By the Committee on Health Care; and Senator Margolis

587-1743-06

A bill to be entitled

An act relating to wellness programs for state employees; amending s. 110.123, F.S.; defining the term "aged-based and gender-based benefits" for purposes of the state group insurance program; creating the Florida State Employees Wellness Council within the Department of Management Services; providing for membership; providing for reimbursement of per diem and travel expenses; providing purpose and duties of the council; providing an effective date.

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

Section 1. Paragraph (h) of subsection (3) of section 110.123, Florida Statutes, is amended, and subsection (13) is added to that section, to read:

110.123 State group insurance program.--

(3) STATE GROUP INSURANCE PROGRAM.--

(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. <u>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 woman's health education.</u>

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 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.

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, 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.

(13) WELLNESS COUNCIL.--

(a) There is created within the department the Florida State Employee Wellness Council.

(b) The council shall be an advisory body to the department to provide health education information to employees and to assist the department in developing minimum

benefits for all health care providers when providing age-based and gender-based wellness benefits.

(c) The council shall be composed of nine members appointed by the Governor. When making appointments to the council, the Governor shall appoint persons who are residents of the state and who are highly knowledgeable concerning, active in, and recognized leaders in the health and medical field, at least one of whom must be an employee of the state. Council members shall equitably represent the broadest spectrum of the health industry and the geographic areas of the state. Not more than one member of the council may be from any one company, organization, or association.

(d)1. Council members shall be appointed to 4-year terms, except that the initial terms shall be staggered. The Governor shall appoint three members to 2-year terms, three members to 3-year terms, and three members to 4-year terms.

2. A member's absence from three consecutive meetings shall result in his or her automatic removal from the council. A vacancy on the council shall be filled for the remainder of the unexpired term.

(e) The council shall annually elect from its membership one member to serve as chair of the council and one member to serve as vice chair.

(f) The first meeting of the council shall be called by the chairperson not more than 60 days after the council members are appointed by the Governor. The council shall thereafter meet at least once quarterly and may meet more often as necessary. The department shall provide staff assistance to the council which shall include, but not be limited to, keeping records of the proceedings of the council

and serving as custodian of all books, documents, and papers filed with the council.

(g) A majority of the members of the council constitutes a quorum.

(h) Members of the council shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061 while performing their duties.

(i) The council shall:

1. Work to encourage participation in wellness programs by state employees. The council may prepare informational programs and brochures for state agencies and employees.

2. In consultation with the department, develop standards and criteria for age-based and gender-based wellness programs.

3. In consultation with the department, recommend a "healthy food and beverage" menu for cafeterias and other food-service establishments located in buildings owned, operated, or leased by the state.

Section 2. This act shall take effect July 1, 2006.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 382

The committee substitute requires the Florida State Employee Wellness Council to develop wellness benefits for all health care providers instead of only HMOs. It also requires that at least one of the council members be an employee of the state.