Health & Human Services Committee

Tuesday, February 14, 2017
3:30 PM – 5:30 PM
Morris Hall (17 HOB)

Richard Corcoran
Speaker

W. Travis Cummings
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time:	Tuesday, February 14, 2017 03:30 pm
End Date and Time:	Tuesday, February 14, 2017 05:30 pm
Location:	Morris Hall (17 HOB)
Duration:	2.00 hrs

Consideration of the following proposed committee bill(s):

PCB HHS 17-01 -- State Group Insurance Program

Overview of the state employee group health insurance plan - Tami Fillyaw, Director, Division of State Group Insurance, Department of Management Services

Presentation on Medicaid nursing home billing data – Beth Kidder, Deputy Secretary, Agency for Health Care Administration

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Monday, February 13, 2017.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, February 13, 2017.

NOTICE FINALIZED on 02/07/2017 4:00PM by Iseminger.Bobbye

Tami Fillyaw
DMS

Overview of the State Group Health Insurance Program

House Health & Human Services Committee

February 14, 2017

Chad Poppell, Secretary

Topics

- ✓ Division of State Group Insurance
  - Administration and Governance
- ✓ Financial View
  - At-a-Glance
  - Actual/Projected Health Program Spend
- ✓ Participants and Plan Enrollment
  - Plan Options and Contracted Service Areas
  - Cost Sharing and Premiums
  - Trends in Enrollment
  - History of Premium Contributions

Division of State Group Insurance

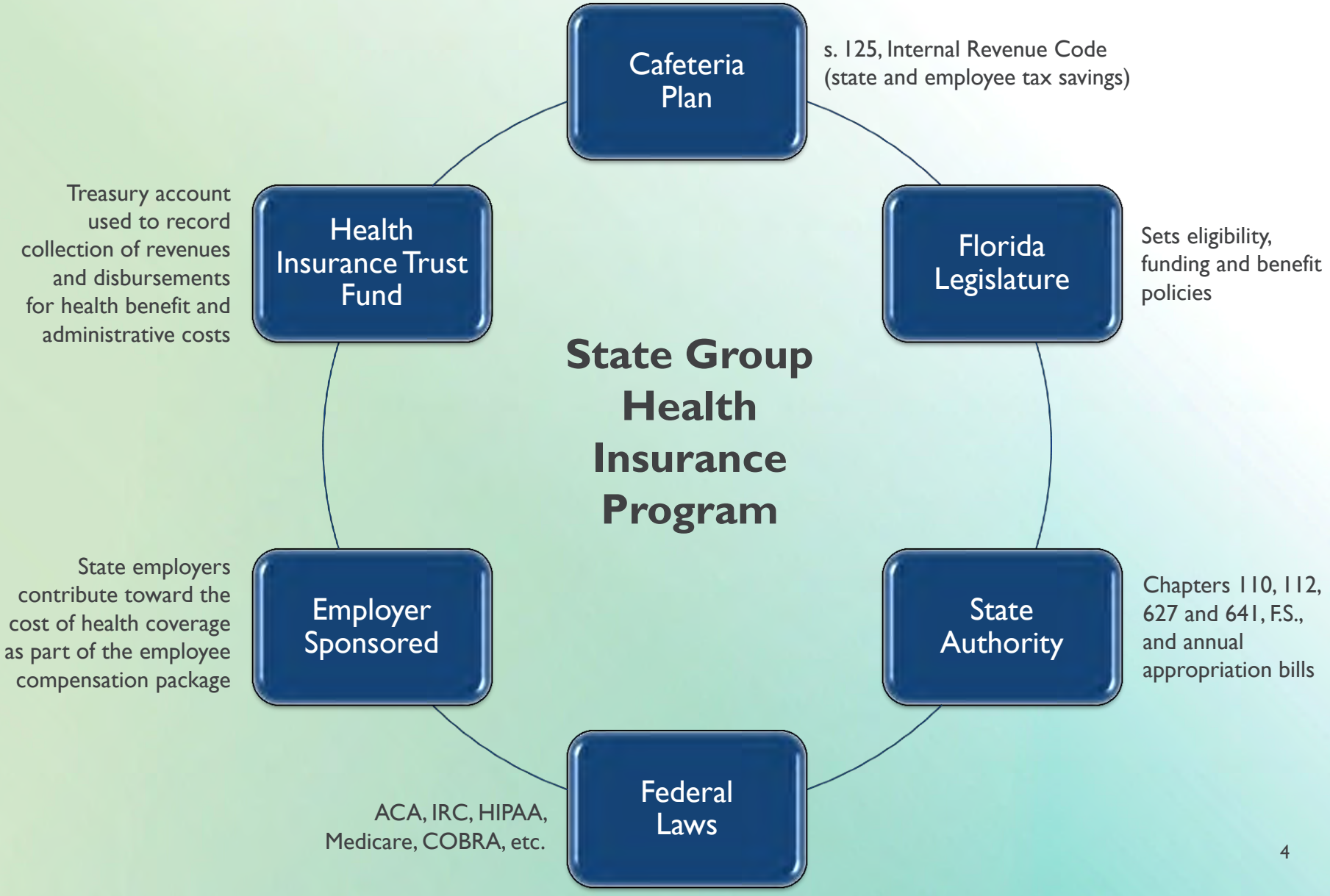
Procure and administer a comprehensive package of tax-favored insurance benefits pursuant to s. 110.123, F.S.

- Standard or high deductible health plan with an integrated HSA
- Medical and dependent care reimbursement accounts
- Life, dental and vision insurance
- Disability, accident, cancer and other income replacement plans

Administration:

- 22 positions
- People First
- Contracts with insurance carriers and service providers
- Actuarial, benefit, audit and legal consultant services

Governance


Cafeteria Plan
s. 125, Internal Revenue Code (state and employee tax savings)
Florida Legislature
Sets eligibility, funding and benefit policies
State Authority
Chapters 110, 112, 627 and 641, F.S., and annual appropriation bills
Federal Laws
ACA, IRC, HIPAA, Medicare, COBRA, etc.
Employer Sponsored
State employers contribute toward the cost of health coverage as part of the employee compensation package
Health Insurance Trust Fund
Treasury account used to record collection of revenues and disbursements for health benefit and administrative costs
State Group Health Insurance Program

Financial View

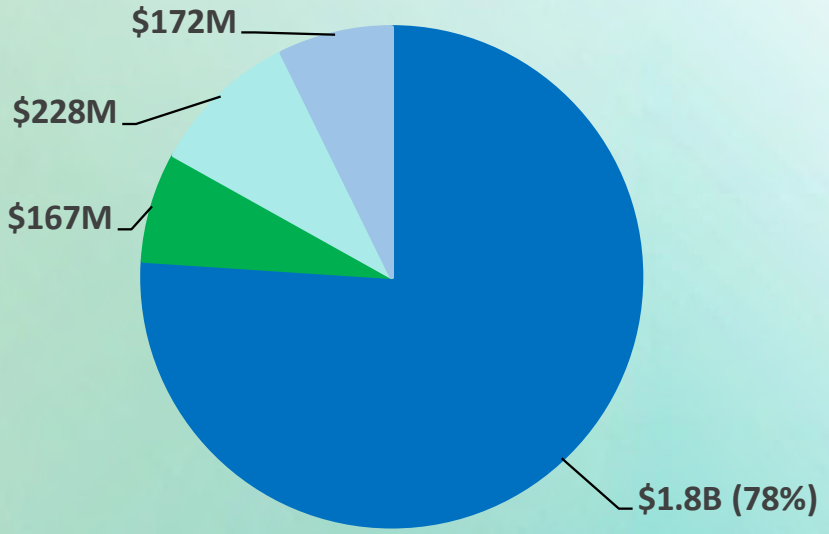
Fiscal Year 2016-17

Projected health care and administrative spend: $2.3 billion

- Medical: 72% | Rx: 25% | Administration: 3%
- Annual Spend Growth: Medical: 5.9% | Rx: 8.8% | Aggregate: 6.2%
- Cash Balance: $571.6 million

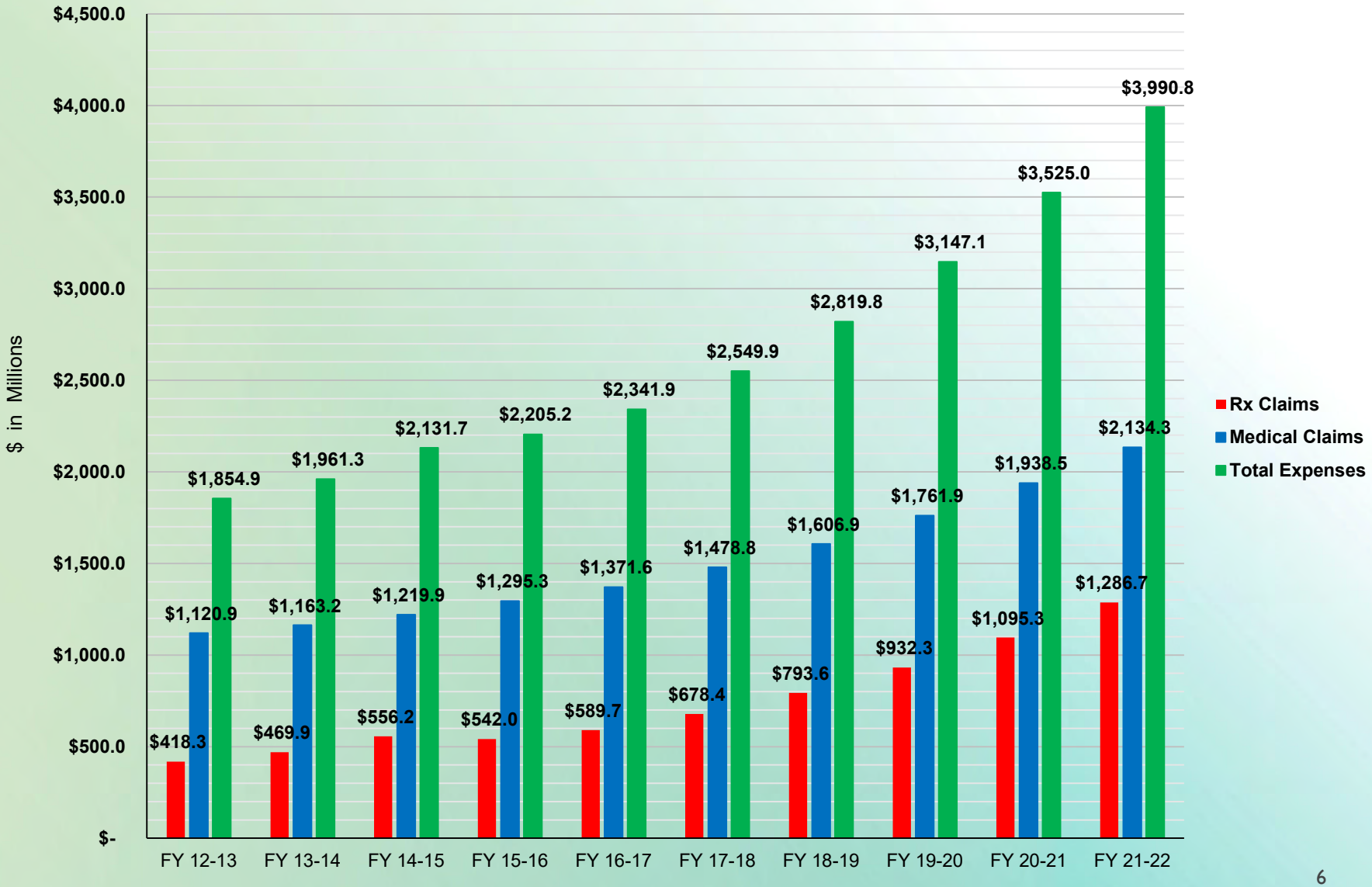
Projected Revenues

- State Revenues
- Employee Contributions
- Retiree Contributions
- Other Revenue



Information as reported by the Self-Insurance Revenue Estimating Conference.

Actual/Projected Health Program Spend



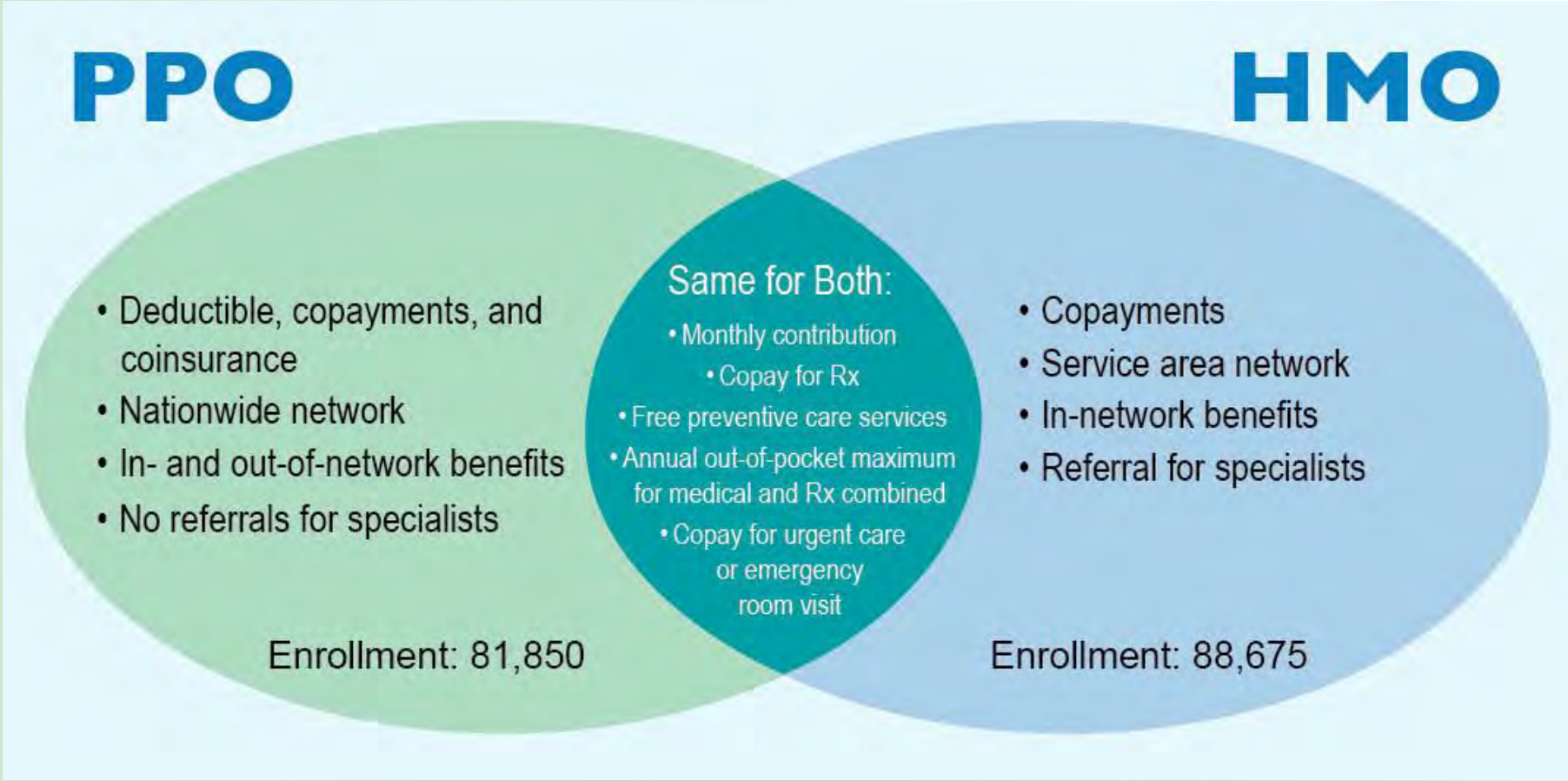
Participants

Covered Lives: 366,080

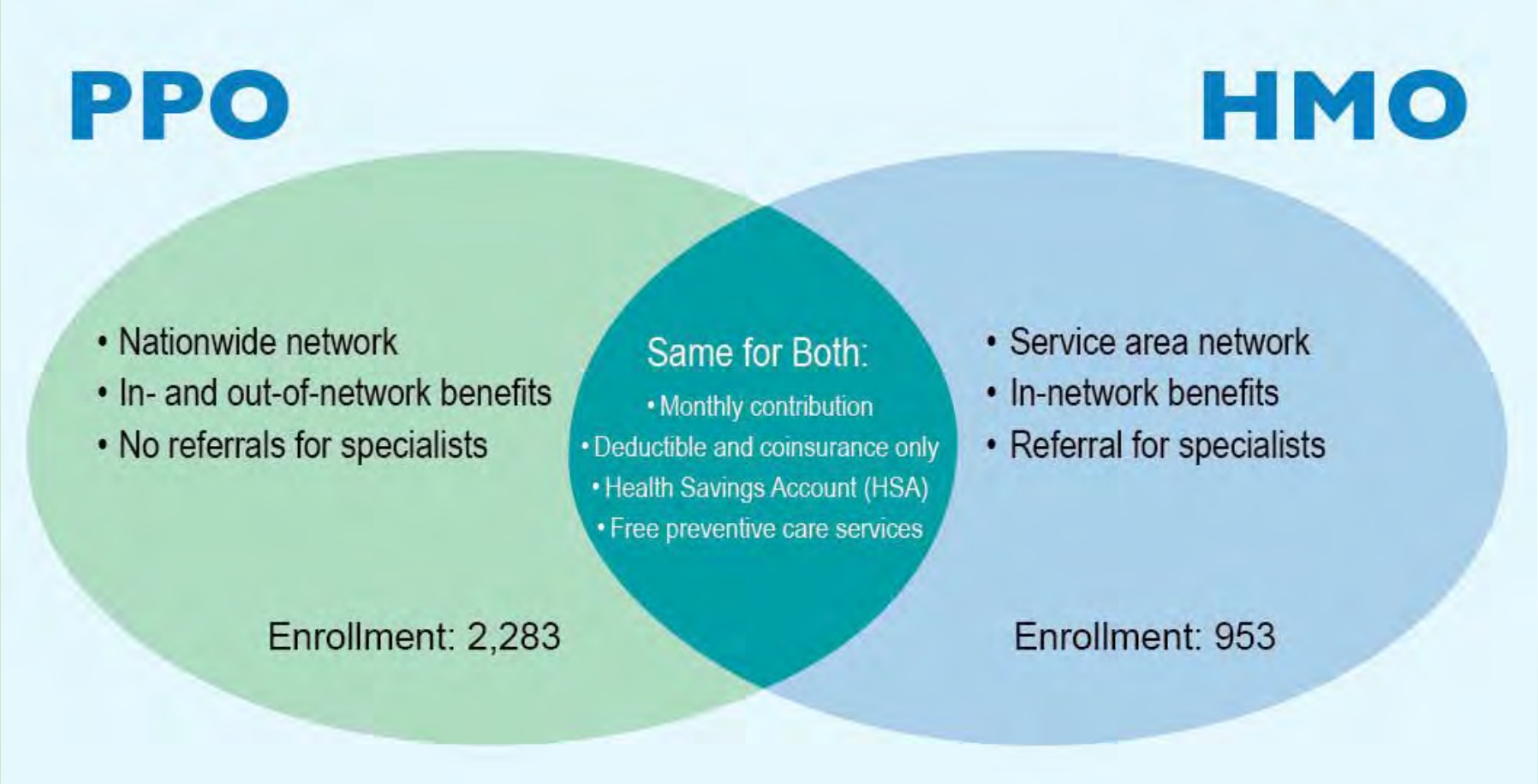
Policyholders: 173,761

Percentages based on policyholders

Standard Health Plan Options



High Deductible Health Plan Options

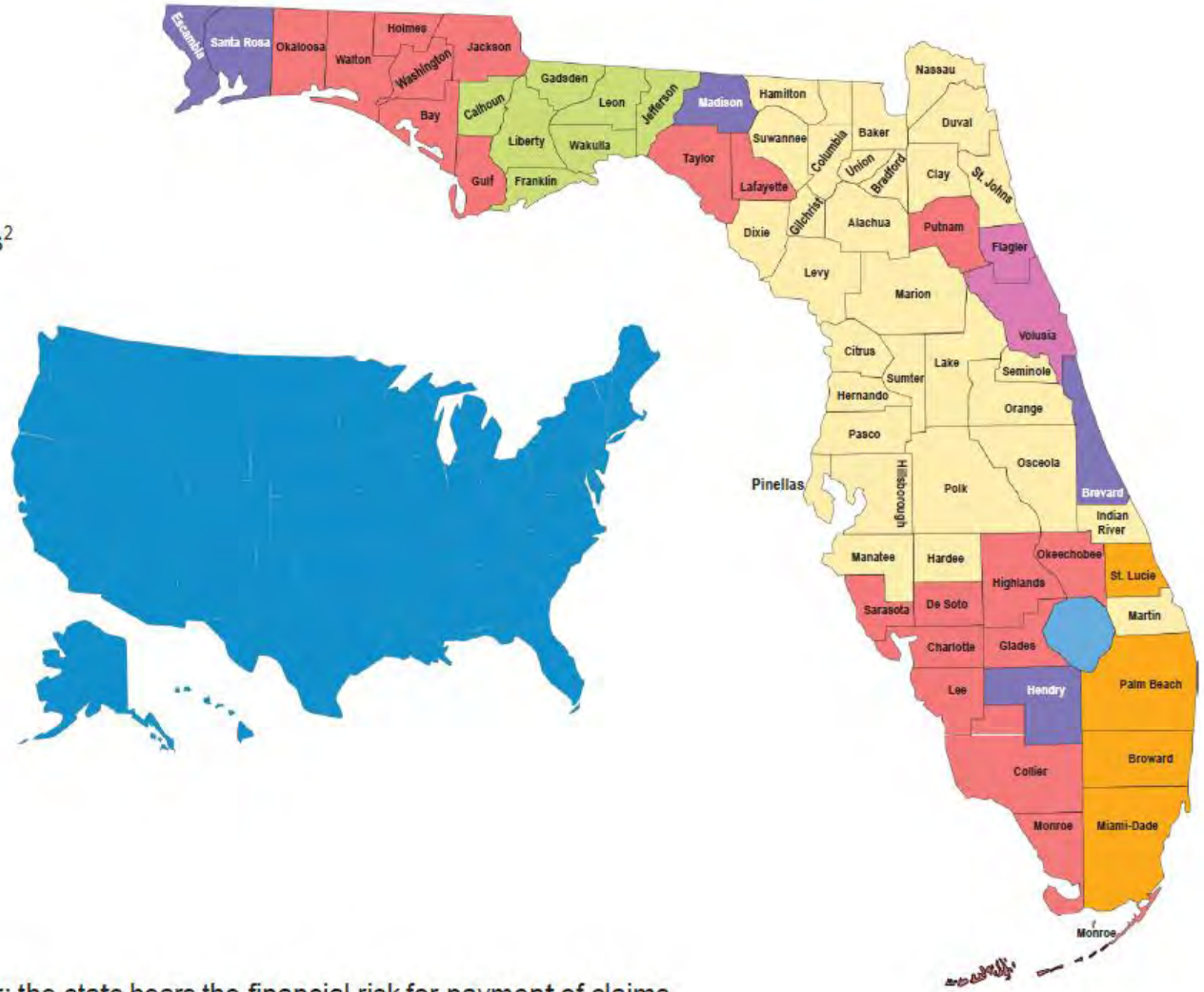


Contracted Service Areas

HMO
- Aetna[1]
- AvMed[1]
- AvMed[1] & Aetna[1]
- AvMed[1] & Florida Health Care Plans[2]
- Capital Health Plan[2]
- UnitedHealthcare[1]

PPO[1]
- Florida Blue

Prescription Drug Program[1]
- CVS/Caremark



[1]Self-insured/third-party administrator: the state bears the financial risk for payment of claims.
[2]Fully insured: the HMO bears the financial risk for payment of claims.

Prescription Drugs

- Automatic enrollment in the self-insured Prescription Drug Program when enrolled in a health plan
- Open formulary – Cover all federal legend drugs
- National network of participating retail pharmacies and a mail order program
- Three-tier copayment structure:
  - Generic | Preferred Brand | Non-Preferred Brand
- FY 2016-17 projected prescription drug spend: $589.7 million
- Prescription drug trend is on the rise
  - Generics have peaked
  - Generic price inflation
  - Brand inflation
- CVS/Caremark: contracted pharmacy benefit manager

Wellness Features

Wellness Benefits	HMO Plans[1]	PPO Plans
Online Tools	✓	✓
Health Risk Assessments	✓	✓
Fitness Membership	✓	✓
Smoking Cessation	✓	✓
Weight Management	✓	✓
Nutritional Counseling	✓	✓
Nutritional Supplement Discounts	✓	
Health Counseling	✓	✓
Prenatal Education	✓	✓
Massage and Acupuncture	✓	✓
Exercise Classes	✓	✓
Fitness Equipment, Apparel, Footwear Discounts	✓	✓

[1]Discounts, programs and services vary by HMO

Cost Sharing

	Standard Health Plan			High Deductible Health Plan	
	Network Only (HMO)	Network (PPO)	Out-of-Network (PPO)	Network (PPO & HMO)	Out-of-Network (PPO Only)
Deductible	None	$250 | $500 Single | Family	$750 | $1,500 Single | Family	$1,300 | $2,600 Single | Family	$2,500 | $5,000 Single | Family
Primary Care	$20 copayment	$15 copayment	40% of out-of-network allowance plus the amount between the charge and the allowance	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	$40 copayment	$25 copayment			
Urgent Care	$25 copayment	$25 copayment			After meeting deductible, 20% of out-of-network allowance
Emergency Room	$100 copayment	$100 copayment			
Hospital Stay	$250 copayment	20% after $250 copayment	40% after $500 copayment plus the amount between the charge and the allowance		After meeting deductible, 40% after $1,000 copayment plus the amount between the charge and the allowance
Generic | Preferred | Non-Preferred	$7 | $30 | $50 Retail	$7 | $30 | $50 Retail	Pay in full - file claim for reimbursement	After meeting deductible 30% | 30% | 50% Retail and Mail Order	Pay in full - file claim for reimbursement
	$14 | $60 | $100 Mail Order	$14 | $60 | $100 Mail Order			
Out-of-Pocket Maximum[1]	$1,500 | $3,000 Single | Family (medical copays)	$2,500 | $5,000 Single | Family (medical coinsurance)		$3,000 | $6,000 Single | Family (medical/Rx coinsurance)	$7,500 | $15,000 Single | Family (medical/Rx coinsurance)

[1]The Affordable Care Act out-of-pocket limit for 2017 for the Standard Plan is $7,150 single and $14,300 family for combined in-network medical and Rx member cost share. For the High Deductible Plan, the 2017 limits are $4,300 single and $8,600 family for combined in-network medical and Rx member cost share.

Monthly Premiums & Contributions

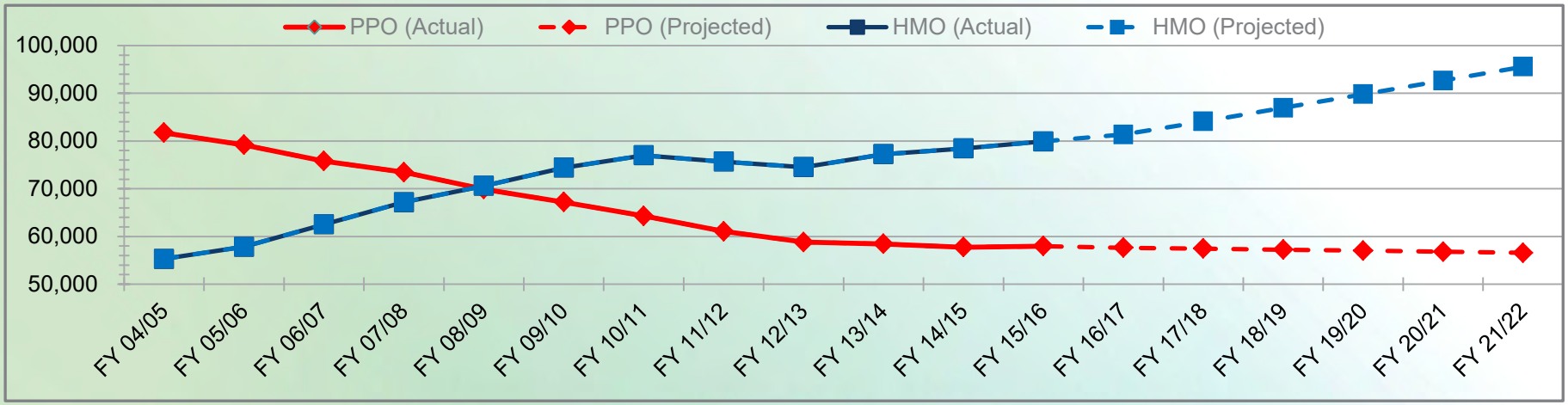
Subscriber Category	Coverage Type	PPO & HMO Standard			PPO & HMO High Deductible		
		Employer	Enrollee	Total	Employer[1]	Enrollee	Total
Career Service[2] & OPS	Single	642.84	50.00	692.84	642.84	15.00	657.84
	Family	1,379.60	180.00	1,559.60	1,379.60	64.30	1,443.90
	Spouse	1,529.60	30.00	1,559.60	1,413.92	30.00	1,443.92
SES & SMS	Single	684.50	8.34	692.84	649.50	8.34	657.84
	Family	1,529.60	30.00	1,559.60	1,413.90	30.00	1,443.90
Pre-Medicare Retiree	Single	0.00	692.84	692.84	0.00	628.50	628.50
	Family	0.00	1,559.60	1,559.60	0.00	1,387.78	1,387.78
Over-age Dependent	Single	0.00	692.84	692.84	0.00	616.18	616.18

Plan Name	Plan Type	Medicare I	Medicare II	Medicare III
		Single – One Eligible	Family – One Eligible	Family – Both Eligible
Self-Insured PPO & HMO[3]	Standard	388.38	1,119.85	776.76
	HIHP	292.76	917.13	585.51

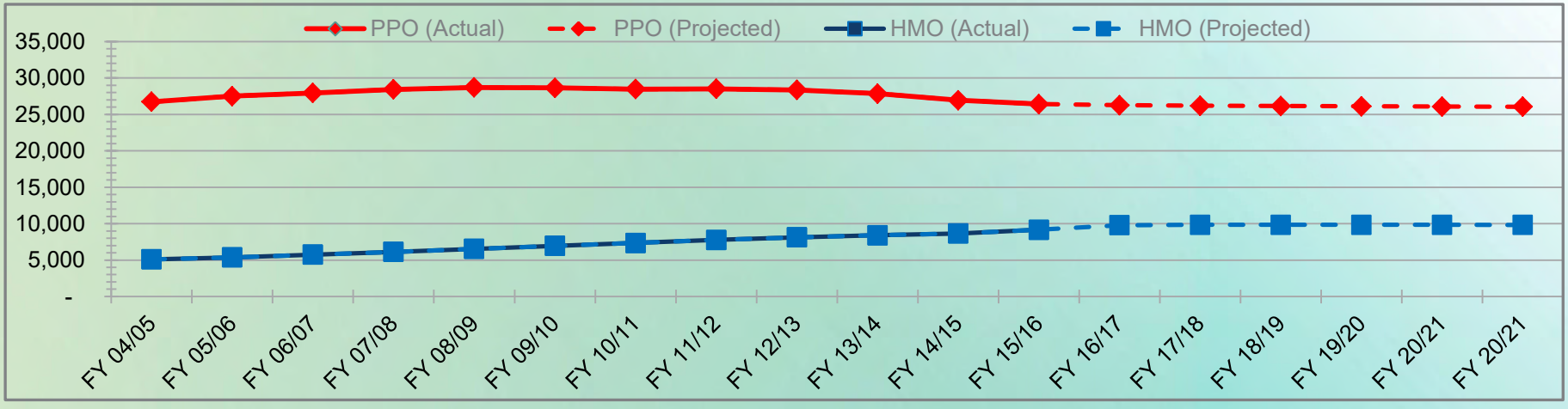
[1] Includes employer tax-free Health Savings Account (HSA) contribution - $41.66 and $83.33 per month for single and family coverage, respectively.
[2] COBRA participants pay the full single or family premium plus a 2 percent administrative fee.
[3] Fully-insured HMOs offer a Medicare Advantage Plan. The lower premiums are federally approved and are subject to change each plan year.

Plan Enrollment

Employee Enrollment

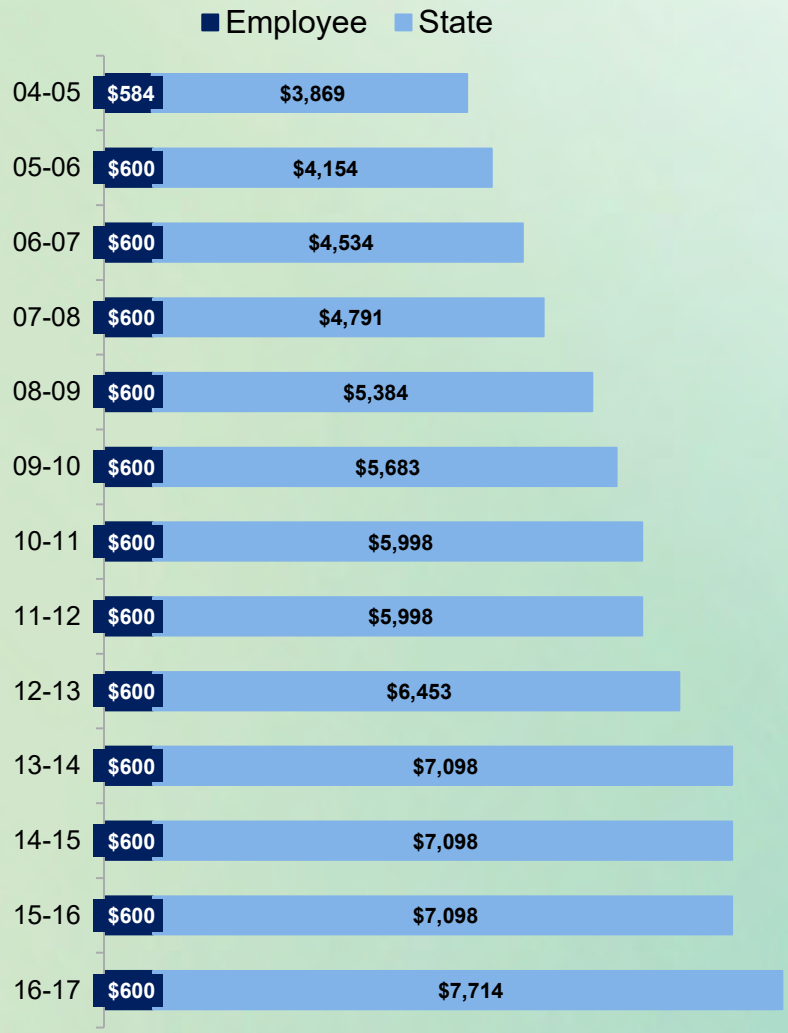


Retiree Enrollment

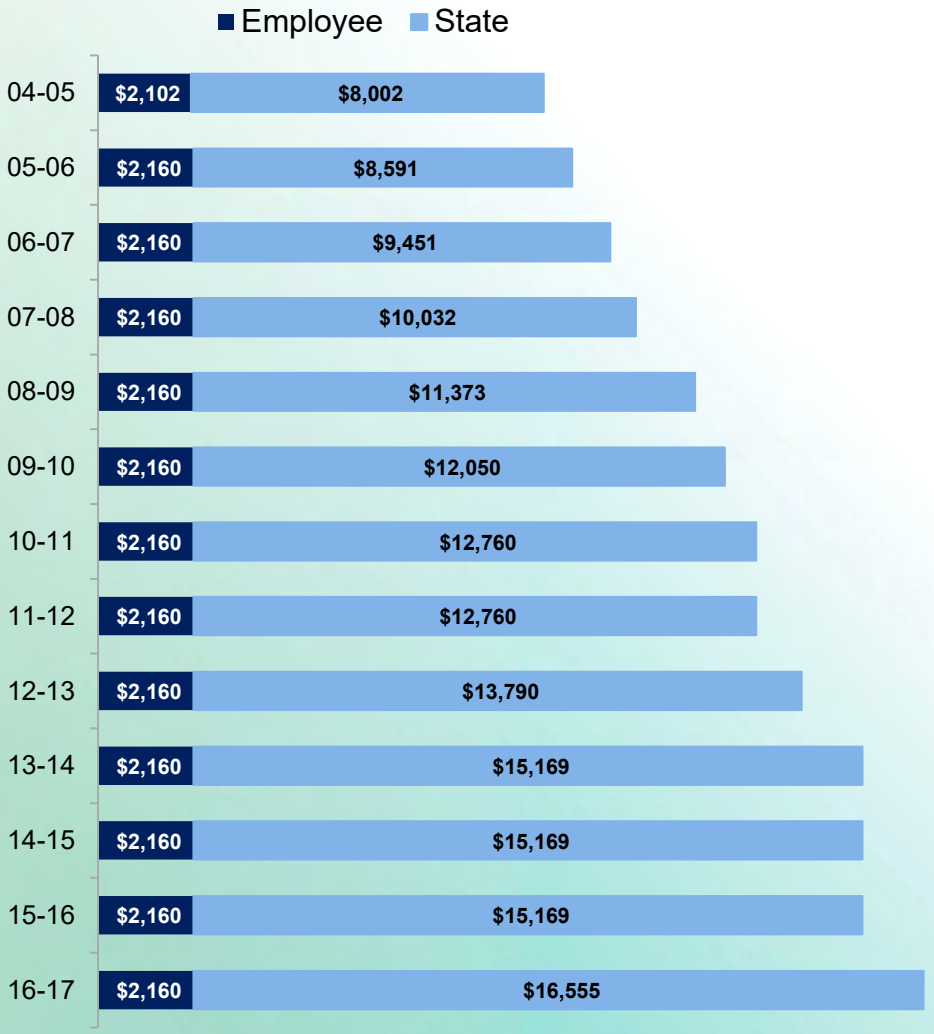


Change in Premiums

Single Coverage Annual Premium



Family Coverage Annual Premium



Thank You

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State of Florida
Division of State Group Insurance

MARKET-BASED FRAMEWORK FOR HEALTH PLAN PROGRAM CHANGES

January 2014

Mercer Health & Benefits, Atlanta, GA

MARSH & McLENNAN COMPANIES

Agenda

- **Purpose** – To identify opportunities to improve the State of Florida's health plan by comparing today's program to critical success factors, approaches and trends in the employer market today
- Background – basic definitions
- Summary of key findings and observations
- Supporting information to help answer some key questions*
- Discussion & questions
- Appendix (supporting background and detail)

*** Key Questions:**

- How do the State of Florida plans and premiums compare to market surveys?
- How might "best practice" consumerism and "defined contribution" (DC) pricing of plans work for us?
- How do we differ from successful plans that use wellness, incentives, "consumer-driven health plans" (CDHP), and member health and engagement programs and techniques?
- What are three alternative approaches, or phases to consider, to embrace these findings?
- What are some of the key considerations to be evaluated?

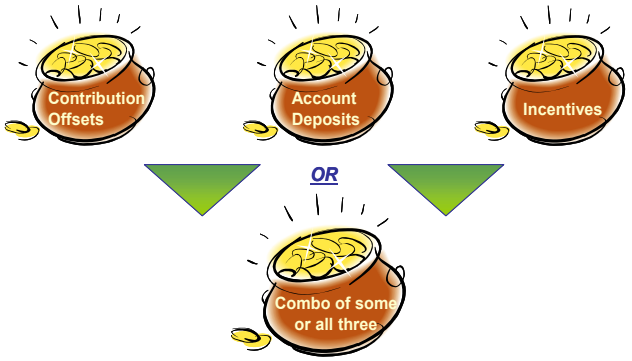
Background — basic definitions
Consumerism, consumer-driven health plans (CDHP) and accounts

- **"Consumerism" –** an activity that encourages or empowers improved health, or informed, or responsible spending for, or use of, healthcare related goods or services
- **CDHP** – typically a Preferred Provider Organization (PPO) medical plan with a "high deductible" and an "account"
- **Accounts** – typically a Health Savings Account ("HSA"), or a Health Reimbursement Arrangement ("HRA")
- State of Florida – offers CDHP options (i.e., Health Investor Health Plans (HIHP)) with an HSA account (both PPO HSAs and HMO HSAs are offered)
- CDHP plans – provide employee incentives (via lower premiums, up-front account deposits that carry over from year to year, visible account balances, etc.) to encourage employees to be active participants in their healthcare consumption and health

Employers create plan savings with some combination of …

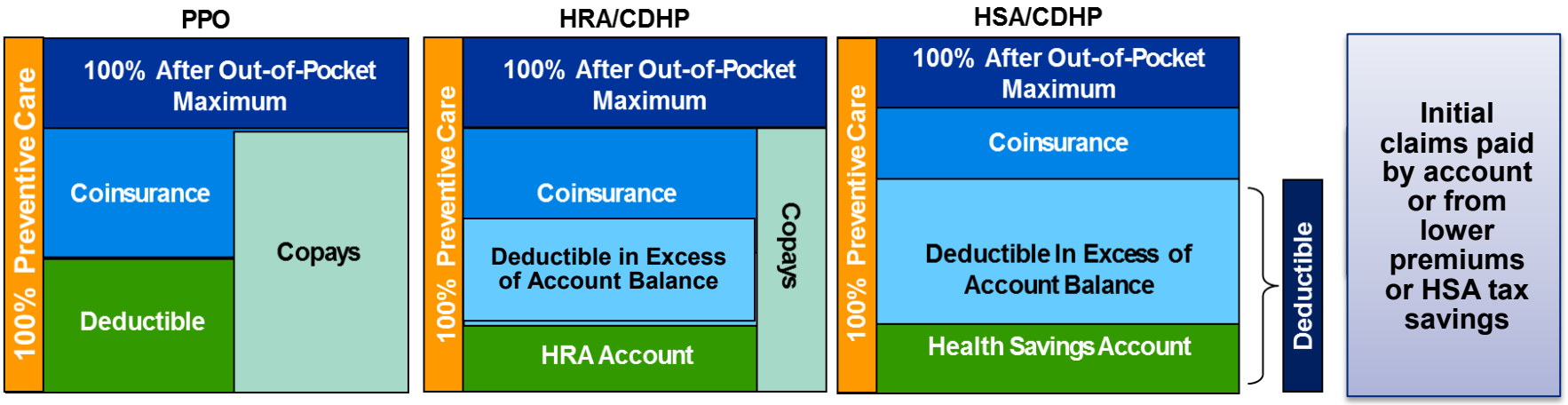
- Increased deductibles
- Increased coinsurance
- Increased or eliminated copays

… to redeploy dollars saved using some combination of:



Background — basic definitions
Comparison of PPO vs. HSA vs. HRA

Consumer Driven Health Plans — a high-deductible PPO with a health savings account (HSA) or health reimbursement account (HRA)



Primary Differences	HRA	HSA
Account Description	Notional / non-cash; claims paid from general plan assets	Employee-owned cash; deposits in a financial institution
Account is in the employee's name and remains theirs after withdrawing from plan	No	Yes
Employee Contributions Allowed	No	Yes (and tax favored)
Employer Contribution Allowed	Yes	Yes (and tax favored)
Plan must meet qualified high deductible plan design requirements (e.g., eligibility limits, minimum deductibles, maximum out-of-pocket limits, no co-pays, etc.)	No	Yes

Background — basic definitions
Consumerism and the role of defined contribution

Key Concepts

- Properly pricing each plan option to fairly reflect the true difference in the value of benefits from each option is a critical component to consumerism

- Employers are increasingly basing their contributions on the lowest cost plan (e.g., CDHP plan), and using defined contribution (i.e., requiring employees to pay more or "buy-up" for more expensive coverage)

Defined contribution strategies

1. **Core / "buy-up or buy-down" approach**
   - Employer sets the dollar contribution annually that will be contributed:
     - Based on a dollar budget or % of the cost for a "core" plan option
2. **Fixed employer increase approach**
   - This approach allows an employer to manage the longer term increases in their medical costs and incentivizes employees to actively engage in their health care decision making
   - Employer increases their contribution by a set amount each year for the "core" plan:
     - Approach requires employees to pay the projected difference in the cost increase
     - Increase is typically determined in advance based on budgets, not year-to-year medical inflation
3. **Flat dollar subsidy / voucher**
   - Allows employees to use HRAs to purchase individual coverage (vs. getting taxable cash back)
   - Approach is rare; employers who attempt to use this DC strategy will likely be subject to the $2,000 (per employee) employer minimum value penalty regulations under the Affordable Care Act

Summary of key findings and observations

1. **The State of Florida's plans lag some key large employer survey* trends:**
   - State of Florida enrollment is in plans with lower premiums and higher benefits than industry benchmarks
   - Virtually no (~1%) enrollment in State HIHP / HSA plans, versus significant growth of CDHPs nationally
   - Employers increasingly use incentives to grow participation in new wellness / condition-specific programs
     – State of Florida has no incentives and few such programs

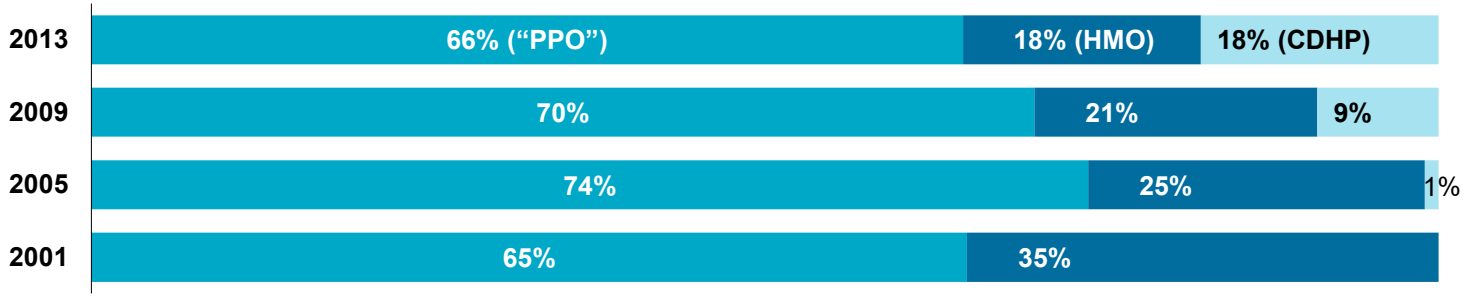
2. **Effective employer health plans use common success strategies to help control costs:**
   - They encourage good purchasing behavior by offering a broad range of benefit choices that use defined contribution and “buy-up / buy-down” consumerism pricing
   - They focus on employee engagement – wellness, incentives, employee education and “account-based” Health Savings “HSA” and Health Reimbursement “HRA” plans

3. **Significant financial opportunity exists for the State of Florida:**
   - Begin building the foundation to improve health and significantly lower health costs over time
   - Change requires “breaking inertia,” substantial communication and investment, and strategies to respond to health care reform’s 2018 excise tax (or “Cadillac tax”)
   - Timing will be impacted by unique State of Florida implementation needs and HR issues

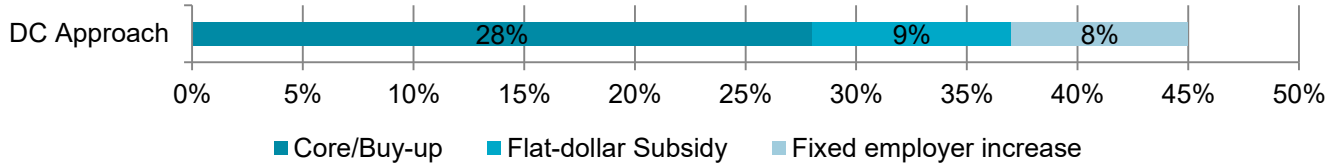
*Mercer Employer-Sponsored Health Plan Annual Survey – “Large Employer (LE)“ has 500 or more employees

Survey findings and observations for large employers (LEs) Versus State of Florida plans and premiums

- State of Florida HMO enrollment (56%) and CDHP (HIHP <1%) is higher and lower than LEs, respectively



- 45% of LE's use a DC approach; the State of Florida charges the same for both HMO and PPO plans



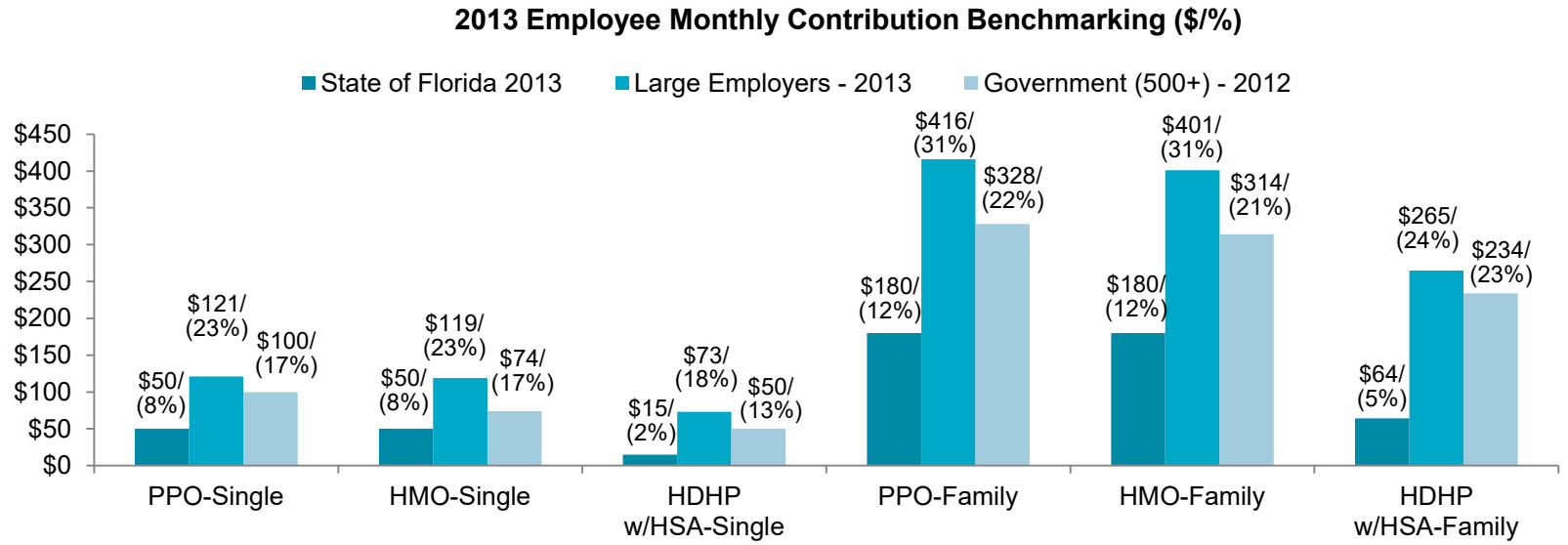
- State of Florida's total plan costs and annual trend increases are higher than Mercer survey National data, partly given the very limited number of historical State of Florida design and premium changes

	National	State of Florida
PPO 2013 Medical Plan Cost	$10,658 (South $9,894)	$13,400 average career service premium
HMO 2013 Medical Plan Cost	$11,134 (South $10,753)	
Annual Cost increases since 2007 **before** plan changes	7.4% - 9.8%	Approximately 6% - 8%
Annual Cost increases since 2007 **after** plan changes	4.1% - 6.9%	Approximately 6% - 8%
Increase in PPO / HMO Single and Family employee contributions since 2007	Single: 36% - 38%, Family 20% - 26%	0% for career service employees
Pre-Medicare Retiree's % share of medical costs	37%, for 49% who share costs*	100% of established non-actuarial value
Medicare Retiree's % share of medical costs	38%, for 46% who share costs*	100% of retiree rate

*Of the 24% Medicare and 17% pre-Medicare eligible total surveyed employers that offer any coverage

Survey findings and observations
Versus State of Florida plans and premiums

- Plan value is determined by the richness of benefits or “actuarial value.” (AV) is defined as the percentage of total average claims dollars paid by an employer’s plan
- Average LE PPO plan has AV of 87% versus the State of Florida's PPO AV of 86% – roughly the same
- More than half of the State of Florida's enrollment is in HMOs with a 93% AV
- State of Florida employee contributions – dollar contributions and cost sharing percentages – are both much lower (refer to chart below) than market levels



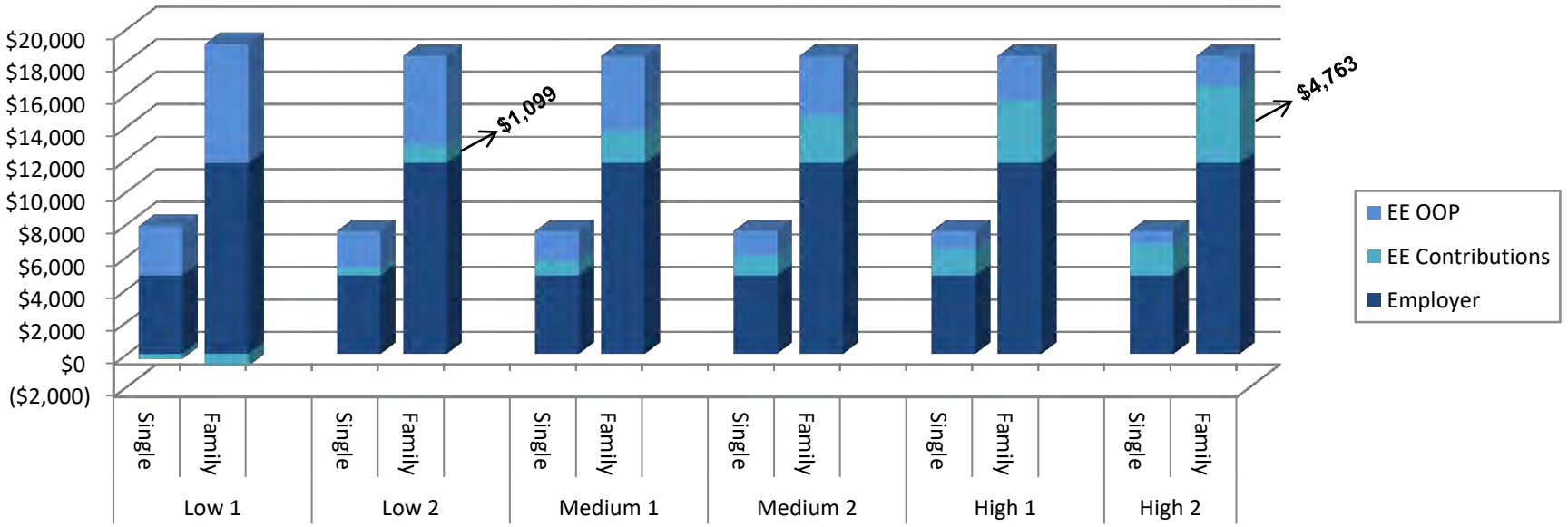
Note: 2013 Employee cost sharing % shown in ()
Source: Mercer’s 2012 and 2013 National Survey of Employer-Sponsored Health Plans

- Supporting data for other elements compared to 2012 benchmark ranges in Appendix (p. 18)

“Best healthcare practice” — illustration 1: based on national survey data
Consumerism and DC approach to pricing plan options

Start with solid foundation success elements – offer broad choice of benefit plans with fairly priced or defined contribution premiums to encourage consumerism

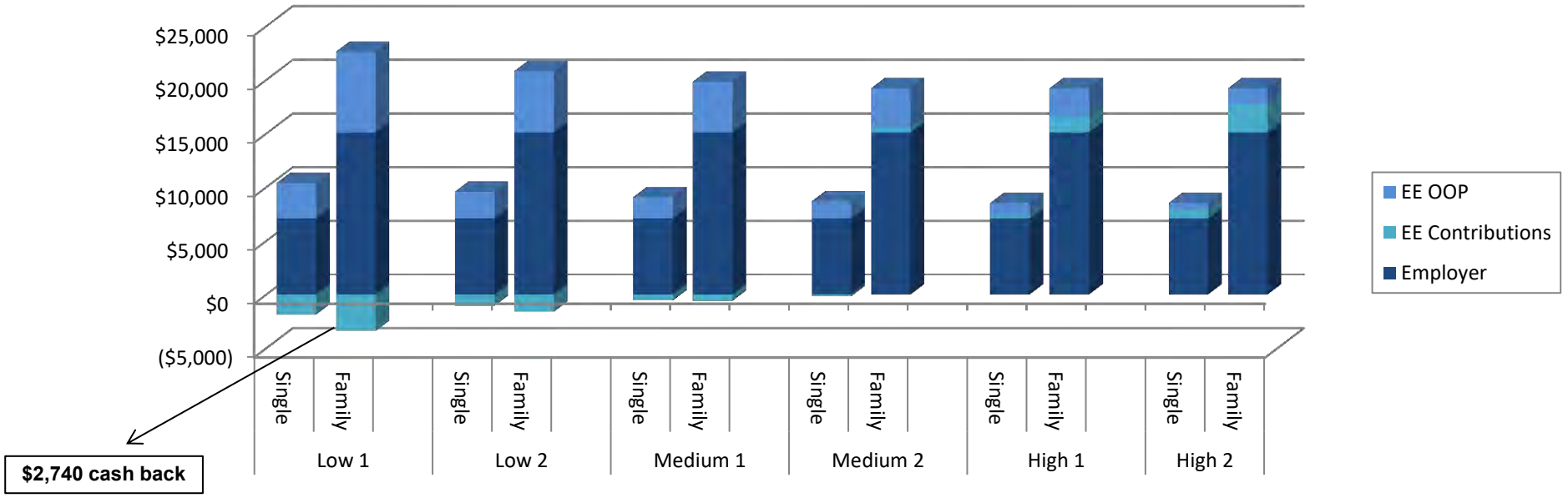
- Offer a complete range of plan options with significantly different actuarial values (see 30% spread below); For the Low 2 plan (70% AV), employee contributions are $1,511 less ($1,964 minus $453) than the High 2 (90% AV) for Single Coverage, and $3,664 less (**$4,763 minus $1,099**) for Family coverage
- Reflect true benefit value differences by providing an equal core “buy-up / buy-down” employer DC amount (i.e., $4,835 in the table), regardless of the plan selected
- Make the sum of employee contributions and out-of-pocket (OOP) equal for every plan option



“Best healthcare practice” — illustration 2: based on State of Florida plans
Consumerism and DC approach to pricing plan options (continued)

Consumerism unlikely until a buy-up / buy-down approach is adopted that engages employees with accurately priced, broader options, and higher contributions

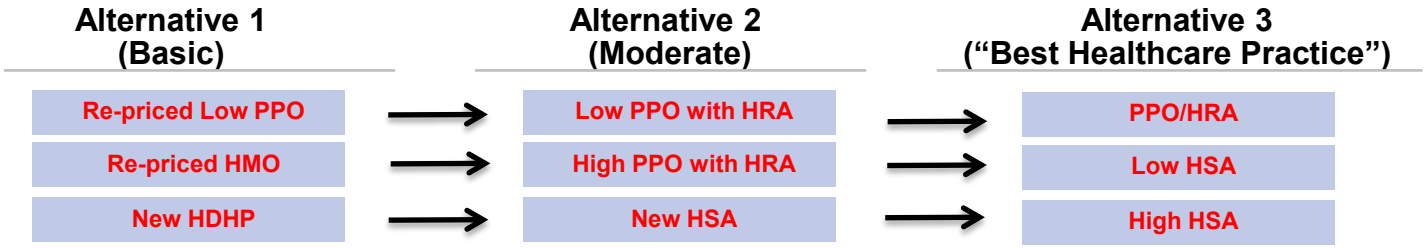
- 99% of enrollees are in plans with the same employee contributions and only a 7% difference in richness of benefits (“actuarial value”), creating little consumerism, or real choice, between benefits and premiums
- It would be a challenge to offer new, less rich benefit options alongside current plans and contributions – large taxable “cash back” (with HR, communication and administrative issues) may be required
- “Adverse selection” can also be a big issue – including employees or dependents who today do not participate – may choose to “opt back in” to the plan to obtain both benefits and significant “cash back”



Engagement via wellness, incentives, consumerism and health activities
Current plans lag some key employer trends

- **The State has little HIHP / HSA enrollment (~1%)** – likely little chance of CDHP growth until actions are taken to "break the inertia" (e.g., investment in effective communication campaigns, varying prices by plan, active and mandatory open enrollment, visible leadership endorsement, account-based incentives, etc.)
- **Successful, large organizations partner CDHPs with accounts, wellness and incentives:**
  - 62% of employers with >5,000 employees used incentives in 2012 – up from 39% in 2010
  - Incentives drive program effectiveness – completion rates for health risk assessments and biometric screenings are twice as high when incentives are used
- **Employers are rapidly adopting CDHPs** to simultaneously achieve multiple objectives:
  - Avoiding or delaying the 40% health care reform "Cadillac tax," effective 2018
  - Maximize employee engagement with consumer purchasing choices and health activities
  - Achieving financial savings by avoiding (versus cutting) costs – significant cumulative 5-year savings
- **We illustrate 3 alternative pathways (next slide)** to add over time new consumer choices, integrate health management and CDHP; and leading to a "best health care practice" state (alternative 3)
- **Pace of change is dependent** on the degree of activity with the following actions:
  - Revising the number and type of plans offered, with prices accurately reflecting benefit costs by plan
  - Embracing CDHP options relative to more traditional plan types
  - Introducing incentives and disincentives to encourage CDHP, wellness and healthier behavior

Health management — illustrative pathways for the State of Florida
"Relative" pros / cons of 3 alternatives



Dimension	Alternative 1 (Basic)	Alternative 2 (Moderate)	Alternative 3 ("Best Healthcare Practice")
Financial	Savings primarily available via plan design cuts or increased contributions	→	Significant trend reduction over time and "win-win" savings via avoided costs
Employee impact & health consumption	Limited or modest health improvement; minimal behavior change, and limited negative impact on employees	→	Greatest opportunity for reduction of health risks, with significant change to how employees engage in their health
Organizational	Minimal administrative impact	→	Significant administrative impact; requires cultural shift over time
	No direct or short-term impact on employee attraction and retention	→	High potential HR impact (+/-); consider competitiveness of wages, as benefits move toward CDHP / "best practice"
	Impact to employee relations limited to higher cost-shifting and cuts over time	→	Potentially large employee relations impact (+/-) during the transition, with financial "win-win" over time avoids cuts
	Basic communication and benefit delivery needs	→	Extensive internal / external communication; infrastructure investments needed (e.g., web tools, incentives, portals)

Key considerations

- This document highlights the more unique differences and critical success factors for the State of Florida
- Adopting major fundamental and comprehensive program change likely requires multiple years to decide and implement, perhaps transitioning to an ultimate state over multiple years and three or more phases
- **Some foundation / strategy decisions are particularly key given the current state of the program:**
  - Short- and long-term financial goals, and potential impact on broader HR / total rewards objectives
  - Desired competitive position and resulting savings from traditional plan design and contribution changes
  - Comfort with trade-offs from moving to CDHP plans – “how far, how fast?” – for your participants
  - Interest in offering a broad choice of plan options with proper pricing and defined contribution
  - Desire and flexibility to pursue incentives and disincentives to support health initiatives
- **Key practical items to consider even after core decisions are made:**
  - Impact of general changes on special groups (e.g., early retirees, Medicare-eligible retirees, “payalls”)
  - Activities to support change (data analyses, compliance, procurements, communication, administrative)
  - Timing will be impacted by unique State of Florida implementation needs and HR issues

Appendix

Background
Project Objectives

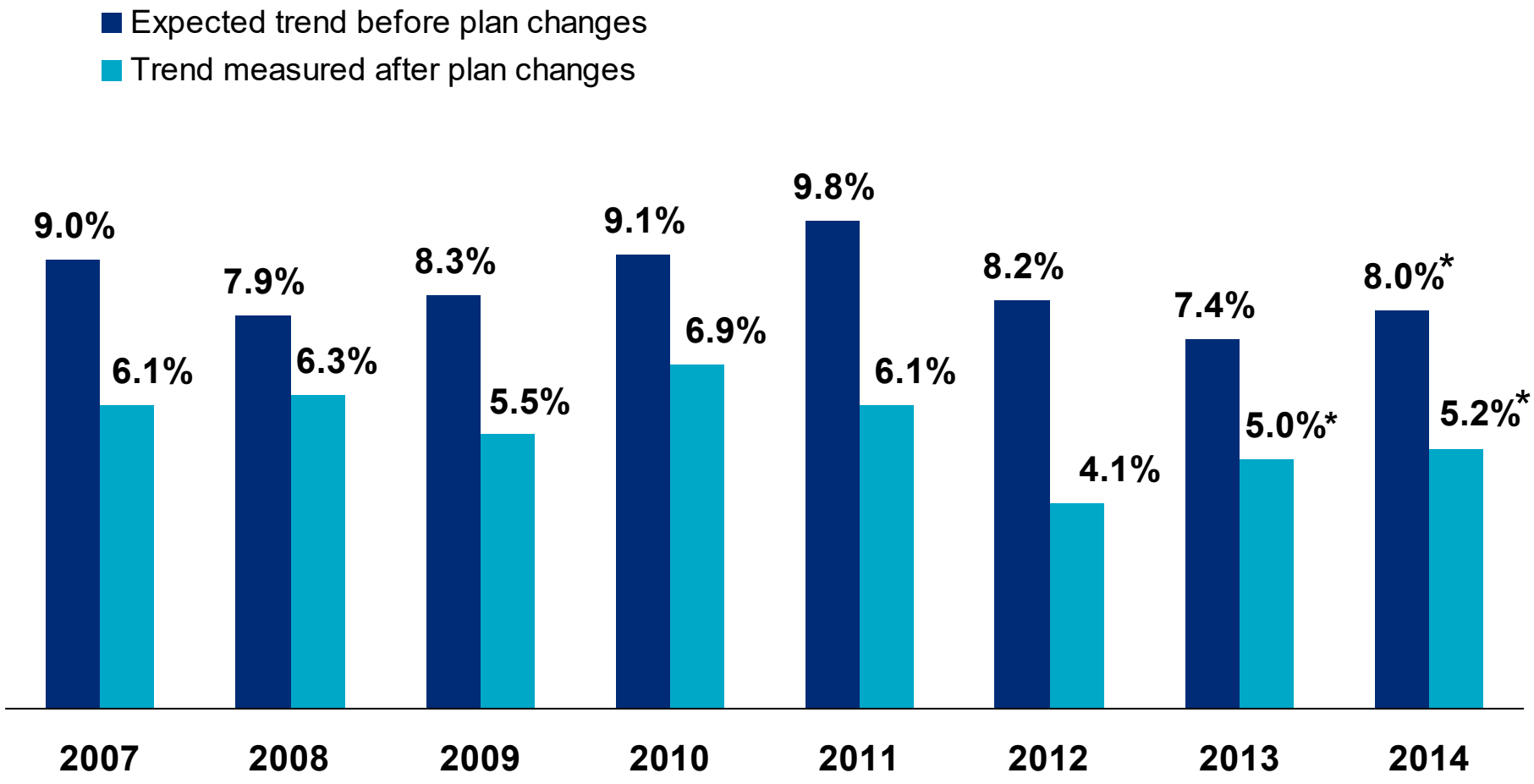
- The Department of Management Services, Division of State Group Insurance, (DSGI) requested that Mercer assist in developing a market-based, strategic framework for changes to the State of Florida's medical and prescription drug plans

Objectives:

- Mercer agreed to provide a PowerPoint presentation that meets the following objectives:
  - Provides an overview of trends in employer responses to health insurance market changes including an identification of critical program elements necessary to build the framework of a successful multi-year strategic plan
  - Reviews and analyzes the State's current program against market survey data and best practices
  - Discusses and illustrates three alternative approaches that could be used as part of a multi-year strategy. The alternative approaches will take into consideration the speed and intensity of change to the State's program over three to five years
  - Discusses the potential implications of the "Cadillac tax" regulation scheduled to take effect in 2018
  - Discusses any specific concerns that are unique to the State's program, or employee groups, such as early retirees, Medicare-eligible retirees, "payalls," etc.

Background
Market trends

Employers see underlying cost trend falling below 8%. They plan to hold their actual cost increase to around 5.2% in 2014



* Projected

State of Florida annual trend preliminary data indicates that increases after plan changes has ranged from 6% - 8% (except for FY 2011-2012 when self-funding / Rx changes were made)

Foundation — plan offerings

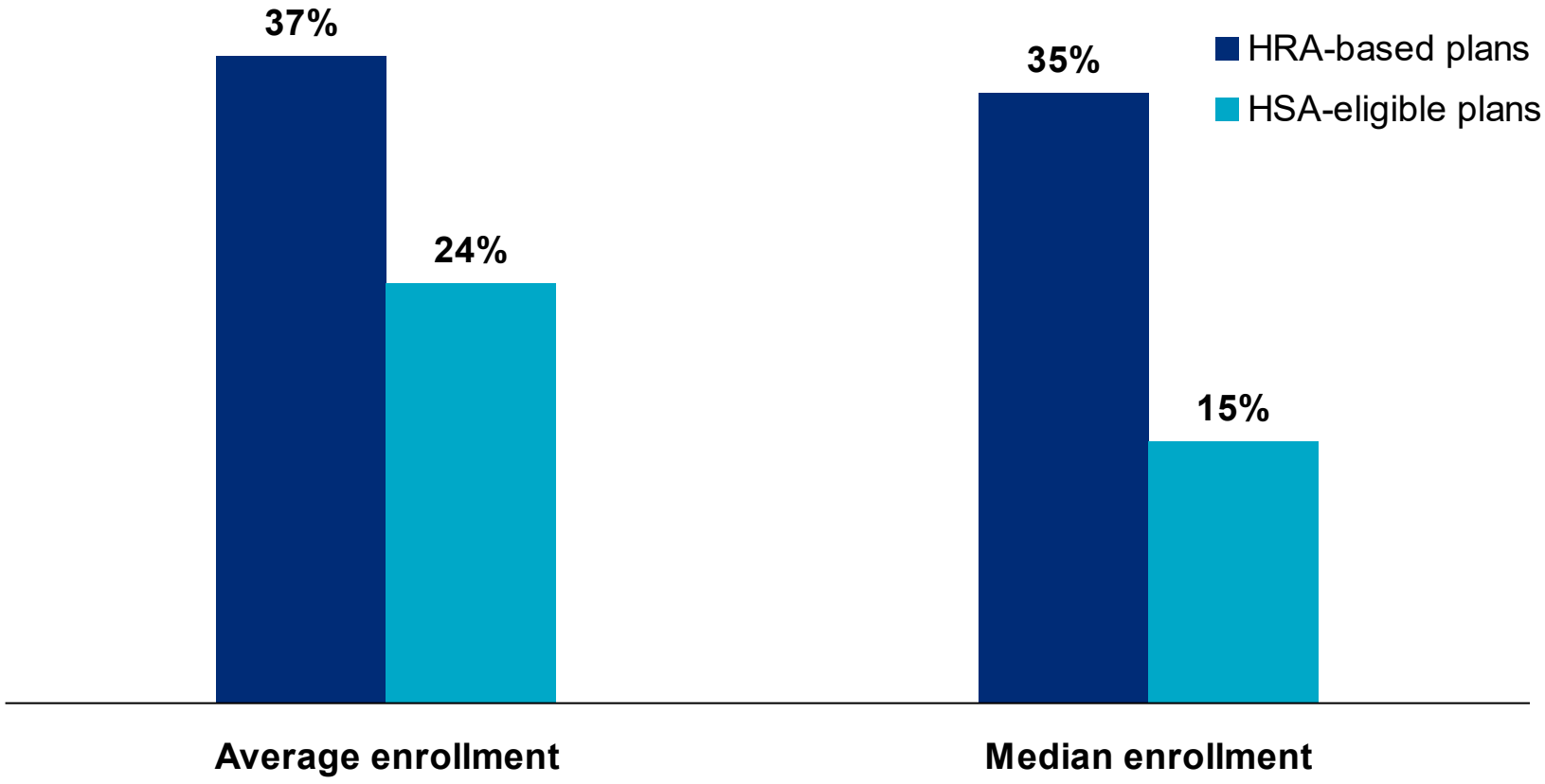
Consumer-Driven Health Plans (CDHP)

- Over the past three years (Table below), both the percentage of large employers offering CDHPs, and the percentage of covered employees enrolled in CDHPs, has nearly doubled:
  - In 2012, over a third of all large employers offered a CDHP, and 15% of their employees were enrolled. The larger the employer, the more likely they are to offer a CDHP
  - Of employers with 20,000 or more employees, 65% offered a CDHP in 2012
  - The State of Florida, like other large employers, offers a CDHP option (i.e., Health Investor Health Plans (HIHP)) with a health savings account (both PPO and HMO are offered)

Number of employees	2008	2009	2010	2011	2012	Very likely to offer CDHP in 2013
10 - 499	9%	15%	16%	20%	22%	21%
500 - 999	14%	16%	18%	26%	35%	36%
1,000 - 4,999	22%	20%	24%	34%	33%	39%
5,000 - 9,999	28%	42%	39%	42%	46%	49%
10,000 - 19,999	40%	39%	41%	46%	53%	59%
20,000 or more	45%	43%	51%	48%	59%	65%

Employees increasingly enrolled in HRA and HSA account-based plans

Percent of covered employees enrolled*, among large CDHP sponsors



*When CDHP is offered as an option alongside other medical plan choice

Foundation — competitive position
Plan design comparison to benchmark ranges

- The table shows the **medians** for surveyed plan provisions. Note that while the HRAs have similar survey data for the cost-sharing provisions shown (similar to qualified high deductible plans like with HSAs), employers often retain the use of HRAs with physician and/or pharmacy co-pays (i.e., more likely to report such HRAs as PPOs)
- Benchmark ranges based on National Jumbo, Large, Government, and State employers

2012 Mercer Survey Data	Benchmark Ranges				2013 State of Florida			
	PPO	HMO	HSA	HRA	PPO - Standard	HMO - Standard	PPO - Health Investor	HMO - Health Investor
Employee Contribution $ - Single	$100-$117	$74-$132	$35-$66	$73-$82	**$50**	**$50**	**$15**	**$15**
Employee Contribution % - Single	14%-25%	15%-23%	4%-19%	3%-23%	**8%**	**8%**	**2%**	**2%**
Employee Contribution $ - Family	$270-$391	$300-$373	$164-$259	$274-$308	**$180**	**$180**	**$64**	**$64**
Employee Contribution % - Family	21%-29%	17%-28%	14%-23%	5%-27%	**12%**	**12%**	**5%**	**5%**
Deductible - Single*	$300-$500	$0	$1,500	$1,500	$250	$0	$1,250	$1,250
Deductible - Family*	$750-$1,000	$0	$3,000	$3,150-$3,300	$500	$0	$2,500	$2,500
Coinsurance	20%	0%	20%	15%-20%	20%	0%	20%	20%
Out-of-Pocket Maximum - Single	$1,500-$2,500	None	$3,300-$3,800	$3,000-$3,525	$2,750	$1,500	$4,250	$4,250
Out-of-Pocket Maximum - Family	$3,250-$5,000	None	$5,700-$6,000	$5,025-$6,000	$5,500	$3,000	$8,500	$8,500
% active employees enrolled	57%-66%	18%-33%	4%-16%	4%-16%	42.5%	56.2%	0.9%	0.4%
Employer Contribution to HSA - Single	N/A	N/A	$500-$750	N/A	N/A	N/A	$500	$500
Employer Contribution to HSA - Family	N/A	N/A	$1,000-$1,520	N/A	N/A	N/A	$1,000	$1,000
Employer Contribution to HRA - Single	N/A	N/A	N/A	$500-$782	N/A	N/A	N/A	N/A
Employer Contribution to HRA - Family	N/A	N/A	N/A	$1,000-$2,296	N/A	N/A	N/A	N/A

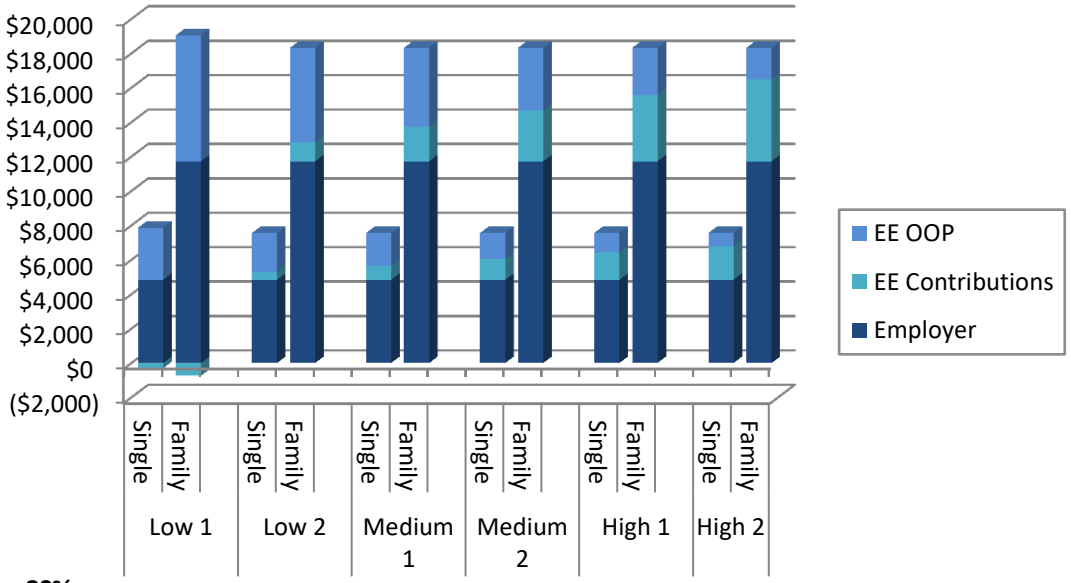
Note: Out-of-pocket maximums include deductible.

Red = notable variations

*__Average__ Deductible for National Large Employers for PPO is $666 Single and $1,545 Family, and HSA is $1,808 Single and $3,655 Family.
Source: Mercer's 2012 National Survey of Employer-Sponsored Health Plans

"Best healthcare practice" / trends — national survey illustration
A consumerism and defined contribution approach to pricing plan options

Illustration 1: Offer a Mix of Account-Based and Traditional Plans and Use a Defined Contribution (Core / Buy-Up / Buy-Down) Approach



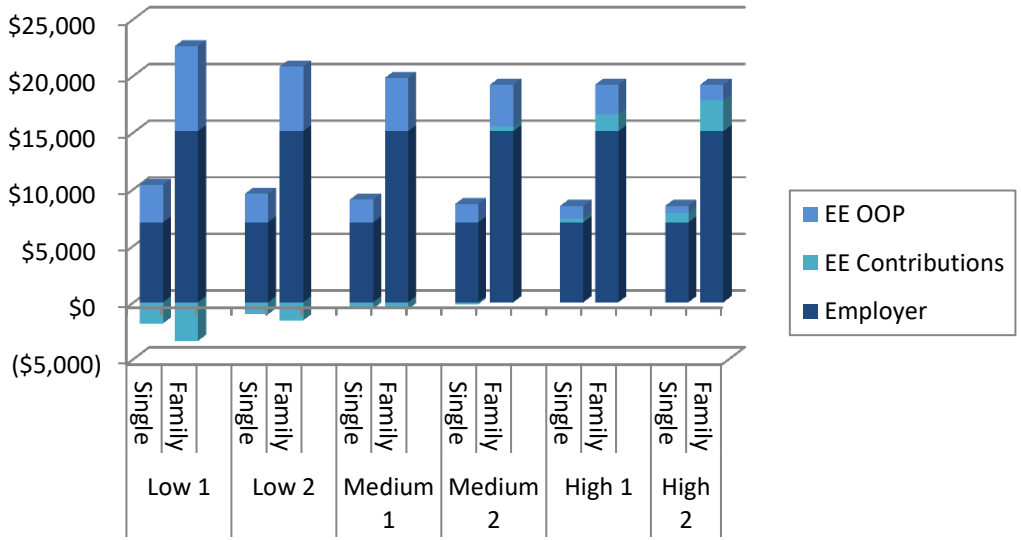
Single/Family - 20%

	PEPY	Plans Vary by Actuarial Values					
	Actuarial Value	0.60	0.70	0.75	0.80	0.85	0.90
Single	Total Plan Cost	$4,533	$5,288	$5,666	$6,044	$6,422	$6,799
	Employer Paid	$4,835	$4,835	$4,835	$4,835	$4,835	$4,835
	EE Contributions	($302)	$453	$831	$1,209	$1,586	$1,964
	EE OOP	$3,022	$2,266	$1,889	$1,511	$1,133	$755
Family	Total Plan Cost	$10,992	$12,824	$13,740	$14,656	$15,572	$16,488
	Employer Paid	$11,725	$11,725	$11,725	$11,725	$11,725	$11,725
	EE Contributions	-$733	$1,099	$2,015	$2,931	$3,847	$4,763
	EE OOP	$7,328	$5,496	$4,580	$3,664	$2,748	$1,832

"Best healthcare practice" / trends — State of Florida illustration
A consumerism and defined contribution approach to pricing plan options

Illustration 2: How the State of Florida's Plans Might Look if Part of a Consumerism Portfolio Offering (using the current 12% employee approximate cost share of aggregate premium levels)

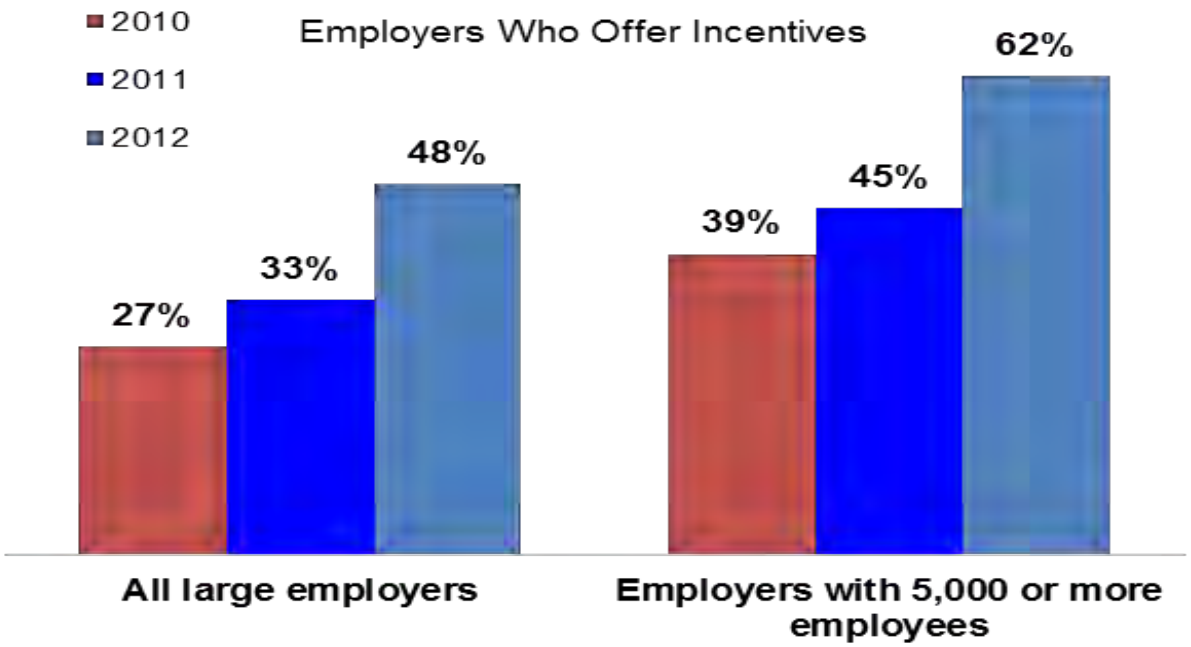
- The red circled numbers show pricing to buy-up / buy-down from the Standard PPO



	PEPY	Plans Vary by Actuarial Values					
					CDHP w/ HRA or HSAs	Standard PPO	Standard HMO
	Actuarial Value	0.60	0.70	0.75	0.80	0.86	0.93
Single	Total Plan Cost	$5,200	$6,000	$6,500	$6,900	$7,400	$7,900
	Employer Paid	$7,063	$7,063	$7,063	$7,063	$7,063	$7,063
	EE Contributions	($1,863)	($1,063)	($563)	-$163	$337	$837
	EE OOP	$3,300	$2,500	$2,000	$1,600	$1,100	$600
Family	Total Plan Cost	$11,700	$13,500	$14,500	$15,500	$16,600	$17,800
	Employer Paid	$14,440	$14,440	$14,440	$14,440	$14,440	$14,440
	EE Contributions	($2,740)	($940)	$60	$1,060	$2,160	$3,360
	EE OOP	$7,500	$5,700	$4,700	$3,700	$2,600	$1,400

Health management — incentives
Prevalence among large employers

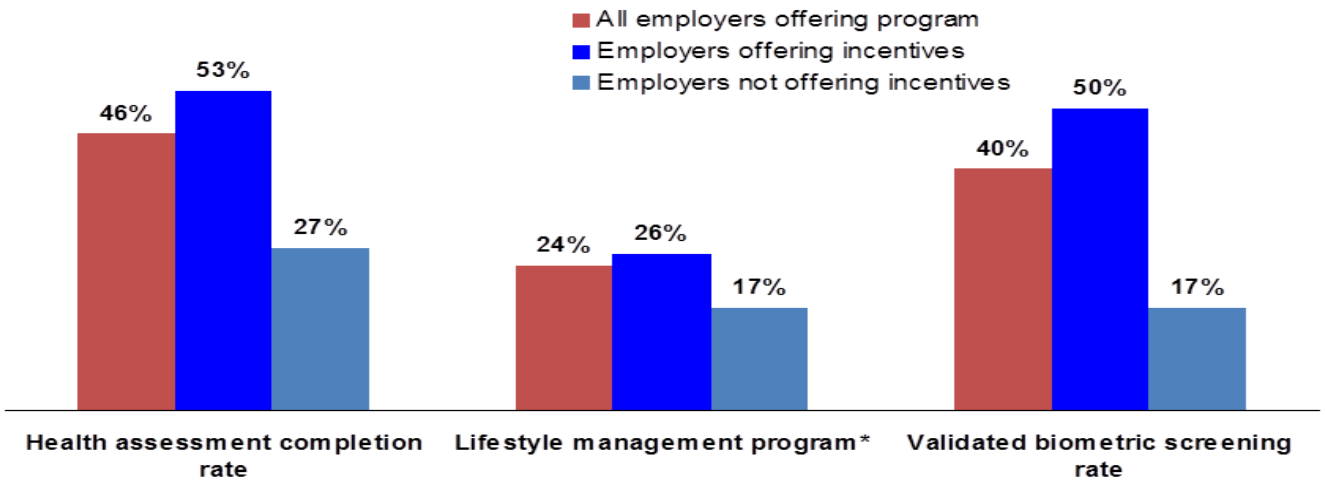
- The use of wellness and incentives is growing and large employers are tying incentives to wellness programs that include behavior modification, health assessment completion, and biometric screenings. Disincentives and outcome-based incentives are on the rise



- Almost half of all large employers (48%) in 2012 used incentives
- 62% of employers with 5,000 or more employees used incentives in 2012

Health management — incentives
Impact on participation in wellness programs

- When incentives are used:
  - Health assessment completion participation rates nearly doubled (from 27% to 53%)
  - Biometric screening participation rates more than doubled (from 17% to 50%)
  - Participation rates in lifestyle coaching increased from 17% to 26%



*Lifestyle management participation is defined as employees who had an assessment completed

Health management — engagement
Keys to CDHP enrollment (10%-50%) — key implementation decisions

	Initial Projected Enrollment	Moderate Enrollment	Higher* Enrollment
• Meaningfully lower EE CDHP / further increased PPO contributions	✓	✓	✓*
• Active enrollment (versus passive) / "Break Inertia" drop current plans	✓		
• Effective communication / education strategy and employer endorsement:			
– Visible leadership endorsement as key initiative	✓		
– Intensive / aggressive communication campaign and investment			✓*
– Communication of future strategy 2014+ (full-replacement)			✓*
– One or more mandatory meetings	✓		
• Plan design considerations and employee incentives:			
– Meaningful funding by company of CDHP ($500 single / $1,000 Family)	✓		
– Transition from copays to coinsurance for office visits			✓*
– Remove Rx copays (coinsurance with cap or make Rx subject to medical deductible)		✓	✓*
– Offer 1st year only additional incentive for CDHP enrollment (e.g., $500)			✓*
– Up-front, income-based, matching, voluntary benefit offered CDHP deposits		✓	
• Offer automatic enrollment CDHP or only CDHP plans to new hires			✓*
• Projected enrollment	0%-20%	20%-30%	30%-50%

***A combination of all the checked items likely needed to get 30-50% 1st year CDHP enrollment**

Innovation — health care reform
"Cadillac tax"

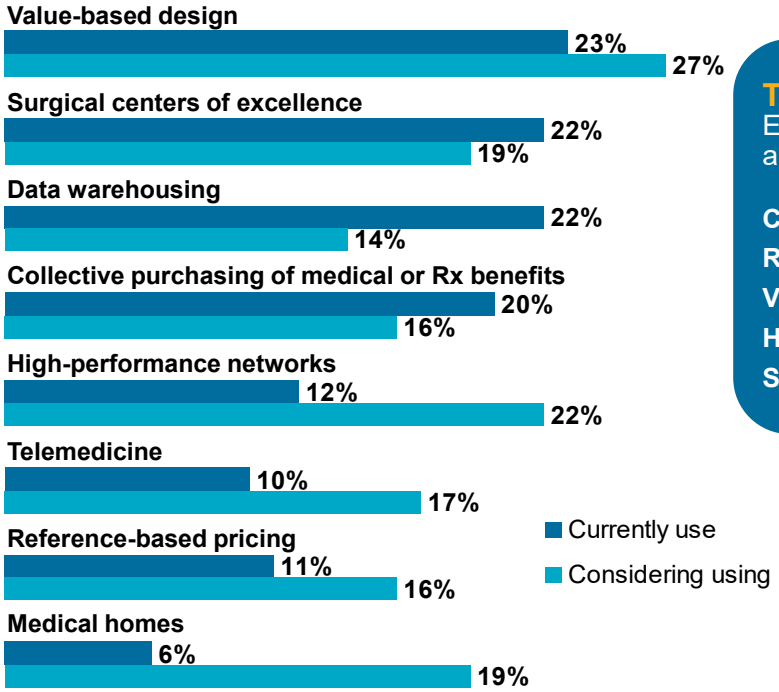
- A 40% "Cadillac tax" will be levied on the aggregate cost of employer-sponsored coverage in 2018
- The tax will apply on behalf of employees, former employees and surviving spouses who receive employer-sponsored coverage with a value equal or greater than $10,200 for "self-only," and $27,500 for "coverage other than self-only"
- Higher thresholds ($11,850 / $30,950) will apply to retirees and workers in high-risk professions and for single multi-employer plan coverage ($27,500)
- Cost indexing will apply after 2018, and will be based on the consumer price index (CPI) +1% for 2018 and 2019. After 2020, cost indexing will be based on CPI with no additional margin
- As 2018 approaches, employers like the State of Florida will need to consider whether to adjust their plan designs and plan offerings to avoid the "Cadillac tax"
- Of all PPACA provisions employers are currently facing, 48% of employers surveyed in Mercer's 2012 National Survey of Employer-Sponsored Health Plans said that their biggest worry is the "Cadillac tax"

Innovation — population specific

- What considerations are there for particular groups at the State of Florida?
  - Early Retiree Approach – Lower cost options would be available to early retirees, likely benefiting those who want lower contributions by selecting from additional new options. While early retirees do not pay the full actuarial value, they can continue to pay the “established” active premiums as they do today. Public exchange options exist as well
  - Payall Approach – “Payall” employees currently pay very low contributions so implementing a DC approach that is calibrated to current contribution levels would likely result in large taxable “cash back” (with HR, communication and administrative issues) for this group. Potential higher contribution strategies or limiting plan options may need to be discussed if the goal is to introduce consumerism or avoid risk selection for this group
  - Medicare-eligible retirees Approach – Medicare-eligible retirees may have alternative options available such as Medicare Advantage and Supplement plans. The State could procure its own Medicare Advantage plan or use private exchanges to offer all market options. Since Medicare-eligible retirees pay the full premium, they are unaffected by a defined contribution approach

Innovation — other trends

- Within the spectrum of innovations are those that can improve the quality of care employees receive and make care delivery more efficient
- While many of these and other new solutions are still emerging and may have limited cost savings potential unless used in conjunction with consumerism, early results are promising:
  - For example, more than half of the employers that have implemented reference-based pricing, value-based design, and high-performance networks have already been able to document a positive impact on cost



Top 5 cost savers
Employers using strategy that achieved lower cost as a result:

Collective purchasing	70%
Reference-based pricing	57%
Value-based design	56%
High-performance networks	51%
Surgical center of excellence	43%

Innovation — observations and considerations

- While innovation is rapidly expanding throughout the market, it is increasingly difficult to identify sustainable strategies with likely strong “ROI” for the organization, particularly relative to the risk of unknown health care reform, regulatory, provider, insurer, technology and consumer factors
- The suitability of these innovations for a particular large employer is largely dependent on the employer’s ability to identify and commit to longer term objectives, priorities and resources
- How many resources (staff, IT, budgets, communications, various group’s and constituent support) will be available for health management, innovative and provider initiatives?
- Responding to known and unknown Health Care Reform considerations is a significant compliance, financial and strategic consideration (e.g., the Cadillac tax needs to be closely monitored)

Disclaimer

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use


MERCER

PCB HHS 17-01

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHS 17-01 State Group Insurance Program
SPONSOR(S): Health & Human Services Committee
TIED BILLS: **IDEN./SIM. BILLS:**

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

PCB HHS 17-01 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 2018, DMS is directed to contract with at least one entity that provides online health care price and quality information, including the average price paid for health care services and providers by county. The contract requires the entity to allow enrollees to shop for health care using the information provided to select higher quality, lower cost services and providers. The contract also requires the entity to identify any savings realized by the enrollee, and share those savings with the enrollee

Beginning in the 2020 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, 2019. The IBC will also provide ongoing assessments and analysis for the program.

The bill directs DMS to recommend employee contribution rates for standard plans and high deductible health plans for the 2018 plan year reflecting the actual benefit difference between the HMO and the PPO plans for both self-insured and fully insured products. The proposed enrollee premium rates for the 2018 plan year must be submitted to the Legislative Budget Commission (LBC) for review and approval. If the LBC does not approve the proposed rates, the rates provided in the 2017-18 General Appropriations Act will apply.

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, 2017.

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 92% toward the total annual premium for active employees for a total of $1.80 billion out of total premium of $1.95 billion for active employees during FY 2016-17[2]. Retirees and COBRA participants contributed an additional $233.3 million in premiums, with $158.9 million more in other revenue for a total of $2.34 billion in total revenues.[3]

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[4] even though it offers relatively narrow health plan options compared to other cafeteria plans.

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[1] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.
[2] Florida Legislature, Office of Economic and Demographic Research, Self-Insurance Estimating Conference, *State Employees' Group Health Self-Insurance Trust Fund- Report on the Financial Outlook for Fiscal Years Ending June 30, 2017 through June 30, 2022*, adopted December 9, 2016, page 6, available at http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf
[3] Id.
[4] 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.

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 maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs[5].

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[6] 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 had been renewed for the 2015 plan year.[7]

Additionally, the program offers two high-deductible health plans (HDHP[8]) with health savings accounts (HSAs)[9]. 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 $1,300 for individual and $2,600 for family for network providers.[10] 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[11] to a limit of $3,400 for single coverage and $6,750 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.

[5] The HMOs include Aetna, AvMed, Capital Health Plan, Florida Health Care Plans and UnitedHealthcare.
[6] ITN NO.: DMS 10/11-011
[7] After extending the existing HMO contracts for the 2016 and 2017 plan years, DMS is currently procuring HMOs for the next contract period and expects to complete the procurement process and award contracts to the HMOs during or after the 2017 Regular Legislative Session.
[8] 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.
[9] 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 $6,550 for individual and $13,100 for family coverage. These amounts are adjusted annually by the IRS.
[10] Internal Revenue Service, *Revenue Procedure 2016-28*, April 29, 2016 (setting contribution limits for 2017 calendar year) available at https://www.irs.gov/pub/irs-drop/rp-16-28.pdf (last viewed February 10, 2017).
[11] Id., The IRS annually sets the contribution limit as adjusted by inflation.

	HMO Standard	PPO Standard	
	Network Only	Network	Out-of-Network
Deductible	None	$250 | $500 Single | Family	$750 | $1,500 Single | Family
Primary Care	$20 copayment	$15 copayment	40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist	$40 copayment	$25 copayment	
Urgent Care	$25 copayment	$25 copayment	
Emergency Room	$100 copayment	$100 copayment	
Hospital Stay	$250 copayment	20% after $250 copayment	40% after $500 copayment plus the amount between the charge and the allowance
Generic | Preferred | Non-Preferred Prescriptions	$7 | $30 | $50 Retail	$7 | $30 | $50 Retail	Pay in full, file claim
	$14 | $60 | $100 Mail Order	$14 | $60 | $100 Mail Order	
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	$1,300 | $2,600 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		After meeting deductible, 20% of out-of-network allowance
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)[12] as an optional benefit for employees. The FSA is funded though pre-tax payroll deductions from the employee's salary[13]. 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 $2,600[14] and subsequently adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement.[15] 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.[16] 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:

	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	$2,600 annually	Single - $3,400 Family - $6,750 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;[17]	IRC 213(d) expenses	Post-tax health insurance premiums and IRC 213(d) expenses
High Deductible Health Plan Required?	No	Yes Minimum deductible: Single - $1,300 Family - $2,600 Max out-of-pocket: Single - $6,550 Family - $13,100	No

[12] Sec. 125 I.R.C.; see *IRS Publication 969* (2014) available at https://www.irs.gov/pub/irs-pdf/p969.pdf (last viewed February 10, 2017).
[13] Employers are also allowed to contribute to FSAs.
[14] Internal Revenue Service, *Revenue Procedure 2016-55*, October 25, 2016 (setting contribution limit for 2017 calendar year) available at https://www.irs.gov/pub/irs-drop/rp-16-55.pdf (last viewed February 10, 2017).
[15] Beginning in 2013, an employee may carryover up to $500 into the next calendar year.
[16] 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.
[17] 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.

Employer and Employee Contributions

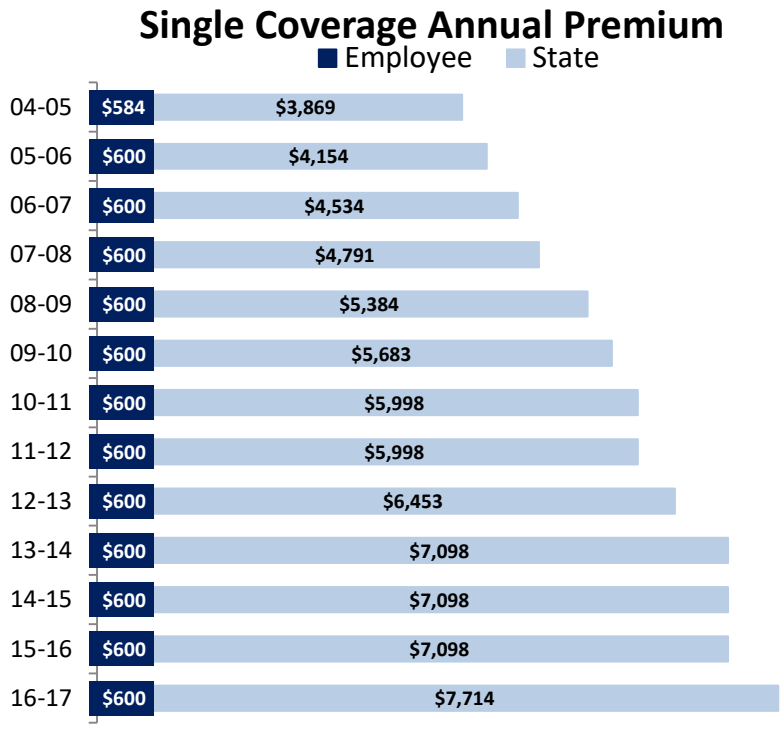
The state program is considered employer-sponsored since the state contracts with providers and contributes a substantial amount on behalf of the employee toward the cost of the insurance premium. The state's employer contribution is part of a state employee's overall compensation. The state program 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[18] of the state and the employee to employee health insurance premium.

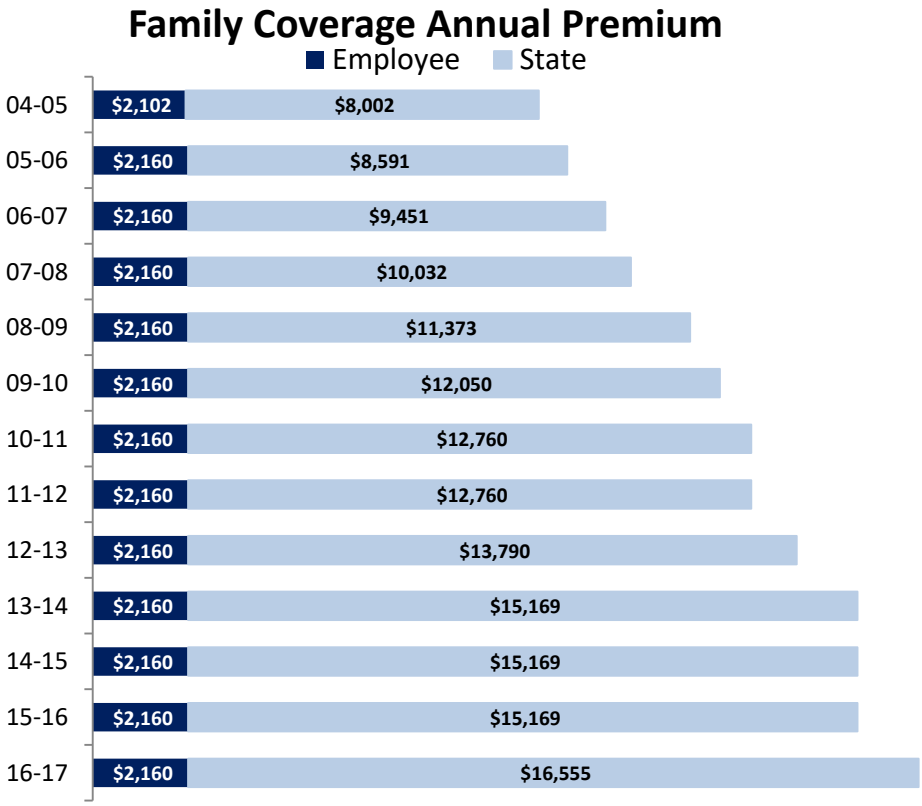
Subscriber Category	Coverage Type	PPO and HMO Standard			PPO and HMO Health Investor		
		Employer	Enrollee	Total	Employer*	Enrollee	Total
Career Service/ OPS	Single	$642.84	$50.00	$692.84	$642.84	$15.00	$657.84
	Family	$1,379.60	$180.00	$1,559.60	$1,379.60	$64.30	$1,443.90
	Spouse	$1,529.60	$30.00	$1,559.60	$1,413.92	$30.00	$1,443.92
"Payalls" (SES/SMS)	Single	$684.50	$8.34	$692.84	$549.50	$8.34	$657.84
	Family	$1,529.60	$30.00	$1,559.60	$1,413.90	$30.00	$1,443.90

* Includes employer tax-free Health Savings Account (HSA) contribution - $41.66 and $83.33 per month ($500 and $1,000 annually) for single and family coverage, respectively

The state program is projected to spend $2.34 billion in FY 2016-2017 in health benefit costs.[19] 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.[20]

[18] Department of Management Services, State Employees' Group Health Self-Insurance Trust Fund, *Premium Rate Table Effective January 2017 for February 2017 Coverage,* available at http://mybenefits.myflorida.com/content/download/130052/808071/DSGI_-_Premium_Table_Effective_January_2017_for_February_2017_Coverage.pdf (last viewed February 8, 2017).
[19] Supra, FN 2, page 4.
[20] Department of Management Services, *Overview of the State Group Health Insurance Program,* presentation to the Health and Human Services Committee on February 14, 2017, slide 15 (on file with Health and Human Services Committee staff).


Single Coverage Annual Premium
Employee
State
04-05 $584 $3,869
05-06 $600 $4,154
06-07 $600 $4,534
07-08 $600 $4,791
08-09 $600 $5,384
09-10 $600 $5,683
10-11 $600 $5,998
11-12 $600 $5,998
12-13 $600 $6,453
13-14 $600 $7,098
14-15 $600 $7,098
15-16 $600 $7,098
16-17 $600 $7,714


Family Coverage Annual Premium
Employee
State
04-05 $2,102 $8,002
05-06 $2,160 $8,591
06-07 $2,160 $9,451
07-08 $2,160 $10,032
08-09 $2,160 $11,373
09-10 $2,160 $12,050
10-11 $2,160 $12,760
11-12 $2,160 $12,760
12-13 $2,160 $13,790
13-14 $2,160 $15,169
14-15 $2,160 $15,169
15-16 $2,160 $15,169
16-17 $2,160 $16,555

Plan Enrollment

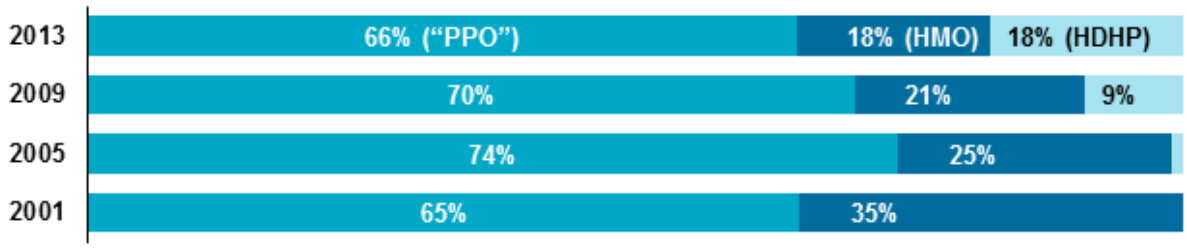
The state program has 366,080 covered lives and 173,761 policyholders.[21] Currently, 51.4% of enrollees chose the standard HMO and 48.6% chose the standard PPO.[22] Only 1.6% of enrollees chose either HDHP.[23] During the open enrollment period for 2015, PPO enrollment increased slightly, by 0.05%, and HMO enrollment decreased by 0.46%.[24] Open Enrollment trends forecasted from FY 2016-17 through 2020-21 show an average annual decrease in PPO plan enrollment of 0.5% and an average increase in HMO plan enrollment of 2.5%.[25]

Employer Sponsored Insurance Trends

In 2010, DSGI contracted with Mercer Consulting to prepare a Benchmarking Report[26] (report) for the state. The report compares Florida's program to the programs of other large employers[27], 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[28] and the benchmark premium for large national employers ranges from $270 to $391 with the company paying 71% to 79% of the premium.[29]

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[30]:



Mercer's latest survey of employer health plans reveals that near 3 in 10 employees were enrolled in an HDHP in 2016.[31]

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[21] Id. at slide 7.
[22] Supra, FN 2 at page 1.
[23] Id. at page 2.
[24] Florida Legislature, Office of Economic and Demographic Research, Self-Insurance Estimating Conference, State Employees' Group Health Self-Insurance Trust Fund, *Report on the Financial Outlook*, March 9, 2015, page 1, available at http://edr.state.fl.us/Content/conferences/healthinsurance/archives/150309healthins.pdf (last viewed February 10, 2017).
[25] Supra, FN 22.
[26] 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.
[27] For the purpose of the report, "large employers" had 500 or more employees.
[28] The state contributes 92% of the premium for the individual PPO plan.
[29] *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.
[30] Id. at slide 6.
[31] Mercer, *Mercer survey: Health benefit cost growth slows to 2.4% in 2016 as enrollment in high-deductible plans climbs*, October 26, 2016, available at https://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html (last viewed February 8, 2017).

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%.[32] 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[33] 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.[34] The state program has plans with lower employee premiums and higher benefits than industry benchmarks.[35] There is virtually no enrollment in HDHPs versus significant growth nationally.[36] Florida's plan costs and annual trend increase are higher than national survey data.[37] State employees 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.[38] Consequently, 99 percent of enrollees chose the HMO or PPO with little to no incentive to choose the HDHP.[39]

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[40] in the same plan."[41] 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

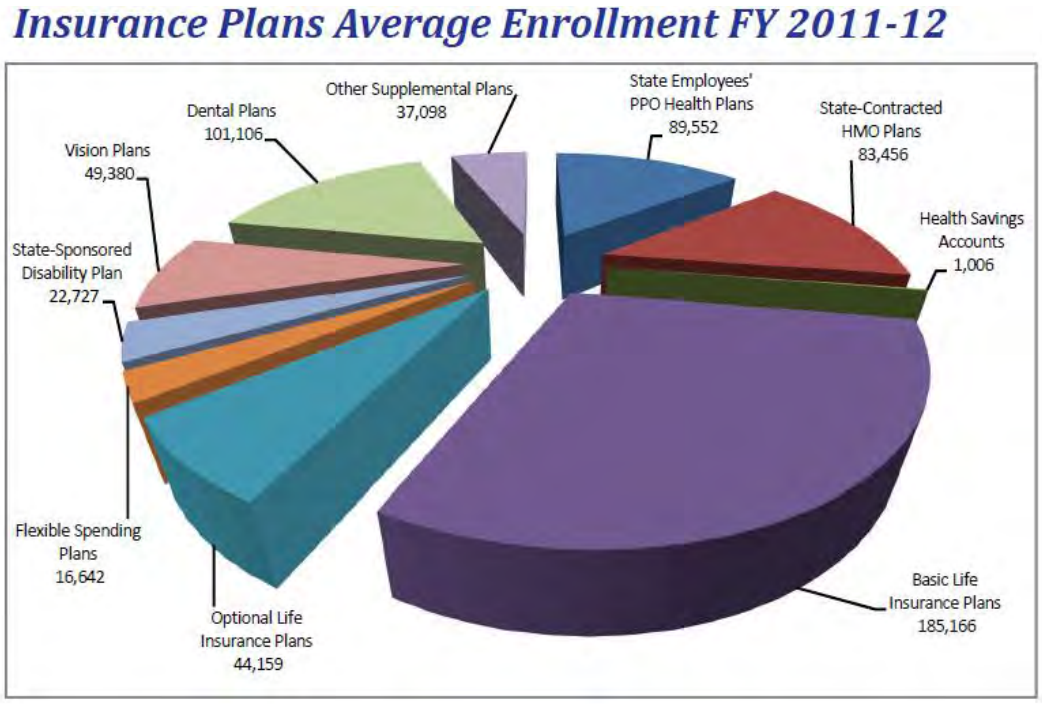
[32] Supra, FN 29 at slide 20.
[33] Buck Consultants, *Strategic Health Plan Options for the State of Florida* (September 29, 2011), available at: http://www.dms.myflorida.com/content/download/81468/468856/version/1/file/Strategic+Health+Plan+Options+for+the+State+of+Florida+9-30-11+-+Final.pdf (last viewed on February 8, 2017).
[34] Supra, FN 29 at slide 5.
[35] Id.
[36] Id.
[37] Supra, FN 29 at slide 6.
[38] Foster and Foster, *Actuarial Value Contribution Analysis,* March 20, 2015 at page 3.
[39] Supra, FN 29 at slide 9.
[40] The coverage tier is either individual or family.
[41] S. 110.123(3)(f), F.S.

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.

Because DMS is currently procuring HMO contracts for the SGI program, the value of the benefits offered by the HMOs that will receive a contract is unknown. Employee contribution rates that reflect the different values of the HMO and the PPO cannot be determined until the conclusion of the procurement. The bill directs DMS to determine and recommend employee contribution rates for standard plans and high deductible health plans for the 2018 plan year reflecting the actuarial benefit difference between the HMO and the PPO plans for both self-insured and fully insured products. The proposed enrollee premium rates for the 2018 plan year must be submitted to the LBC for review and approval. If the LBC does not approve the proposed rates, the rates provided in the 2017-18 General Appropriations Act will apply.

Additional Benefits

Many state employees enroll in products offered by the state program other than health insurance:



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 and Cost Savings Sharing

The costs of health care procedures are often unknown and unknowable to consumers and can vary dramatically among providers.[42] For example, the average Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,500 to $33,000 across geographic areas for lower extremity joint replacement, which includes hips and knees.[43]

The 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.[44]

The bill directs DMS to contract with at least one entity that provides online health care price and quality information, including the average price paid for health care services and providers by county. The contract requires the entity to allow enrollees to shop for health care using the information provided to select higher quality, lower cost services and providers. The contract also requires the entity to

[42] *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 on February 8, 2017). *Does Knowing Medical Prices Save Money? CalPERS Experiment Says Yes*, Kaiser Health News, 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 on February 8, 2017).
[43] U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services, *Comprehensive Care for Joint Replacement Model*, available at https://innovation.cms.gov/initiatives/cjr (last viewed February 10, 2017).
[44] *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/ (last viewed on February 8, 2017).

identify any savings realized between what the enrollee pays for a service or provider and the average price paid for the same service or provider. The bill provides for the enrollee and state to share any savings generated by the enrollee's choice of providers. 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 2019, 2020, and 2021, 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 2020 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. The employee 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 employee's pay.[45]

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[46] 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:

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

Family Coverage	Current Plan 88% - 92% AV	80% AV Coverage	70% AV Coverage	60% AV Coverage
State Contribution	$16,555	$16,555	$16,555	$16,555
Plan Cost	$18,715	$14,972	$13,101	$11,229
Employee Contribution	$2,160	$0	$0	$0
Employee Receives	$0	$1,583	$3,454	$5,326

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, 2019, 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 state group insurance program.
Section 2: Creates s. 110.12303, F.S., relating to state group insurance program; additional benefits; price transparency program; reporting.
Section 3: Creates s. 110.12304, F.S., relating to independent benefits consultant.

Section 4: Creates an unnumbered section of law authorizing the Department of Management Services to determine and recommend premiums for employees in the state group insurance plan for the 2018 plan year, submit the proposed premium rates to the Legislative Budget Commission for approval, and providing for application of the premium rates in the 2017-18 General Appropriations Act if the Legislative Budget Commission does not approve the proposed premium rates.

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 2017-2018 fiscal year to implement the act.

Section 6: Provides an effective date of July 1, 2017.

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.

The provision requiring DMS to determine and propose employee premium rates that reflect the actuarial benefit difference between the HMO, PPO and HDHPs for plan year 2018, if implemented, will be cost neutral to the state. Employees will generally have a choice between richer benefits and lower premiums.

DMS has previously indicated that the fiscal impact of the development of the tiered premium structure in plan year 2020 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:

DMS has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to 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 an employee to use a specified portion of the state's contribution to purchase additional program benefits and supplemental benefits under certain circumstances; providing for the program to offer health plans in specified benefit levels; requiring the Department of Management Services to develop a plan for implementation of the benefit levels; providing reporting requirements; providing for expiration of the implementation plan; creating s. 110.12303, F.S.; authorizing additional benefits to be included in the program; 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 and reporting requirements; requiring the department to contract with an entity to provide enrollees with online information on health care services and providers; providing contract and reporting requirements; creating s. 110.12304, F.S.; directing the department to contract with an

independent benefits consultant; providing qualifications and duties of the independent benefits consultant; providing reporting requirements; providing that the department shall determine and recommend premiums for enrollees for the 2018 plan year; providing requirements for the determination of premiums; requiring the department to submit premium rates to the Legislative Budget Commission by a specified date for review and approval; requiring premium rates to be consistent with the total budgeted amount for the program in the General Appropriations Act for the 2017-2018 fiscal year; providing an appropriation 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, and paragraph (k) is added to subsection (3) of that section, 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 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, is employed for less than 8 months during any 12-month period, but does not include a person paid from other-

personal-services (OPS) funds. 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" 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. "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 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 2020 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 which is under contract with the state in accordance with criteria established by this section and 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, 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 which:

a. Serves 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 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 2018 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, and the department shall issue a request for proposal or invitation to negotiate for ~~insurance~~ providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the department may enter into

contract negotiations with ~~insurance~~ providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, except as provided in subparagraph (f)3., no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans. With respect to dental coverage, the division shall include in any solicitation or contract for any state group dental program made after July 1, 2001, a comprehensive indemnity dental plan option which offers enrollees a completely unrestricted choice of dentists. If a dental plan is endorsed, or in some manner recognized as the preferred product, such plan shall include a comprehensive indemnity dental plan option which provides enrollees with a 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 2020 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~~.

(k) In consultation with the independent benefits consultant described in s. 110.12304, the department shall develop a plan for implementation of the benefit levels

described in paragraph (j). The plan shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2019, and include recommendations for:

1. Employer and employee contribution policies.

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

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

This paragraph expires July 1, 2019.

Section 2. Section 110.12303, Florida Statutes, is created to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—Beginning with the 2018 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 authorized pursuant to part I of chapter 636.

(b) Discount medical plan organizations authorized pursuant to 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)(a) The department shall contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures which 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 enrollee's out-of-pocket medical expenses.

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

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

(3) The department shall contract with an entity that

provides enrollees with online information on the cost and quality of health care services and providers, allows an enrollee to shop for health care services and providers, and rewards the enrollee by sharing savings generated by the enrollee's choice of services or providers. The contract shall require the entity to:

(a) Establish an Internet-based, consumer-friendly platform that educates and informs enrollees about the price and quality of health care services and providers, including the average amount paid in each county for health care services and providers. The average amounts paid for such services and providers may be expressed for service bundles, which include all products and services associated with a particular treatment or episode of care, or for separate and distinct products and services.

(b) Allow enrollees to shop for health care services and providers using the price and quality information provided on the Internet-based platform.

(c) Permit a certified bargaining agent of state employees to provide educational materials and counseling to enrollees regarding the Internet-based platform.

(d) Identify the savings realized to the enrollee and state if the enrollee chooses high-quality, lower-cost health care services or providers, and facilitate a shared savings payment to the enrollee. The amount of shared savings shall be

determined by a methodology approved by the department and shall maximize value-based purchasing by enrollees. 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 2019, 2020, and 2021, 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 implementation of this subsection.

Section 3. 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 insurer.

(b) Have an ownership interest in a health maintenance

organization or insurer.

(c) Have a direct or indirect financial interest in a health maintenance organization or 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 under 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 that 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 with the submission of any necessary plan revisions for federal review.

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

(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 by January 1 of each year.

Section 4. For the 2018 plan year, the Department of Management Services shall determine and recommend premiums for enrollees that reflect the actual differences in costs to the program for each of the health maintenance organization and the preferred provider organization plan options offered in the state group insurance program for both self-insured and fully insured plans. The premium alternatives for the plan options shall reflect the costs to the program for both medical and prescription drug benefits. By July 1, 2017, the department shall submit the proposed enrollee premium rates for the 2018 plan year to the Legislative Budget Commission for review and approval. If the Legislative Budget Commission does not approve the proposed rates, the rates provided in the 2017-2018 General Appropriations Act shall apply. The premium rates for employers shall be the same as those established for the state group insurance program in the General Appropriations Act for the 2017-2018 fiscal year.

Section 5. (1) For the 2017-2018 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 and 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 in Salaries and Benefits and $688 in 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 in Special Categories Contracted Services and $7,546 in Expenses.

Section 6. This act shall take effect July 1, 2017.

Beth Kidder
AHCA

Medicaid
Long-term Care Program

Beth Kidder
Deputy Secretary for Medicaid
Agency for Health Care Administration

House Health & Human Services Committee

February 14, 2017

Overview

- Program background
- Nursing facility transition
- Cost savings
- Billing data

Statewide Medicaid Managed Care: Fully Integrated Long-term Care Program

- Long-term Care program covers:
  - Nursing facility
    - Furnishes medical or allied inpatient care
    - Institution; more restrictive; generally more costly
  - Home and Community Based Services
    - Care in the home, family home, or assisted living facility
    - Designed to prevent or delay facility placement
    - Less restrictive, generally less costly

Member Characteristics

- All members must meet nursing facility level of care
- Enrolled in the program by:
  - Residing in a nursing facility or
  - Being scored as most frail and in need of services
- Average enrollee:
  - 67% age 75 and older
  - Needs assistance with more than one activity of daily living (e.g., bathing, dressing, eating, toileting), and 75% need help with three or more.

Nursing Facility "Transition"

- Transition: When a LTC enrollee leaves a nursing facility to move to a community setting
  - Community: Their own home, their family home, assisted living facility
- 12.1% **decrease** in the number of Medicaid recipients residing in a nursing facility since program implementation (2013-2016)

Who Makes Transition Happen?

- LTC plan care managers work with the individual to develop a plan for transition
- Modify their existing home (e.g., grab bars in bathroom) or locate a safe, affordable place to live
- Arrange for in-home supports (e.g., personal care aide, medical equipment and supplies, home-delivered meals)
- LTC plan can pay security and utility deposits, moving costs, basic home furnishings

Why is Transition Important?

- Enhances quality of life
- Complies with Americans with Disabilities Act and Florida Statutes
- Saves money

Transition Improves Quality of Life

- Living in the community means:
  - Being at home with loved ones
  - Living in a setting where they have cherished memories
  - Visiting with friends in a setting with which they are familiar and comfortable
  - Being a part of supportive communities
- 2016 LTC Enrollee Satisfaction Survey shows that:
  - 76% of respondents stated that their quality of life has improved since enrolling in their LTC plan.

Transition Complies with Federal & State Law

- Americans with Disabilities Act
  - Requires that individuals with disabilities be given opportunity to "receive services in the least restrictive setting appropriate to their needs"
- Florida Statute
  - Requires that the LTC program incorporate financial incentives to reduce the percentage of individuals on Medicaid in nursing facilities by 3% each year
  - Goal: No more than 35% of the state's Medicaid long-term care recipients are in nursing facilities.

Transition Avoids Increased Costs

- Without the transitions that have taken place since the LTC program implementation, Medicaid LTC services would have cost an additional:
  - $284 million in FY 2014-2015
  - $432 million in FY 2015-2016
  - $200 million per year in subsequent years

Transition Continues Even After a Year-Long Nursing Facility Stay

- Out of all LTC program enrollees who have transitioned from a nursing facility to a home-like setting, 64% transitioned **after** more than 60 days of enrollment in the health plan.
  - Enrollment in the LTC plan generally occurs after a 60 day stay in a nursing facility, so you can assume the stay began at least 60 days earlier
- 20 % of transitions occur after 365 days enrollment in the health plan.

Long-term Care Program Payments

- The Agency pays LTC plans a monthly capitation payment to provide services to their enrollees.
- Plans must pay for all covered services for their enrollees, regardless of whether the cost of those services exceeds the capitation rate received from the Agency.
- Plans are required to pay nursing facilities and hospice providers the rate set by the Agency.

LTC Plan Requirements for Prompt Payment of Nursing Facility Claims

- Plans have contractual requirements regarding the prompt payment of clean claims.
- The LTC plan must have a process for handling and addressing the resolution of provider complaints concerning claims issues.
- Providers can report any provider payment issues to the Agency.

LTC Plan Requirements for Prompt Payment of Nursing Facility Claims

- The Agency is required to contract with an organization to provide assistance with the resolution of claim disputes that are not resolved by providers and health plans.
  - The Agency currently contracts with Maximus, an independent dispute resolution organization.
  - All providers who provide services to recipients in licensed HMOs (including Medicaid and commercial HMOs) can utilize the Agency's Maximus Contract to file a dispute.

LTC Plan Requirements for Prompt Payment of Nursing Facility Claims

- Clean claim:
  - A claim that can be processed without obtaining additional information from the provider or a third party.
- Electronically submitted clean claims:
  - Must pay within **10** business days of submission
- Paper clean claims:
  - Must pay within **20** business days of submission

Reasons Why a Nursing Facility Claim May Not Be Paid Timely

- Facility does not timely submit claims
  - LTC plans have no control over the time it takes for a facility to prepare and submit a claim
- Not a clean claim
  - E.g., Missing or inappropriate values in required claim fields.
- Claim requires additional documentation for payment
- Failure by plan to approve claim for payment.

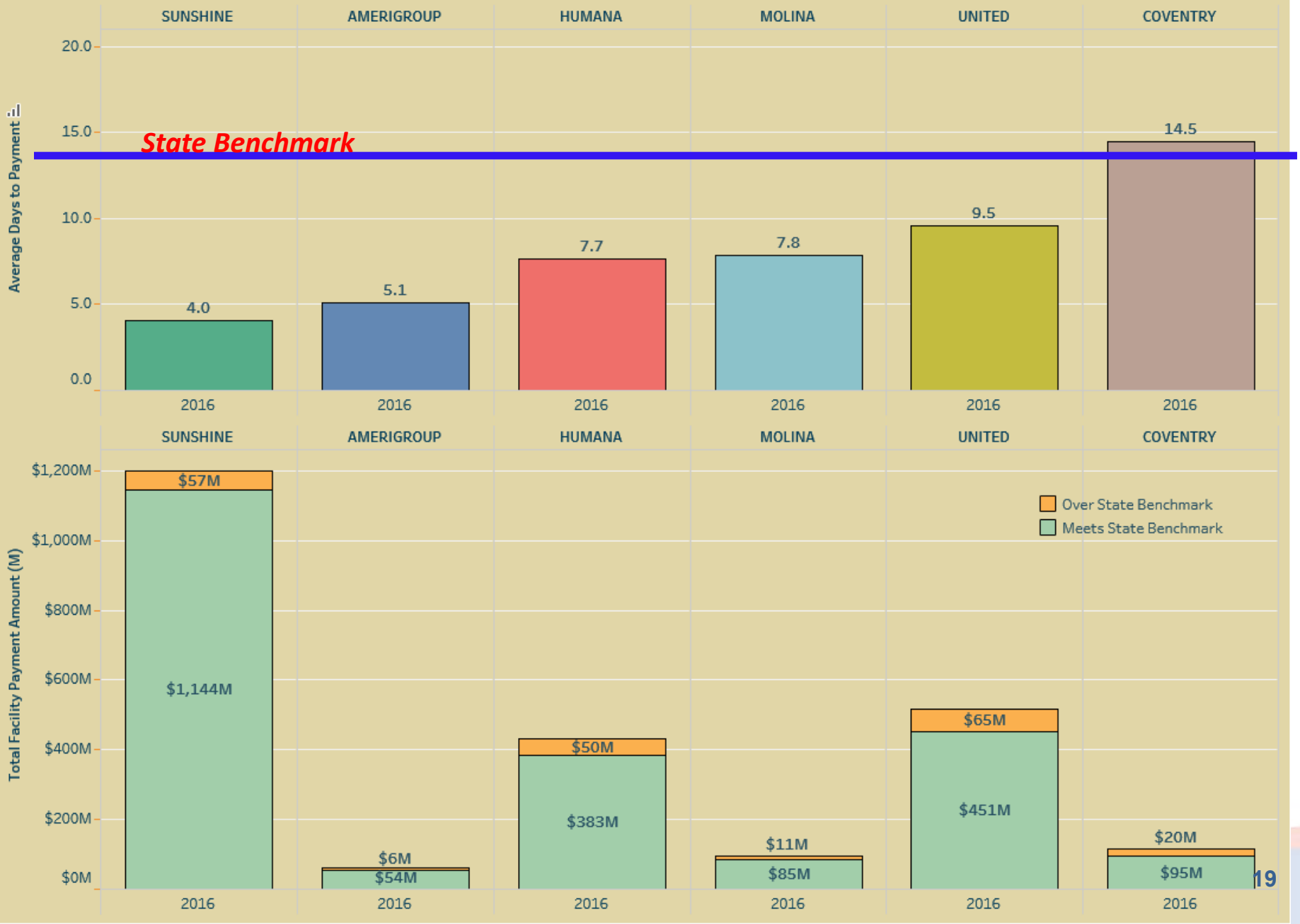
Nursing Facility Claims Payment Analysis: Methodology and Assumptions

- The Agency analyzed paid claims data to determine how quickly LTC plans are paying nursing facility claims.
- The analysis uses calendar year 2016 data and includes:
  - Dates of Service January 2016 through December 2016
  - Dates of Payment January 2016 through December 2016
- January through September 2016 claims are reconciled to the LTC plans' financial reports (Achieved Savings Rebate)

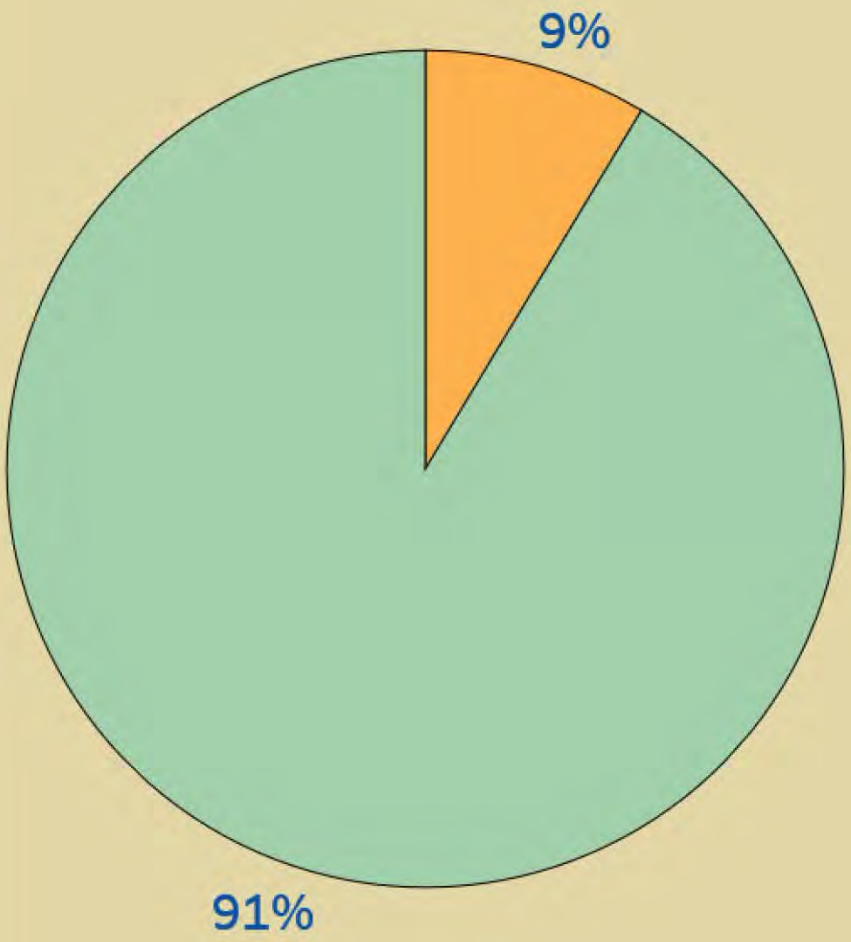
Nursing Facility Claims Payment Analysis: Methodology and Assumptions

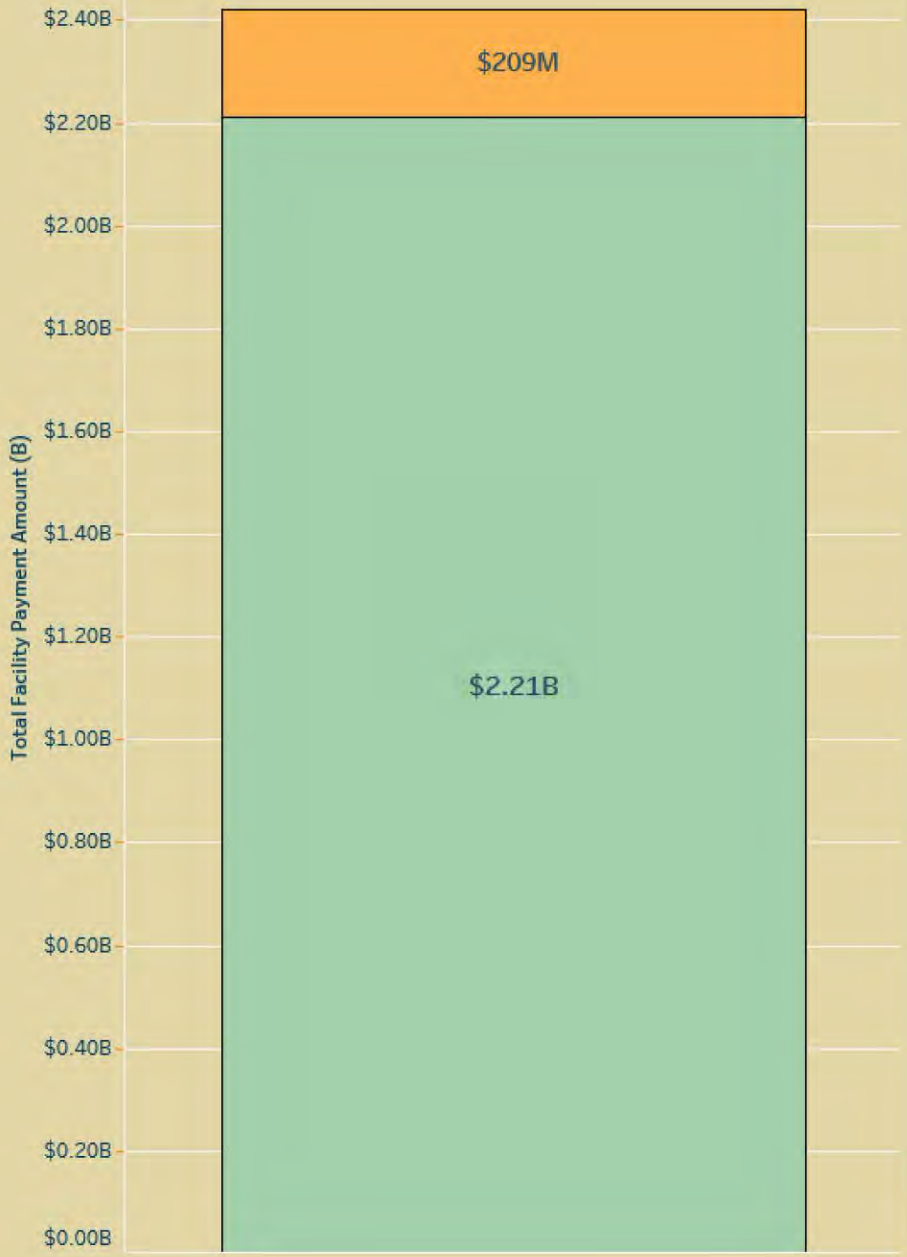
- Assumes all claims were submitted to the LTC plan 1 week after the date of service.
- 14 calendar days equates to 10 business days.
- All claims are treated as if they were submitted electronically, even though there is a longer timeframe to pay paper claims.

Summary of Payment Timelines and Associated Dollars

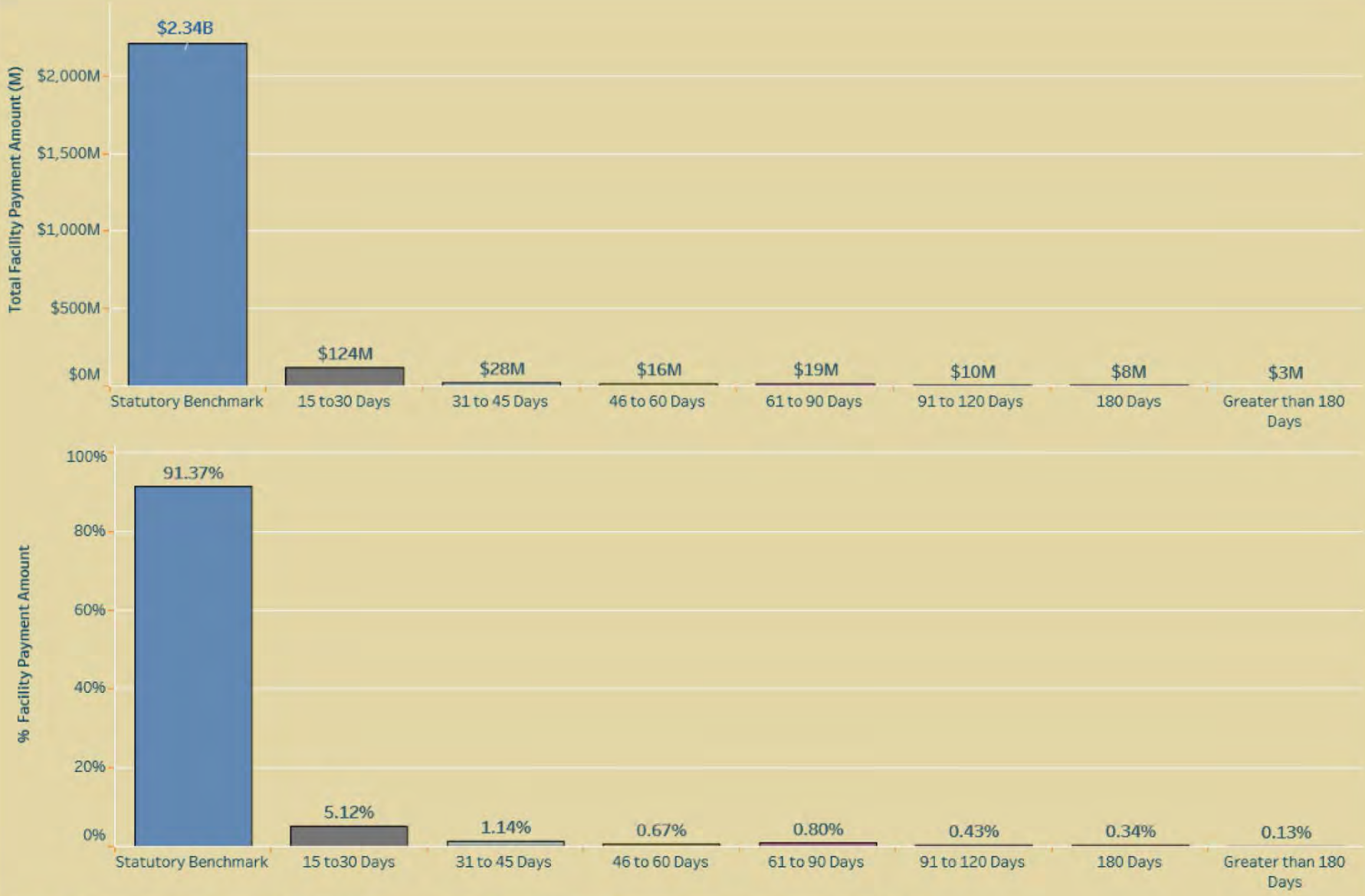


91% of Nursing Home Claims Paid Within State Benchmark





Summary of Payment Timelines and Associated Dollars



Source: LTC Encounter Dataset - Jan2016 Last Update: 2/9/2017 1:46:25 PM Workbook: LTC Claims Payment Print Version Update 2-9-16

Enforcing Compliance with the Contract

- The Agency monitors health plans to ensure they comply with their contract, e.g.:
  - Weekly reviews of recipient and provider complaints
  - Analysis of dozens of regular reports from plans
- If plans are out of compliance with their contract the Agency can impose:
  - Corrective action plans
  - Monetary liquidated damages, and/or
  - Sanctions (monetary or non-monetary)
- Have assessed and collected $80,000 in fines to two Long-Term care plans.

Questions?