

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7007    PCB HHS 17-01    State Group Insurance Program  
**SPONSOR(S):** Health & Human Services Committee, Brodeur  
**TIED BILLS:**            **IDEN./SIM. BILLS:** SB 900

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	11 Y, 6 N	Poche	Calamas
1) Appropriations Committee	18 Y, 9 N	Delaney	Leznoff

### 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, preferred 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.

HB 7007 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 towards the 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 provisions 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.

**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

**STORAGE NAME:** h7007a.APC

**DATE:** 3/8/2017

## 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<sup>1</sup>, 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<sup>2</sup>. 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.<sup>3</sup>

###### 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<sup>4</sup> even though it offers relatively narrow health plan options compared to other cafeteria plans.

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<sup>1</sup> The Spouse Program provides discounted rates for family coverage when both spouses work for the state.

<sup>2</sup> 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>

<sup>3</sup> Id.

<sup>4</sup> 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<sup>5</sup>.

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<sup>6</sup> 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.<sup>7</sup>

Additionally, the program offers two high-deductible health plans (HDHP<sup>8</sup>) with health savings accounts (HSAs)<sup>9</sup>. 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.<sup>10</sup> 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<sup>11</sup> 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.

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<sup>5</sup> The HMOs include Aetna, AvMed, Capital Health Plan, Florida Health Care Plans and UnitedHealthcare.

<sup>6</sup> ITN NO.: DMS 10/11-011

<sup>7</sup> 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.

<sup>8</sup> High-deductible health plans with linked HSAs are also called consumer-directed health plans (CDHP) because costs of health care are more visible to the enrollee.

<sup>9</sup> 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.

<sup>10</sup> 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).

<sup>11</sup> Id., The IRS annually sets the contribution limit as adjusted by inflation.

	HMO Standard	PPO Standard	
	Network Only	Network	Out-of-Network
<b>Deductible</b>	None	\$250   \$500 Single   Family	\$750   \$1,500 Single   Family
<b>Primary Care</b>	\$20 copayment	\$15 copayment	40% of out-of-network allowance plus the amount between the charge and the allowance
<b>Specialist</b>	\$40 copayment	\$25 copayment	
<b>Urgent Care</b>	\$25 copayment	\$25 copayment	
<b>Emergency Room</b>	\$100 copayment	\$100 copayment	
<b>Hospital Stay</b>	\$250 copayment	20% after \$250 copayment	40% after \$500 copayment plus the amount between the charge and the allowance
<b>Generic   Preferred   Non-Preferred Prescriptions</b>	\$7   \$30   \$50 Retail	\$7   \$30   \$50 Retail	Pay in full, file claim
	\$14   \$60   \$100 Mail Order	\$14   \$60   \$100 Mail Order	
<b>Out-of-Pocket Maximum</b>	\$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)
<b>Deductible</b>	\$1,300   \$2,600 Single   Family	\$2,500   \$5,000 Single   Family
<b>Primary Care</b>	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
<b>Specialist</b>		After meeting deductible, 20% of out-of-network allowance
<b>Urgent Care</b>		
<b>Emergency Room</b>		
<b>Hospital Stay</b>		After meeting deductible, 40% after \$1,000 copayment plus the amount between the charge and the allowance
<b>Generic   Preferred   Non-Preferred Prescriptions</b>	After meeting deductible, 30%   30%   50% Retail and Mail Order	Pay in full, file claim
<b>Out-of-Pocket Maximum</b>	\$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)<sup>12</sup> as an optional benefit for employees. The FSA is funded through pre-tax payroll deductions from the employee's salary<sup>13</sup>. 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<sup>14</sup> and subsequently adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement.<sup>15</sup> 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.<sup>16</sup> 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:

	<b>FSA</b>	<b>HSA</b>	<b>HRA</b>
<b>Who funds the account?</b>	Employee and employer (optional)	Employee, employer, and other individuals	Employer
<b>How is it funded?</b>	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
<b>Account Owner</b>	Employer	Employee	Employer
<b>Contribution Limits</b>	\$2,600 annually	Single - \$3,400 Family - \$6,750 Over 55 - additional \$1,000 for single coverage	Set by employer
<b>Rollover of Funds?</b>	Up to \$500 (federal law)	Yes	Yes, as determined by employer
<b>Medical Expenses Allowed</b>	IRC 213(d) expenses; <sup>17</sup>	IRC 213(d) expenses	Post-tax health insurance premiums and IRC 213(d) expenses
<b>High Deductible Health Plan Required?</b>	No	Yes Minimum deductible: Single - \$1,300 Family - \$2,600 Max out-of-pocket: Single - \$6,550 Family - \$13,100	No

<sup>12</sup> 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).

<sup>13</sup> Employers are also allowed to contribute to FSAs.

<sup>14</sup> 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).

<sup>15</sup> Beginning in 2013, an employee may carryover up to \$500 into the next calendar year.

<sup>16</sup> 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.

<sup>17</sup> 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<sup>18</sup> 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.<sup>19</sup> The aggregate annual growth in spending for the state program during the current fiscal year is 6.2 percent.<sup>20</sup> Annual growth is forecasted to rise to more than 11 percent in future fiscal years.<sup>21</sup> 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.<sup>22</sup>

<sup>18</sup> 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](http://mybenefits.myflorida.com/content/download/130052/808071/DSGI_-_Premium_Table_Effective_January_2017_for_February_2017_Coverage.pdf) (last viewed February 8, 2017).

<sup>19</sup> Supra, FN 2, page 4.

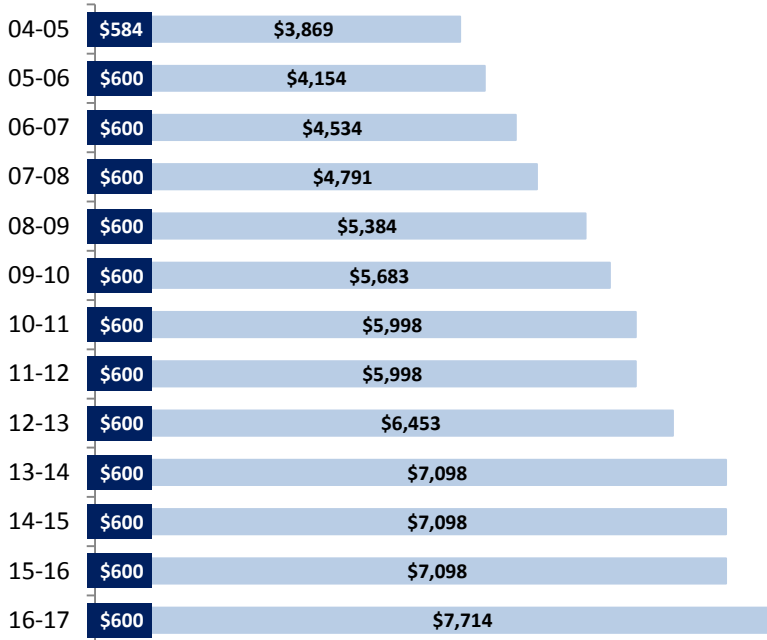
<sup>20</sup> Department of Management Services, *Overview of the State Group Health Insurance Program*, presentation to the Health and Human Services Committee on February 14, 2017, slide 5 (on file with Health and Human Services Committee staff).

<sup>21</sup> Supra, FN 2, page 3.

<sup>22</sup> Supra, FN 20 at slide 15.

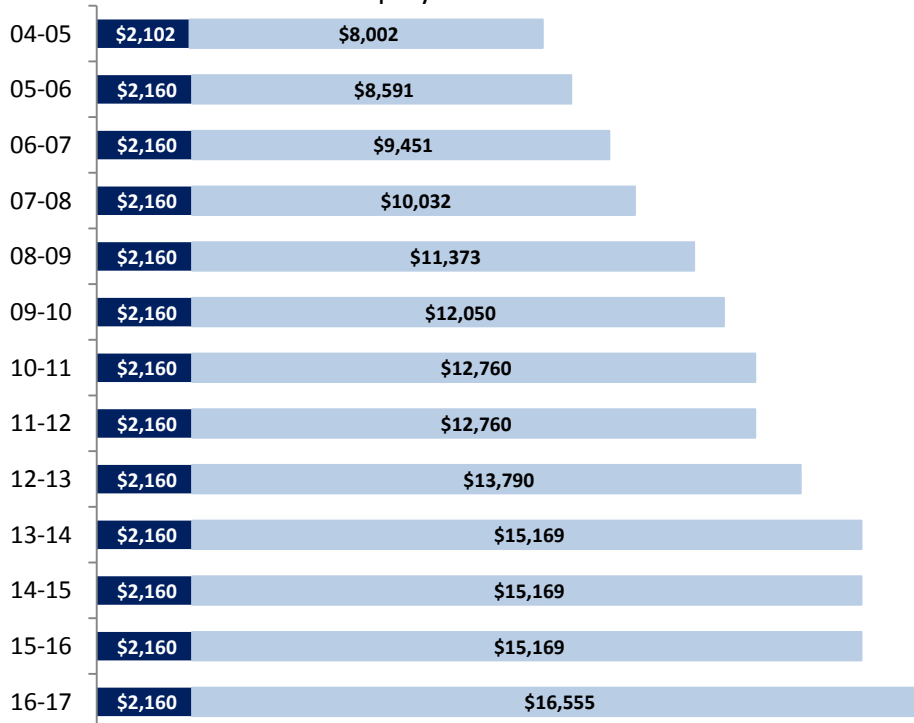
## Single Coverage Annual Premium

■ Employee ■ State



## Family Coverage Annual Premium

■ Employee ■ State



## Plan Enrollment

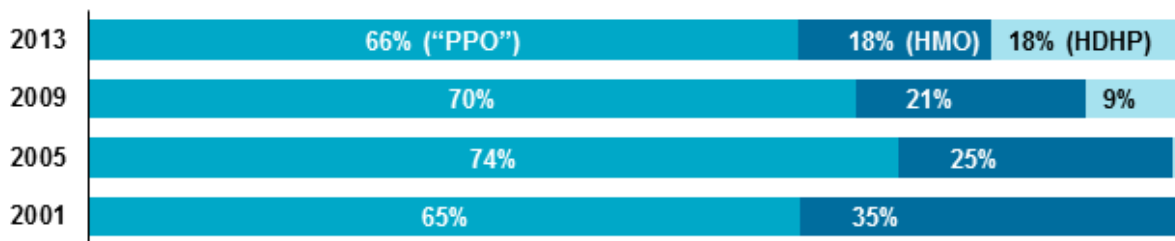
The state program has 366,080 covered lives and 173,761 policyholders.<sup>23</sup> Currently, 51.4% of enrollees who chose the standard plan selected an HMO while 48.6% chose the PPO.<sup>24</sup> Only 1.9% of enrollees chose either HDHP.<sup>25</sup> During the open enrollment period for 2015, PPO enrollment increased slightly, by 0.05%, and HMO enrollment decreased by 0.46%.<sup>26</sup> 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%.<sup>27</sup>

### Employer Sponsored Insurance Trends

In 2010, DSGI contracted with Mercer Consulting to prepare a Benchmarking Report<sup>28</sup> (report) for the state. The report compares Florida's program to the programs of other large employers<sup>29</sup>, 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<sup>30</sup> and the benchmark premium for large national employers ranges from \$270 to \$391 with the company paying 71% to 79% of the premium.<sup>31</sup>

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<sup>32</sup>:



Mercer's latest survey of employer health plans reveals that near 3 in 10 employees were enrolled in an HDHP in 2016.<sup>33</sup>

<sup>23</sup> Id. at slide 7.

<sup>24</sup> Supra, FN 2 at page 1.

<sup>25</sup> Supra, FN 21 at slides 8-9.

<sup>26</sup> 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).

<sup>27</sup> Supra, FN 23.

<sup>28</sup> 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>.

<sup>29</sup> For the purpose of the report, "large employers" had 500 or more employees.

<sup>30</sup> The state contributes 92% of the premium for the individual PPO plan.

<sup>31</sup> *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.

<sup>32</sup> Id. at slide 6.

<sup>33</sup> 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%.<sup>34</sup> 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<sup>35</sup> 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.<sup>36</sup> The state program has plans with lower employee premiums and higher benefits than industry benchmarks.<sup>37</sup> There is virtually no enrollment in HDHPs versus significant growth nationally.<sup>38</sup> Florida's plan costs and annual trend increase are higher than national survey data.<sup>39</sup> 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.<sup>40</sup> Consequently, 99 percent of enrollees chose the HMO or PPO with little to no incentive to choose the HDHP.<sup>41</sup>

## **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<sup>42</sup> in the same plan."<sup>43</sup> 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

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<sup>34</sup> Supra, FN 31 at slide 20.

<sup>35</sup> 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).

<sup>36</sup> Supra, FN 31 at slide 5.

<sup>37</sup> Id.

<sup>38</sup> Id.

<sup>39</sup> Supra, FN 31 at slide 6.

<sup>40</sup> Foster and Foster, *Actuarial Value Contribution Analysis*, March 20, 2015 at page 3.

<sup>41</sup> Supra, FN 31 at slide 9.

<sup>42</sup> The coverage tier is either individual or family.

<sup>43</sup> S. 110.123(3)(f), F.S.

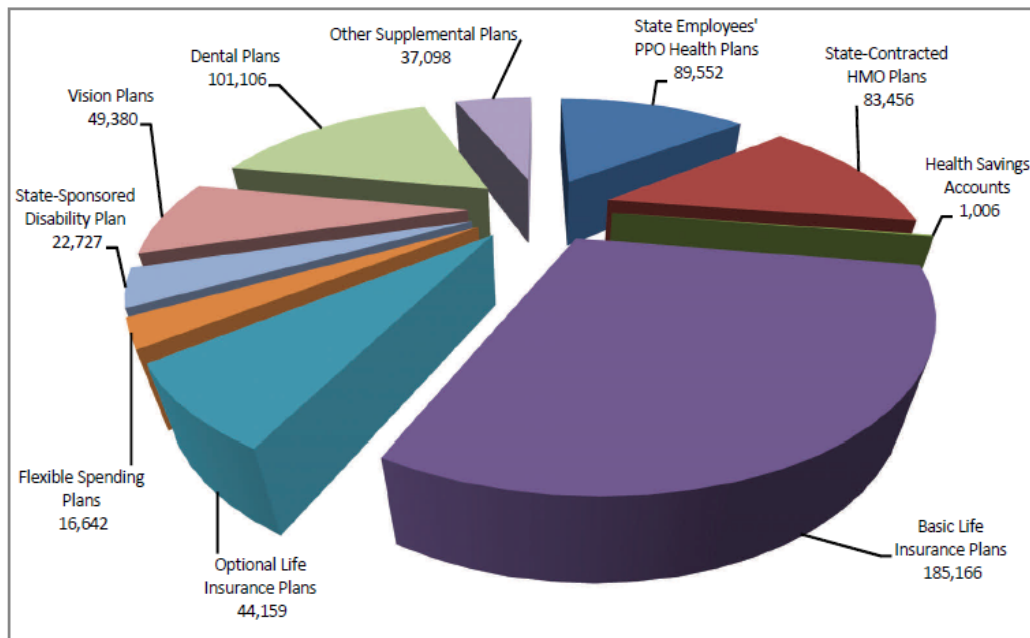
uniform premium amounts in the General Appropriations Act for state paid premiums. The premiums are deposited into the Trust Fund and used to pay the expenses of the state program.

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:

### *Insurance Plans Average Enrollment FY 2011-12*



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.<sup>44</sup> 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.<sup>45</sup>

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.<sup>46</sup>

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

<sup>44</sup> *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](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).

<sup>45</sup> 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).

<sup>46</sup> *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.<sup>47</sup>

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<sup>48</sup> 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:

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<sup>47</sup> The employee must use part of the employer contribution to purchase health insurance. The employee may not receive pay in lieu of benefits.

<sup>48</sup> 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**