HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	SB 2508	**FINAL HOUSE FLOOR ACTION:**	
SUBJECT/SHORT TITLE	State Group Insurance Program	110 **Y's** 2 **N's**	
SPONSOR(S):	Appropriations	**GOVERNOR'S ACTION:**	Approved
COMPANION BILLS:	SB 2510		

SUMMARY ANALYSIS

Senate Bill 2508 passed the Senate on May 8, 2017, as amended by the conference committee. The House concurred in the conference committee amendment to the Senate bill and subsequently passed the bill as amended on May 8, 2017.

The bill authorizes the Division of State Group Insurance Program (DSGI) within the Department of Management Services (DMS) to conduct a dependent eligibility verification audit.

Currently, s. 110.123, F.S., creates the State Group Insurance Program (program) to be administered by the DSGI within the DMS. The state program is optional, and is a benefit program for state employees of all state agencies, state universities, the court system, and the Legislature. The program consists of health, life, dental, vision, disability, and other supplemental insurance benefits.

The bill amends s. 110.12301, F.S., directing the DMS to contract with a third party provider to verify the eligibility of all dependents currently participating in the state program. The DMS is required to notify all members of the Health Insurance Plan regarding the eligibility criteria for dependents by September 1, 2017.

The bill also amends s. 110.12315, F.S., updating the state employee Prescription Drug Program. The bill makes modifications to permanently codify changes annually made to the program through the implementing bill and general appropriations act since 2010.

The fiscal impact of the bill is indeterminate; however, the DMS anticipates that the bill will result in significant cost avoidance by eliminating ineligible dependents from coverage.

This bill was approved by the Governor on June 16, 2017, ch. 2017-127, L.O.F., and will become effective on July 1, 2017.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

State Group Insurance Program

Currently, s. 110.123, F.S., creates the State Group Insurance Program (program) to be administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS). The state program is optional, and is a benefit program for state employees of all state agencies, state universities, the court system, and the Legislature. The program consists of health, life, dental, vision, disability, and other supplemental insurance benefits.

Plan Enrollment

Currently, the state has approximately 366,681 covered lives and 176,274 policyholders. According to data submitted by the DMS, there are 78,806 spouses and 112,601 other dependents listed as covered dependents in the state plan's records.

Dependent Eligibility

The program currently covers state agency employees, retirees, and eligible dependents. A dependent may be eligible for coverage based on a relationship to the member under the following circumstances:

- A current spouse to whom the member is legally married;
- A biological child or adopted child of the member through the calendar year in which the child turns age 26;
- A child of the member who is permanently mentally or physically disabled. The member's child may continue health insurance coverage after reaching 26 years of age if the child is unmarried and dependent on the member for care and financial support;
- A stepchild – a child of the member's current spouse through the calendar year in which the child turns age 26;
- A foster child placed in the member's home through the calendar year in which the child turns age 26;
- A newborn dependent of a member's covered child for up to 18 months of age, as long as the newborn's parent remains covered; and,
- An over-age dependent until the calendar year in which the child turns age 30, if unmarried.

During open enrollment each year, or in the event of a qualifying status change, dependents may be added or removed as covered dependents. Currently, the DMS collects minimal information to determine the eligibility of covered dependents.

State Health Insurance Plans

The program currently provides four options for employees and retirees to choose as their health plan. Two options are the PPO Standard Health Plan or the PPO High Deductible Health Plan. These plans are administered by a third party administrator, Florida Blue. The other two options are the HMO Standard Plan or the HMO High Deductible Health Plan. These plans are administered by third party administrators Aetna, AvMed, and United Health Care as self-insured plans based on geographic regions of the state. Additionally, there are two fully-insured HMO plans, Capital Health Plan and Florida Health Plan, which are offered in other areas of the state.

Pharmacy Benefits

The program also offers pharmacy benefits to members of the plan. The program currently covers all federal legend drugs (open formulary) for covered medical conditions, employing very limited utilization review and clinical review for traditional or specialty prescription drugs. Specialty drugs, consisting of high-cost prescription medications, are used to treat complex, chronic conditions. Specialty drugs often require special handling, such as refrigeration while shipping, and specific types of administration, such as injection or infusion.

The federal out-of-pocket limit applies to members of the state group self-insured health plans and insured HMOs, all of which include prescription drug coverage. The prescription drugs and supplies are split into copayment tiers which determine the out-of-pocket costs a member must bear. The tiers are as follows:

	STANDARD PLANS		HIGH DEDUCTIBLE PLANS	
TIER	**Copayment for Retail[1] Pharmacy**	**Copayment for Mail Order [2]Pharmacy**	**Coinsurance for Retail Pharmacy**	**Coinsurance for Mail Order Pharmacy**
Generic:	$7	$14	30%	30%
Preferred Brand Name Drugs:	$30	$60	30%	30%
Nonpreferred Brand Name Drugs:	$50	$100	50%	50%

Effect of the Bill

The bill amends s. 110.12301, F.S., directing the DMS to contract with a third party provider to verify the eligibility of all dependents currently participating in the state program. The DMS is required to notify all members of the Health Insurance Plan regarding the eligibility criteria for dependents by September 1, 2017. This will provide members with the ability to update or remove ineligible dependents from participation in the program. Beginning December 1, 2017, after the closure of open enrollment, the selected vendor will begin collecting documentation prescribed in the bill, to verify dependent eligibility. The bill also provides that foreign-born subscribers, who are unable to obtain necessary documentation within a specified time period, may execute a signed affidavit attesting to the eligibility requirements. All documentation collected shall be retained until July 1, 2019, and destroyed as soon as practicable thereafter.

The bill also amends s. 110.12315, F.S., updating the state employee Prescription Drug Program. The bill makes modifications to permanently codify changes annually made to the program through the Implementing Bill and General Appropriations Act since 2010. Specifically, the bill retains the current three tier program in administering the prescription drug program, codifying the current copayment structure of $7 for generic drugs, $30 for preferred brand name drugs, and $50 for nonpreferred brand name drugs. Otherwise, the copayment structure would revert to the December 31, 2010 copayment levels of $10 for generic drugs, $25 for preferred brand name drugs, and $40 for nonpreferred brand name drugs, each year.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

[1] For up to a 30-day supply of prescription drugs and supplies.
[2] For up to a 90-day supply of prescription drugs and supplies.

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Indeterminate, see *Fiscal Comments.*

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The fiscal impact of the bill is indeterminate; however, the DMS anticipates that the bill will result in significant cost avoidance by eliminating ineligible dependents from coverage.

The bill conforms to the FY 2017-2018 General Appropriations Act (GAA), as $1.0 million in funding is provided in the GAA to competitively procure a contract with a third party provider to perform dependent eligibility audits. The DMS has suggested that any contract agreed upon by the DMS and the third party provider would have a “claw back” provision to ensure that savings generated from the audit would exceed the $1.0 million appropriation.