By Senator Brandes

22-01105-16 20161434__

A bill to be entitled

An act relating to the state group insurance program; amending s. 110.123, F.S.; revising applicability of certain definitions; defining the term "plan year"; authorizing the program to include additional benefits; authorizing employees to use a certain portion of the state's contribution to purchase additional program benefits and supplemental benefits under specified circumstances; requiring the program to offer health plans with specified benefit levels; requiring the Department of Management Services to develop a plan for implementation of the benefit levels; requiring the department to submit the plan to the Governor and the Legislature; creating s. 110.12303, F.S.; authorizing additional benefits to be included in the program beginning with the 2017 plan year; requiring the department to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures; providing contract requirements; requiring the department to report to the Governor and the Legislature regarding the contract; requiring the department to establish a price transparency pilot project in certain areas of the state; prescribing pilot project requirements; requiring the department to annually report to the Governor and the Legislature regarding the pilot project; creating s. 110.12304, F.S.; requiring the department to competitively procure an independent benefits consultant; specifying prohibitions, qualifications, and duties of the consultant; requiring the consultant to assist the department in preparing recommendations to be

submitted to the Governor and the Legislature by a specified date; requiring the General Appropriations Act to establish premiums for enrollees for the 2017 plan year which reflect the differences in benefit design and value among health maintenance organization plan options and preferred provider organization plan options; establishing the share of the health insurance premium for employees, early retirees, and COBRA and Medicare participants participating in the State Group Insurance Plan for specified health care plans and coverage periods; providing appropriations and authorizing positions; providing an effective date.

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

Section 1. Subsection (2) and paragraphs (b), (f), (h), and (j) of subsection (3) of section 110.123, Florida Statutes, are amended to read:

110.123 State group insurance program.—

(2) DEFINITIONS.—As used in ss. 110.123-110.1239 ~~this section~~, the term:

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

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

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

(c) "Full-time state employees" means employees of all branches or agencies of state government holding salaried positions who are paid by state warrant or from agency funds and who work or are expected to work an average of at least 30 or more hours per week; employees paid from regular salary appropriations for 8 months' employment, including university personnel on academic contracts; and employees paid from other-personal-services (OPS) funds as described in subparagraphs 1. and 2. The term includes all full-time employees of the state universities. The term does not include seasonal workers who are paid from OPS funds.

1. For persons hired before April 1, 2013, the term includes any person paid from OPS funds who:

a. Has worked an average of at least 30 hours or more per week during the initial measurement period from April 1, 2013, through September 30, 2013; or

b. Has worked an average of at least 30 hours or more per week during a subsequent measurement period.

2. For persons hired after April 1, 2013, the term includes any person paid from OPS funds who:

a. Is reasonably expected to work an average of at least 30 hours or more per week; or

b. Has worked an average of at least 30 hours or more per

week during the person's measurement period.

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

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

(f) "Part-time state employee" means an employee of any branch or agency of state government who is paid by state warrant from salary appropriations or from agency funds, and who is employed for less than an average of 30 hours per week or, if on academic contract or seasonal or other type of employment which is less than year-round, who is employed for less than 8 months during any 12-month period. The term~~, but~~ does not include a person paid from other-personal-services (OPS) funds, but~~. The term~~ includes all part-time employees of the state universities.

(g) "Plan year" means a calendar year.

(h)~~(g)~~ "Retired state officer or employee" or "retiree" means any state or state university officer or employee who retires under a state retirement system or a state optional annuity or retirement program or is placed on disability retirement, and who was insured under the state group insurance program at the time of retirement, and who begins receiving retirement benefits immediately after retirement from state or state university office or employment. The term also includes any state officer or state employee who retires under the Florida Retirement System Investment Plan established under part

II of chapter 121 if he or she:

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

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

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

(j) ~~(i)~~ "Seasonal workers" has the same meaning as provided under 29 C.F.R. s. 500.20(s)(1).

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

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

(m) ~~(l)~~ "State group insurance program" or "programs" means the package of insurance plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section, including the state group health insurance plan or plans, health maintenance organization plans, TRICARE supplemental insurance plans, and other plans required or authorized by law.

(n) ~~(m)~~ "State officer" means any constitutional state officer, any elected state officer paid by state warrant, or any

appointed state officer who is commissioned by the Governor and who is paid by state warrant.

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

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

(3) STATE GROUP INSURANCE PROGRAM.—

(b) It is the intent of the Legislature to offer a comprehensive package of health insurance and retirement benefits and a personnel system for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans which best suit their individual needs. ~~Therefore,~~ The state group insurance program ~~is established which~~ may include the state group health insurance plan or plans, health maintenance

organization plans, group life insurance plans, TRICARE supplemental insurance plans, group accidental death and dismemberment plans, ~~and~~ group disability insurance plans, ~~.~~ ~~Furthermore, the department is additionally authorized to establish and provide as part of the state group insurance program any~~ other group insurance plans or coverage choices, and other benefits authorized by law ~~that are consistent with the provisions of this section~~.

(f) Except as provided for in subparagraph (h)2., the state contribution toward the cost of any plan in the state group insurance program must ~~shall~~ be uniform with respect to all state employees in a state collective bargaining unit participating in the same coverage tier in the same plan. This section does not prohibit the development of separate benefit plans for officers and employees exempt from the career service or the development of separate benefit plans for each collective bargaining unit. For the 2019 plan year and thereafter, if the state's contribution is more than the premium cost of the health plan selected by the employee, subject to federal limitation, the employee may elect to have the balance:

1. Credited to the employee's flexible spending account;

2. Credited to the employee's health savings account;

3. Used to purchase additional benefits offered through the state group insurance program; or

4. Used to increase the employee's salary.

(h)1. A person eligible to participate in the state group insurance program may be authorized by rules adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a

health maintenance organization plan that ~~which~~ is under contract with the state in accordance with criteria established by this section and such ~~by said~~ rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

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

a. The department shall establish a schedule of minimum benefits for health maintenance organization coverage, which must include ~~and that schedule shall include:~~ physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; age-based and gender-based wellness benefits; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO. As used in this paragraph, the term "age-based and gender-based wellness benefits" includes aerobic exercise, education in alcohol and substance abuse prevention, blood cholesterol screening, health risk appraisals, blood pressure screening and education, nutrition education, program planning, safety belt education,

smoking cessation, stress management, weight management, and women's health education.

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

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

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

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

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

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

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

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

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

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

d. Is willing to participate in the state group insurance program at a cost of premiums that is not more ~~greater~~ than 95

percent of the cost of HMO premiums accepted by the department in each service area; and

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

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

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

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 months after termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of

prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

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

8. The department may establish and direct, with respect to collective bargaining issues, a comprehensive package of insurance benefits that may include supplemental health and life coverage, dental care, long-term care, vision care, and other benefits it determines necessary to enable state employees to select from among benefit options that best suit their individual and family needs. Beginning with the 2017 plan year, the package of benefits may also include products and services described in s. 110.12303.

a. Based upon a desired benefit package, the department

shall issue a request for proposal or invitation to negotiate for ~~health insurance~~ providers interested in participating in the state group insurance program or~~, 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 must ~~shall~~ provide state employees with the most cost-effective and comprehensive coverage available; however, except as provided in subparagraph (f)3., ~~no~~ state or agency funds may not ~~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 must ~~shall~~ include a comprehensive indemnity dental plan option that ~~which~~ provides

enrollees ~~with~~ a completely unrestricted choice of dentists.

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

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

(j) For the 2019 plan year and thereafter, health plans shall be offered in the following benefit levels:

1. Platinum level, which shall have an actuarial value of at least 90 percent.

2. Gold level, which shall have an actuarial value of at least 80 percent.

3. Silver level, which shall have an actuarial value of at least 70 percent.

4. Bronze level, which shall have an actuarial value of at least 60 percent ~~Notwithstanding paragraph (f) requiring uniform contributions, and for the 2011-2012 fiscal year only, the state contribution toward the cost of any plan in the state group insurance plan is the difference between the overall premium and the employee contribution. This subsection expires June 30, 2012~~.

Section 2. In consultation with the independent benefits consultant described in s. 110.12304, Florida Statutes, as created by this act, the Department of Management Services shall develop a plan for the implementation of the benefit levels

described in s. 110.123(3)(j), Florida Statutes. The department shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2018, and include recommendations for:

(a) Employer and employee contribution policies.

(b) Steps necessary for maintaining or improving total employee compensation levels when the transition is initiated.

(c) An education strategy to inform employees of the additional choices available in the state group insurance program.

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

110.12303 State group insurance program; additional benefits; price transparency pilot program; reporting.—Beginning with the 2017 plan year:

(1) In addition to the comprehensive package of health insurance and other benefits required or authorized to be included in the state group insurance program, the package of benefits may also include products and services offered by:

(a) Prepaid limited health service organizations as authorized by part I of chapter 636.

(b) Discount medical plan organizations as authorized by part II of chapter 636.

(c) Prepaid health clinics licensed under part II of chapter 641.

(d) Licensed health care providers, including hospitals and other health facilities, health care clinics, and health professionals, who sell service contracts and arrangements for a specified amount and type of health services.

(e) 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.

(f) 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.

(g) Entities that provide health services or treatments through a bidding process.

(h) Entities that provide health services or treatments through the bundling or aggregating of health services or treatments.

(i) Entities that provide other innovative and cost-effective health service delivery methods.

(2) The department shall:

(a) Contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures that may be accessed at the option of the enrollee. The contract shall require the entity to:

1. Have procedures and evidence-based standards to ensure the inclusion of only high-quality health care providers.

2. Provide assistance to the enrollee in accessing and coordinating care.

3. Provide cost savings to the state group insurance program to be shared with both the state and the enrollee. Cost savings payable to an enrollee may be:

a. Credited to the enrollee's flexible spending account;

b. Credited to the enrollee's health savings account;

c. Credited to the enrollee's health reimbursement account; or

d. Paid as additional health plan reimbursements not exceeding the amount of the employee's out-of-pocket medical expenses.

4. Provide an educational campaign for enrollees to learn about the services offered by the entity.

(b) Report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, on or before January 15 of each year, on the participation level and cost savings to both the enrollee and the state resulting from any contract described in this subsection.

(3) The department shall establish a 3-year price transparency pilot project in at least one area, but in not more than three areas, of the state where a substantial percentage of the state group insurance program enrollees live. The purpose of the project is to reward value-based pricing by publishing the prices of certain diagnostic and elective surgical procedures and sharing with the enrollee and the state any savings generated by the enrollee's choice of providers.

(a) Participation in the project shall be voluntary for enrollees.

(b) The department shall designate between 20 and 50 diagnostic procedures and elective surgical procedures that are commonly used by enrollees.

(c) Health plans shall provide the department with the contracted price by provider for each designated procedure. The department shall post the prices on its website and shall

designate one price per procedure as the benchmark price, using a mean, an average, or other method of comparing the prices.

(d) If an enrollee participating in the project selects a provider that performs the designated procedure at a price below the benchmark price for that procedure, the enrollee shall receive from the state 50 percent of the difference between the price of the procedure by the selected provider and the benchmark price. The amount payable to the enrollee may be:

1. Credited to the enrollee's flexible spending account;

2. Credited to the enrollee's health savings account;

3. Credited to the enrollee's health reimbursement account; or

4. Paid as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

(e) On or before January 1 of 2018, 2019, and 2020, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level, amount paid to enrollees, and cost savings to both the enrollees and the state resulting from the price transparency pilot project.

Section 4. Section 110.12304, Florida Statutes, is created to read:

110.12304 Independent benefits consultant.—

(1) The department shall competitively procure an independent benefits consultant.

(2) The independent benefits consultant may not:

(a) Be owned or controlled by a health maintenance organization or an insurer.

(b) Have an ownership interest in a health maintenance organization or an insurer.

(c) Have a direct or an indirect financial interest in a health maintenance organization or an insurer.

(3) The independent benefits consultant must have substantial experience in consultation and design of employee benefit programs for large employers and public employers, including experience with plans that qualify as cafeteria plans pursuant to s. 125 of the Internal Revenue Code of 1986.

(4) The independent benefits consultant shall:

(a) Provide an ongoing assessment of trends in benefits and employer-sponsored insurance which affect the state group insurance program.

(b) Conduct a comprehensive analysis of the state group insurance program, including available benefits, coverage options, and claims experience.

(c) Identify and establish appropriate adjustment procedures necessary to respond to any risk segmentation that may occur when increased choices are offered to employees.

(d) Assist the department in the submission of any necessary plan revisions for federal review.

(e) Assist the department in ensuring compliance with applicable federal regulations and state rules.

(f) Assist the department in monitoring the adequacy of funding and reserves for the state self-insured plan.

(g) Assist the department in preparing recommendations for any modifications to the state group insurance program, which shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than

January 1 of each year.

Section 5. For the 2017 plan year, the General Appropriations Act must implement premiums for enrollees which reflect the differences in benefit design and value among the health maintenance organization (HMO) plan options and the preferred provider organization (PPO) plan options offered in the state group insurance program.

(1) Effective July 1, 2016, for the coverage period beginning August 1, 2016, and continuing through December 31, 2016, the employee's share of the health insurance premiums for the standard plans remains $50 per month for individual coverage and $180 per month for family coverage.

(2) Effective December 1, 2016, for the coverage period beginning January 1, 2017, the employee's share of the health insurance premium for the standard HMO plan is $60 per month for individual coverage and $200 per month for family coverage. For the same coverage period, the employee's share of the health insurance premium for the standard PPO plan is $45 per month for individual coverage and $170 per month for family coverage. For the same coverage period, the employee's share of the health insurance premium for Capital Health Plan is $40 per month for individual coverage and $170 per month for family coverage.

(3) Effective July 1, 2016, for the coverage period beginning August 1, 2016, and continuing through December 31, 2016, the employee's share of the health insurance premium for the high-deductible health plans remains $15 per month for individual coverage and $64.30 per month for family coverage.

(4) Effective December 1, 2016, for the coverage period beginning January 1, 2017, the employee's share of the health

insurance premium for the high-deductible health plans is $10 per month for individual coverage and $50 per month for family coverage.

(5) Effective July 1, 2016, for the coverage period beginning August 1, 2016, the employee's share of the health insurance premium for the standard PPO plan, the standard HMO plan, and Capital Health Plan remains $8.34 per month for individual coverage and $30 per month for family coverage for employees filling positions with "agency payall" benefits.

(6) Effective July 1, 2016, for the coverage period beginning August 1, 2016, and continuing through December 31, 2016, the employee's share of the health insurance premium for the high-deductible health plans remains $8.34 per month for individual coverage and $30 per month for family coverage for employees filling positions with "agency payall" benefits.

(7) Effective December 1, 2016, for the coverage period beginning January 1, 2017, the employee's share of the health insurance premium for the high-deductible health plans is $8.34 per month for individual coverage and $25 per month for family coverage for employees filling positions with "agency payall" benefits.

(8) Effective July 1, 2016, for the coverage period beginning August 1, 2016, and continuing through December 31, 2016, the employee's share of the health insurance premium for the standard plans and the high-deductible health plans remains $30 per month for each employee participating in the Spouse Program in accordance with rules of the Department of Management Services.

(9) Effective December 1, 2016, for the coverage period

beginning January 1, 2017, the employee's share of the health insurance premium for the standard plans remains $30 for each employee participating in the Spouse Program in accordance with rules of the Department of Management Services.

(10) Effective December 1, 2016, for the coverage period beginning January 1, 2017, the employee's share of the health insurance premium for the high-deductible health plans is $25 for each employee participating in the Spouse Program in accordance with rules of the Department of Management Services.

(11) Effective July 1, 2016, for the coverage period beginning August 1, 2016, an "early retiree" participating in a standard plan shall continue to pay a monthly premium equal to 100 percent of the total premium charged, including state and employee contributions, for an active employee participating in the standard plan.

(12) Effective July 1, 2016, for the coverage period beginning August 1, 2016, and continuing through December 31, 2016, an "early retiree" participating in a high-deductible health plan shall continue to pay $564.86 per month for individual coverage and $1,245.03 per month for family coverage.

(13) Effective December 1, 2016, for the coverage period beginning January 1, 2017, an "early retiree" participating in a high-deductible health plan shall pay $559.86 per month for individual coverage and $1,230.73 per month for family coverage.

(14) Effective July 1, 2016, for the coverage period beginning August 1, 2016, and continuing through December 31, 2016, the monthly premium for Medicare participants in the standard plans remains $359.61 for "one eligible," $1,036.90 for "one under/one over," and $719.22 for "both eligible."

(15) Effective December 1, 2016, for the coverage period beginning January 1, 2017, the monthly premium for Medicare participants in the standard PPO plan is $356.49 for "one eligible," $1,027.89 for "one under/one over," and $712.97 for "both eligible." For the same coverage period, the monthly premium for Medicare participants participating in the standard HMO plan is $371.32 for "one eligible," $1,070.67 for "one under/one over," and $742.64 for "both eligible."

(16) Effective July 1, 2016, for the coverage period beginning August 1, 2016, the monthly premium for Medicare participants in the high-deductible health plan is $271.07 for "one eligible," $849.19 for "one under/one over," and $542.14 for "both eligible."

(17) Effective July 1, 2016, for the coverage period beginning August 1, 2016, the monthly premium for Medicare participants enrolled in a fully insured standard HMO plan or an HMO high-deductible health plan is equal to the negotiated monthly premium for the selected state-contracted health maintenance organization.

(18) Effective July 1, 2016, for the coverage period beginning August 1, 2016, a COBRA participant in the State Group Health Insurance Program shall continue to pay a premium equal to 102 percent of the total premium charged, including state and employee contributions, for an active employee participating in the program.

(19) Effective July 1, 2016, for the coverage period beginning August 1, 2016, the state share of State Group Health Insurance Program premiums is the same as those in effect on July 1, 2014, pursuant to chapter 2014-51, Laws of Florida.

Section 6. (1) For the 2016-2017 fiscal year, the sums of $151,216 in recurring funds and $507,546 in nonrecurring funds are appropriated from the State Employees Health Insurance Trust Fund to the Department of Management Services, and two full-time equivalent positions with associated salary rate of 120,000 are authorized, for the purpose of implementing this act.

(2)(a) The recurring funds appropriated in this section shall be allocated to the following specific appropriation categories within the Insurance Benefits Administration Program: $150,528 to "Salaries and Benefits" and $688 to "Special Categories-Transfer to Department of Management Services-Human Resources Purchased per Statewide Contract."

(b) The nonrecurring funds appropriated in this section shall be allocated to the following specific appropriation categories: $500,000 to "Special Categories Contracted Services" and $7,546 to "Expenses."

Section 7. This act shall take effect July 1, 2016.