HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHSC 15-02 State Group Insurance Program
SPONSOR(S): Health & Human Services Committee; Brodeur
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	14 Y, 4 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.

The bill directs DMS to establish employee contribution rates for the 2017 plan year which reflect the full 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 and 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.
- Fund 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 state may experience both costs and savings. See fiscal comments.

The bill has 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[7]. The Health Investor PPO Plan is the statewide HDHP with an integrated health saving account. It is also administered by Florida Blue. The Health Investor HMO Plan is an HDHP with an integrated health saving account 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 health savings account 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. A health savings account is owned by the employee and is portable.

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

<table>
<tr><th></th><th>HMO
Standard</th><th colspan="2">PPO
Standard</th></tr>
<tr><th></th><th>Network Only</th><th>Network</th><th>Out-of-Network</th></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>
</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 health savings accounts 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.

Out-of-Pocket Maximum	$1,500 | $3,000 Single | Family	$2,500 | $5,000 (coinsurance only) Single | Family

	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.

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.

[9] Sec. 125 I.R.C.; *see* IRS Publication 969 (2014) available at http://www.irs.gov/pub/irs-pdf/p969.pdf (last viewed March 14, 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.

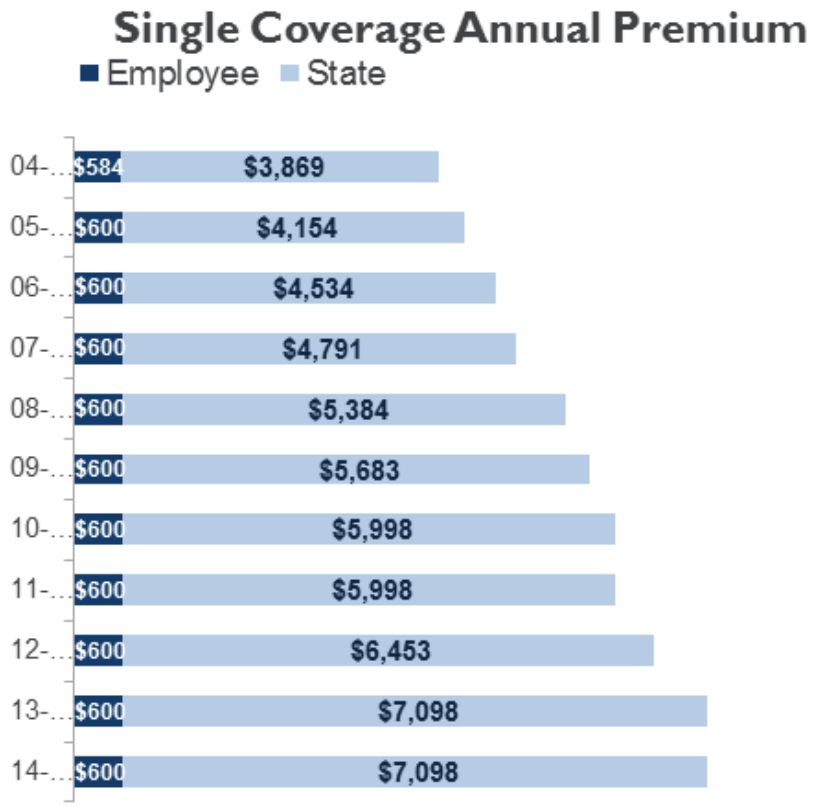
The following chart shows the monthly contributions[12] of the state and the employee to employee health insurance premiums.

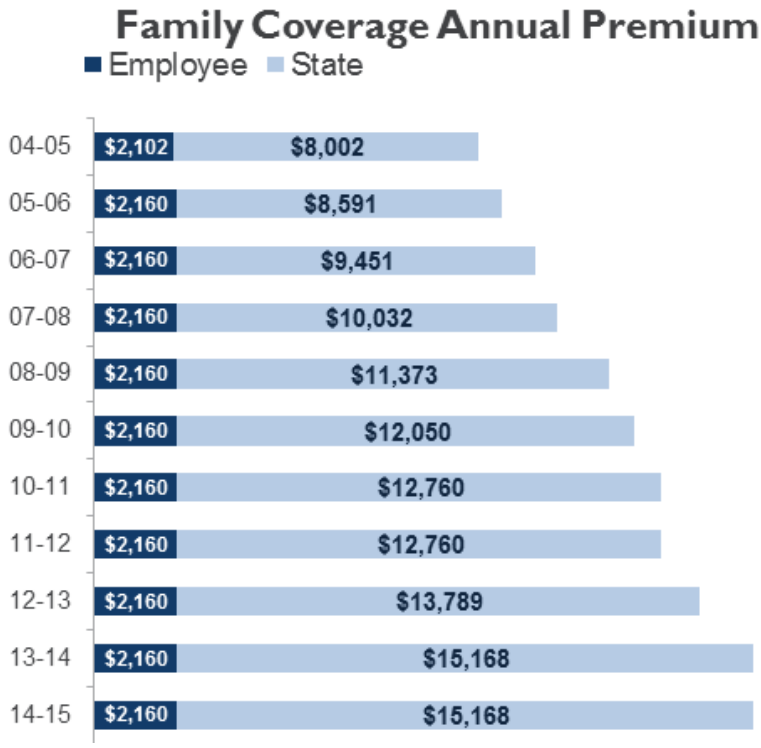
Subscriber Category	Coverage Type	PPO and HMO Standard			PPO and HMO Health Investor		
		Employer	Enrollee	Total	Employer*	Enrollee	Total
Career Service /OPS	Single	591.52	50.00	641.52	591.52	15.00	606.52
	Family	1,264.06	180.00	1,444.06	1,264.06	64.30	1,328.36
	Spouse	1,429.08	30.00	1,459.08	1,298.36	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.[13] 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 chart.[14]

[12] 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).
[13] Id.
[14] Id at slide 15.





Plan Enrollment

The state program has 361,342 covered lives and 173,097 policyholders.[15] Currently, 50.7% of enrollees chose the standard HMO and 47.9% chose the standard PPO.[16] Only 1.4% of enrollees chose either HDHP.[17] During the most recent open enrollment, PPO enrollment increased slightly, by

[15] Supra at FN 12, slide 5.
[16] Id. at slide 7.
[17] Id. at slide 8.

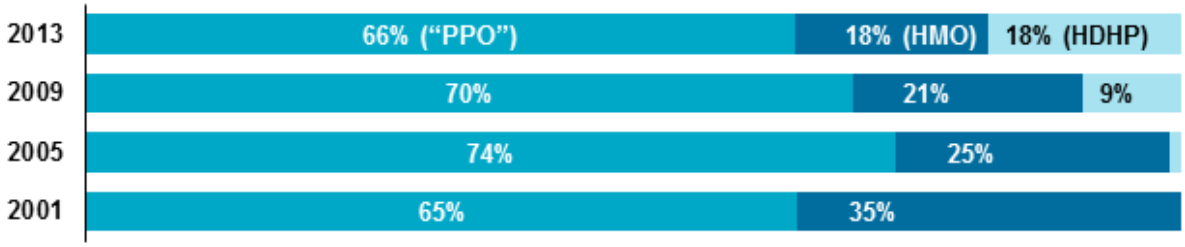
0.05%, and HMO enrollment decreased by 0.46%.[18] Five year Open Enrollment trends show that annual enrollment in the PPO plans decreased.[19]

Employer Sponsored Insurance Trends

In 2010, DSGI contracted with Mercer Consulting to prepare a Benchmarking Report[20] (report) for the state. The report compares Florida's program to the programs of other large employers[21], 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.

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[22] and the benchmark premium for large national employers ranges from $270 to $391 with the company paying 71% to 79% of the premium.[23]

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[24]:



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%.[25] Accordingly, enrollees in the state program gravitate toward the high value, low cost HMO because they experience no price difference between the plans.

[18] 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 March 14, 2015).
[19] Supra at FN 12, slide 10.
[20] 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
[21] For the purpose of the report, "large employers" had 500 or more employees.
[22] The state contributes 92% of the premium for the individual PPO plan.
[23] *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.
[24] Mercer at slide 6.
[25] Mercer at slide 20.

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[26] 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.[27] The state program has plans with lower premiums and higher benefits than industry benchmarks.[28] There is virtually no enrollment in HDHPs versus significant growth nationally.[29] Florida's plan costs and annual trend increase are higher than national survey data.[30] State employees have little real choice among health plan options since there is only a 7% difference in the "richness of the benefits" between the HMO and PPO, and the price is the same.[31] Consequently, 99% of enrollees chose the HMO or PPO with little to no incentive to choose the HDHP.[32]

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[33] in the same plan."[34] Since there is a 7% difference is 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 directs DMS to establish employee contribution rates for 2017 plan year that reflect the full 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.

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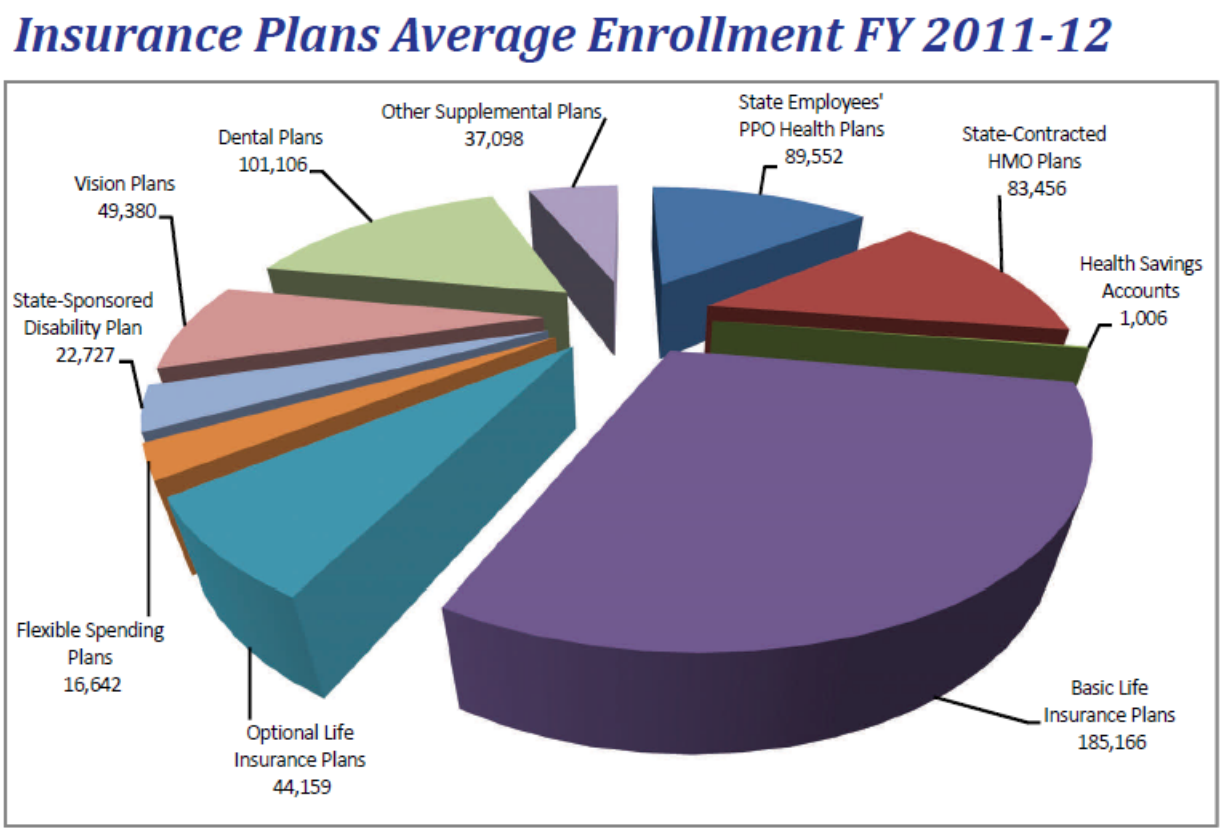
[26] Buck Consultants, *Strategic Health Plan Options for the State of Florida* (September 29, 2011), available at: http://www.dms.myflorida.com/content/download/81468/468856/version/1/file/Strategic+Health+Plan+Options+for+the+State+of+Florida+9-30-11+-+Final.pdf (last viewed on March 14, 2015).
[27] Mercer at slide 5.
[28] Mercer at slide 5.
[29] Mercer at slide 5.
[30] Mercer at slide 6.
[31] Mercer at slide 9.
[32] Mercer at slide 9.
[33] The coverage tier is either individual or family.
[34] S. 110.123(3)(f), F.S.

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 flexible spending account;
- To the enrollee's health savings account;
- To the enrollee's health reimbursement account; 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.[35] The following chart shows the extreme price differences across the country of the average cost to Medicare for a joint replacement.

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

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

California Public Employees' Retirement System (CalPERS), the second largest benefits program in the country started a "reference pricing" initiative in 2011. CalPERS set a threshold of $30,000 for hospital payments for both for inpatient hip and knee replacements and designated certain hospitals where enrollees could get care at or below that price. If enrollees had surgery at designated hospitals, they paid only their plans' typical deductible and coinsurance up to the out-of-pocket maximum. Patients could go to other in-network hospitals for care but were responsible for both the typical cost sharing and all allowed amounts exceeding the $30,000 threshold, which were not subject to an out-of-pocket maximum. The initiative resulted in $2.8 million for CalPERS and $300,000 in savings for enrollees in 2011 without sacrificing quality.[36]

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

[35] How to Bring the Price of Health Care Into the Open, The Wall Street Journal, Melinda Beck, February 23, 2014, available at: http://online.wsj.com/news/articles/SB10001424052702303650204579375242842086688?mod=trending_now_5 (last viewed March 14, 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 March 14, 2015).
[36] The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer, Center for Studying Health System Change, Amanda E. Lechner, Rebecca Gourevitch, Paul B. Ginsburg, Research Brief No. 30, December 2013, available at: http://www.hschange.org/CONTENT/1397/#ib6 (last viewed March 14, 2015).

surgical procedures and sharing any savings generated by the enrollee's choice of providers. Participation in the project will be voluntary for state employees.

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

If an employee participating in the project selects a provider who offers the procedure at a price below the benchmark, the state shall pay 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 flexible spending account;
- To the employee's health savings account;
- To the employee's health reimbursement account; 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 flexible spending arrangement.
- Use part of the employer contribution to pay for health insurance and have the balance credited to a health savings account.
- Use part of the employer contribution to pay for health insurance and use the balance to purchase additional benefits offered through the state group insurance program.
- Use part of the employer contribution to pay for health insurance and have the balance used to increase the employees pay.[37]

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).

The following chart illustrates a hypothetical[38] 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:

[37] The employee must use part of the employer contribution to purchase health insurance. The employee may not receive pay in lieu of benefits.
[38] All examples must be hypothetical since the 2018 benefit structure and plan actuarial values cannot be known at this time.

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

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

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.

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 requiring the Department of Management Services to recommend premium alternatives normalized to reflect benefit design and value for state group health insurance plan and fully insured HMO plans; requiring the General Appropriations Act for the 2017 plan year to establish enrollee premiums that reflect the differences in benefit design and value among the HMO plan options and the PPO plan options.

Section 5: Appropriates $151,216 in recurring funds and $507,546 in nonrecurring funds and authorizes 2 full-time equivalent positions and associated salary rate for the 2015-2016 fiscal year to implement the act.

Section 6: Provides an effective date of July 1, 2015, except as otherwise expressly provided in the act and except for this section, which shall take effect upon becoming a law.

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 has an indeterminate fiscal impact as a result of the contract with the IBC. DMS will have costs associated with contracting with the IBC, but may experience overall savings by contracting with a single consultant for multiple tasks.

The state and its employees may experience savings as a result of the price transparency pilot project.

Beginning in FY 2017-2018, employees will be given a choice of benefit packages. Consequently, the state may experience an overall savings if employees choose lower-cost options. The state may experience savings due to the changes in plan design to the state group insurance program if the changes result in lower overall program costs or a lower rate of cost increase for the program.

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