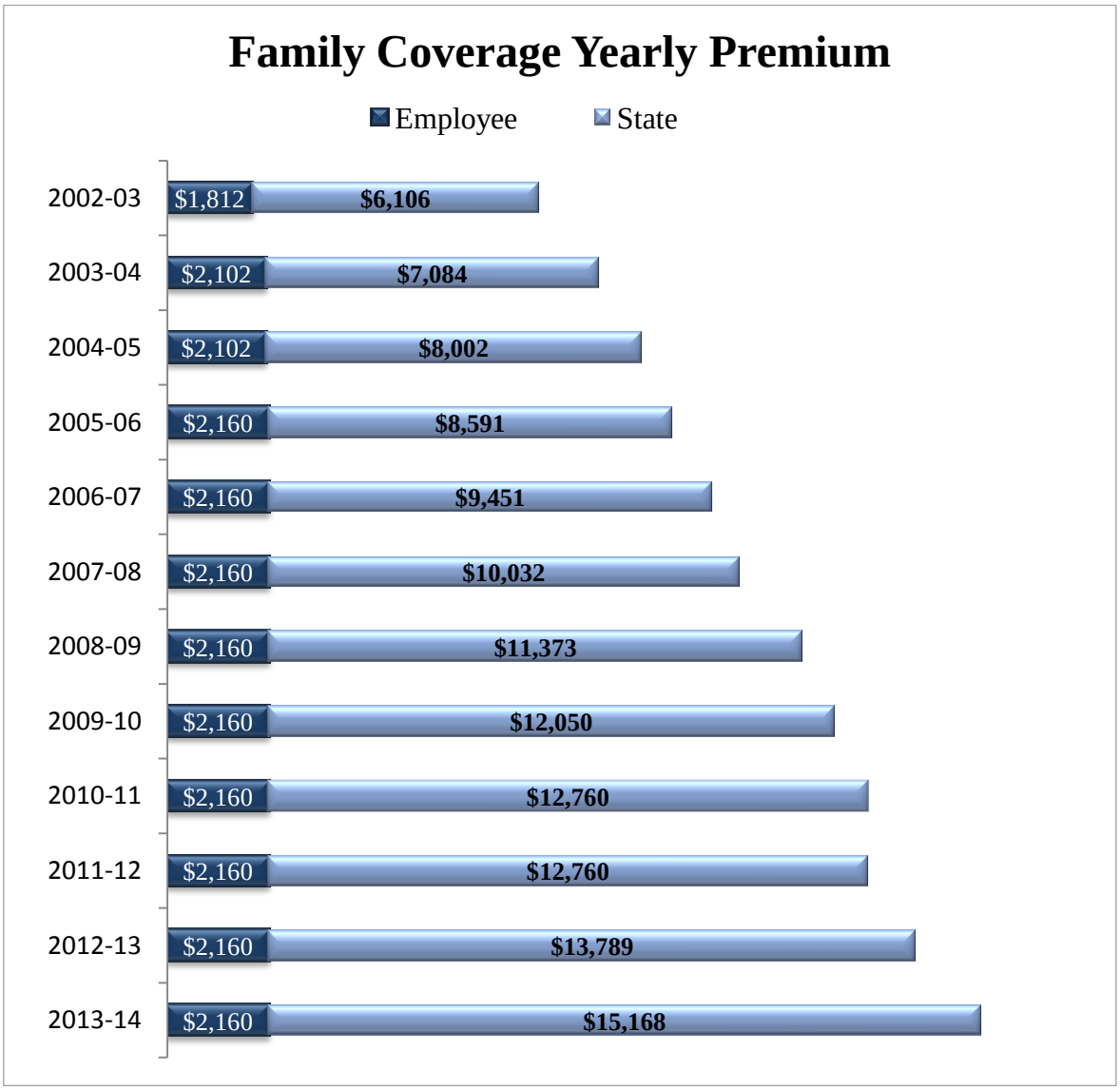
[25] Id.
[26] Id.
[27] Sec. 125 I.R.C.; see IRS Publication 969 (2013) available at http://www.irs.gov/publications/p969/ar02.html#en_US_2013_publink1000204174 (last viewed 3/16/14).
[28] Employers are also allowed to contribute to FSAs.
[29] Beginning in 2013, an employee may carryover up to $500 into the next calendar year.
[30] State Employees' Group Health Self-Insurance Trust Fund, Report on the Financial Outlook, March 3, 2014.

Service /OPS	Family	1,264.06	180.00	1,444.06	1,264.06	64.30	1,328.36
	Spouse	1,429.08	30.00	1,459.08	1,298.36	30.00	1,328.36
"Payalls" (SES/SMS)	Individual	637.34	8.34	645.68	598.18	8.34	606.52
	Family	1,429.06	30.00	1,459.06	1,298.36	30.00	1,328.36

* Includes employer tax-free Health Savings Account (HSA) contribution - $41.66 and $83.33 per month for single and family coverage, respectively

The state program is estimated to spend $2.2 billion in FY 2014-15 in health benefit costs.[31] The aggregate annual spending growth rate of the program is 8.6%. The state has absorbed almost all of the cost of the increase and employee contributions have remained the same for the last nine years as illustrated by the following chart.

[31] Id.



Plan Enrollment

The state program has 361,482 covered lives and 173,127 policyholders. Currently, 50.2% of enrollees chose the standard HMO and 48.6% chose the standard PPO. Only 1.2% of enrollees chose either HDHP. [32] During the most recent open enrollment, PPO enrollment decreased by 1.3% and HMO enrollment increased by 3.3%. Five year Open Enrollment trends show that annual enrollment in the PPO plans decreased an average of 0.9% and HMO membership increased 2.5%.[33]

Employer Sponsored Insurance Trends

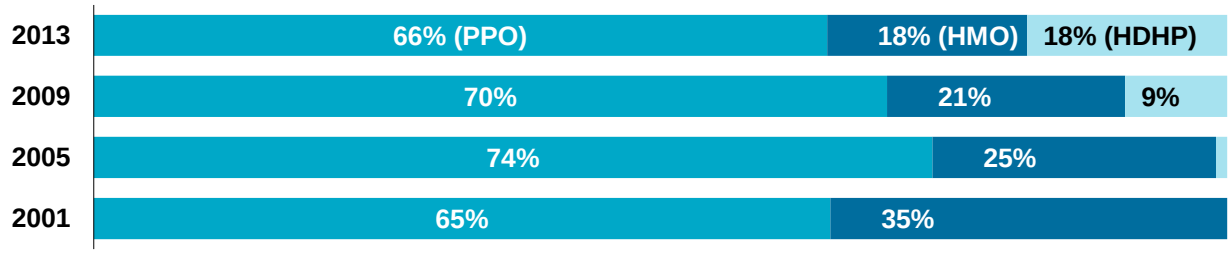
In 2010, DSGI contracted with Mercer Consulting to prepare a Benchmarking Report[34] (report) for the state group insurance program. The report compares Florida's state group insurance program to the programs of other large employers[35], both in the public and in the private sectors. The report found that

[32] Overview of the State Group Health Insurance Program, Department of Management Services, presentation to the Health and Human Services Committee on January 16, 2014.
[33] State Employees' Group Health Self-Insurance Trust Fund, Report on the Financial Outlook, March 3, 2014
[34] Mercer Consulting, State of Florida Benchmarking Report (March 24, 2011), available at: http://www.dms.myflorida.com/index.php/content/download/81470/468862/version/1/file/2010+Benchmarking+Report+for+State+of+Florida.pdf
[35] For the purpose of the report, "large employers" had 500 or more employees.

the State of Florida contributes a higher percentage of the premium to employee health benefits than other states and private employers. At the time, Florida paid 84% of the monthly premium for a family PPO plan, but the average for large national employers was 69%. This results in Florida state employees paying less in monthly premiums than other states' and private industry employees. For example, the monthly premium for a family PPO plan for a Florida state employee is $180 and in 2011, the average premium for large national employers was $361.

Today, the monthly premium for a family PPO plan for a Florida state employee is still $180; however, the state now pays 88% of the premium[36] and the benchmark premium for large national employers ranges from $270 to $391 with the company paying 71% to 79% of the premium.[37]

The national trend among large employer health plans is increasing enrollment in high-deductible health plans (HDHP) and declining enrollment in HMOs as illustrated in the following chart[38]:



The state program's trend is the reverse of the national trend in HMO, PPO, and HDHP plans primarily due to the HMO's high actuarial value and the same employee premiums for the HMO and PPO. The actuarial value (AV) measures the percentage of expected medical costs that a health plan will cover and is generally considered a measure of the health plan's generosity. The state program's standard HMO as an AV of 93%, the standard PPO has an AV of 86%, and the HDHP has an AV of 80%.[39] Accordingly, enrollees in the state program gravitate toward the high value, low cost HMO because they experience no price difference between the plans.

Employee Choice

The FY 11-12 General Appropriations Act directed DMS to develop a report of plan alternatives and options for the state program. DMS contracted with Buck Consultants which released its report[40] on September 29, 2011. The report concludes:

> The state's current approach to its health plan is best described as paternalistic, whereby the state serves as the architect/custodian of the plan, providing generous benefits and allowing employees to be passive and perhaps even entitled, with little concern about costs. Historically prevalent among large and governmental employers, this approach is rapidly being replaced by initiatives that focus on increasing and improving consumerism behaviors. In the consumerism approach the employer and employees maintain shared accountability, with the employer providing a supportive environment, partnering with employees and enabling them to make informed decisions, considering costs and outcomes of the health care services they seek and receive.

[36] The state contributes 92% of the premium for the individual PPO plan.
[37] Market-Based Framework for Health Plan Program Changes, Mercer Health & Benefits, presentation to the Health and Human Services Committee on January 16, 2014, at slide 18.
[38] Mercer at slide 6.
[39] Mercer at slide 20.
[40] Buck Consultants, Strategic Health Plan Options for the State of Florida (September 29, 2011), available at: http://www.dms.myflorida.com/index.php/content/download/81468/468856/version/1/file/Strategic+Health+Plan+Options+for+the+State+of+Florida+9-30-11+-+Final.pdf

In a presentation before the Health and Human Services Committee on January 16, 2014, Mercer Health & Benefits (Mercer) reported that the state program is behind other large employers in key survey trends[41]. The state program has plans with lower employee premiums and higher benefits than industry benchmarks.[42] There is virtually no enrollment in HDHPs and limited growth versus significant growth nationally.[43] Florida's plan costs and annual cost trends are higher than national survey data.[44] State employees have little real choice among health plan options since there is only a 7% difference in the "richness of the benefits" between the HMO and PPO, and the price is the same.[45] Consequently, 99% of enrollees chose the HMO or PPO with little to no incentive to choose the HDHP.[46]

Effects of the Bill

Premium Alternative Options

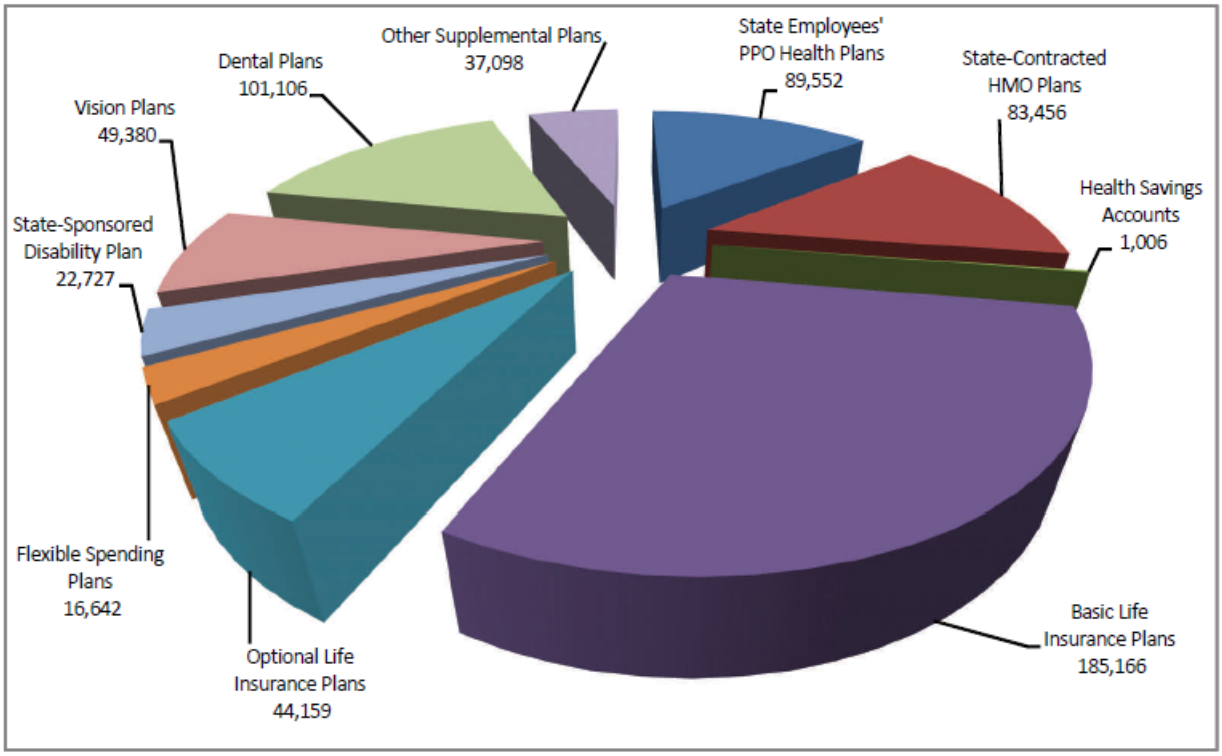
The bill directs the department to recommend premium alternatives for the 2016 plan year that reflect the cost to the program for the medical and prescription drug benefits, along with associated administrative costs and fees. The department is to report the results to the Governor, Speaker of the House of Representatives and the President of the Senate by December 1, 2014 for consideration in establishing premiums for the 2016 plan year during the 2015 Legislative Session.

Additional Benefits

The following chart illustrates that many state employees enroll in products offered by the state program other than health insurance.

[41] Mercer at slide 5.
[42] Mercer at slide 5.
[43] Mercer at slide 5.
[44] Mercer at slide 6.
[45] Mercer at slide 9.
[46] Mercer at slide 9.

Insurance Plans Average Enrollment FY 2011-12



The bill allows DMS to contract for additional products to be included in the state program. These include:

- Prepaid limited health service organizations as authorized under part I of chapter 636.
- Discount medical plan organizations as authorized under part II of chapter 636.
- Prepaid health clinic service providers licensed under part II of chapter 641.
- Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, and other licensed health care providers, who sell service contracts and arrangements for a specified amount and type of health services.
- Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, who sell service contracts and arrangements for a specified amount and type of health services.
- Corporate entities that provide specific health services in accordance with applicable state law and sell service contracts and arrangements for a specified amount and type of health services.
- Entities that provide health services or treatments through a bidding process.
- Entities that provide health services or treatments through bundling or aggregating the health services or treatments.
- Entities that provide other innovative and cost-effective health service delivery methods.

The bill also directs DMS to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures. These bundled services will be another option for state employees. The entity will be required to have procedures and evidence-based standards to assure only high quality health care providers. Assistance must be provided to the enrollee in accessing care and in the coordination of the care. The bundled services must provide cost savings to the state program and the enrollee. The selected entity must provide an educational campaign for employees to learn about the offered services.

By January 15 of each year, DMS must report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level and cost-savings to both the enrollee and the state resulting from the contract.

Price Transparency Pilot Project

The costs of health care procedures are often unknown and unknowable to consumers and can vary dramatically among providers.[47] The following chart shows the extreme price differences across the country of the average cost to Medicare for a joint replacement.

	Hospital Charges	Actual Payment
Maryland	$21,230	$20,048
Delaware	$32,629	$14,765
Hawaii	$39,463	$18,512
Georgia	$46,856	$13,303
Pennsylvania	$51,014	$13,679
South Carolina	$57,557	$13,651
Arkansas	$63,290	$21,160
New Jersey	$66,639	$15,059
Nevada	$71,782	$13,621
California	$88,238	$17,187

Note: This includes all joints other than hips.
Source: Centers for Medicare & Medicaid Services, May 8, 2013

California Public Employees' Retirement System (CalPERS), the second largest benefits program in the country started a "reference pricing" initiative in 2011. CalPERS set a threshold of $30,000 for hospital payments for both for inpatient hip and knee replacements and designated certain hospitals where enrollees could get care at or below that price. If enrollees had surgery at designated hospitals, they paid only their plans' typical deductible and coinsurance up to the out-of-pocket maximum. Patients could go to other in-network hospitals for care but were responsible for both the typical cost sharing and all allowed amounts exceeding the $30,000 threshold, which were not subject to an out-of-pocket maximum. The initiative resulted in $2.8 million for CalPERS and $300,000 in savings for enrollees in 2011 without sacrificing quality.[48]

The bill directs DMS to implement, beginning in 2015, a 3-year price transparency pilot project. The purpose of the pilot is to reward value-based pricing by publishing the prices of certain diagnostic and surgical procedures and sharing any savings generated by the enrollee's choice of providers. Participation in the project will be voluntary for state employees.

DMS must select between one and three areas of the state for the project. DMS will designate between 20 and 50 diagnostic procedures and elective surgical procedures that are commonly utilized by enrollees. The health plans will provide to DMS the contracted prices by provider for these procedures. DMS shall designate a benchmark price for each procedure.

If an employee participating in the project selects a provider who offers the procedure at a price below the benchmark, the state shall pay the employee fifty percent of the difference between the benchmark and the price paid. The payment will be taxable income to the employee.

By January 1 of 2016, 2017, and 2018, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level, the amount

[47] How to Bring the Price of Health Care Into the Open, The Wall Street Journal, Melinda Beck, February 23, 2014, available at: http://online.wsj.com/news/articles/SB10001424052702303650204579375242842086688?mod=trending_now_5 (last viewed March 17, 2014). Does Knowing Medical Prices Save Money? CalPERS Experiment Says Yes, Kaiser Health New, Ankita Rao, December 6, 2013, available at: http://capsules.kaiserhealthnews.org/index.php/2013/12/does-knowing-medical-prices-save-money-calpers-experiment-says-yes/ (last viewed March 17, 2014).

[48] The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer, Center for Studying Health System Change, Amanda E. Lechner, Rebecca Gourevitch, Paul B. Ginsburg, Research Brief No. 30, December 2013, available at: http://www.hschange.org/CONTENT/1397/#ib6 (last viewed March 17, 2014).

paid to enrollees, and cost-savings to both the enrollees and the state resulting from the price transparency pilot project.

Additional Benefit Choices

Beginning in the 2017 plan year, the bill provides that state employees will have health plan choices at four different benefit levels. These levels are:

- Platinum Level (at least 90% AV)
- Gold Level (at least 80% AV)
- Silver Level (at least 70% AV)
- Bronze Level (at least 60% AV)

The state will make a defined contribution for each employee toward the cost of purchasing a health plan. Employees will have the following options:

- Use the entire employer contribution to pay for health insurance and pay any additional premium if the cost of the plan exceeds the employer contribution.
- Use part of the employer contribution to pay for health insurance and have the balance credited to a flexible spending arrangement.
- Use part of the employer contribution to pay for health insurance and have the balance credited to a health savings account.
- Use part of the employer contribution to pay for health insurance and use the balance to purchase additional benefits offered through the state group insurance program.
- Use part of the employer contribution to pay for health insurance and have the balance used to increase the employees pay[49].

The state currently pays 92 percent of the employee's premium for an individual plan and 88 percent for a family plan for a 93% AV plan (HMO) or an 86% AV plan (PPO). If the state continued this level contribution, it would give each career service employee a contribution of $7,098.24 for individual and $15,168.72 per family.

The following chart illustrates a hypothetical[50] example for a Career Service employee with a family plan and a defined contribution benchmarked using the current state contribution, current employee contribution, and the current plan cost:

[49] The employee must use part of the employer contribution to purchase health insurance. The employee may not receive pay in lieu of benefits.

[50] All examples must be hypothetical since the 2017 benefit structure and plan actuarial values cannot be known at this time.

Family Coverage	Current Plan (86% - 93% AV)	80% AV Coverage	70% AV Coverage	60% AV Coverage
State Contribution	$15,168	$15,168	$15,168	$15,168
Plan Cost	$17,328	$14,344	$12,852	$11,361
Employee Contribution	$2,160	$0	$0	$0
Employee Receives	$0	$824	$2,316	$3,807

Under this hypothetical, the employee may choose the same value health plan as the employee has today and pay the same amount as today. Unlike today, the employee may also choose a different health plan and use the remainder toward other health benefits or receive additional salary.

Prescription Drug Program

The bill amends s. 110.12315, F.S., to allow an enrollee in either the PPO or HMO plan option to fill a prescription for a 90-day supply of a maintenance drug by mail order or at a retail pharmacy. The reimbursement rate for the retail pharmacy shall be the same as the reimbursement rate for mail order. The pharmacy dispensing fee shall be the fee negotiated by the department in its contract with the PBM. Also, the copayment will be the same for the enrollee whether the prescription is filled by mail order or at a retail pharmacy.

The bill places the following provisions in s. 110.12315, F.S.:

- The department shall maintain a list of preferred brand name drugs
- The department shall maintain a list of maintenance drugs.
- Preferred provider option health plan members may have prescriptions for maintenance drugs filled up to three times as a 30-day supply through a retail pharmacy; thereafter, prescriptions for the same maintenance drug must be filled as a 90-day supply either through the department's contracted mail order pharmacy or through a retail pharmacy.
- Health maintenance organization health plan members may have prescriptions for maintenance drugs filled as a 90-day supply either through a mail order pharmacy or through a retail pharmacy.

Independent Benefits Consultant

The bill also directs DMS to competitively procure an independent benefits consultant (IBC). The IBC must not be, or have a financial relationship, in an HMO or insurer. Additionally, the IBC must have substantial experience in designing and administering benefit plans for large employers and public employers.

The IBC will assist DMS in developing a plan for the implementation of the new benefit levels in the state program. The plan shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives no later than January 1, 2016, and include recommendations for:

- Employer and employee contribution policies.
- Steps necessary for maintaining or improving total employee compensation levels when the transition is initiated.
- An education strategy to inform employees on the additional choices available in the state group insurance program.

The ongoing duties of the IBC include:

- Providing assessments of trends in benefits and employer sponsored insurance that affect the state group insurance program.
- Conducting comprehensive analysis of the state group insurance program including available benefits, coverage options, and claims experience.
- Identifying and establishing appropriate adjustment procedures necessary to respond to any risk segmentation that may occur when increased choices are offered to employees.
- Assist the department with:
    - The submission of any needed plan revisions for federal review.
    - Ensuring compliance with applicable federal and state regulations.
    - Monitoring the adequacy of funding and reserves for the state self-insured plan.

The IBC will assist DMS in preparing recommendations for any modifications to the state group insurance program no later than January 1 of each year which shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

B. SECTION DIRECTORY:

Section 1: Amends s. 110.123, F.S., relating to the State Group Insurance Program.
Section 2: Creates s. 110.12303, F.S., relating to the State Group Insurance Program; additional benefits; price transparency pilot program; reporting.
Section 3: Creates s. 110.12301, F.S., relating to the Independent Benefits Consultant.
Section 4: Directs the department to develop and report on premium alternatives.
Section 5: Amends s. 110.12315, F.S., relating to the prescription drug program.
Section 6: Provides an appropriation.
Section 7: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may expand opportunities for private companies to contract to provide certain services to the state and to state employees.

D. FISCAL COMMENTS:

The bill appropriates $151,216 in recurring trust funds and $507,546 in nonrecurring trust funds, and two full-time equivalent positions to DMS to implement the administrative provisions of this act. The positions and recurring funds are provided primarily for the implementation of the transparency pilot and the procurement and administration of certain medical and surgical services. The nonrecurring funds are provided to procure the services of the Independent Benefit Consultant required in the bill.

DMS indicated that the fiscal impact of the price transparency pilot project is indeterminate. The number and availability of providers willing to provide transparent pricing in the select pilot areas is unknown. Limited competition may inhibit the ability of the pilot project to influence competition and limit employee's selection of vendors. Additionally, the methodology used by DMS to determine appropriate benchmarks will be critical in the amount of 'savings' that will be shared with the employee, and ultimately any potential savings or costs to the state.

DMS also indicated that the fiscal impact of the development of the tiered premium structure in plan year 2017 is indeterminate. The cost or savings to the state produced will be dependent on the specifics of the premium and cost-sharing arrangement ultimately established by the Legislature in implementing the tiered premium structure. The tiers and premium cost-sharing can be designed to be essentially cost-neutral to the state.

Department staff indicated verbally that allowing 90-day refills at retail locations will have an indeterminate fiscal impact on the state due to the potential, but unknown, impact on negotiated discount rates with the state's pharmacy PBM. Particularly, if there is a substantial shift of maintenance drug prescriptions from mail-order to retail. In addition, the department's ability to negotiate dispensing fees may result in an indeterminate savings.

The department noted some concerns that various provisions included in the bill could put the tax favored status of the plan at risk if implemented without due caution.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Management Services has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES