Senator Diaz moved the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause and insert:

Section 1. Paragraph (d) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(d)1. Notwithstanding chapter 287 and the authority of the department, for the purpose of protecting the health of, and providing medical services to, state employees participating in
the state group insurance program, the department may contract
to retain the services of professional administrators for the
state group insurance program. The agency shall follow good
purchasing practices of state procurement to the extent
practicable under the circumstances.

2. Each vendor in a major procurement, and any other vendor
if the department deems it necessary to protect the state’s
financial interests, shall, at the time of executing any
contract with the department, post an appropriate bond with the
department in an amount determined by the department to be
adequate to protect the state’s interests but not higher than
the full amount estimated to be paid annually to the vendor
under the contract.

3. Each major contract entered into by the department
pursuant to this section shall contain a provision for payment
of liquidated damages to the department for material
noncompliance by a vendor with a contract provision. The
department may require a liquidated damages provision in any
contract if the department deems it necessary to protect the
state’s financial interests.

4. Section 120.57(3) applies to the department’s
contracting process, except:
   a. A formal written protest of any decision, intended
decision, or other action subject to protest shall be filed
within 72 hours after receipt of notice of the decision,
intended decision, or other action.
   b. As an alternative to any provision of s. 120.57(3), the
department may proceed with the bid selection or contract award
process if the director of the department sets forth, in
writing, particular facts and circumstances that demonstrate the
necessity of continuing the procurement process or the contract
award process in order to avoid a substantial disruption to the
provision of any scheduled insurance services.

5. The department shall make arrangements as necessary to
contribute claims data of the state group health insurance plan
to the contracted vendor selected by the Agency for Health Care
Administration pursuant to s. 408.05(3)(c).

6. Each contracted vendor for the state group health
insurance plan shall contribute Florida claims data to the
contracted vendor selected by the Agency for Health Care
Administration pursuant to s. 408.05(3)(c).

7. Each contract for health care benefits or health care
administrative services which is executed, renewed, or extended
after July 1, 2021, must require the contractor to accommodate
changes to the law which occur during the term of the contract.
The parties may modify the contract to provide for an extension
of time, term, or increase in compensation, based on changes in
the law that materially cause an increase in the contracted
services or the scope of work under the contract.

Section 2. Section 110.12303, Florida Statutes, is amended
to read:

110.12303 State group insurance program; additional
benefits; price transparency program; reporting.—Beginning with
the 2018 plan year:

(1) In addition to the comprehensive package of health
insurance and other benefits required or authorized to be
included in the state group insurance program, the package of
benefits may also include products and services offered by:
(a) Prepaid limited health service organizations authorized pursuant to part I of chapter 636.
(b) Discount medical plan organizations authorized pursuant to part II of chapter 636.
(c) Prepaid health clinics licensed under part II of chapter 641.
(d) Licensed health care providers, including hospitals and other health care facilities, health care clinics, and health professionals, who sell service contracts and arrangements for a specified amount and type of health services.
(e) 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.
(f) 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.
(g) Entities that provide health services or treatments through a bidding process.
(h) Entities that provide health services or treatments through the bundling or aggregating of health services or treatments.
(i) Entities that provide international prescription services.
(j) Entities that provide optional participation in a Medicare Advantage Prescription Drug Plan.
(k) Entities that provide other innovative and cost-
effective health service delivery methods.

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

1. Have procedures and evidence-based standards to ensure the inclusion of only high-quality health care providers.
2. Provide assistance to the enrollee in accessing and coordinating care.
3. Provide cost savings to the state group insurance program to be shared with both the state and the enrollee. Cost savings payable to an enrollee may be:
   a. Credited to the enrollee’s flexible spending account;
   b. Credited to the enrollee’s health savings account;
   c. Credited to the enrollee’s health reimbursement account;
   or
d. Paid as additional health plan reimbursements not exceeding the amount of the enrollee’s out-of-pocket medical expenses.
4. Provide an educational campaign for enrollees to learn about the services offered by the entity.

(b) On or before January 15 of each year, the department shall 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 the contract or contracts described in this subsection.

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

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

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

(c) Permit a certified bargaining agent of state employees to provide educational materials and counseling to enrollees regarding the Internet-based platform.

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

1. Credited to the enrollee’s flexible spending account;
2. Credited to the enrollee’s health savings account; 
3. Credited to the enrollee’s health reimbursement account; 
or 
4. Paid as additional health plan reimbursements not exceeding the amount of the enrollee’s out-of-pocket medical expenses.

(e) On or before 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, amount paid to enrollees, and cost-savings to both the enrollees and the state resulting from the implementation of this subsection.

(4) The department shall offer, as a voluntary supplemental benefit option, international prescription services that offer safe maintenance medications at a reduced cost to enrollees and that meet the standards of the United States Food and Drug Administration personal importation policy.
not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs and supplies. Drugs excluded from the formulary must be available for inclusion if a physician, advanced registered nurse practitioner, or physician assistant prescribing a pharmaceutical clearly states on the prescription that the excluded drug is medically necessary. Prescription drugs and supplies first made available in the marketplace after January 1, 2020, may not be covered by the prescription drug program until specifically included in the list of covered prescription drugs and supplies.

(b) Not later than October 1, 2019, and by each October 1 thereafter, the department must submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives the list of prescription drugs and supplies that will be excluded from program coverage for the next plan year. If the department proposes to exclude prescription drugs and supplies after the plan year has commenced, the department must provide notice to the Governor, the President of the Senate, and the Speaker of the House of Representatives of such exclusions at least 60 days before implementation of such exclusions.

(10) In addition to the comprehensive package of health insurance and other benefits required or authorized to be included in the state group insurance program, the program must provide coverage for medically necessary prescription and nonprescription enteral formulas and amino-acid-based elemental formulas for home use, regardless of the method of delivery or intake, which are ordered or prescribed by a physician. As used in this subsection, the term “medically necessary” means the
formula to be covered represents the only medically appropriate
source of nutrition for a patient. Such coverage may not exceed
an amount of $20,000 annually for any insured individual.

Section 4. Effective December 31, 2019, section 8 of
chapter 99-255, Laws of Florida, is repealed.

Section 5. Effective January 1, 2020, section 627.6387,
Florida Statutes, is created to read:

627.6387 Shared savings incentive program.—
(1) This section and ss. 627.6648 and 641.31076 may be
cited as the “Patient Savings Act."

(2) As used in this section, the term:

(a) “Health care provider” means a hospital or facility
licensed under chapter 395; an entity licensed under chapter
400; a health care practitioner as defined in s. 456.001; a
blood bank, plasma center, industrial clinic, or renal dialysis
facility; or a professional association, partnership,
corporation, joint venture, or other association for
professional activity by health care providers. The term
includes entities and professionals outside of this state with
an active, unencumbered license for an equivalent facility or
practitioner type issued by another state, the District of
Columbia, or a possession or territory of the United States.

(b) “Health insurer” means an authorized insurer offering
health insurance as defined in s. 624.603.

(c) “Shared savings incentive” means a voluntary and
optional financial incentive that a health insurer may provide
to an insured for choosing certain shoppable health care
services under a shared savings incentive program and may
include, but is not limited to, the incentives described in s.
626.9541(4)(a).
(d) “Shared savings incentive program” means a voluntary and optional incentive program established by a health insurer pursuant to this section.
(e) “Shoppable health care service” means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer’s shared savings incentive program. Shoppable health care services may be provided within or outside of this state and include, but are not limited to:
1. Clinical laboratory services.
2. Infusion therapy.
3. Inpatient and outpatient surgical procedures.
4. Obstetrical and gynecological services.
5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.
6. Physical and occupational therapy services.
7. Radiology and imaging services.
8. Prescription drugs.
9. Services provided through telehealth.
(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer’s shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:
(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before
program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(d) Publish on a webpage easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the insured’s participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured’s account as a return or reduction in premium, or credit the shared savings incentive amount to the insured’s flexible spending account, health savings account, or health reimbursement account, such that the amount does not constitute income to the insured.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:
1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

   (4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

   (b) A shared saving incentive amount provided as a return or reduction in premium reduces the health insurer’s direct written premium by the shared saving incentive dollar amount for the purposes of the taxes in ss. 624.509 and 624.5091.

(5) The commission may adopt rules necessary to implement and enforce this section.

Section 6. Effective January 1, 2020, section 627.6648, Florida Statutes, is created to read:

627.6648 Shared savings incentive program.—
(1) This section and ss. 627.6387 and 641.31076 may be cited as the “Patient Savings Act.”

(2) As used in this section, the term:

(a) “Health care provider” means a hospital or facility licensed under chapter 395; an entity licensed under chapter 400; a health care practitioner as defined in s. 456.001; a blood bank, plasma center, industrial clinic, or renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers. The term includes entities and professionals outside of this state with an active, unencumbered license for an equivalent facility or practitioner type issued by another state, the District of Columbia, or a possession or territory of the United States.

(b) “Health insurer” means an authorized insurer offering health insurance as defined in s. 624.603. The term does not include the state group health insurance program provided under s. 110.123.

(c) “Shared savings incentive” means a voluntary and optional financial incentive that a health insurer may provide to an insured for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(d) “Shared savings incentive program” means a voluntary and optional incentive program established by a health insurer pursuant to this section.

(e) “Shoppable health care service” means a lower-cost, high-quality nonemergency health care service for which a shared
savings incentive is available for insureds under a health insurer’s shared savings incentive program. Shoppable health care services may be provided within or outside of this state and include, but are not limited to:

1. Clinical laboratory services.
2. Infusion therapy.
3. Inpatient and outpatient surgical procedures.
4. Obstetrical and gynecological services.
5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.
6. Physical and occupational therapy services.
7. Radiology and imaging services.
8. Prescription drugs.
9. Services provided through telehealth.

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer’s shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal,
and an applicant for insurance at the time of enrollment, of the
availability of the shared savings incentive program and the
procedure to participate in the program.

(d) Publish on a webpage easily accessible to insureds and
to applicants for insurance a list of shoppable health care
services and health care providers and the shared savings
incentive amount applicable for each service. A shared savings
incentive may not be less than 25 percent of the savings
generated by the insured’s participation in any shared savings
incentive offered by the health insurer. The baseline for the
savings calculation is the average in-network amount paid for
that service in the most recent 12-month period or some other
methodology established by the health insurer and approved by
the office.

(e) At least quarterly, credit or deposit the shared
savings incentive amount to the insured’s account as a return or
reduction in premium, or credit the shared savings incentive
amount to the insured’s flexible spending account, health
savings account, or health reimbursement account, such that the
amount does not constitute income to the insured.

(f) Submit an annual report to the office within 90
business days after the close of each plan year. At a minimum,
the report must include the following information:

1. The number of insureds who participated in the program
during the plan year and the number of instances of
participation.

2. The total cost of services provided as a part of the
program.

3. The total value of the shared savings incentive payments
made to insureds participating in the program and the values
distributed as premium reductions, credits to flexible spending
accounts, credits to health savings accounts, or credits to
health reimbursement accounts.

4. An inventory of the shoppable health care services
offered by the health insurer.

(4)(a) A shared savings incentive offered by a health
insurer in accordance with this section:

1. Is not an administrative expense for rate development or
rate filing purposes.

2. Does not constitute an unfair method of competition or
an unfair or deceptive act or practice under s. 626.9541 and is
presumed to be appropriate unless credible data clearly
demonstrates otherwise.

(b) A shared saving incentive amount provided as a return
or reduction in premium reduces the health insurer’s direct
written premium by the shared saving incentive dollar amount for
the purposes of the taxes in ss. 624.509 and 624.5091.

(5) The commission may adopt rules necessary to implement
and enforce this section.

Section 7. Effective January 1, 2020, section 641.31076,
Florida Statutes, is created to read:

641.31076 Shared savings incentive program.—
(1) This section and ss. 627.6387 and 627.6648 may be cited
as the “Patient Savings Act.”

(2) As used in this section, the term:
(a) “Health care provider” means a hospital or facility
licensed under chapter 395; an entity licensed under chapter
400; a health care practitioner as defined in s. 456.001; a
blood bank, plasma center, industrial clinic, or renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers. The term includes entities and professionals outside of this state with an active, unencumbered license for an equivalent facility or practitioner type issued by another state, the District of Columbia, or a possession or territory of the United States.

(b) "Health maintenance organization" has the same meaning as provided in s. 641.19. The term does not include the state group health insurance program provided under s. 110.123.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health maintenance organization may provide to a subscriber for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 641.3903(15).

(d) "Shared savings incentive program" means a voluntary and optional incentive program established by a health maintenance organization pursuant to this section.

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization’s shared savings incentive program. Shoppable health care services may be provided within or outside of this state and include, but are not limited to:

1. Clinical laboratory services.
2. Infusion therapy.
3. Inpatient and outpatient surgical procedures.
4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

(3) A health maintenance organization may offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from the health maintenance organization’s shared savings list. A subscriber may not be required to participate in a shared savings incentive program. A health maintenance organization that offers a shared savings incentive program must:

(a) Establish the program as a component part of the contract of coverage provided by the health maintenance organization and notify the subscribers and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify a subscriber annually and at the time of renewal, and an applicant for coverage at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(d) Publish on a webpage easily accessible to subscribers and to applicants for coverage a list of shoppable health care services and health care providers and the shared savings
incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the subscriber’s participation in any shared savings incentive offered by the health maintenance organization. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health maintenance organization and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber’s account as a return or reduction in premium, or credit the shared savings incentive amount to the subscriber’s flexible spending account, health savings account, or health reimbursement account, such that the amount does not constitute income to the subscriber.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of subscribers who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to subscribers participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health maintenance organization.
(4) A shared savings incentive offered by a health maintenance organization in accordance with this section:
(a) Is not an administrative expense for rate development or rate filing purposes.
(b) Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 641.3903 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.
(5) The commission may adopt rules necessary to implement and enforce this section.

Section 8. The Division of State Group Insurance within the Department of Management Services is directed to analyze the efficiency and effectiveness of providing health coverage by health maintenance organizations to enrollees participating in the state group insurance program on a county basis, on a regional basis, and on a statewide basis. Not later than January 1, 2020, the division shall recommend to the Governor, the President of the Senate, and the Speaker of the House of Representatives the service areas the division determines to be the most efficient and effective to provide health insurance coverage for the 2023 plan year.

Section 9. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2019.

================= T I T L E A M E N D M E N T =================
And the title is amended as follows:
Delete everything before the enacting clause and insert:
A bill to be entitled
An act relating to health insurance; amending s. 110.123, F.S.; requiring that certain contracts under the state group insurance program which are executed, renewed, or extended after a certain date require the contractor to accommodate changes to the law that occur during the term of the contract; authorizing the parties to the contract to make certain modifications to the contract; amending s. 110.12303, F.S.; removing an obsolete date; adding products and services offered by certain entities to a list of products and services that may be included in the package of health insurance and other benefits under the state group insurance program; requiring the Department of Management Services to offer, as a voluntary supplemental benefit option, certain international prescription services; amending s. 110.12315, F.S.; requiring the department to implement formulary management cost-saving measures beginning with the 2020 plan year; specifying requirements for such measures; providing that certain prescription drugs and supplies may not be covered until specifically included in the formulary; requiring the department to report to the Governor and the Legislature regarding formulary exclusions by a specified date and annually thereafter; requiring the coverage of certain medically necessary enteral formulas and elemental formulas; defining the term “medically necessary”; specifying an annual coverage limit; repealing s. 8 of ch. 99-255, Laws of Florida, relating to a restriction
prohibiting the department from implementing prior authorization or restricted formulary programs within the state employees’ prescription drug program; creating ss. 627.6387, 627.6648, and 641.31076, F.S.; providing a short title; defining terms; authorizing individual and group health insurers and health maintenance organizations, respectively, to offer shared savings incentive programs to insureds and subscribers; providing that insureds and subscribers are not required to participate in such programs; specifying requirements for health insurers and health maintenance organizations offering such programs; requiring the Office of Insurance Regulation to review filed descriptions of programs and make a certain determination; providing notification and account credit or deposit requirements for insurers and health maintenance organizations; specifying the minimum shared savings incentive and the basis for calculating savings; specifying requirements for annual reports submitted by health insurers and health maintenance organizations to the office; providing construction; providing that certain shared saving incentive amounts reduce a health insurer’s direct written premium for purposes of the insurance premium tax and the retaliatory tax; authorizing the Financial Services Commission to adopt rules; requiring the Division of State Group Insurance within the department to analyze the efficiency and effectiveness of providing health coverage by health maintenance organizations by
specified bases to state group insurance program enrollees; requiring the division to make a certain recommendation to the Governor and the Legislature by a certain date; providing effective dates.