



HB 7089, Engrossed 1

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1 A bill to be entitled
2 An act relating to the state group insurance program;
3 amending s. 110.123, F.S.; revising applicability of
4 certain definitions; defining the term "plan year";
5 authorizing the program to include additional
6 benefits; authorizing an employee to use a specified
7 portion of the state's contribution to purchase
8 additional program benefits and supplemental benefits
9 under certain circumstances; providing for the program
10 to offer health plans in specified benefit levels;
11 requiring the Department of Management Services to
12 develop a plan for implementation of the benefit
13 levels; providing reporting requirements; providing
14 for expiration of the implementation plan; creating s.
15 110.12303, F.S.; authorizing additional benefits to be
16 included in the program; requiring the department to
17 contract with at least one entity that provides
18 comprehensive pricing and inclusive services for
19 surgery and other medical procedures; providing
20 contract and reporting requirements; requiring the
21 department to contract with an entity to provide
22 enrollees with online information on health care
23 services and providers; providing contract and
24 reporting requirements; creating s. 110.12304, F.S.;
25 directing the department to contract with an
26 independent benefits consultant; providing



27 | qualifications and duties of the independent benefits
 28 | consultant; providing reporting requirements;
 29 | providing that the department shall determine and
 30 | recommend premiums for enrollees for the 2017 plan
 31 | year; providing requirements for the determination of
 32 | premiums; requiring the department to submit premium
 33 | rates to the Legislative Budget Commission by a
 34 | specified date for review and approval; requiring
 35 | premium rates to be consistent with the total budgeted
 36 | amount for the program in the General Appropriations
 37 | Act for the 2016-2017 fiscal year; providing an
 38 | appropriation and authorizing positions; providing an
 39 | effective date.

40 |

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

42 |

43 | Section 1. Subsection (2) and paragraphs (b), (f), (h),
 44 | and (j) of subsection (3) of section 110.123, Florida Statutes,
 45 | are amended, and paragraph (k) is added to subsection (3) of
 46 | that section, to read:

47 | 110.123 State group insurance program.—

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

50 | (a) "Department" means the Department of Management
 51 | Services.

52 | (b) "Enrollee" means all state officers and employees,



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53 | retired state officers and employees, surviving spouses of
54 | deceased state officers and employees, and terminated employees
55 | or individuals with continuation coverage who are enrolled in an
56 | insurance plan offered by the state group insurance program.
57 | "Enrollee" includes all state university officers and employees,
58 | retired state university officers and employees, surviving
59 | spouses of deceased state university officers and employees, and
60 | terminated state university employees or individuals with
61 | continuation coverage who are enrolled in an insurance plan
62 | offered by the state group insurance program.

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

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

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



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

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

83 a. Is reasonably expected to work an average of at least
84 30 hours or more per week; or

85 b. Has worked an average of at least 30 hours or more per
86 week during the person's measurement period.

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

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

94 (f) "Part-time state employee" means an employee of any
95 branch or agency of state government paid by state warrant from
96 salary appropriations or from agency funds, and who is employed
97 for less than an average of 30 hours per week or, if on academic
98 contract or seasonal or other type of employment which is less
99 than year-round, is employed for less than 8 months during any
100 12-month period, but does not include a person paid from other-
101 personal-services (OPS) funds. The term includes all part-time
102 employees of the state universities.

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

104 (h) ~~(g)~~ "Retired state officer or employee" or "retiree"



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105 means any state or state university officer or employee who
106 retires under a state retirement system or a state optional
107 annuity or retirement program or is placed on disability
108 retirement, and who was insured under the state group insurance
109 program at the time of retirement, and who begins receiving
110 retirement benefits immediately after retirement from state or
111 state university office or employment. The term also includes
112 any state officer or state employee who retires under the
113 Florida Retirement System Investment Plan established under part
114 II of chapter 121 if he or she:

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

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

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

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

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

130 (l)~~(k)~~ "State-contracted HMO" means any health maintenance



131 organization under contract with the department to participate
132 in the state group insurance program.

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

141 (n)~~(m)~~ "State officer" means any constitutional state
142 officer, any elected state officer paid by state warrant, or any
143 appointed state officer who is commissioned by the Governor and
144 who is paid by state warrant.

145 (o)~~(n)~~ "Surviving spouse" means the widow or widower of a
146 deceased state officer, full-time state employee, part-time
147 state employee, or retiree if such widow or widower was covered
148 as a dependent under the state group health insurance plan,~~a~~
149 TRICARE supplemental insurance plan, or a health maintenance
150 organization plan established pursuant to this section at the
151 time of the death of the deceased officer, employee, or retiree.
152 "Surviving spouse" also means any widow or widower who is
153 receiving or eligible to receive a monthly state warrant from a
154 state retirement system as the beneficiary of a state officer,
155 full-time state employee, or retiree who died prior to July 1,
156 1979. For the purposes of this section, any such widow or



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157 widower shall cease to be a surviving spouse upon his or her
158 remarriage.

159 (p) ~~(e)~~ "TRICARE supplemental insurance plan" means the
160 Department of Defense Health Insurance Program for eligible
161 members of the uniformed services authorized by 10 U.S.C. s.
162 1097.

163 (3) STATE GROUP INSURANCE PROGRAM.—

164 (b) It is the intent of the Legislature to offer a
165 comprehensive package of health insurance and retirement
166 benefits and a personnel system for state employees which are
167 provided in a cost-efficient and prudent manner, and to allow
168 state employees the option to choose benefit plans which best
169 suit their individual needs. ~~Therefore,~~ The state group
170 insurance program ~~is established which~~ may include the state
171 group health insurance plan or plans, health maintenance
172 organization plans, group life insurance plans, TRICARE
173 supplemental insurance plans, group accidental death and
174 dismemberment plans, ~~and~~ group disability insurance plans, ~~and~~
175 ~~Furthermore, the department is additionally authorized to~~
176 ~~establish and provide as part of the state group insurance~~
177 ~~program any other group insurance plans or coverage choices, and~~
178 other benefits authorized by law ~~that are consistent with the~~
179 ~~provisions of this section.~~

180 (f) Except as provided for in subparagraph (h)2., the
181 state contribution toward the cost of any plan in the state
182 group insurance program shall be uniform with respect to all



183 state employees in a state collective bargaining unit
184 participating in the same coverage tier in the same plan. This
185 section does not prohibit the development of separate benefit
186 plans for officers and employees exempt from the career service
187 or the development of separate benefit plans for each collective
188 bargaining unit. For the 2019 plan year and thereafter, if the
189 state's contribution is more than the premium cost of the health
190 plan selected by the employee, subject to federal limitation,
191 the employee may elect to have the balance:

- 192 1. Credited to the employee's flexible spending account;
- 193 2. Credited to the employee's health savings account;
- 194 3. Used to purchase additional benefits offered through
195 the state group insurance program; or
- 196 4. Used to increase the employee's salary.

197 (h)1. A person eligible to participate in the state group
198 insurance program may be authorized by rules adopted by the
199 department, in lieu of participating in the state group health
200 insurance plan, to exercise an option to elect membership in a
201 health maintenance organization plan which is under contract
202 with the state in accordance with criteria established by this
203 section and by said rules. The offer of optional membership in a
204 health maintenance organization plan permitted by this paragraph
205 may be limited or conditioned by rule as may be necessary to
206 meet the requirements of state and federal laws.

207 2. The department shall contract with health maintenance
208 organizations seeking to participate in the state group



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209 insurance program through a request for proposal or other
210 procurement process, as developed by the Department of
211 Management Services and determined to be appropriate.

212 a. The department shall establish a schedule of minimum
213 benefits for health maintenance organization coverage, and that
214 schedule shall include: physician services; inpatient and
215 outpatient hospital services; emergency medical services,
216 including out-of-area emergency coverage; diagnostic laboratory
217 and diagnostic and therapeutic radiologic services; mental
218 health, alcohol, and chemical dependency treatment services
219 meeting the minimum requirements of state and federal law;
220 skilled nursing facilities and services; prescription drugs;
221 age-based and gender-based wellness benefits; and other benefits
222 as may be required by the department. Additional services may be
223 provided subject to the contract between the department and the
224 HMO. As used in this paragraph, the term "age-based and gender-
225 based wellness benefits" includes aerobic exercise, education in
226 alcohol and substance abuse prevention, blood cholesterol
227 screening, health risk appraisals, blood pressure screening and
228 education, nutrition education, program planning, safety belt
229 education, smoking cessation, stress management, weight
230 management, and women's health education.

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

234 c. The department may require detailed information from



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

254 d. The department may limit the number of HMOs that it
255 contracts with in each service area based on the nature of the
256 bids the department receives, the number of state employees in
257 the service area, or any unique geographical characteristics of
258 the service area. The department shall establish by rule service
259 areas throughout the state.

260 e. All persons participating in the state group insurance



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261 program may be required to contribute towards a total state
262 group health premium that may vary depending upon the plan,
263 coverage level, and coverage tier selected by the enrollee and
264 the level of state contribution authorized by the Legislature.

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

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

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

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

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

284 d. Is willing to participate in the state group insurance
285 program at a cost of premiums that is not greater than 95
286 percent of the cost of HMO premiums accepted by the department



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287 | in each service area; and

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

289 |

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

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

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



313 termination of the contract. Each party to the terminated
314 contract shall allow an enrollee who has initiated a course of
315 prenatal care, regardless of the trimester in which care was
316 initiated, to continue care and coverage until completion of
317 postpartum care. This does not prevent a provider from refusing
318 to continue to provide care to an enrollee who is abusive,
319 noncompliant, or in arrears in payments for services provided.
320 For care continued under this subparagraph, the program and the
321 provider shall continue to be bound by the terms of the
322 terminated contract. Changes made within 30 days before
323 termination of a contract are effective only if agreed to by
324 both parties.

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

334 8. The department may establish and direct, with respect
335 to collective bargaining issues, a comprehensive package of
336 insurance benefits that may include supplemental health and life
337 coverage, dental care, long-term care, vision care, and other
338 benefits it determines necessary to enable state employees to



339 | select from among benefit options that best suit their
340 | individual and family needs. Beginning with the 2017 plan year,
341 | the package of benefits may also include products and services
342 | described in s. 110.12303.

343 | a. Based upon a desired benefit package, the department
344 | shall issue a request for proposal or invitation to negotiate
345 | for ~~health insurance~~ providers interested in participating in
346 | the state group insurance program, and the department shall
347 | issue a request for proposal or invitation to negotiate for
348 | ~~insurance~~ providers interested in participating in the non-
349 | health-related components of the state group insurance program.
350 | Upon receipt of all proposals, the department may enter into
351 | contract negotiations with ~~insurance~~ providers submitting bids
352 | or negotiate a specially designed benefit package. Insurance
353 | providers offering or providing supplemental coverage as of May
354 | 30, 1991, which qualify for pretax benefit treatment pursuant to
355 | s. 125 of the Internal Revenue Code of 1986, with 5,500 or more
356 | state employees currently enrolled may be included by the
357 | department in the supplemental insurance benefit plan
358 | established by the department without participating in a request
359 | for proposal, submitting bids, negotiating contracts, or
360 | negotiating a specially designed benefit package. These
361 | contracts shall provide state employees with the most cost-
362 | effective and comprehensive coverage available; however, except
363 | as provided in subparagraph (f)3., no state or agency funds
364 | shall be contributed toward the cost of any part of the premium



365 of such supplemental benefit plans. With respect to dental
366 coverage, the division shall include in any solicitation or
367 contract for any state group dental program made after July 1,
368 2001, a comprehensive indemnity dental plan option which offers
369 enrollees a completely unrestricted choice of dentists. If a
370 dental plan is endorsed, or in some manner recognized as the
371 preferred product, such plan shall include a comprehensive
372 indemnity dental plan option which provides enrollees with a
373 completely unrestricted choice of dentists.

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

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

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

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

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

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



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391 4. Bronze level, which shall have an actuarial value of at
392 least 60 percent ~~Notwithstanding paragraph (f) requiring uniform~~
393 ~~contributions, and for the 2011-2012 fiscal year only, the state~~
394 ~~contribution toward the cost of any plan in the state group~~
395 ~~insurance plan is the difference between the overall premium and~~
396 ~~the employee contribution. This subsection expires June 30,~~
397 ~~2012.~~

398 (k) In consultation with the independent benefits
399 consultant described in s. 110.12304, the department shall
400 develop a plan for implementation of the benefit levels
401 described in paragraph (j). The plan shall be submitted to the
402 Governor, the President of the Senate, and the Speaker of the
403 House of Representatives by January 1, 2018, and include
404 recommendations for:

- 405 1. Employer and employee contribution policies.
406 2. Steps necessary for maintaining or improving total
407 employee compensation levels when the transition is initiated.
408 3. An education strategy to inform employees of the
409 additional choices available in the state group insurance
410 program.

411
412 This paragraph expires July 1, 2018.

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

415 110.12303 State group insurance program; additional
416 benefits; price transparency program; reporting.—Beginning with



417 the 2017 plan year:

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

422 (a) Prepaid limited health service organizations
423 authorized pursuant to part I of chapter 636.

424 (b) Discount medical plan organizations authorized
425 pursuant to part II of chapter 636.

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

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

432 (e) Provider organizations, including service networks,
433 group practices, professional associations, and other
434 incorporated organizations of providers, who sell service
435 contracts and arrangements for a specified amount and type of
436 health services.

437 (f) Entities that provide specific health services in
438 accordance with applicable state law and sell service contracts
439 and arrangements for a specified amount and type of health
440 services.

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



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

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

448 (2) (a) The department shall contract with at least one
449 entity that provides comprehensive pricing and inclusive
450 services for surgery and other medical procedures which may be
451 accessed at the option of the enrollee. The contract shall
452 require the entity to:

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

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

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

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

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

462 c. Credited to the enrollee's health reimbursement

463 account; or

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

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



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

475 (3) The department shall contract with an entity that
476 provides enrollees with online information on the cost and
477 quality of health care services and providers, allows an
478 enrollee to shop for health care services and providers, and
479 rewards the enrollee by sharing savings generated by the
480 enrollee's choice of services or providers. The contract shall
481 require the entity to:

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

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

494 (c) Permit a certified bargaining agent of state employees



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495 to provide educational materials and counseling to enrollees
496 regarding the Internet-based platform.

497 (d) Identify the savings realized to the enrollee and
498 state if the enrollee chooses high-quality, lower-cost health
499 care services or providers, and facilitate a shared savings
500 payment to the enrollee. The amount of shared savings shall be
501 determined by a methodology approved by the department and shall
502 maximize value-based purchasing by enrollees. The amount payable
503 to the enrollee may be:

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

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

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

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

511 (e) On or before January 1 of 2018, 2019, and 2020, the
512 department shall report to the Governor, the President of the
513 Senate, and the Speaker of the House of Representatives on the
514 participation level, amount paid to enrollees, and cost-savings
515 to both the enrollees and the state resulting from the
516 implementation of this subsection.

517 Section 3. Section 110.12304, Florida Statutes, is created
518 to read:

519 110.12304 Independent benefits consultant.—

520 (1) The department shall competitively procure an



521 independent benefits consultant.

522 (2) The independent benefits consultant may not:

523 (a) Be owned or controlled by a health maintenance

524 organization or insurer.

525 (b) Have an ownership interest in a health maintenance

526 organization or insurer.

527 (c) Have a direct or indirect financial interest in a

528 health maintenance organization or insurer.

529 (3) The independent benefits consultant must have

530 substantial experience in consultation and design of employee

531 benefit programs for large employers and public employers,

532 including experience with plans that qualify as cafeteria plans

533 under s. 125 of the Internal Revenue Code of 1986.

534 (4) The independent benefits consultant shall:

535 (a) Provide an ongoing assessment of trends in benefits

536 and employer-sponsored insurance that affect the state group

537 insurance program.

538 (b) Conduct a comprehensive analysis of the state group

539 insurance program, including available benefits, coverage

540 options, and claims experience.

541 (c) Identify and establish appropriate adjustment

542 procedures necessary to respond to any risk segmentation that

543 may occur when increased choices are offered to employees.

544 (d) Assist the department with the submission of any

545 necessary plan revisions for federal review.

546 (e) Assist the department in ensuring compliance with



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547 | applicable federal and state regulations.

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

550 | (g) Assist the department in preparing recommendations for
551 | any modifications to the state group insurance program which
552 | shall be submitted to the Governor, the President of the Senate,
553 | and the Speaker of the House of Representatives by January 1 of
554 | each year.

555 | Section 4. For the 2017 plan year, the Department of
556 | Management Services shall determine and recommend premiums for
557 | enrollees that reflect the actual differences in costs to the
558 | program for each of the health maintenance organization and the
559 | preferred provider organization plan options offered in the
560 | state group insurance program for both self-insured and fully
561 | insured plans. The premium alternatives for the plan options
562 | shall reflect the costs to the program for both medical and
563 | prescription drug benefits. By July 1, 2016, the department
564 | shall submit the proposed enrollee premium rates for the 2017
565 | plan year to the Legislative Budget Commission for review and
566 | approval. If the Legislative Budget Commission does not approve
567 | the proposed rates, the rates provided in the 2016-2017 General
568 | Appropriations Act shall apply. The premium rates for employers
569 | shall be the same as those established for the state group
570 | insurance program in the General Appropriations Act for the
571 | 2016-2017 fiscal year.

572 | Section 5. (1) For the 2016-2017 fiscal year, the sums of



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573 \$151,216 in recurring funds and \$507,546 in nonrecurring funds
574 are appropriated from the State Employees Health Insurance Trust
575 Fund to the Department of Management Services, and two full-time
576 equivalent positions and associated salary rate of 120,000 are
577 authorized, for the purpose of implementing this act.

578 (2) (a) The recurring funds appropriated in this section
579 shall be allocated to the following specific appropriation
580 categories within the Insurance Benefits Administration Program:
581 \$150,528 in Salaries and Benefits and \$688 in Special Categories
582 Transfer to Department of Management Services—Human Resources
583 Purchased per Statewide Contract.

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

588 Section 6. This act shall take effect July 1, 2016.