HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: HB 5009 PCB APC 22-05 State Group Insurance Program
SPONSOR(S): Appropriations Committee, Stevenson
TIED BILLS: **IDEN./SIM. BILLS:**

FINAL HOUSE FLOOR ACTION: 108 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Approved

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SUMMARY ANALYSIS

HB 5009 passed the House on March 14, 2022, as amended by the conference committee, and subsequently passed the Senate on March 14, 2022.

The bill conforms to the Fiscal Year 2022-2023 General Appropriations Act (GAA). The GAA contains $2.8 million and 3.00 positions related to the creation of an anti-fraud unit within the Division of State Group Insurance. *See* Fiscal Comments.

The State Group Insurance Program (SGI 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). The SGI Program is an optional benefit for most state employees employed by executive branch agencies, state universities, the court system, and the Legislature and includes health, life, dental, vision, disability, and other supplemental insurance benefits. The SGI Program typically makes benefits changes on a plan year basis, January 1 through December 31.

In Fiscal Year 2021-2022, the SGI Program will serve nearly 170,000 enrolled employees at the cost of $2.9 billion. The Revenue Estimating Conference forecasts the SGI Program will serve approximately the same number of employees at a cost of $3.1 billion in Fiscal Year 2022-2023.

The bill amends statutes to make the following changes:

- Provides that eligible former employees of state government may reenroll in the SGI Program within 24 months of separation from employment which occurred on or after July 1, 2022. All eligible former employees must pay the same premiums as early retirees.
- Directs DMS to establish an anti-fraud unit within DSGI by December 31, 2022. Specifically, DMS must establish and maintain a designated anti-fraud unit to investigate and report possible fraudulent insurance acts by insureds, persons making claims for services against the State Employees Health Insurance Trust Fund, or vendors under contract with the division. The bill authorizes the division to contract for the provisions related to the anti-fraud division and requires DMS to designate staff with the primary responsibility of implementing those provisions.
- Ratifies DMS' rule to create nine HMO regions across the state pursuant to s. 110.123(3)(h) 2.d., F.S.
- Amends s. 110.12303, F.S., to allow SGI enrollee's cost-share to be waived, subject to Internal Revenue Service limits, in the Price Transparency Program.
- Repeals the Metal Tier health plan contained in s. 110.123(3)(J), F.S.

The bill was approved by the Governor on June 2, 2022, ch. 2022-160, L.O.F., and will become effective on July 1, 2022.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

State Group Insurance Program

The State Group Insurance Program (SGI 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). The SGI Program is an optional benefit for most state employees employed by executive branch agencies, state universities, the court system, and the Legislature and includes health, life, dental, vision, disability, and other supplemental insurance benefits. The SGI Program typically makes benefits changes on a plan year basis, January 1 through December 31.

In Fiscal Year 2021-2022, the SGI Program will serve nearly 170,000 enrolled employees at the cost of $2.9 billion.[1] The Revenue Estimating Conference forecasts the SGI Program will serve approximately the same number of employees at a cost of $3.1 billion in Fiscal Year 2022-2023.[2]

Eligible Employees

The SGI Program is open to the following individuals:

- All state officers;
- All state employees paid from "salaries and benefits" appropriation categories, regardless of the number of hours worked;
- Retired state officers and state employees;
- Surviving spouses of deceased state officers and state employees;
- Certain terminated state officers and state employees; and
- Certain state employees paid from Other Personal Services (OPS) appropriation categories.

For OPS employees hired after April 1, 2013, to be eligible to participate in the health insurance program, the employee must[3]:

- Be reasonably expected to work an average of at least 30 hours per week; and
- Have worked an average of at least 30 hours per week during the employee's measurement period (which is 12 consecutive months[4] of employment).

Employees enrolled in the SGI Program who separate from covered-employment are no longer covered by the benefits of the SGI Program. An exception would be continuation of SGI benefits under the federal COBRA (Consolidated Omnibus Reconciliation Act) law, which generally allows individuals who separate from employment to extend health care coverage for up to 18 months. Under COBRA, former employees must pay the full cost of insurance premiums, plus an administrative fee of 2 percent.

Metal Tier Plans

Chapter 2017-88, Laws of Florida, directed DMS, beginning with the 2020 plan year, to offer health plans with four specific levels of actuarial values. If the state's contribution towards the health insurance premium was more than the cost of the plan selected by the employee, then the employee could use the remainder to: 1) fund a flexible spending arrangement or health saving account; 2) purchase additional benefits offered through the state plan; or 3) increase the employee salary with the health care savings. The four levels of plans included:

- A platinum level plan, which must have an actuarial value of at least 90 percent.
- A gold level plan, which must have an actuarial value of at least 80 percent.
- A silver level plan, which must have an actuarial value of at least 70 percent.

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[1] State Employees' Group Health Self-Insurance Trust Fund Revenue Estimating Conference, January 13, 2022.
[2] *Id.*
[3] S. 110.123(2)(c)2., F.S.
[4] S. 110.123(13)(d), F.S.

- A bronze level plan, which must have an actuarial value of at least 60 percent[5]

DMS contracted with a consultant to assist with the implementation of the Metal Tier Plans. The consultant's report estimated that 80 percent of state employees would enroll in the platinum level plan and six percent in the bronze level plan.[6] The report also predicted that employees choosing the platinum level plan would actually pay considerably more than the current monthly health insurance premium. Employees in the bronze level plan may have experienced a savings over the current health premiums. However, a main concern with the implementation of Metal Tiers was the 29,000 eligible state employees who "opt out" of coverage in the state health plan. If the "opt out" employees enrolled in the bronze plan and chose the family coverage, the premiums paid by state agencies for health insurance would have increased annually by $464 million. Premiums paid by state employees would have increased by $10 million annually. The report estimated an overall increase of $525 million annually to implement Metal Tiers.[7]

Metal Tiers implementation has been held in abeyance through the General Appropriation Act's Implementing Bill each year since passage.

Anti-Fraud Investigative Units

Section 626.9891, F.S., requires each insurer admitted to do business in Florida to establish and maintain a designated anti-fraud unit or contract with others to investigate and report possible fraudulent insurance acts. Each insurer must adopt an anti-fraud plan and submit the plan to the Division of Investigative and Forensic Services within the Department of Financial Services (DFS).

The SGI Program is not an insurer for purposes of this requirement, however, and has not established or contracted for an anti-fraud investigative unit or adopted an anti-fraud plan. Insurance fraud in Florida is prosecuted under ch. 817, F.S.

The National Health Care Anti-Fraud Association estimates that the financial losses due to health care fraud is about 3 percent of total health care spending, which totaled $3.6 trillion in the United States in 2018.[8] This means health care fraud costs could have exceeded $100 billion. The State Employees' Group Health Self-Insurance Estimating Conference financial outlook from January 13, 2022, estimates the state will spend $3.1 billion in Fiscal Year 2022-2023 for SGI Program costs.[9] The impact of a 3 percent loss due to fraud would cost the state up to $93 million.

Agency Rulemaking

A rule is an agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency.[10] The Legislature grants an agency rulemaking authority through statute and authorizes an agency to adopt, develop, establish, or otherwise create a rule.[11] To adopt a rule, an agency must have a general grant of authority to implement a specific law through rulemaking.[12] The specific statute being interpreted or implemented

[5] S. 110.123(3)(j), F.S.
[6] *Implementation of Metal Tier Health Plans in the State Group Health Insurance Program*, prepared by Foster & Foster for State of Florida, Department of Management Services, Division of State Group Insurance, p. 155.
[7] *Id.*, p. 159.
[8] National Health Care Anti-Fraud Association, *The Challenge of Health Care Fraud*, https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/ (last visited Feb. 4, 2022).
[9] State Employees' Group Health Insurance Trust Fund Report on Financial Outlook adopted by the Self-Insurance Estimating Conference on January 13, 2022.
[10] S. 120.52(16), F.S.
[11] Ss. 120.52(17) and 120.536(1), F.S.
[12] S. 120.536(1), F.S.

through rulemaking must provide specific standards and guidelines to preclude the administrative agency from exercising unbridled discretion in creating policy or applying the law.[13]

The formal rulemaking process begins by an agency giving notice of the proposed rule.[14] The notice is published by the Department of State in the Florida Administrative Register[15] and must include an explanation of the purpose and effect of the rule, the specific legal authority for the rule, the full text of the rule, a summary of the agency's statement of estimated regulatory cost (SERC), if one is prepared, whether legislative ratification is required, and how a party may request a public hearing on the proposed rule.[16]

Price Transparency Program

Beginning with the 2018 plan year, DMS was directed to contract with at least one entity to provide enrollees with an online comparison for health care services and providers which would include comprehensive pricing and services for surgery and other medical procedures. Enrollees could access the services and share in any cost savings to the state group insurance program. The cost savings payable to the enrollee could 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.

DMS Rulemaking – State Group Health Self-Insurance Plan

Section 110.123(3)(h)2.d., F.S., gives DMS the discretion to award health maintenance organization (HMO) contracts on a regional or statewide basis. DMS has chosen to award HMO contracts on a county-by-county basis, with one HMO per county. The smaller geographic area of individual counties rather than a region may limit DMS' negotiating ability when procuring contracts. In 2019, to address this issue, the Legislature required DMS to adopt regions throughout the state, which must be ratified by the Legislature prior to becoming effective.

On July 10, 2019, DMS published an initial notice of rule development to establish a definition for HMO Region to implement the statutory requirement that DMS establish regions throughout the state which an HMO is authorized by contract to provide services to SGI Program enrollees. In October 2019, DMS published the proposed rule in the Florida Administrative Register. On December 10, 2021, DMS submitted the proposed rule to the President of the Senate and the Speaker of the House of Representatives. Ratification will be completed upon this bill becoming law.[17]

Effect of the Bill

Eligible Former Employees

The bill authorizes eligible former employees to participate in the SGI Program. The bill defines "eligible former employee" as a former state officer or employee who was enrolled in the state group insurance program for at least six cumulative years with an employer or employers participating in the state group insurance program, and who was enrolled in the state group insurance program at the time of his or her separation from employment and who whose separation from employment occurred on or after July 1, 2022.

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[13] *Sloban v. Florida Board of Pharmacy,* 982 So. 2d 26, 29-30 (Fla. 1st DCA 2008); *Board of Trustees of the Internal Improvement Trust Fund v. Day Cruise Association, Inc.,* 794 So. 2d 696, 704 (Fla. 1st DCA 2001).
[14] S. 120.54(3)(a), F.S.
[15] S. 120.55, F.S.
[16] S. 120.54(3)(a), F.S.
[17] S. 120.541, F.S.

Eligible former employees may enroll in the state health insurance coverage at any time within 24 months of his or her separation from employment. The options offered to such former employees must provide the same health insurance coverage as provided to retirees, except for life insurance and flexible spending account plans, and under the same premium payment conditions in effect for early retirees.

Current Premiums for "Early Retirees"[18]	Cost
High Deductible Plan – Individual	$736.80
High Deductible Plan – Family	$1,632.05
Standard Plan – enhance benefits – Individual	$805.12
Standard Plan – enhance benefits – Family	$1,801.08

Metal Tier Plans

The bill repeals the section of law directing DMS to implement health insurance plans at four different actuarial levels beginning with the 2020 plan year.[19] The Metal Tiers plan has not been implemented.

Anti-Fraud Investigative Units

By December 31, 2022, the Division of State Group Insurance is required to:

- Establish and maintain a designated anti-fraud unit[20] to investigate and report possible fraudulent insurance acts by insureds, persons making claims for services against the State Employees Health Insurance Trust Fund, or vendors under contract with the division. The bill authorizes the division to contract for the provision of these services.
- Adopt an anti-fraud plan.
- Designate staff with the primary responsibility of implementing the anti-fraud provisions in this bill.

Price Transparency Program

The bill amends the statute to potentially incentive utilization of transparency services by waiving member cost-share, subject to Internal Revenue Service limits. The bill also defines “enrollee cost-sharing liability” to mean the amount a health care plan enrollee is responsible for paying for a covered service. The term includes deductibles, coinsurance, and copays, but does not include premiums.

Ratification of DMS Rules – State Group Health Self-Insurance Plan

Effective upon becoming a law, this bill ratifies the following DMS rules filed for adoption with the Department of State to satisfy the requirements in s. 110.123(3)(h)2.d., F.S.:

- Rule 60P-1.003, F.A.C., entitled Definitions.
- Rule 60P-2.002, F.A.C., entitled Eligibility and Enrollment.
- Rule 60P-2.003, F.A.C., entitled Changes in Coverage.

Rule 60P-1.003, F.A.C. creates the following nine HMO regions across the state:

- Region 1: Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, and Washington counties.
- Region 2: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla counties.
- Region 3: Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Suwannee, and Union counties.
- Region 4: Baker, Clay, Duval, Flagler, Nassau, Putnam, St. Johns, and Volusia counties.
- Region 5: Brevard, Indian River, Lake, Orange, Osceola, and Seminole counties.

[18] Ch. 2021-36, L.O.F., pp 425-426.
[19] S. 110.123(3)(J), F.S.
[20] The bill provides that the term “designated anti-fraud unit” means a distinct unit within the Division of State Group Insurance which is made up of employees whose principal responsibilities are the investigation and disposition of claims and who are also assigned to investigate fraud.

- Region 6: Citrus, Desoto, Hardee, Hernando, Highlands, Manatee, Pasco, Pinellas, Polk, Sarasota, and Sumter counties.
- Region 7: Martin, Okeechobee, Palm Beach, and St. Lucie counties.
- Region 8: Charlotte, Collier, Glades, Hendry, and Lee counties.
- Region 9: Broward, Miami-Dade, and Monroe counties.

HB 5003, the “Implementing Bill,” (section 83) provides DMS authorization in Fiscal Years 2021-2022 or 2022-2023, to competitively procure HMO service contracts for the plan year beginning January 1, 2024.

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:

None.

D. FISCAL COMMENTS:

The General Appropriations Act for Fiscal Year 2022-2023 (GAA) provides a total of $2.8 million to implement the provisions of HB 5009. Specifically, the GAA provides the State Group Insurance Program:

- $335,001 and three positions, for the creation of an anti-fraud unit within the Division of State Group Insurance (DSGI).
- $2.2 million ($1.3 million nonrecurring) to contract with a vendor for a comprehensive fraud analytic solution that will review billing information to help detect fraud, waste, and abuse in the state health program. The anti-fraud unit will likely provide an overall cost savings through the detection and prevention of fraud.
- $310,000 in nonrecurring funding for programing and implementation costs related to the “eligible former employees” returning to the state health plan. Former employees choosing to participate in the state health plan will be paying the same premium cost as “early retirees” and will likely have minimal fiscal impact on the state health plan. The adoption of the HMO regions rule will likely provide a potential cost savings and better negotiating ability for DMS when procuring HMO contracts.