The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Governmental Oversight and Accountability

BILL:	HB 7007
INTRODUCER:	Health and Human Services Committee and Representative Brodeur
SUBJECT:	State Group Insurance Program
DATE:	April 21, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peacock	Ferrin	GO	**Pre-meeting**
2.			AGG	
3.			AP	
4.			RC	

I. Summary:

HB 7007 amends provisions of the State Group Health Insurance Program (Program). The bill, for plan year 2020 and thereafter, requires the Department of Management Services (DMS) to offer four health insurance coverage levels of at least a certain actuarial value under the Program as follows: Platinum – 90 percent, Gold – 80 percent, Silver – 70 percent, and Bronze – 60 percent. The state will make a defined contribution for each employee toward the cost of purchasing a health plan. If the state's contribution is more than the premium cost of the health plan selected by the employee, the bill specifies that the employee will be permitted to allocate unused state health insurance contributions to other benefits or as salary. The bill requires the DMS to recommend contribution policies and employee education strategies regarding the coverage levels and other benefit alternatives.

Beginning with plan year 2018, the bill permits the DMS to procure new types of health care products and services. For plan year 2018, the bill also requires the DMS to contract with an entity to provide enrollees with an online cost comparison for health care services and providers and at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures. Enrollees may access these services, and the bill provides for the sharing of any savings. The DMS must report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on certain criteria, including cost-savings to both enrollees and the state resulting from implementation of the Internet-based platform and the comprehensive services.

The bill requires the DMS to competitively procure an independent benefits consultant to assist the agency in developing a plan for implementation of the new benefit levels in the Program. This plan must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2019.

By July 1, 2017, the DMS must submit proposed enrollee premium rates that reflect the differences in costs to the Program for each of the health maintenance organizations and the preferred provider organization plan options for the 2018 plan year to the Legislative Budget Commission for review and approval.

The bill appropriates $151,216 in recurring funds and $507,546 in nonrecurring funds from the State Employees Health Insurance Trust Fund to DMS and authorizes 2 full-time equivalent positions and $120,000 of associated salary rate for the 2017-2018 fiscal year to implement the act.

The bill provides an effective date of July 1, 2017.

II. Present Situation:

State Employee Health Insurance Program

The State Group Insurance Program (Program) is created by s. 110.123, F.S., and the DMS, through the Division of State Group Insurance (DSGI), administers the Program.[1] The Program is an optional benefit offered as part of the total compensation package for all state employees[2] including all state agencies, state universities, the court system, and the Legislature. The Program is governed by the Internal Revenue Code, federal laws, such as the Patient Protection and Affordable Care Act, Health Insurance Portability and Accountability Act, Consolidated Omnibus Budget Reconciliation Act, Medicare, and other provisions of law.

The DMS's projected health care and administrative spend for state fiscal year 2016-2017 is approximately $2.3 billion.[3] This amount is broken down into the following cost categories: medical (72%), prescription drugs (8.8%), and administration of the Program (3%).

The Program qualifies as a "cafeteria plan,"[4] which offers flexible benefits under Section 125 of the Internal Revenue Code and allows employees to choose from a "menu" of benefits offered by the employer, including medical, accident, disability, vision, dental and group term life insurance. 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, and contributions made by the employee are not subject to federal income or social security taxes. In Florida, the Program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

[1] Chapter 60P, Florida Administrative Code, also governs the Program. The DMS has limited rule-making authority.
[2] *See* Section 110.123(2)(b), F.S. Surviving spouses of deceased state officers and employees, retired state officers and employees, individuals with continuation coverage, e.g. COBRA, and eligible dependents are eligible to participate in the Program.
[3] Department of Management Services, *Overview of the State Group Health Insurance Program*, presentation to the Senate Appropriations Subcommittee on General Government on February 15, 2017 (Copy on file with the Senate Governmental Oversight and Accountability Committee).
[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 offers four types of health plans from which an eligible employee may choose: a standard statewide Preferred Provider Organization (PPO) Plan, a Health Investor PPO Plan, a standard Health Maintenance Organization (HMO) Plan, or a Health Investor HMO Plan.

The PPO plan is the statewide, self-insured health plan administered by Florida Blue. 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 HMO plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs. Two of the HMOs (Capital Health Plan and Florida Health Plans) operate on a traditional fully insured model in which the HMOs assume all financial risk for the covered benefits. The other three (Aetna, AvMed, and United Health Care) operate on a self-insured model under which the state bears the risk of the medical claims.

Additionally, the Program offers two high-deductible health plans (HDHP)[5] with health savings accounts (HSAs).[6] 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.[7] 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[8] 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.

Currently, the Program offers flexible spending accounts (FSAs)[9] as an optional benefit for employees. The FSA is funded though pre-tax payroll deductions from the employee's salary.[10] The funds can be used to pay for medical expenses that are not covered by the employees' health plan. Prior to 2013, there was no limit on the contribution to a FSA; however, it is now limited to $2,600[11] and subsequently adjusted for inflation. Unlike the HSA, the FSA is a "use it or lose

[5] 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.
[6] 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.
[7] 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 on April 21, 2017).
[8] *Id*. The IRS annually sets the contribution limit as adjusted by inflation.
[9] Section 125 I.R.C.; see *IRS Publication 969* (2016) available at https://www.irs.gov/pub/irs-pdf/p969.pdf (last viewed on April 21, 2017).
[10] Employers are also allowed to contribute to FSAs.
[11] 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 on April 21, 2017).

it" arrangement.[12] If the employee does not annually use the contributions to the FSA, the contributions are forfeited.

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.[13] 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 charts illustrate the benefit design of each of the plan choices and the distinctions between FSAs, HSAs, and HRAs:

<table>
<tr><th></th><th>HMO
Standard</th><th colspan="2">PPO
Standard</th></tr>
<tr><td></td><td>Network Only</td><td>Network</td><td>Out-of-Network</td></tr>
<tr><td>Deductible</td><td>None</td><td>$250 | $500
Single | Family</td><td>$750 | $1,500
Single | Family</td></tr>
<tr><td>Primary Care</td><td>$20 copayment</td><td>$15 copayment</td><td rowspan="3">40% of out-of-network allowance plus the amount between the charge and the allowance</td></tr>
<tr><td>Specialist</td><td>$40 copayment</td><td>$25 copayment</td></tr>
<tr><td>Urgent Care</td><td>$25 copayment</td><td>$25 copayment</td></tr>
<tr><td>Emergency Room</td><td>$100 copayment</td><td>$100 copayment</td><td>40% after $500 copayment plus the amount between the charge and the allowance</td></tr>
<tr><td>Hospital Stay</td><td>$250 copayment</td><td>20% after
$250 copayment</td><td rowspan="2">Pay in full, file claim</td></tr>
<tr><td rowspan="2">Generic | Preferred | Non-Preferred Prescriptions</td><td>$7 | $30 | $50
Retail</td><td>$7 | $30 | $50
Retail</td></tr>
<tr><td>$14 | $60 | $100
Mail Order</td><td>$14 | $60 | $100
Mail Order</td></tr>
<tr><td>Out-of-Pocket Maximum</td><td>$1,500 | $3,000
Single | Family</td><td colspan="2">$2,500 | $5,000 (coinsurance only)
Single | Family</td></tr>
</table>

[12] Beginning in 2013, an employee may carryover up to $500 into the next calendar year.
[13] 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.

	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

	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;[14]	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

The PPO and HMO plans provide similar coverage, including prescription drug benefits, with the main difference being member cost share. The current standard PPO plan has higher member cost share (deductibles, copayments and coinsurance); while the current standard HMO plans have a lower member cost share with copayments only.

The high deductible plans have the highest member cost share (high deductible and coinsurance only) and meet the federal requirement of a minimum value plan that is affordable, as well as the Internal Revenue Code requirements that allow enrollment in a HSA. The annual contribution from the State Employee Health Insurance Trust Fund to an employee's HSA is $500 for single coverage and $1,000 for family coverage.[15] These contributions are funded as part of the employer paid premium for health insurance coverage and are made in equal monthly installments throughout the plan year. The participant may draw upon these funds to meet qualified medical expenses.[16]

DMS-contracted service providers and fully insured HMOs have established networks of contracted physicians, hospitals, clinics, surgical centers and other appropriately licensed health care providers. The DMS relies upon the clinical expertise provided through its contracts with the service providers to determine medical necessity, process claims and appeals, develop medical coverage guidelines, and provide other clinical review and support as needed.

The DMS is not a party to the private business contracts between the service providers and their network providers. Negotiated network provider contracts, including fee schedules, network discounts and similar financial terms, are considered proprietary and trade secret by the DMS's service providers and are specifically protected as such under s. 110.123(5)(a), F.S., and ch. 119, F.S., as well as in contracts between the service providers and their network health care providers.

Health plan documents that describe the summary of benefits and coverages are approved annually in the General Appropriations Act. Annual revisions to such documents only include clarifications or changes consistent with new legislation. The DMS is not authorized to change covered benefits.

Enrollees are allowed to elect only one health insurance plan under the Program.

[14] Section 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.
[15] Section 110.123(12), F.S., provides that for the 2014-2015 fiscal year and thereafter, the state's contribution from the State Employee Health Insurance Trust Fund into the member's health savings account shall be set in the annual General Appropriations Act.
[16] 26 U.S.C. s. 213(d).

Plan Enrollment

The Program has 367,953 covered lives and 175,944 policyholders.[17] Of the participants in the program, 54.6 percent are from agencies, 24.1 are from universities, 21 percent are retirees and other former employees, and .3 percent are from statutorily defined agencies.[18] Currently, 52.9 percent of enrollees who chose the standard plan selected an HMO while 47.1 percent chose the PPO.[19] Only 2 percent of enrollees chose either HDHP.[20] During the open enrollment period for 2015, PPO enrollment increased slightly, by 0.46 percent, and HMO enrollment decreased by 3.14 percent.[21]

Contribution Tiers and Amounts

The 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[22] shows the monthly contributions of the state and the employee to employee health insurance premium.

Subscriber Type	**Tier or Coverage Type**	**Standard Plans (PPO and HMO)**			**Health Investor Plans (PPO and HMO)**		
		Employer	Employee	Total	Employer*	Employee	Total
Career Service/ OPS	**Single**	$624.84	$50.00	$692.84	$624.84	$15.00	$657.84
	Family	$1,379.60	$180.00	$1,559.60	$1,379.60	$64.30	$1,443.90
	Spouse[23]	$1,529.60	$30.00	$1,559.60	$1,413.92	$30.00	$1,443.92
SES/ SMS/ Others	**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
*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.							

Cadillac Tax

Section 9001 of the Affordable Care Act specifies an excise tax ("Cadillac Tax") on high cost employer-sponsored health coverage. Beginning with taxable year 2020, the tax will be equal to 40 percent of the amount considered to be an "excess benefit," which is defined as the difference between the cost of health benefits and an applicable annual limitation threshold set by the federal legislation, with allowable health cost adjustments to the threshold. If the total cost of

[17] Department of Management Services, Email dated April 21, 2017 (Copy on file with the Senate Governmental Oversight and Accountability Committee).
[18] *See supra* note 3.
[19] *See supra* note 17.
[20] *Id*.
[21] *Id*.
[22] Department of Management Services, Premium Rate Table, Effective Jan. 2017 for Feb. 2017 coverage, available at http://mybenefits.myflorida.com/content/download/130052/808071/DSGI_-_Premium_Table_Effective_January_2017_for_February_2017_Coverage.pdf (last visited on April 20, 2017).
[23] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.

health benefits (not premium, but actual cost) for any plans exceed the federal thresholds, the state will be required to pay this tax for each employee enrolled in those plans.

III. Effect of Proposed Changes:

Section 1 amends s. 110.123, F.S., regarding the state group insurance program.

The term "plan year" is defined as a calendar year.

This section expands the scope of the state group insurance program to include other benefits authorized by law.

For plan year 2020 and thereafter, the state will make a defined contribution for each employee toward the cost of purchasing a health plan. If the state's contribution is more than the premium cost of the health plan selected by the employee, subject to any federal limitation, the bill provides that the employee may elect to have the balance:

- Credited to the employee's FSA;
- Credited to the employee's HSA;
- Used to purchase additional benefits offered through the state group insurance program; or
- Used to increase the employee's salary.

For the 2020 plan year and each plan year thereafter, health plans must be offered in the following benefit levels:

- Platinum level, which shall have an actuarial value of at least 90 percent.
- Gold level, which shall have an actuarial value of at least 80 percent.
- Silver level, which shall have an actuarial value of at least 70 percent.
- Bronze level, which shall have an actuarial value of at least 60 percent.

In consultation with the independent benefits consultant described in s. 110.12304, F.S., the DMS must develop a plan for implementation of the benefit levels described above. The plan must 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:

- Employer and employee contribution policies;
- Steps necessary for maintaining or improving total employee compensation levels when the transition is initiated; and
- An education strategy to inform employees of the additional choices available in the state group insurance program.

Section 2 creates s. 110.12303, F.S.

Beginning with the 2018 plan year, this section allows the DMS to offer the following products and services, in addition to the comprehensive package of health insurance and other benefits required or authorized to be included in the state group insurance program:

- Prepaid limited health service organizations authorized pursuant to part I of chapter 636, F.S.;
- Discount medical plan organizations authorized pursuant to part II of chapter 636, F.S.;

- Prepaid health clinics licensed under part II of chapter 641, F.S.;
- 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;
- 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 the bundling or aggregating of health services or treatments; and
- Entities that provide other innovative and cost-effective health service delivery methods.

Next, the DMS is required to 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 must require the entity to:

- Have procedures and evidence-based standards to ensure the inclusion of only high-quality health care providers;
- Provide assistance to enrollees in accessing and coordinating care;
- 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:
  - Credited to the enrollee's flexible spending account;
  - Credited to the enrollee's health savings account;
  - Credited to the enrollee's health reimbursement account; or
  - Paid as additional health plan reimbursements not exceeding the amount of the employee's out-of-pocket medical expenses.
- Provide an educational campaign for enrollees to learn about the services offered by the entity.

The DMS is required to report on or before January 15 of each year 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 any contracts described in this subsection.

Additionally, the DMS must 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 any savings generated by the enrollee's choice of services or providers. The contract requires the entity to:

- 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;

- Allow enrollees to shop for health care services and providers using the price and quality information provided on the Internet-based platform;
- Permit a certified bargaining agent of state employees to provide educational materials and counseling to enrollees regarding the Internet-based platform;
- 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 DMS and shall maximize value-based purchasing by enrollees. The amount payable to the enrollee may be:
  - Credited to the enrollee's FSA;
  - Credited to the enrollee's HSA;
  - Credited to the enrollee's health reimbursement account; or
  - Paid as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

Furthermore, the DMS is required to report on or before January 1 of 2019, 2020, and 2021, 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 implementation of this subsection.

Section 3 creates s. 110.12304, F.S., requiring the DMS to competitively procure an independent benefits consultant.

The independent benefits consultant may not:
- Be owned or controlled by an HMO or insurer;
- Have an ownership interest in an HMO or insurer; or
- Have a direct or indirect financial interest in an HMO or insurer.

The independent benefits consultant must have substantial experience in consultation and design of employee benefit programs for large and public employers, including plans that qualify as cafeteria plans pursuant to s. 125 of the Internal Revenue Code of 1986.

The independent benefits consultant must:
- Provide an ongoing assessment of trends in benefits and employer-sponsored insurance that affect the state group insurance program;
- Conduct a comprehensive analysis of the state group insurance program, including available benefits, coverage options, and claims experience;
- Identify and establish appropriate adjustment procedures necessary to respond to any risk segmentation that may occur when increased choices are offered to employees;
- Assist the DMS with the submission of any necessary plan revisions for federal review;
- Assist the DMS in ensuring compliance with applicable federal and state regulations;
- Assist the DMS in monitoring the adequacy of funding and reserves for the state self-insured plan; and
- Assist the DMS 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 creates an unnumbered section of law authorizing the DMS to determine and recommend premiums for enrollees that reflect the actual differences in costs to the state group insurance program for each HMO and the PPO plan options offered in the state group insurance program for both self-insured and fully insured plans. The premium alternatives for the plan options must reflect the costs to the state group insurance program for both medical and prescription drug benefits.

By July 1, 2017, the DMS must submit the proposed enrollee premium rates for the 2018 plan year to the Legislative Budget Commission (LBC) for review and approval. If the LBC does not approve the proposed rates, the rates established in the 2017-2018 General Appropriations Act will 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 appropriates $151,216 in recurring funds and $507,546 in nonrecurring funds from the State Employees Health Insurance Trust Fund to DMS and authorizes 2 full-time equivalent positions and $120,000 of associated salary rate for the 2016-2017 fiscal year to implement the act.

The recurring funds appropriated shall be allocated to specified appropriation categories within the Insurance Benefits Administration Program, as follows:

- $150,528 in Salaries and Benefits; and
- $688 in Special Categories Transfer to DMS-Human Resources Purchased per Statewide Contract.

The recurring funds appropriated shall be allocated to specified appropriation categories, as follows:

- $500,000 in Special Categories Contracted Services; and
- $7,546 in Expenses.

Section 6 provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The mandate restrictions do not apply because the bill does not require counties or municipalities to spend funds, reduce the counties' or municipalities' ability to raise revenue or reduce the percentage of state tax shared with counties or municipalities.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Indeterminate.

C. Government Sector Impact:

This bill provides funding as follows for Fiscal Year 2016-2017:

- $151,216 in recurring funds from the State Employees' Health Insurance Trust Fund;
- $507,546 in non-recurring funds from the State Employees' Health Insurance Trust Fund; and
- Two FTEs with $120,000 in associated salary rate.

The state's personnel system, People First, would have to be customized to accommodate the changes as described in the bill. These changes would require an overhaul of the front-end election process to support the various breakouts described in the bill and to ensure subscribers elect sufficient coverage to meet the federal minimum coverage requirements; would require a redesign of the electronic benefits and confirmation statements; and would require all insurance and payroll related interface files, payment detail files and reports to be updated and thoroughly tested with the insurance providers, state agencies and the employers' payroll systems. These subsidiary systems would also have to be updated to accept these changes. The fiscal impact associated with making these changes has not been determined.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 112.0801(1), F.S., requires public employers to offer to retirees the same health and hospitalization coverage as is offered to employees at a premium cost of no more than the premium cost applicable to active employees. However, s. 110.123(4)(e), F.S., states that no state contribution for the cost of any part of the premium shall be made for retirees or surviving spouses for any type of coverage under the state group insurance program. Accordingly, it appears that retirees would have access to the various coverages and plans offered as part of the state group insurance program, but would not be able to receive contributions to FSAs, HSAs, or other reimbursements for health care costs.

VIII. Statutes Affected:

This bill substantially amends section 110.123 of the Florida Statutes.

This bill creates sections 110.12303 and 110.12304 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.