HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 21A State Group Insurance Program
SPONSOR(S): Brodeur
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Committee	12 Y, 5 N	Poche	Calamas

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, prefer provider plan (PPO) plan, and a high-deductible health plan (HDHP) with a health saving account (HSA). However, only one benefit level is offered for each plan type. Additionally, the employee's premium for the HMO and PPO are the same, even though the HMO provides greater benefits.

HB 21A establishes employee contribution rates for standard plans and high deductible health plans for the 2016 plan year reflecting the actuarial benefit difference between the HMO and the PPO. Employees will be given a choice between paying more for the higher value HMO and paying less, compared to the prior year, for the lower value PPO. Employees will have a choice between richer benefits or greater take-home pay.

The bill adds new products and services to the program by giving DMS broad authority to contract for a wide variety of additional products and services. Employees will be able to purchase 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. The contract requires cost savings to the program, which will be shared by the state and the enrollee.

Beginning in 2016, 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 2018 plan year, the bill provides that state employees will have health plan choices at four different benefit levels. If the state's contribution for premium is more than the cost of the plan selected by the employee, then the employee may use the remainder to:

- Fund a flexible spending arrangement or a health savings account.
- Purchase additional benefits offered through the state group insurance program.
- Increase the employee's salary.

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 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, 2017. The IBC will also provide ongoing assessments and analysis for the program.

The bill provides $151,216 in recurring trust fund and $507,546 in nonrecurring trust fund authority to the Department of Management Services, and 2 full-time equivalent positions to implement the administrative provision of the act. The provisions of the bill are expected to have a positive, but indeterminate, fiscal impact on the state. See fiscal comments.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

State Group Insurance Program

Overview

The State Group Insurance Program (state 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 state 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 contributed 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 contributed $393 million and remaining $89 million was from other sources such as interest, refunds, and rebates.

Cafeteria Plans

A cafeteria plan is a plan that offers flexible benefits under Section 125 of the Internal Revenue Code. Employees choose from a "menu" of benefits. The plan can provide a number of selections, including medical, accident, disability, vision, dental and group term life insurance. It can 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 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 it 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 plan. The preferred provider organization (PPO) plan is the statewide, self-insured health plan administered by Florida Blue, whose current contract is for the 2015 through 2018 plan years. The administrator is responsible for processing health claims, providing access to a Preferred Provider Care Network, and managing customer service, utilization review, and case management functions. The standard health

[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.

maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs[4].

Prior to the 2011 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 HMO 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 2015 plan year.

Additionally, the program offers two high-deductible health plans (HDHP[6]) with health savings accounts (HSAs)[7]. The Health Investor PPO Plan is the statewide HDHP with an integrated HSA. It is also administered by Florida Blue. The Health Investor HMO Plan is an HDHP with an integrated HSA in which the state has contracted with multiple state and regional HMOs. Both have an individual deductible of $1,350 for individual and $2,600 for family for network providers. The state makes a $500 per year contribution to the HSA for single coverage and a $1,000 per year contribution for family coverage. The employee may make additional annual contributions[8] to a limit of $3,350 for single coverage and $6,650 for family coverage. Both the employer and employee contributions are not subject to federal income tax on the employee's income. Unused funds roll over automatically every year. An HSA is owned by the employee and is portable.

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

<table>
<tr><th></th><th>HMO
Standard</th><th colspan="2">PPO
Standard</th></tr>
<tr><td></td><td>Network Only</td><td>Network</td><td>Out-of-Network</td></tr>
<tr><td>Deductible</td><td>None</td><td>$250 | $500
Single | Family</td><td>$750 | $1,500
Single | Family</td></tr>
<tr><td>Primary Care</td><td>$20 copayment</td><td>$15 copayment</td><td rowspan="4">40% of out-of-network allowance plus the amount between the charge and the allowance</td></tr>
<tr><td>Specialist</td><td>$40 copayment</td><td>$25 copayment</td></tr>
<tr><td>Urgent Care</td><td>$25 copayment</td><td>$25 copayment</td></tr>
<tr><td>Emergency Room</td><td>$100 copayment</td><td>$100 copayment</td></tr>
<tr><td>Hospital Stay</td><td>$250 copayment</td><td>20% after
$250 copayment</td><td>40% after $500 copayment plus the amount between the charge and the allowance</td></tr>
<tr><td rowspan="2">Generic | Preferred | Non-Preferred Prescriptions</td><td>$7 | $30 | $50
Retail</td><td>$7 | $30 | $50
Retail</td><td rowspan="2">Pay in full, file claim</td></tr>
<tr><td>$14 | $60 | $100
Mail Order</td><td>$14 | $60 | $100
Mail Order</td></tr>
<tr><td>Out-of-Pocket Maximum</td><td>$1,500 | $3,000
Single | Family</td><td colspan="2">$2,500 | $5,000 (coinsurance only)
Single | Family</td></tr>
</table>

[4]The HMOs include Aetna, AvMed, Capital Health Plan, Coventry Health Care of Florida, Florida Health Care Plans and UnitedHealthcare.
[5] ITN NO.: DMS 10/11-011
[6] High-deductible health plans with linked HSAs are also call 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 $1,300 for single plans and $2,600 for family coverage, but annual out-of-pocket expenses cannot exceed $6,450 for individual and $12,900 for family coverage. These amounts are adjusted annually by the IRS.
[8] The IRS annually sets the contribution limit as adjusted by inflation.

	PPO and HMO Health Investor	
	Network	Out-of-Network (PPO Only)
Deductible	$1,250 | $2,500 Single | Family	$2,500 | $5,000 Single | Family
Primary Care	After meeting deductible, 20% of network allowed amount	After meeting deductible, 40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist		
Urgent Care		
Emergency Room		
Hospital Stay		After meeting deductible, 40% after $1,000 copayment plus the amount 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) Single | Family	$7,500 | $15,000 (coinsurance only) Single | Family

Flexible Spending Accounts

Currently, the state program offers flexible spending accounts (FSAs)[9] as an optional benefit for employees. The FSA is funded though pre-tax payroll deductions from the employee's salary[10]. 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, it is now limited to $2,500 and subsequently adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement.[11] If the employee does not annually use the contributions to the FSA, the contributions are forfeited.

Health Reimbursement Arrangements

Health reimbursement arrangements (HRAs) are defined contribution benefits established by an employer for their employees. Each year, an employer determines a specified amount, or a defined contribution benefit, of pre-tax dollars to assist employees with medical expenses. The employer can determine minimum and maximum contribution amounts; there are no federal limits. Typically associated with an HDHP, an HRA is entirely funded by the employer and provides tax-free reimbursements to employees for medical expenses.[12] Unlike a FSA, an HRA is not a "use it or lose it" arrangement, but the employer may cap the rollover amount. The state program does not currently offer HRAs.

The following chart shows the distinctions among FSAs, HSAs, and HRAs:

[9] Sec. 125 I.R.C.; *see* IRS Publication 969 (2014) available at http://www.irs.gov/pub/irs-pdf/p969.pdf (last viewed May 31, 2015).
[10] Employers are also allowed to contribute to FSAs.
[11] Beginning in 2013, an employee may carryover up to $500 into the next calendar year.
[12] An HRA can only be used for qualified medical expenses defined under s. 213(d), I.R.C., including health insurance and long-term care insurance.

	FSA	HSA	HRA
Who funds the account?	Employee and employer (optional)	Employee, employer, and other individuals	Employer
How is it funded?	Employee payroll deduction; employer direct contribution - money is held by employer in "fund"	Cash contributions to bank account owned by employee	Employer pays up to promised amount
Account Owner	Employer	Employee	Employer
Contribution Limits	$2,550 annually	Single - $3,350 Family - $6,650 Over 55 - additional $1,000 for single coverage	Set by employer
Rollover of Funds?	Up to $500 (federal law)	Yes	Yes, as determined by employer
Medical Expenses Allowed	IRC 213(d) expenses;[13] No personal health insurance	IRC 213(d) expenses; No employer limitations	Health insurance premiums and IRC 213(d) expenses, as determined by employer
High Deductible Health Plan Required?	No	Yes Minimum deductible: Single - $1,300 Family - $2,600 Max out-of-pocket: Single - $6,450 Family - $12,900	No

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's employer contribution is part of a state employee's overall compensation. The state program is a defined-benefit program. In a defined-contribution program, the employer pays a set amount toward the monthly premium and the employee pays the remainder.

The following chart shows the monthly contributions[14] of the state and the employee to employee health insurance premiums.

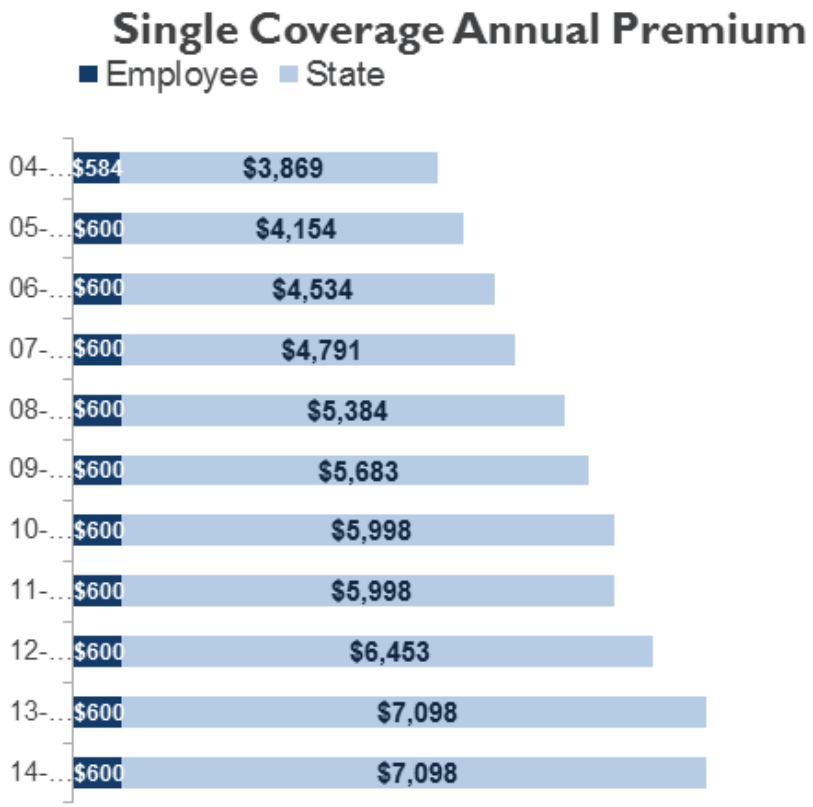
[13] S. 213(d), I.R.C., permits the deduction of expenses paid for medical care of the taxpayer, his or her spouse, or a dependent. Medical care includes amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease; transportation necessary for medical care; qualified long-term care services; and health insurance or long-term care insurance.

[14] Department of Management Services, *Overview of the State Group Health Insurance Program*, presentation to the Health and Human Services Committee on March 12, 2015, slide 6 (on file with Committee staff).

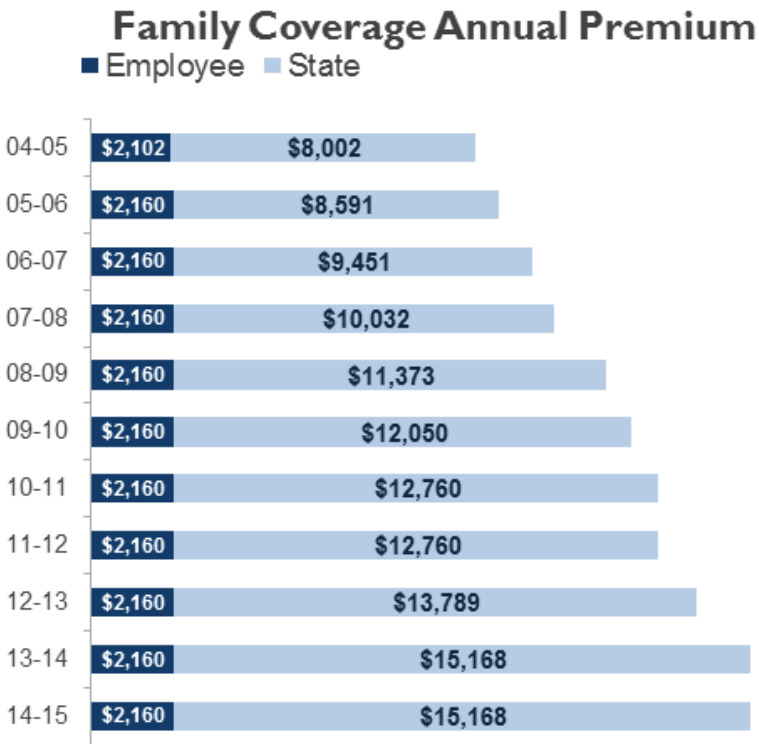
Subscriber Category	Coverage Type	PPO and HMO Standard			PPO and HMO Health Investor		
		Employer	Enrollee	Total	Employer*	Enrollee	Total
Career Service/ OPS	Single	$591.52	$50.00	$641.52	$591.52	$15.00	$606.52
	Family	$1,264.06	$180.00	$1,444.06	$1,264.06	$64.30	$1,328.36
	Spouse	$1,429.08	$30.00	$1,459.08	$1,298.36	$30.00	$1,328.36
"Payalls" (SES/SMS)	Single	$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 projected to spend $2.2 billion in FY 2015-2016 in health benefit costs.[15] The aggregate annual spending growth rate of the program is 9.5%. 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 charts.[16]



[15] Id.
[16] Id. at slide 15.



Plan Enrollment

The state program has 361,342 covered lives and 173,097 policyholders.[17] Currently, 50.7% of enrollees chose the standard HMO and 47.9% chose the standard PPO.[18] Only 1.4% of enrollees chose either HDHP.[19] During the most recent open enrollment, PPO enrollment increased slightly, by 0.05%, and HMO enrollment decreased by 0.46%.[20] Five year Open Enrollment trends show that annual enrollment in the PPO plans decreased.[21]

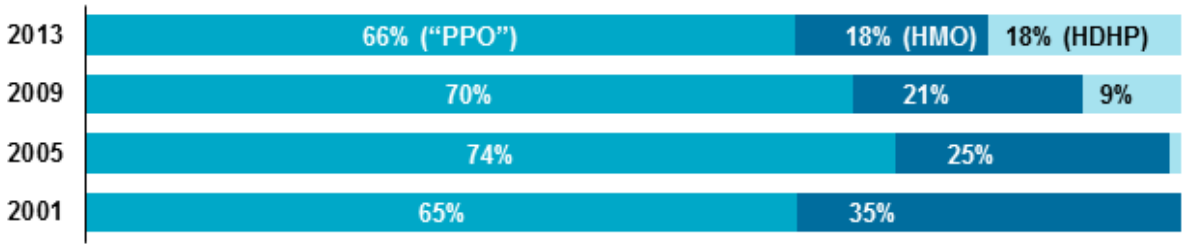
Employer Sponsored Insurance Trends

In 2010, DSGI contracted with Mercer Consulting to prepare a Benchmarking Report[22] (report) for the state. The report compares Florida's program to the programs of other large employers[23], both in the public and in the private sectors. The report found that 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' employees and private 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.

[17] Supra at FN 14, slide 5.
[18] Id. at slide 7.
[19] Id. at slide 8.
[20] State Employees' Group Health Self-Insurance Trust Fund, *Report on the Financial Outlook*, March 9, 2015, available at http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf (last viewed May 31, 2015).
[21] Supra at FN 14, slide 10.
[22] Mercer Consulting, *State of Florida Benchmarking Report* (March 24, 2011), available at: http://www.dms.myflorida.com/content/download/81475/468865/version/1/file/2010+Small+Employer+Benchmarking+Report+for+State+of+Florida.pdf
[23] For the purpose of the report, "large employers" had 500 or more employees.

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[24] and the benchmark premium for large national employers ranges from $270 to $391 with the company paying 71% to 79% of the premium.[25]

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[26]:



The state program's trend is the reverse of the national trend in HMO, PPO, and HDHP because of the HMO's high actuarial value and no difference in premiums between 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%.[27] 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 2011-2012 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[28] 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.

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.[29] The state program has plans with lower employee premiums and higher benefits than industry benchmarks.[30] There is virtually no enrollment in HDHPs versus significant growth nationally.[31] Florida's plan costs and annual trend increase are higher than national survey data.[32] State employees

[24] The state contributes 92% of the premium for the individual PPO plan.
[25] *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.
[26] Mercer at slide 6.
[27] Mercer at slide 20.
[28] Buck Consultants, *Strategic Health Plan Options for the State of Florida* (September 29, 2011), available at: http://www.dms.myflorida.com/content/download/81468/468856/version/1/file/Strategic+Health+Plan+Options+for+the+State+of+Florida+9-30-11+-+Final.pdf (last viewed on May 31, 2015).
[29] Mercer at slide 5.
[30] Mercer at slide 5.
[31] Mercer at slide 5.
[32] Mercer at slide 6.

have little real choice among health plan options since there is only a 4 percent difference in the "richness of the benefits" between the HMO and PPO, and the price is the same.[33] Consequently, 99 percent of enrollees chose the HMO or PPO with little to no incentive to choose the HDHP.[34]

Effect of the Bill

Premium Adjustments

Current law provides that "the state contribution toward the cost of any plan in the state group insurance program shall be uniform with respect to all state employees . . .participating in the same coverage tier[35] in the same plan."[36] Since there is a 4 percent difference in the actuarial value between the HMO and the PPO, the state currently pays more from the State Employees' Group Health Self-Insurance Trust Fund (Trust Fund) for the HMO benefits. However, each year the Legislature sets uniform premium amounts in the General Appropriations Act for state paid premiums. The premiums are deposited into the Trust Fund and used to pay the expenses of the state program.

The bill establishes employee contribution rates, for the 2016 plan year, that reflect the actuarial benefit difference between the HMO and the PPO. Employees will have a choice between paying more for the higher value HMO and paying less for the lower value PPO. Employees will have a choice between richer benefits and greater take-home pay and the state will still make a uniform contribution on behalf of each employee.

The proposed employee contribution rates are primarily based upon the actuarial value of the benefits provided as determined by a consultant contracted with by the Department of Management Services, with the exception of Capital Health Plan (CHP),[37] which are based upon the actual premium cost.[38] The proposed employee contribution rates are a compromise position between the current employee premium structure and the rates that would reflect a purer actuarial value as determined by the consultant.[39] Adjustments were made to premiums calculated in the initial actuarial study to moderate relatively large differences between employee premiums for HMO and PPO plans to ease the transition, and to ensure that all employees, regardless of class or plan, continued to contribute a share of the premiums. The intent is to create more equity between the actual cost of benefits being provided and employee premiums, without creating a disproportionately negative impact on any group of employees. There is no net impact on the overall employee contribution or the state's contribution.

The following methodology was used to adjust the premiums calculated in the original study to determine an appropriate level of employee premium contributions for the 2016 plan year:

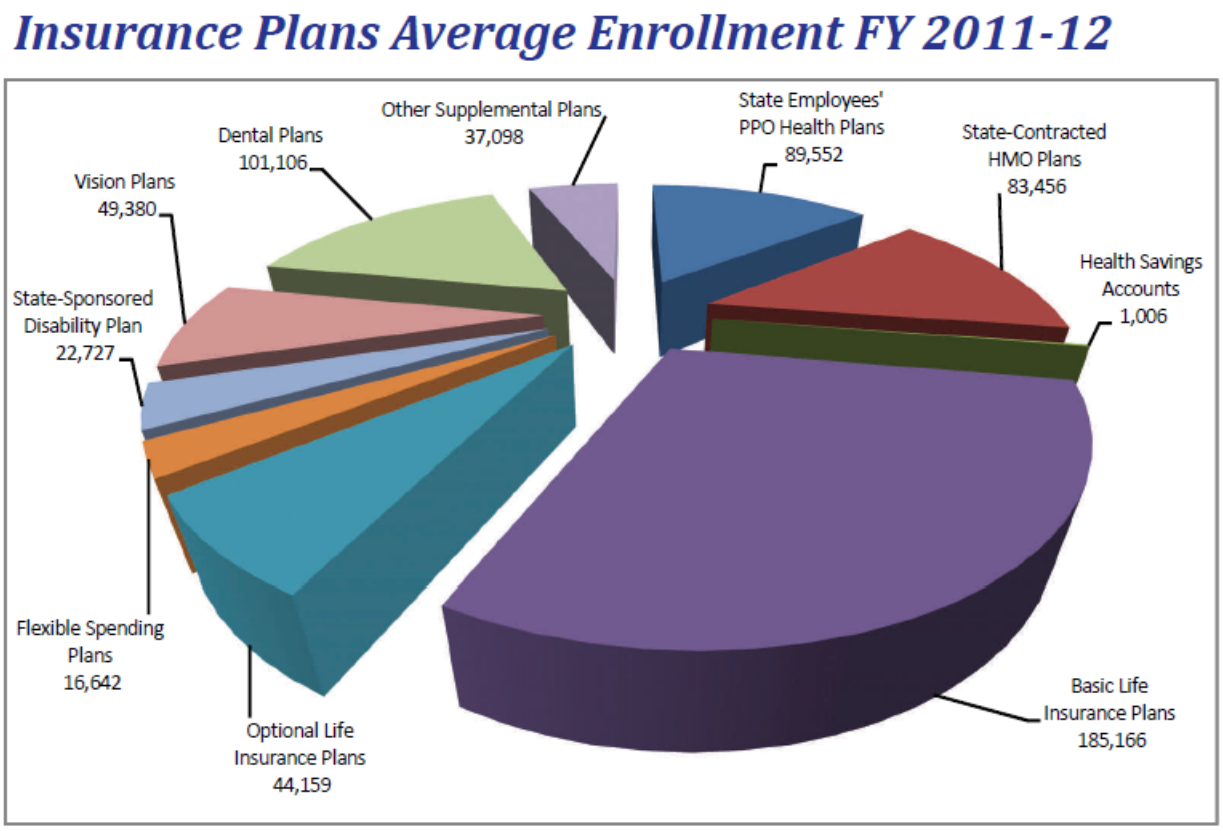
- Career Service Premiums – The premium spread determined in the initial actuarial study between the HMO, PPO and CHP premiums was moderated by proportionally increasing the employee contribution for the PPO and CHP and proportionally reducing the employee contribution for the HMO. The intent was to gradually begin to recognize the actual difference in plan values and avoid a dramatic initial premium change for employees
- "Payall" Premiums – Rather than reducing premiums to zero or a very low amount, employee contribution levels were kept at the same amount for "payalls." The premiums for this class of employees are already extremely low, with little room to better align actuarial value.
- High Deductible Health Plan Premiums – Employee contributions were reduced by a moderate and roughly proportional amount recognizing the lower value of the plans. Lowering the premiums to zero, as the initial study calculated, would likely result in a large number of

[33] Foster and Foster, *Actuarial Value Contribution Analysis,* March 20, 2015 at page 3.
[34] Mercer at slide 9.
[35] The coverage tier is either individual or family.
[36] S. 110.123(3)(f), F.S.
[37] Capital Health Plan is the fully-insured HMO located in Tallahassee with approximately 30,200 subscribers in Leon County and the surrounding areas.
[38] Foster and Foster, *Actuarial Value Contribution Analysis,* March 27, 2015 at page 1.
[39] Foster and Foster, *Actuarial Value Contribution Analysis*, March 30, 2015 at page 1

employees that are currently opting-out of the plan, for a variety of reasons, to opt back in. This would have a significant negative fiscal impact on the state.
- Premiums for early retirees and Medicare participants were not adjusted from the original study.

Additional Benefits

Many state employees enroll in products offered by the state program other than health insurance, as illustrated in the following chart:



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.
- 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 are included. 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, which will be shared by the state and the enrollee. The cost savings payable to an enrollee can be paid:

- To the enrollee's FSA;
- To the enrollee's HSA;
- To the enrollee's HRA; or
- To the enrollee as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

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 contract.

Price Transparency Pilot Project

The costs of health care procedures are often unknown and unknowable to consumers and can vary dramatically among providers.[40] 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 reportedly resulted in $2.8 million savings for CalPERS and $300,000 in savings for enrollees in 2011 without sacrificing quality.[41]

[40] 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 May 31, 2015). 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 May 31, 2015).

[41] 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 May 31, 2015).

The bill directs DMS to implement beginning in 2016 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 at least 20 but no more than 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. The list of procedures and benchmark prices will be published on the DMS website and allow an employee participating in the pilot project to easily access the information.

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

- To the employee's FSA;
- To the employee's HSA;
- To the employee's HRA; or
- To the employee as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

By January 1 of 2017, 2018, and 2019, 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 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 2018 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 FSA.
- Use part of the employer contribution to pay for health insurance and have the balance credited to an HSA.
- 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.[42]

The state currently pays 92 percent of the employee's premium for an individual plan and 88 percent for a family plan for a Platinum level plan (HMO) or a Gold level plan (PPO).

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

The following chart illustrates a hypothetical[43] 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:

Family Coverage	Current Plan 89% - 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.

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 any 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, 2017, 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 program.

The ongoing duties of the IBC include:

- Providing assessments of trends in benefits and employer sponsored insurance that affect the state program.
- Conducting comprehensive analysis of the state 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 necessary 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 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.

[43] All examples must be hypothetical since the 2018 benefit structure and plan actuarial values cannot be known at this time.

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. 110.12304, F.S., relating to Independent Benefits Consultant.
Section 4: Creates an unnumbered section of law establishing enrollee premiums for standard plans and high deductible plans in the General Appropriations Act for the 2016 plan year.
Section 5: Appropriates $151,216 in recurring funds and $507,546 in nonrecurring funds and authorizes 2 full-time equivalent positions and 120,000 of associated salary rate for the 2015-2016 fiscal year to implement the act.
Section 6: Provides for any law amended by a law enacted during the 2015 Regular Session also amended by this act to be construed as enacted in the same session of the Legislature, and full effect given to each if possible.
Section 7: Provides an effective date of July 1, 2015.

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 will provide additional opportunities for private companies to contract to provide services to the state and its employees.

D. FISCAL COMMENTS:

The bill appropriates $507,546 in nonrecurring trust funds and $151,216 in recurring trust funds and 2 FTEs to DMS to implement the administrative provisions of the bill. The positions and recurring funds are provided primarily for the implementation and continued administration of the price transparency pilot project, the administration of certain medical and surgical services provided for in the bill, and the implementation of communication and education components of the bill. The nonrecurring funds are provided to procure consulting services, conduct actuarial analysis, provide procurement support, assist in the development of the premium tiers and the reference pricing pilot project, and assist in the

development of communication and education tools to provide employees with the means to make well-informed and educated choices.

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 in some areas may inhibit the ability of the pilot project to influence competition and limit employees' selection of vendors and constrain potential savings. Additionally, the methodology used by DMS to determine appropriate benchmark prices in the price transparency pilot project will determine the amount savings realized by the state and the savings shared with the employee.

The provision requiring DMS to develop employee contribution rates that reflect the actuarial benefit difference between the HMO, PPO and HDHPs for plan year 2016, if implemented, will be cost neutral to the state. Employees will generally have a choice between richer benefits and lower premiums.

DMS also indicated that the fiscal impact of the development of the tiered premium structure in plan year 2018 is indeterminate. The cost or savings to the state will be dependent on the specifics of the premium and cost-sharing arrangement ultimately established by the Legislature in implementing the tiered structure. The tiers and premium structure can be designed to be cost-neutral to the state.

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