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

27 duties of the independent benefits consultant;
28 providing reporting requirements; providing that the
29 General Appropriations Act shall establish premiums
30 for enrollees that reflect the differences in benefit
31 design and value among the health maintenance
32 organization plan options and the preferred provider
33 organization plan options; establishing the share of
34 the health insurance premium for employees, early
35 retirees, and Medicare participants participating in
36 the State Group Insurance Plan for specified health
37 care plans and coverage periods; providing an
38 appropriation and authorizing positions; providing for
39 construction of the act in pari materia with laws
40 enacted during the 2015 Regular Session of the
41 Legislature; providing an effective date.
42
43 Be It Enacted by the Legislature of the State of Florida:
44
45 Section 1. Subsection (2) and paragraphs (b), (f), (h),
46 and (j) of subsection (3) of section 110.123, Florida Statutes,
47 are amended, and paragraph (k) is added to subsection (3) of
48 that section, to read:
49 110.123 State group insurance program.—
50 (2) DEFINITIONS.—As used in ss. 110.123-110.1239 ~~this~~
51 ~~section~~, the term:
52 (a) "Department" means the Department of Management

53 Services.
54 (b) "Enrollee" means all state officers and employees,
55 retired state officers and employees, surviving spouses of
56 deceased state officers and employees, and terminated employees
57 or individuals with continuation coverage who are enrolled in an
58 insurance plan offered by the state group insurance program.
59 "Enrollee" includes all state university officers and employees,
60 retired state university officers and employees, surviving
61 spouses of deceased state university officers and employees, and
62 terminated state university employees or individuals with
63 continuation coverage who are enrolled in an insurance plan
64 offered by the state group insurance program.
65 (c) "Full-time state employees" means employees of all
66 branches or agencies of state government holding salaried
67 positions who are paid by state warrant or from agency funds and
68 who work or are expected to work an average of at least 30 or
69 more hours per week; employees paid from regular salary
70 appropriations for 8 months' employment, including university
71 personnel on academic contracts; and employees paid from other-
72 personal-services (OPS) funds as described in subparagraphs 1.
73 and 2. The term includes all full-time employees of the state
74 universities. The term does not include seasonal workers who are
75 paid from OPS funds.
76 1. For persons hired before April 1, 2013, the term
77 includes any person paid from OPS funds who:
78 a. Has worked an average of at least 30 hours or more per

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79 week during the initial measurement period from April 1, 2013,
80 through September 30, 2013; or
81 b. Has worked an average of at least 30 hours or more per
82 week during a subsequent measurement period.
83 2. For persons hired after April 1, 2013, the term
84 includes any person paid from OPS funds who:
85 a. Is reasonably expected to work an average of at least
86 30 hours or more per week; or
87 b. Has worked an average of at least 30 hours or more per
88 week during the person's measurement period.
89 (d) "Health maintenance organization" or "HMO" means an
90 entity certified under part I of chapter 641.
91 (e) "Health plan member" means any person participating in
92 a state group health insurance plan, a TRICARE supplemental
93 insurance plan, or a health maintenance organization plan under
94 the state group insurance program, including enrollees and
95 covered dependents thereof.
96 (f) "Part-time state employee" means an employee of any
97 branch or agency of state government paid by state warrant from
98 salary appropriations or from agency funds, and who is employed
99 for less than an average of 30 hours per week or, if on academic
100 contract or seasonal or other type of employment which is less
101 than year-round, is employed for less than 8 months during any
102 12-month period, but does not include a person paid from other-
103 personal-services (OPS) funds. The term includes all part-time
104 employees of the state universities.

105 (g) "Plan year" means a calendar year.
106 (h) ~~(g)~~ "Retired state officer or employee" or "retiree"
107 means any state or state university officer or employee who
108 retires under a state retirement system or a state optional
109 annuity or retirement program or is placed on disability
110 retirement, and who was insured under the state group insurance
111 program at the time of retirement, and who begins receiving
112 retirement benefits immediately after retirement from state or
113 state university office or employment. The term also includes
114 any state officer or state employee who retires under the
115 Florida Retirement System Investment Plan established under part
116 II of chapter 121 if he or she:
117 1. Meets the age and service requirements to qualify for
118 normal retirement as set forth in s. 121.021(29); or
119 2. Has attained the age specified by s. 72(t)(2)(A)(i) of
120 the Internal Revenue Code and has 6 years of creditable service.
121 (i) ~~(h)~~ "State agency" or "agency" means any branch,
122 department, or agency of state government. "State agency" or
123 "agency" includes any state university for purposes of this
124 section only.
125 (j) ~~(i)~~ "Seasonal workers" has the same meaning as provided
126 under 29 C.F.R. s. 500.20(s)(1).
127 (k) ~~(j)~~ "State group health insurance plan or plans" or
128 "state plan or plans" mean the state self-insured health
129 insurance plan or plans offered to state officers and employees,
130 retired state officers and employees, and surviving spouses of

131 deceased state officers and employees pursuant to this section.
132 (l) ~~(k)~~ "State-contracted HMO" means any health maintenance
133 organization under contract with the department to participate
134 in the state group insurance program.
135 (m) ~~(l)~~ "State group insurance program" or "programs" means
136 the package of insurance plans offered to state officers and
137 employees, retired state officers and employees, and surviving
138 spouses of deceased state officers and employees pursuant to
139 this section, including the state group health insurance plan or
140 plans, health maintenance organization plans, TRICARE
141 supplemental insurance plans, and other plans required or
142 authorized by law.
143 (n) ~~(m)~~ "State officer" means any constitutional state
144 officer, any elected state officer paid by state warrant, or any
145 appointed state officer who is commissioned by the Governor and
146 who is paid by state warrant.
147 (o) ~~(n)~~ "Surviving spouse" means the widow or widower of a
148 deceased state officer, full-time state employee, part-time
149 state employee, or retiree if such widow or widower was covered
150 as a dependent under the state group health insurance plan, ~~a~~
151 TRICARE supplemental insurance plan, or a health maintenance
152 organization plan established pursuant to this section at the
153 time of the death of the deceased officer, employee, or retiree.
154 "Surviving spouse" also means any widow or widower who is
155 receiving or eligible to receive a monthly state warrant from a
156 state retirement system as the beneficiary of a state officer,

157 full-time state employee, or retiree who died prior to July 1,
158 1979. For the purposes of this section, any such widow or
159 widower shall cease to be a surviving spouse upon his or her
160 remarriage.
161 (p) ~~(o)~~ "TRICARE supplemental insurance plan" means the
162 Department of Defense Health Insurance Program for eligible
163 members of the uniformed services authorized by 10 U.S.C. s.
164 1097.
165 (3) STATE GROUP INSURANCE PROGRAM.—
166 (b) It is the intent of the Legislature to offer a
167 comprehensive package of health insurance and retirement
168 benefits and a personnel system for state employees which are
169 provided in a cost-efficient and prudent manner, and to allow
170 state employees the option to choose benefit plans which best
171 suit their individual needs. ~~Therefore,~~ The state group
172 insurance program ~~is established which~~ may include the state
173 group health insurance plan or plans, health maintenance
174 organization plans, group life insurance plans, TRICARE
175 supplemental insurance plans, group accidental death and
176 dismemberment plans, ~~and~~ group disability insurance plans, ~~.~~
177 ~~Furthermore, the department is additionally authorized to~~
178 ~~establish and provide as part of the state group insurance~~
179 ~~program any~~ other group insurance plans or coverage choices, and
180 other benefits authorized by law ~~that are consistent with the~~
181 ~~provisions of this section~~.
182 (f) Except as provided for in subparagraph (h)2., the

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183 state contribution toward the cost of any plan in the state
184 group insurance program shall be uniform with respect to all
185 state employees in a state collective bargaining unit
186 participating in the same coverage tier in the same plan. This
187 section does not prohibit the development of separate benefit
188 plans for officers and employees exempt from the career service
189 or the development of separate benefit plans for each collective
190 bargaining unit. For the 2018 plan year and thereafter, if the
191 state's contribution is more than the premium cost of the health
192 plan selected by the employee, subject to federal limitation,
193 the employee may elect to have the balance:
194 1. Credited to the employee's flexible spending account;
195 2. Credited to the employee's health savings account;
196 3. Used to purchase additional benefits offered through
197 the state group insurance program; or
198 4. Used to increase the employee's salary.
199 (h)1. A person eligible to participate in the state group
200 insurance program may be authorized by rules adopted by the
201 department, in lieu of participating in the state group health
202 insurance plan, to exercise an option to elect membership in a
203 health maintenance organization plan which is under contract
204 with the state in accordance with criteria established by this
205 section and by said rules. The offer of optional membership in a
206 health maintenance organization plan permitted by this paragraph
207 may be limited or conditioned by rule as may be necessary to
208 meet the requirements of state and federal laws.

209 2. The department shall contract with health maintenance
210 organizations seeking to participate in the state group
211 insurance program through a request for proposal or other
212 procurement process, as developed by the Department of
213 Management Services and determined to be appropriate.
214 a. The department shall establish a schedule of minimum
215 benefits for health maintenance organization coverage, and that
216 schedule shall include: physician services; inpatient and
217 outpatient hospital services; emergency medical services,
218 including out-of-area emergency coverage; diagnostic laboratory
219 and diagnostic and therapeutic radiologic services; mental
220 health, alcohol, and chemical dependency treatment services
221 meeting the minimum requirements of state and federal law;
222 skilled nursing facilities and services; prescription drugs;
223 age-based and gender-based wellness benefits; and other benefits
224 as may be required by the department. Additional services may be
225 provided subject to the contract between the department and the
226 HMO. As used in this paragraph, the term "age-based and gender-
227 based wellness benefits" includes aerobic exercise, education in
228 alcohol and substance abuse prevention, blood cholesterol
229 screening, health risk appraisals, blood pressure screening and
230 education, nutrition education, program planning, safety belt
231 education, smoking cessation, stress management, weight
232 management, and women's health education.
233 b. The department may establish uniform deductibles,
234 copayments, coverage tiers, or coinsurance schedules for all

235 participating HMO plans.
236 c. The department may require detailed information from
237 each health maintenance organization participating in the
238 procurement process, including information pertaining to
239 organizational status, experience in providing prepaid health
240 benefits, accessibility of services, financial stability of the
241 plan, quality of management services, accreditation status,
242 quality of medical services, network access and adequacy,
243 performance measurement, ability to meet the department's
244 reporting requirements, and the actuarial basis of the proposed
245 rates and other data determined by the director to be necessary
246 for the evaluation and selection of health maintenance
247 organization plans and negotiation of appropriate rates for
248 these plans. Upon receipt of proposals by health maintenance
249 organization plans and the evaluation of those proposals, the
250 department may enter into negotiations with all of the plans or
251 a subset of the plans, as the department determines appropriate.
252 Nothing shall preclude the department from negotiating regional
253 or statewide contracts with health maintenance organization
254 plans when this is cost-effective and when the department
255 determines that the plan offers high value to enrollees.
256 d. The department may limit the number of HMOs that it
257 contracts with in each service area based on the nature of the
258 bids the department receives, the number of state employees in
259 the service area, or any unique geographical characteristics of
260 the service area. The department shall establish by rule service

261 areas throughout the state.
262 e. All persons participating in the state group insurance
263 program may be required to contribute towards a total state
264 group health premium that may vary depending upon the plan,
265 coverage level, and coverage tier selected by the enrollee and
266 the level of state contribution authorized by the Legislature.
267 3. The department is authorized to negotiate and to
268 contract with specialty psychiatric hospitals for mental health
269 benefits, on a regional basis, for alcohol, drug abuse, and
270 mental and nervous disorders. The department may establish,
271 subject to the approval of the Legislature pursuant to
272 subsection (5), any such regional plan upon completion of an
273 actuarial study to determine any impact on plan benefits and
274 premiums.
275 4. In addition to contracting pursuant to subparagraph 2.,
276 the department may enter into contract with any HMO to
277 participate in the state group insurance program which:
278 a. Serves greater than 5,000 recipients on a prepaid basis
279 under the Medicaid program;
280 b. Does not currently meet the 25-percent non-
281 Medicare/non-Medicaid enrollment composition requirement
282 established by the Department of Health excluding participants
283 enrolled in the state group insurance program;
284 c. Meets the minimum benefit package and copayments and
285 deductibles contained in sub-subparagraphs 2.a. and b.;
286 d. Is willing to participate in the state group insurance

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287 program at a cost of premiums that is not greater than 95
288 percent of the cost of HMO premiums accepted by the department
289 in each service area; and
290 e. Meets the minimum surplus requirements of s. 641.225.
291
292 The department is authorized to contract with HMOs that meet the
293 requirements of sub-subparagraphs a.-d. prior to the open
294 enrollment period for state employees. The department is not
295 required to renew the contract with the HMOs as set forth in
296 this paragraph more than twice. Thereafter, the HMOs shall be
297 eligible to participate in the state group insurance program
298 only through the request for proposal or invitation to negotiate
299 process described in subparagraph 2.
300 5. All enrollees in a state group health insurance plan, a
301 TRICARE supplemental insurance plan, or any health maintenance
302 organization plan have the option of changing to any other
303 health plan that is offered by the state within any open
304 enrollment period designated by the department. Open enrollment
305 shall be held at least once each calendar year.
306 6. When a contract between a treating provider and the
307 state-contracted health maintenance organization is terminated
308 for any reason other than for cause, each party shall allow any
309 enrollee for whom treatment was active to continue coverage and
310 care when medically necessary, through completion of treatment
311 of a condition for which the enrollee was receiving care at the
312 time of the termination, until the enrollee selects another

313 treating provider, or until the next open enrollment period
314 offered, whichever is longer, but no longer than 6 months after
315 termination of the contract. Each party to the terminated
316 contract shall allow an enrollee who has initiated a course of
317 prenatal care, regardless of the trimester in which care was
318 initiated, to continue care and coverage until completion of
319 postpartum care. This does not prevent a provider from refusing
320 to continue to provide care to an enrollee who is abusive,
321 noncompliant, or in arrears in payments for services provided.
322 For care continued under this subparagraph, the program and the
323 provider shall continue to be bound by the terms of the
324 terminated contract. Changes made within 30 days before
325 termination of a contract are effective only if agreed to by
326 both parties.
327 7. Any HMO participating in the state group insurance
328 program shall submit health care utilization and cost data to
329 the department, in such form and in such manner as the
330 department shall require, as a condition of participating in the
331 program. The department shall enter into negotiations with its
332 contracting HMOs to determine the nature and scope of the data
333 submission and the final requirements, format, penalties
334 associated with noncompliance, and timetables for submission.
335 These determinations shall be adopted by rule.
336 8. The department may establish and direct, with respect
337 to collective bargaining issues, a comprehensive package of
338 insurance benefits that may include supplemental health and life

339 coverage, dental care, long-term care, vision care, and other
340 benefits it determines necessary to enable state employees to
341 select from among benefit options that best suit their
342 individual and family needs. <u>Beginning with the 2016 plan year,</u>
343 <u>the package of benefits may also include products and services</u>
344 <u>described in s. 110.12303.</u>
345 a. Based upon a desired benefit package, the department
346 shall issue a request for proposal or invitation to negotiate
347 for ~~health insurance~~ providers interested in participating in
348 the state group insurance program, and the department shall
349 issue a request for proposal or invitation to negotiate for
350 ~~insurance~~ providers interested in participating in the non-
351 health-related components of the state group insurance program.
352 Upon receipt of all proposals, the department may enter into
353 contract negotiations with ~~insurance~~ providers submitting bids
354 or negotiate a specially designed benefit package. Insurance
355 providers offering or providing supplemental coverage as of May
356 30, 1991, which qualify for pretax benefit treatment pursuant to
357 s. 125 of the Internal Revenue Code of 1986, with 5,500 or more
358 state employees currently enrolled may be included by the
359 department in the supplemental insurance benefit plan
360 established by the department without participating in a request
361 for proposal, submitting bids, negotiating contracts, or
362 negotiating a specially designed benefit package. These
363 contracts shall provide state employees with the most cost-
364 effective and comprehensive coverage available; however, <u>except</u>

365 as provided in subparagraph (f)3., no state or agency funds
366 shall be contributed toward the cost of any part of the premium
367 of such supplemental benefit plans. With respect to dental
368 coverage, the division shall include in any solicitation or
369 contract for any state group dental program made after July 1,
370 2001, a comprehensive indemnity dental plan option which offers
371 enrollees a completely unrestricted choice of dentists. If a
372 dental plan is endorsed, or in some manner recognized as the
373 preferred product, such plan shall include a comprehensive
374 indemnity dental plan option which provides enrollees with a
375 completely unrestricted choice of dentists.
376 b. Pursuant to the applicable provisions of s. 110.161,
377 and s. 125 of the Internal Revenue Code of 1986, the department
378 shall enroll in the pretax benefit program those state employees
379 who voluntarily elect coverage in any of the supplemental
380 ~~insurance~~ benefit plans as provided by sub-subparagraph a.
381 c. Nothing herein contained shall be construed to prohibit
382 insurance providers from continuing to provide or offer
383 supplemental benefit coverage to state employees as provided
384 under existing agency plans.
385 (j) For the 2018 plan year and thereafter, health plans
386 shall be offered in the following benefit levels:
387 1. Platinum level, which shall have an actuarial value of
388 at least 90 percent.
389 2. Gold level, which shall have an actuarial value of at
390 least 80 percent.

391 3. Silver level, which shall have an actuarial value of at
392 least 70 percent.
393 4. Bronze level, which shall have an actuarial value of at
394 least 60 percent ~~Notwithstanding paragraph (f) requiring uniform~~
395 ~~contributions, and for the 2011-2012 fiscal year only, the state~~
396 ~~contribution toward the cost of any plan in the state group~~
397 ~~insurance plan is the difference between the overall premium and~~
398 ~~the employee contribution. This subsection expires June 30,~~
399 ~~2012~~.
400 (k) In consultation with the independent benefits
401 consultant described in s. 110.12304, the department shall
402 develop a plan for implementation of the benefit levels
403 described in paragraph (j). The plan shall be submitted to the
404 Governor, the President of the Senate, and the Speaker of the
405 House of Representatives no later than January 1, 2017, and
406 include recommendations for:
407 1. Employer and employee contribution policies.
408 2. Steps necessary for maintaining or improving total
409 employee compensation levels when the transition is initiated.
410 3. An education strategy to inform employees of the
411 additional choices available in the state group insurance
412 program.
413
414 This paragraph expires July 1, 2017.
415 Section 2. Section 110.12303, Florida Statutes, is created
416 to read:

417 110.12303 State group insurance program; additional
418 benefits; price transparency pilot program; reporting.—Beginning
419 with the 2016 plan year:
420 (1) In addition to the comprehensive package of health
421 insurance and other benefits required or authorized to be
422 included in the state group insurance program, the package of
423 benefits may also include products and services offered by:
424 (a) Prepaid limited health service organizations as
425 authorized by part I of chapter 636.
426 (b) Discount medical plan organizations as authorized by
427 part II of chapter 636.
428 (c) Prepaid health clinics licensed under part II of
429 chapter 641.
430 (d) Licensed health care providers, including hospitals
431 and other health facilities, health care clinics, and health
432 professionals, who sell service contracts and arrangements for a
433 specified amount and type of health services.
434 (e) Provider organizations, including service networks,
435 group practices, professional associations, and other
436 incorporated organizations of providers, who sell service
437 contracts and arrangements for a specified amount and type of
438 health services.
439 (f) Entities that provide specific health services in
440 accordance with applicable state law and sell service contracts
441 and arrangements for a specified amount and type of health
442 services.

443 (g) Entities that provide health services or treatments
444 through a bidding process.
445 (h) Entities that provide health services or treatments
446 through the bundling or aggregating of health services or
447 treatments.
448 (i) Entities that provide other innovative and cost-
449 effective health service delivery methods.
450 (2)(a) The department shall contract with at least one
451 entity that provides comprehensive pricing and inclusive
452 services for surgery and other medical procedures which may be
453 accessed at the option of the enrollee. The contract shall
454 require the entity to:
455 1. Have procedures and evidence-based standards to ensure
456 the inclusion of only high-quality health care providers.
457 2. Provide assistance to the enrollee in accessing and
458 coordinating care.
459 3. Provide cost savings to the state group insurance
460 program to be shared with both the state and the enrollee. Cost
461 savings payable to an enrollee may be:
462 a. Credited to the enrollee's flexible spending account;
463 b. Credited to the enrollee's health savings account;
464 c. Credited to the enrollee's health reimbursement
465 account; or
466 d. Paid as additional health plan reimbursements not
467 exceeding the amount of the employee's out-of-pocket medical
468 expenses.

469 4. Provide an educational campaign for enrollees to learn
470 about the services offered by the entity.
471 (b) On or before January 15 of each year, the department
472 shall report to the Governor, the President of the Senate, and
473 the Speaker of the House of Representatives on the participation
474 level and cost savings to both the enrollee and the state
475 resulting from the contract or contracts described in this
476 subsection.
477 (3) The department shall establish a 3-year price
478 transparency pilot project in at least one area, but not more
479 than three areas, of the state where a substantial percentage of
480 the state group insurance program enrollees live. The purpose of
481 the project is to reward value-based pricing by publishing the
482 prices of certain diagnostic and elective surgical procedures
483 and sharing with the enrollee and the state any savings
484 generated by the enrollee's choice of providers.
485 (a) Participation in the project shall be voluntary for
486 enrollees.
487 (b) The department shall designate at least 20 but no more
488 than 50 diagnostic procedures and elective surgical procedures
489 that are commonly utilized by enrollees.
490 (c) Health plans shall provide the department with the
491 contracted price by provider for each designated procedure. The
492 department shall post the prices on its website and shall
493 designate one price per procedure as the benchmark price, using
494 a mean, average, or other method of comparing the prices.

495 (d) If an enrollee participating in the project selects a
496 provider that performs the designated procedure at a price below
497 the benchmark price for that procedure, the enrollee shall
498 receive from the state 50 percent of the difference between the
499 price of the procedure by the selected provider and the
500 benchmark price. The amount payable to the enrollee may be:
501 1. Credited to the enrollee's flexible spending account;
502 2. Credited to the enrollee's health savings account;
503 3. Credited to the enrollee's health reimbursement
504 account; or
505 4. Paid as additional health plan reimbursements not
506 exceeding the amount of the enrollee's out-of-pocket medical
507 expenses.
508 (e) On or before January 1 of 2017, 2018, and 2019, the
509 department shall report to the Governor, the President of the
510 Senate, and the Speaker of the House of Representatives on the
511 participation level, amount paid to enrollees, and cost savings
512 to both the enrollees and the state resulting from the price
513 transparency pilot project.
514 Section 3. Section 110.12304, Florida Statutes, is created
515 to read:
516 110.12304 Independent benefits consultant.—
517 (1) The department shall competitively procure an
518 independent benefits consultant.
519 (2) The independent benefits consultant may not:
520 (a) Be owned or controlled by a health maintenance

521 organization or insurer.
522 (b) Have an ownership interest in a health maintenance
523 organization or insurer.
524 (c) Have a direct or indirect financial interest in a
525 health maintenance organization or insurer.
526 (3) The independent benefits consultant must have
527 substantial experience in consultation and design of employee
528 benefit programs for large employers and public employers,
529 including experience with plans that qualify as cafeteria plans
530 pursuant to s. 125 of the Internal Revenue Code of 1986.
531 (4) The independent benefits consultant shall:
532 (a) Provide an ongoing assessment of trends in benefits
533 and employer-sponsored insurance that affect the state group
534 insurance program.
535 (b) Conduct a comprehensive analysis of the state group
536 insurance program, including available benefits, coverage
537 options, and claims experience.
538 (c) Identify and establish appropriate adjustment
539 procedures necessary to respond to any risk segmentation that
540 may occur when increased choices are offered to employees.
541 (d) Assist the department with the submission of any
542 necessary plan revisions for federal review.
543 (e) Assist the department in ensuring compliance with
544 applicable federal and state regulations.
545 (f) Assist the department in monitoring the adequacy of
546 funding and reserves for the state self-insured plan.

547 (g) Assist the department in preparing recommendations for
548 any modifications to the state group insurance program which
549 shall be submitted to the Governor, the President of the Senate,
550 and the Speaker of the House of Representatives no later than
551 January 1 of each year.
552 Section 4. For the 2016 plan year, the General
553 Appropriations Act shall implement premiums for enrollees that
554 reflect the differences in benefit design and value among the
555 health maintenance organization (HMO) plan options and the
556 preferred provider organization (PPO) plan options offered in
557 the state group insurance program.
558 (1) Effective July 1, 2015, for the coverage period
559 beginning August 1, 2015, through December 31, 2015, the
560 employee's share of the health insurance premium for the
561 standard plans shall continue to be $50 per month for individual
562 coverage and $180 per month for family coverage.
563 (2) Effective December 1, 2015, for the coverage period
564 beginning January 1, 2016, the employee's share of the health
565 insurance premium for the standard HMO plan shall be $60 per
566 month for individual coverage and $200 per month for family
567 coverage. For the same coverage period, the employee's share of
568 the health insurance premium for the standard PPO plan shall be
569 $45 per month for individual coverage and $170 per month for
570 family coverage. For the same coverage period, the employee's
571 share of the health insurance premium for Capital Health Plan
572 shall be $40 per month for individual coverage and $170 per

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573 month for family coverage.
574 (3) Effective July 1, 2015, for the coverage period
575 beginning August 1, 2015, through December 31, 2015, the
576 employee's share of the health insurance premium for the high-
577 deductible health plans shall continue to be $15 per month for
578 individual coverage and $64.30 per month for family coverage.
579 (4) Effective December 1, 2015, for the coverage period
580 beginning January 1, 2016, the employee's share of the health
581 insurance premium for the high-deductible health plans shall be
582 $10 per month for individual coverage and $50 per month for
583 family coverage.
584 (5) Effective July 1, 2015, for the coverage period
585 beginning August 1, 2015, the employee's share of the health
586 insurance premium for the standard PPO plan, the standard HMO
587 plan, and Capital Health Plan shall continue to be $8.34 per
588 month for individual coverage and $30 per month for family
589 coverage for employees filling positions with "agency payall"
590 benefits.
591 (6) Effective July 1, 2015, for the coverage period
592 beginning August 1, 2015, through December 31, 2015, the
593 employee's share of the health insurance premium for the high-
594 deductible health plans shall continue to be $8.34 per month for
595 individual coverage and $30 per month for family coverage for
596 employees filling positions with "agency payall" benefits.
597 (7) Effective December 1, 2015, for the coverage period
598 beginning January 1, 2016, the employee's share of the health

599 insurance premium for the high-deductible health plans shall be
600 $8.34 per month for individual coverage and $25 per month for
601 family coverage for employees filling positions with "agency
602 payall" benefits.
603 (8) Effective July 1, 2015, for the coverage period
604 beginning August 1, 2015, through December 31, 2015, the
605 employee's share of the health insurance premium for the
606 standard plans and the high-deductible health plans shall
607 continue to be $30 per month for each employee participating in
608 the Spouse Program in accordance with rules of the Department of
609 Management Services.
610 (9) Effective December 1, 2015, for the coverage period
611 beginning January 1, 2016, the employee's share of the health
612 insurance premium for the standard plans shall continue to be
613 $30 for each employee participating in the Spouse Program in
614 accordance with rules of the Department of Management Services.
615 (10) Effective December 1, 2015, for the coverage period
616 beginning January 1, 2016, the employee's share of the health
617 insurance premium for the high-deductible health plans shall be
618 $25 for each employee participating in the Spouse Program in
619 accordance with rules of the Department of Management Services.
620 (11) Effective July 1, 2015, for the coverage period
621 beginning August 1, 2015, an "early retiree" participating in a
622 standard plan shall continue to pay a monthly premium equal to
623 100 percent of the total premium charged, including state and
624 employee contributions, for an active employee participating in

625 the standard plan.
626 (12) Effective July 1, 2015, for the coverage period
627 beginning August 1, 2015, through December 31, 2015, an "early
628 retiree" participating in a high-deductible health plan shall
629 continue to pay $564.86 per month for individual coverage and
630 $1,245.03 per month for family coverage.
631 (13) Effective December 1, 2015, for the coverage period
632 beginning January 1, 2016, an "early retiree" participating in a
633 high-deductible health plan shall pay $559.86 per month for
634 individual coverage and $1,230.73 per month for family coverage.
635 (14) Effective July 1, 2015, for the coverage period
636 beginning August 1, 2015, through December 31, 2015, the monthly
637 premiums for Medicare participants in the standard plans shall
638 continue to be $359.61 for "one eligible," $1,036.90 for "one
639 under/one over," and $719.22 for "both eligible."
640 (15) Effective December 1, 2015, for the coverage period
641 beginning January 1, 2016, the monthly premiums for Medicare
642 participants in the standard PPO plan shall be $356.49 for "one
643 eligible," $1,027.89 for "one under/one over," and $712.97 for
644 "both eligible." For the same coverage period, the monthly
645 premiums for Medicare participants participating in the standard
646 HMO plan shall be $371.32 for "one eligible," $1,070.67 for "one
647 under/one over," and $742.64 for "both eligible."
648 (16) Effective July 1, 2015, for the coverage period
649 beginning August 1, 2015, the monthly premiums for Medicare
650 participants in the high-deductible health plan shall continue

651 to be $271.07 for "one eligible," $849.19 for "one under/one
652 over," and $542.14 for "both eligible."
653 (17) Effective July 1, 2015, for the coverage period
654 beginning August 1, 2015, the monthly premiums for Medicare
655 participants enrolled in a fully insured standard HMO plan or an
656 HMO high-deductible health plan shall be equal to the negotiated
657 monthly premium for the selected state-contracted health
658 maintenance organization.
659 (18) Effective July 1, 2015, for the coverage period
660 beginning August 1, 2015, a COBRA participant in the State Group
661 Health Insurance Program shall continue to pay a premium equal
662 to 102 percent of the total premium charged, including state and
663 employee contributions, for an active employee participating in
664 the program.
665 (19) Effective July 1, 2015, for the coverage period
666 beginning August 1, 2015, the state share of the State Group
667 Health Insurance Program premiums shall be the same as those in
668 effect on July 1, 2014, pursuant to chapter 2014-51, Laws of
669 Florida.
670 Section 5. (1) For the 2015-2016 fiscal year, the sums of
671 $151,216 in recurring funds and $507,546 in nonrecurring funds
672 are appropriated from the State Employees Health Insurance Trust
673 Fund to the Department of Management Services, and two full-time
674 equivalent positions and associated salary rate of 120,000 are
675 authorized, for the purpose of implementing this act.
676 (2)(a) The recurring funds appropriated in this section

677 shall be allocated to the following specific appropriation
678 categories within the Insurance Benefits Administration Program:
679 $150,528 in Salaries and Benefits and $688 in Special Categories
680 Transfer to Department of Management Services—Human Resources
681 Purchased per Statewide Contract.
682 (b) The nonrecurring funds appropriated in this section
683 shall be allocated to the following specific appropriation
684 categories: $500,000 in Special Categories Contracted Services
685 and $7,546 in Expenses.
686 Section 6. If any law amended by this act was also amended
687 by a law enacted during the 2015 Regular Session of the
688 Legislature, such laws shall be construed as if enacted during
689 the same session of the Legislature, and full effect shall be
690 given to each if possible.
691 Section 7. This act shall take effect July 1, 2015.