1 A bill to be entitled
2 An act relating to the state group insurance program;
3 amending s. 110.123, F.S.; revising applicability of
4 certain definitions; defining the term "plan year";
5 authorizing the program to include additional
6 benefits; authorizing an employee to use a certain
7 portion of the state's contribution to purchase
8 additional program benefits and supplemental benefits
9 under specified circumstances; providing for the
10 program to offer health plans in specified benefit
11 levels; providing for the Department of Management
12 Services to develop a plan for implementation of the
13 benefit levels; providing reporting requirements;
14 providing for expiration of the implementation plan;
15 creating s. 110.12303, F.S.; authorizing additional
16 benefits to be included in the program; providing that
17 the department shall contract with at least one entity
18 that provides comprehensive pricing and inclusive
19 services for surgery and other medical procedures;
20 providing contract requirements; providing reporting
21 requirements; providing for the department to
22 establish a 3-year price transparency pilot project in
23 certain areas of the state; providing project
24 requirements; providing reporting requirements;
25 creating s. 110.12304, F.S.; directing the department
26 to contract with an independent benefits consultant;

27 providing qualifications and duties of the independent
28 benefits consultant; providing reporting requirements;
29 requiring the department to adjust certain health plan
30 contribution rates; providing requirements for such
31 adjustments; providing an effective date.
32
33 Be It Enacted by the Legislature of the State of Florida:
34
35 Section 1. Subsection (2) and paragraphs (b), (f), (h),
36 and (j) of subsection (3) of section 110.123, Florida Statutes,
37 are amended, and paragraph (k) is added to subsection (3) of
38 that section, to read:
39 110.123 State group insurance program.—
40 (2) DEFINITIONS.—As used in <u>sections 110.123-110.1239</u> ~~this~~
41 ~~section~~, the term:
42 (a) "Department" means the Department of Management
43 Services.
44 (b) "Enrollee" means all state officers and employees,
45 retired state officers and employees, surviving spouses of
46 deceased state officers and employees, and terminated employees
47 or individuals with continuation coverage who are enrolled in an
48 insurance plan offered by the state group insurance program.
49 "Enrollee" includes all state university officers and employees,
50 retired state university officers and employees, surviving
51 spouses of deceased state university officers and employees, and
52 terminated state university employees or individuals with

53 continuation coverage who are enrolled in an insurance plan
54 offered by the state group insurance program.
55 (c) "Full-time state employees" means employees of all
56 branches or agencies of state government holding salaried
57 positions who are paid by state warrant or from agency funds and
58 who work or are expected to work an average of at least 30 or
59 more hours per week; employees paid from regular salary
60 appropriations for 8 months' employment, including university
61 personnel on academic contracts; and employees paid from other-
62 personal-services (OPS) funds as described in subparagraphs 1.
63 and 2. The term includes all full-time employees of the state
64 universities. The term does not include seasonal workers who are
65 paid from OPS funds.
66 1. For persons hired before April 1, 2013, the term
67 includes any person paid from OPS funds who:
68 a. Has worked an average of at least 30 hours or more per
69 week during the initial measurement period from April 1, 2013,
70 through September 30, 2013; or
71 b. Has worked an average of at least 30 hours or more per
72 week during a subsequent measurement period.
73 2. For persons hired after April 1, 2013, the term
74 includes any person paid from OPS funds who:
75 a. Is reasonably expected to work an average of at least
76 30 hours or more per week; or
77 b. Has worked an average of at least 30 hours or more per
78 week during the person's measurement period.

79 (d) "Health maintenance organization" or "HMO" means an
80 entity certified under part I of chapter 641.
81 (e) "Health plan member" means any person participating in
82 a state group health insurance plan, a TRICARE supplemental
83 insurance plan, or a health maintenance organization plan under
84 the state group insurance program, including enrollees and
85 covered dependents thereof.
86 (f) "Part-time state employee" means an employee of any
87 branch or agency of state government paid by state warrant from
88 salary appropriations or from agency funds, and who is employed
89 for less than an average of 30 hours per week or, if on academic
90 contract or seasonal or other type of employment which is less
91 than year-round, is employed for less than 8 months during any
92 12-month period, but does not include a person paid from other-
93 personal-services (OPS) funds. The term includes all part-time
94 employees of the state universities.
95 (g) "Plan year" means a calendar year.
96 (h) ~~(g)~~ "Retired state officer or employee" or "retiree"
97 means any state or state university officer or employee who
98 retires under a state retirement system or a state optional
99 annuity or retirement program or is placed on disability
100 retirement, and who was insured under the state group insurance
101 program at the time of retirement, and who begins receiving
102 retirement benefits immediately after retirement from state or
103 state university office or employment. The term also includes
104 any state officer or state employee who retires under the

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105 Florida Retirement System Investment Plan established under part
106 II of chapter 121 if he or she:
107 1. Meets the age and service requirements to qualify for
108 normal retirement as set forth in s. 121.021(29); or
109 2. Has attained the age specified by s. 72(t)(2)(A)(i) of
110 the Internal Revenue Code and has 6 years of creditable service.
111 (i) ~~(h)~~ "State agency" or "agency" means any branch,
112 department, or agency of state government. "State agency" or
113 "agency" includes any state university for purposes of this
114 section only.
115 (j) ~~(i)~~ "Seasonal workers" has the same meaning as provided
116 under 29 C.F.R. s. 500.20(s)(1).
117 (k) ~~(j)~~ "State group health insurance plan or plans" or
118 "state plan or plans" mean the state self-insured health
119 insurance plan or plans offered to state officers and employees,
120 retired state officers and employees, and surviving spouses of
121 deceased state officers and employees pursuant to this section.
122 (l) ~~(k)~~ "State-contracted HMO" means any health maintenance
123 organization under contract with the department to participate
124 in the state group insurance program.
125 (m) ~~(l)~~ "State group insurance program" or "programs" means
126 the package of insurance plans offered to state officers and
127 employees, retired state officers and employees, and surviving
128 spouses of deceased state officers and employees pursuant to
129 this section, including the state group health insurance plan or
130 plans, health maintenance organization plans, TRICARE

131 supplemental insurance plans, and other plans required or
132 authorized by law.
133 (n) ~~(m)~~ "State officer" means any constitutional state
134 officer, any elected state officer paid by state warrant, or any
135 appointed state officer who is commissioned by the Governor and
136 who is paid by state warrant.
137 (o) ~~(n)~~ "Surviving spouse" means the widow or widower of a
138 deceased state officer, full-time state employee, part-time
139 state employee, or retiree if such widow or widower was covered
140 as a dependent under the state group health insurance plan, ~~a~~
141 TRICARE supplemental insurance plan, or a health maintenance
142 organization plan established pursuant to this section at the
143 time of the death of the deceased officer, employee, or retiree.
144 "Surviving spouse" also means any widow or widower who is
145 receiving or eligible to receive a monthly state warrant from a
146 state retirement system as the beneficiary of a state officer,
147 full-time state employee, or retiree who died prior to July 1,
148 1979. For the purposes of this section, any such widow or
149 widower shall cease to be a surviving spouse upon his or her
150 remarriage.
151 (p) ~~(o)~~ "TRICARE supplemental insurance plan" means the
152 Department of Defense Health Insurance Program for eligible
153 members of the uniformed services authorized by 10 U.S.C. s.
154 1097.
155 (3) STATE GROUP INSURANCE PROGRAM.—
156 (b) It is the intent of the Legislature to offer a

157 comprehensive package of health insurance and retirement
158 benefits and a personnel system for state employees which are
159 provided in a cost-efficient and prudent manner, and to allow
160 state employees the option to choose benefit plans which best
161 suit their individual needs. ~~Therefore,~~ The state group
162 insurance program ~~is established which~~ may include the state
163 group health insurance plan or plans, health maintenance
164 organization plans, group life insurance plans, TRICARE
165 supplemental insurance plans, group accidental death and
166 dismemberment plans, ~~and~~ group disability insurance plans,~~.~~
167 ~~Furthermore, the department is additionally authorized to~~
168 ~~establish and provide as part of the state group insurance~~
169 ~~program any~~ other group insurance plans or coverage choices, and
170 other benefits authorized by law ~~that are consistent with the~~
171 ~~provisions of this section~~.
172 (f) Except as provided for in subparagraph (h)2., the
173 state contribution toward the cost of any plan in the state
174 group insurance program shall be uniform with respect to all
175 state employees in a state collective bargaining unit
176 participating in the same coverage tier in the same plan. This
177 section does not prohibit the development of separate benefit
178 plans for officers and employees exempt from the career service
179 or the development of separate benefit plans for each collective
180 bargaining unit. For the 2017 plan year and thereafter, if the
181 state's contribution is more than the premium cost of the health
182 plan selected by the employee, subject to any federal

183 limitations, the employee may elect to have the balance:
184 1. Credited to the employee's flexible spending account.
185 2. Credited to the employee's health savings account.
186 3. Used to purchase additional benefits offered through
187 the state group insurance program.
188 4. Used to increase the employee's salary.
189 (h)1. A person eligible to participate in the state group
190 insurance program may be authorized by rules adopted by the
191 department, in lieu of participating in the state group health
192 insurance plan, to exercise an option to elect membership in a
193 health maintenance organization plan which is under contract
194 with the state in accordance with criteria established by this
195 section and by said rules. The offer of optional membership in a
196 health maintenance organization plan permitted by this paragraph
197 may be limited or conditioned by rule as may be necessary to
198 meet the requirements of state and federal laws.
199 2. The department shall contract with health maintenance
200 organizations seeking to participate in the state group
201 insurance program through a request for proposal or other
202 procurement process, as developed by the Department of
203 Management Services and determined to be appropriate.
204 a. The department shall establish a schedule of minimum
205 benefits for health maintenance organization coverage, and that
206 schedule shall include: physician services; inpatient and
207 outpatient hospital services; emergency medical services,
208 including out-of-area emergency coverage; diagnostic laboratory

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209 and diagnostic and therapeutic radiologic services; mental
210 health, alcohol, and chemical dependency treatment services
211 meeting the minimum requirements of state and federal law;
212 skilled nursing facilities and services; prescription drugs;
213 age-based and gender-based wellness benefits; and other benefits
214 as may be required by the department. Additional services may be
215 provided subject to the contract between the department and the
216 HMO. As used in this paragraph, the term "age-based and gender-
217 based wellness benefits" includes aerobic exercise, education in
218 alcohol and substance abuse prevention, blood cholesterol
219 screening, health risk appraisals, blood pressure screening and
220 education, nutrition education, program planning, safety belt
221 education, smoking cessation, stress management, weight
222 management, and women's health education.
223 b. The department may establish uniform deductibles,
224 copayments, coverage tiers, or coinsurance schedules for all
225 participating HMO plans.
226 c. The department may require detailed information from
227 each health maintenance organization participating in the
228 procurement process, including information pertaining to
229 organizational status, experience in providing prepaid health
230 benefits, accessibility of services, financial stability of the
231 plan, quality of management services, accreditation status,
232 quality of medical services, network access and adequacy,
233 performance measurement, ability to meet the department's
234 reporting requirements, and the actuarial basis of the proposed

235 rates and other data determined by the director to be necessary
236 for the evaluation and selection of health maintenance
237 organization plans and negotiation of appropriate rates for
238 these plans. Upon receipt of proposals by health maintenance
239 organization plans and the evaluation of those proposals, the
240 department may enter into negotiations with all of the plans or
241 a subset of the plans, as the department determines appropriate.
242 Nothing shall preclude the department from negotiating regional
243 or statewide contracts with health maintenance organization
244 plans when this is cost-effective and when the department
245 determines that the plan offers high value to enrollees.
246 d. The department may limit the number of HMOs that it
247 contracts with in each service area based on the nature of the
248 bids the department receives, the number of state employees in
249 the service area, or any unique geographical characteristics of
250 the service area. The department shall establish by rule service
251 areas throughout the state.
252 e. All persons participating in the state group insurance
253 program may be required to contribute towards a total state
254 group health premium that may vary depending upon the plan,
255 coverage level, and coverage tier selected by the enrollee and
256 the level of state contribution authorized by the Legislature.
257 3. The department is authorized to negotiate and to
258 contract with specialty psychiatric hospitals for mental health
259 benefits, on a regional basis, for alcohol, drug abuse, and
260 mental and nervous disorders. The department may establish,

261 subject to the approval of the Legislature pursuant to
262 subsection (5), any such regional plan upon completion of an
263 actuarial study to determine any impact on plan benefits and
264 premiums.
265 4. In addition to contracting pursuant to subparagraph 2.,
266 the department may enter into contract with any HMO to
267 participate in the state group insurance program which:
268 a. Serves greater than 5,000 recipients on a prepaid basis
269 under the Medicaid program;
270 b. Does not currently meet the 25-percent non-
271 Medicare/non-Medicaid enrollment composition requirement
272 established by the Department of Health excluding participants
273 enrolled in the state group insurance program;
274 c. Meets the minimum benefit package and copayments and
275 deductibles contained in sub-subparagraphs 2.a. and b.;
276 d. Is willing to participate in the state group insurance
277 program at a cost of premiums that is not greater than 95
278 percent of the cost of HMO premiums accepted by the department
279 in each service area; and
280 e. Meets the minimum surplus requirements of s. 641.225.
281
282 The department is authorized to contract with HMOs that meet the
283 requirements of sub-subparagraphs a.-d. prior to the open
284 enrollment period for state employees. The department is not
285 required to renew the contract with the HMOs as set forth in
286 this paragraph more than twice. Thereafter, the HMOs shall be

287 eligible to participate in the state group insurance program
288 only through the request for proposal or invitation to negotiate
289 process described in subparagraph 2.
290 5. All enrollees in a state group health insurance plan, a
291 TRICARE supplemental insurance plan, or any health maintenance
292 organization plan have the option of changing to any other
293 health plan that is offered by the state within any open
294 enrollment period designated by the department. Open enrollment
295 shall be held at least once each calendar year.
296 6. When a contract between a treating provider and the
297 state-contracted health maintenance organization is terminated
298 for any reason other than for cause, each party shall allow any
299 enrollee for whom treatment was active to continue coverage and
300 care when medically necessary, through completion of treatment
301 of a condition for which the enrollee was receiving care at the
302 time of the termination, until the enrollee selects another
303 treating provider, or until the next open enrollment period
304 offered, whichever is longer, but no longer than 6 months after
305 termination of the contract. Each party to the terminated
306 contract shall allow an enrollee who has initiated a course of
307 prenatal care, regardless of the trimester in which care was
308 initiated, to continue care and coverage until completion of
309 postpartum care. This does not prevent a provider from refusing
310 to continue to provide care to an enrollee who is abusive,
311 noncompliant, or in arrears in payments for services provided.
312 For care continued under this subparagraph, the program and the

313 provider shall continue to be bound by the terms of the
314 terminated contract. Changes made within 30 days before
315 termination of a contract are effective only if agreed to by
316 both parties.
317 7. Any HMO participating in the state group insurance
318 program shall submit health care utilization and cost data to
319 the department, in such form and in such manner as the
320 department shall require, as a condition of participating in the
321 program. The department shall enter into negotiations with its
322 contracting HMOs to determine the nature and scope of the data
323 submission and the final requirements, format, penalties
324 associated with noncompliance, and timetables for submission.
325 These determinations shall be adopted by rule.
326 8. The department may establish and direct, with respect
327 to collective bargaining issues, a comprehensive package of
328 insurance benefits that may include supplemental health and life
329 coverage, dental care, long-term care, vision care, and other
330 benefits it determines necessary to enable state employees to
331 select from among benefit options that best suit their
332 individual and family needs. Beginning with the 2015 plan year,
333 the package of benefits may also include products and services
334 described in s. 110.12303.
335 a. Based upon a desired benefit package, the department
336 shall issue a request for proposal or invitation to negotiate
337 for ~~health insurance~~ providers interested in participating in
338 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, <u>except as provided in subparagraph (f)3.,</u> 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

365 completely unrestricted choice of dentists.
366 b. Pursuant to the applicable provisions of s. 110.161,
367 and s. 125 of the Internal Revenue Code of 1986, the department
368 shall enroll in the pretax benefit program those state employees
369 who voluntarily elect coverage in any of the supplemental
370 ~~insurance~~ benefit plans as provided by sub-subparagraph a.
371 c. Nothing herein contained shall be construed to prohibit
372 insurance providers from continuing to provide or offer
373 supplemental benefit coverage to state employees as provided
374 under existing agency plans.
375 (j) For the 2017 plan year and thereafter, health plans
376 shall be offered in the following benefit levels:
377 1. Platinum level, which shall have an actuarial value of
378 at least 90 percent.
379 2. Gold level, which shall have an actuarial value of at
380 least 80 percent.
381 3. Silver level, which shall have an actuarial value of at
382 least 70 percent.
383 4. Bronze level, which shall have an actuarial value of at
384 least 60 percent ~~Notwithstanding paragraph (f) requiring uniform~~
385 ~~contributions, and for the 2011-2012 fiscal year only, the state~~
386 ~~contribution toward the cost of any plan in the state group~~
387 ~~insurance plan is the difference between the overall premium and~~
388 ~~the employee contribution. This subsection expires June 30,~~
389 ~~2012~~.
390 (k) In consultation with the independent benefits

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391 consultant described in s. 110.12304, the department shall
392 develop a plan for the implementation of the benefit levels
393 described in paragraph (j). The plan shall be submitted to the
394 Governor, the President of the Senate, and the Speaker of the
395 House of Representatives no later than January 1, 2016, and
396 include recommendations for:
397 1. Employer and employee contribution policies.
398 2. Steps necessary for maintaining or improving total
399 employee compensation levels when the transition is initiated.
400 3. An education strategy to inform employees of the
401 additional choices available in the state group insurance
402 program.
403
404 This paragraph expires July 1, 2016.
405 Section 2. Section 110.12303, Florida Statutes, is created
406 to read:
407 110.12303 State group insurance program; additional
408 benefits; price transparency pilot program; reporting.—Beginning
409 with the 2015 plan year:
410 (1) In addition to the comprehensive package of health
411 insurance and other benefits required or authorized to be
412 included in the state group insurance program, the package of
413 benefits may also include products and services offered by:
414 (a) Prepaid limited health service organizations as
415 authorized by part I of chapter 636.
416 (b) Discount medical plan organizations as authorized by

417 part II of chapter 636.
418 (c) Prepaid health clinics licensed under part II of
419 chapter 641.
420 (d) Licensed health care providers, including hospitals
421 and other health facilities, health care clinics, and health
422 professionals, who sell service contracts and arrangements for a
423 specified amount and type of health services.
424 (e) Provider organizations, including service networks,
425 group practices, professional associations, and other
426 incorporated organizations of providers, who sell service
427 contracts and arrangements for a specified amount and type of
428 health services.
429 (f) Corporate entities that provide specific health
430 services in accordance with applicable state law and sell
431 service contracts and arrangements for a specified amount and
432 type of health services.
433 (g) Entities that provide health services or treatments
434 through a bidding process.
435 (h) Entities that provide health services or treatments
436 through bundling or aggregating the health services or
437 treatments.
438 (i) Entities that provide other innovative and cost-
439 effective health service delivery methods.
440 (2)(a) The department shall contract with at least one
441 entity that provides comprehensive pricing and inclusive
442 services for surgery and other medical procedures which may be

443 accessed at the option of the enrollee. The contract shall
444 require the entity to:
445 1. Have procedures and evidence-based standards to ensure
446 the inclusion of only high-quality health care providers.
447 2. Provide assistance to the enrollee in accessing and
448 coordinating care.
449 3. Provide cost savings to the state group insurance
450 program to be shared with both the state and the enrollee.
451 4. Provide an educational campaign for employees to learn
452 about the services offered by the entity.
453 (b) On or before January 15 of each year, the department
454 shall report to the Governor, the President of the Senate, and
455 the Speaker of the House of Representatives on the participation
456 level and cost-savings to both the enrollee and the state
457 resulting from the contract or contracts described in subsection
458 (2).
459 (3) The department shall establish a 3-year price
460 transparency pilot project in at least one area, but not more
461 than three areas, of the state where a substantial percentage of
462 the state group insurance program enrollees live. The purpose of
463 the project is to reward value-based pricing by publishing the
464 prices of certain diagnostic and elective surgical procedures
465 and sharing with the enrollee and the state any savings
466 generated by the enrollee's choice of providers.
467 (a) Participation in the project shall be voluntary for
468 enrollees.

469 (b) The department shall designate between 20 and 50
470 diagnostic procedures and elective surgical procedures that are
471 commonly utilized by enrollees.
472 (c) Health plans shall provide the department with the
473 contracted price by provider for each designated procedure. The
474 department shall post the prices on its website and shall
475 designate one price per procedure as the benchmark price, using
476 a mean, average, or other method of comparing the prices.
477 (d) If an enrollee participating in the project selects a
478 provider that performs the designated procedure at a price below
479 the benchmark price for that procedure, the enrollee shall
480 receive from the state 50 percent of the difference between the
481 price of the procedure by the selected provider and the
482 benchmark price.
483 (e) On or before January 1 of 2016, 2017, and 2018, the
484 department shall report to the Governor, the President of the
485 Senate, and the Speaker of the House of Representatives on the
486 participation level, amount paid to enrollees, and cost-savings
487 to both the enrollees and the state resulting from the price
488 transparency pilot project.
489 Section 3. Section 110.12304, Florida Statutes, is created
490 to read:
491 110.12304 Independent benefits consultant.—
492 (1) The department shall competitively procure an
493 independent benefits consultant.
494 (2) The independent benefits consultant may not:

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495 (a) Be owned or controlled by a health maintenance
496 organization or insurer.
497 (b) Have an ownership interest in a health maintenance
498 organization or insurer.
499 (c) Have a direct or indirect financial interest in a
500 health maintenance organization or insurer.
501 (3) The independent benefits consultant must have
502 substantial experience in consultation and design of employee
503 benefit programs for large employers and public employers,
504 including experience with plans that qualify as cafeteria plans
505 pursuant to s. 125 of the Internal Revenue Code of 1986.
506 (4) The independent benefits consultant shall:
507 (a) Provide an ongoing assessment of trends in benefits
508 and employer-sponsored insurance that affect the state group
509 insurance program.
510 (b) Conduct a comprehensive analysis of the state group
511 insurance program, including available benefits, coverage
512 options, and claims experience.
513 (c) Identify and establish appropriate adjustment
514 procedures necessary to respond to any risk segmentation that
515 may occur when increased choices are offered to employees.
516 (d) Assist the department with the submission of any
517 needed plan revisions for federal review.
518 (e) Assist the department in ensuring compliance with
519 applicable federal and state regulations.
520 (f) Assist the department in monitoring the adequacy of

521 funding and reserves for the state self-insured plan.
522 (g) Assist the department in preparing recommendations for
523 any modifications to the state group insurance program which
524 shall be submitted to the Governor, the President of the Senate,
525 and the Speaker of the House of Representatives no later than
526 January 1 of each year.
527 Section 4. Beginning with the 2015 plan year, the
528 Department of Management Services shall adjust the standard
529 health maintenance organization plan employee contribution rates
530 and the standard preferred provider option plan employee
531 contribution rates to reflect the full actuarial benefit
532 difference between the plans. The adjustment must be revenue
533 neutral to the State Employees' Group Health Self-Insurance
534 Trust Fund and must result in a decrease in employee
535 contribution levels from the 2014 plan year for the standard
536 preferred provider option plan.
537 Section 5. This act shall take effect July 1, 2014.