

**HOUSE OF REPRESENTATIVES STAFF ANALYSIS
FINAL BILL ANALYSIS**

BILL #: CS/HB 1113 Health Insurance Savings Programs
SPONSOR(S): Health Market Reform Subcommittee, Renner and others
TIED BILLS: IDEN./SIM. **BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 0 N, As CS	Grabowski	Crosier
2) Ways & Means Committee	14 Y, 0 N	Aldridge	Langston
3) Health & Human Services Committee	14 Y, 0 N	Grabowski	Calamas
FINAL HOUSE FLOOR ACTION: 105 Y's 2 N's			
GOVERNOR'S ACTION: Approved			

SUMMARY ANALYSIS

CS/HB 1113 passed the House on April 11, 2019. The bill was amended in the Senate on April 30, 2019, and returned to the House. The House concurred in the Senate amendment as amended by the House on May 3, 2019. The Senate concurred with the House amendment and passed the bill as amended on May 3, 2019. The bill includes portions of HB 5009.

The bill creates the Patient Savings Act, which allows health insurers to create a voluntary shared savings incentive program (Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice. When an insured obtains a shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the insured. The bill provides a range of methods by which a Program may financially reward insureds who use shoppable health care services. Insureds may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account. The bill requires that insurers choosing to operate a Program submit an annual report to the Office of Insurance Regulation (OIR) detailing annual participation in the Program.

The bill also directs the Department of Management Services (DMS) to modify the State Group Insurance Program (SGI). Specifically, the bill authorizes DMS to use formulary management techniques to administer the prescription drug program, and authorizes establishment of an optional Medicare Advantage plan for state retirees.

The bill also specifies that DMS shall

- analyze the timelines and terms of its contracts with health benefit vendors and develop an implementation timeline to simultaneously procure such contracts beginning in Plan Year 2023,
- establish, by rule, regions throughout the state for HMO procurements, and submit the rule to the Legislature for ratification 30 days prior to start of 2020 legislative session,
- offer an optional international prescription services program, and
- cover enteral nutritional formulas under certain circumstances.

The bill has an indeterminate, negative fiscal impact on the Department of Revenue and does not affect local government revenues. The bill has a negative fiscal impact of \$2.8 million on the State Employees Group Health Trust Fund for the broadened coverage of enteral formulas but, as a result of formulary management, a positive fiscal impact of \$13.7 million in General Revenue and \$9.2 million in trust funds. See Fiscal Comments.

The bill was approved by the Governor on June 12, 2019, chapter 2019-100, Laws of Florida. The effective date of this bill is July 1, 2019 except as otherwise provided.

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

STORAGE NAME: h1113z1.HMR.DOCX

DATE: 6/13/2019

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Background – Health Insurance Savings Programs

Health Care Price Transparency

The United States is experiencing significant changes in health care payment and delivery. Consumers bear a greater share of health care costs, and more participate in high deductible health plans.¹ Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.² Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.³ Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."⁴ Indeed, the definition or the price or cost of health care has different meanings depending on who is incurring the cost.⁵

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in five Americans with private insurance is enrolled in a high deductible health plan (HDHP). Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.⁶

Among covered workers with a general annual deductible, the average deductible amount for single coverage is \$1,573.⁷ The average annual deductible is similar to last year (\$1,505), but has increased from \$917 in 2010.⁸ Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is \$2,132 in small firms, compared to \$1,355 for workers in large firms.⁹ Sixty-eight percent of covered workers in small firms are in a plan with a deductible of at least \$1,000 for single coverage compared to 54% in large firms; a similar pattern exists for those in plans with a deductible of at least \$2,000 (42% for small firms vs. 20% for large firms). The chart below shows the

¹ U.S. Government Accountability Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 1, available at <http://www.gao.gov/products/GAO-11-791> (last accessed March 20, 2019).

² *Id.* pg. 2.

³ *Id.*

⁴ Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at <https://www.hfma.org/Content.aspx?id=22305> (last accessed January 3, 2019).

⁵ *Id.*

⁶ The Henry J. Kaiser Family Foundation, *2018 Employer Health Benefits Survey*, October 3, 2018, available at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018> (last accessed January 2, 2019).

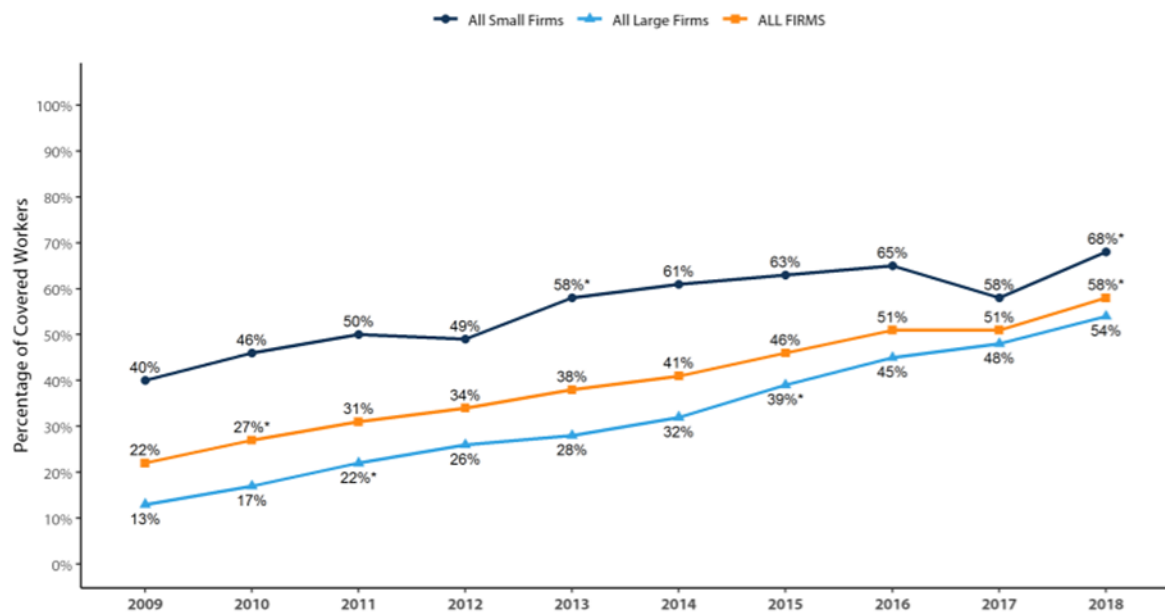
⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

percent of workers enrolled in employer-sponsored insurance with an annual deductible of \$1,000 or more for single coverage by employer size for 2009 through 2018.¹⁰

Figure 7.13
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, by Firm Size, 2009-2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 59% in 2008 to 78% in 2013 to 85% in 2018.¹¹ If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2018 is \$1,350, up 53% from \$883 in 2013 and 212% from \$433 in 2008.¹²

From 2013 to 2018, the average premium for covered workers with family coverage increased 20%, while wages have only increased 12%.¹³ The dramatic increases in the costs of healthcare in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

National Price Transparency Studies

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, “Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending.”¹⁴ This report, conducted

¹⁰ Id, figure 7.13.

¹¹ Id. figure 7.2

¹² Id. figure 7.10

¹³ Id.

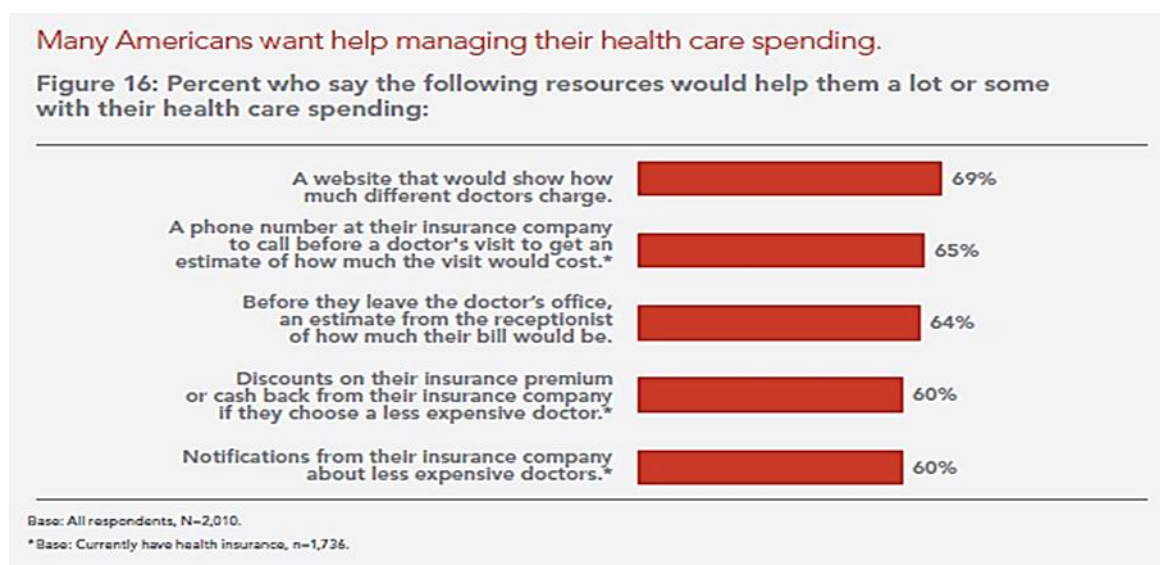
¹⁴ White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, available at <http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf> (last accessed January 3, 2019).

in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save \$100 billion over ten years.

- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases (APCDs), which could save up to \$55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.¹⁵

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated \$18 billion over the 10-year period from 2014 to 2023.¹⁶

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.¹⁷



One study in 2014, which conducted a nationally representative survey of more than 2,000 adults, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.¹⁸ The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.¹⁹

¹⁵ Id.

¹⁶ Id., pg. 1.

¹⁷ Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last accessed January 3, 2019).

¹⁸ Id., pg. 3.

¹⁹ Id., pg. 13.

People with deductibles over \$500 are more likely to seek price information.

Figure 2: Percent who say they have tried to find price information before getting care, by deductible amount:



Base: Currently have health insurance, n=1,736.

Estimates for groups indicated by * are not statistically different from each other, and groups indicated by † are not statistically different from each other; groups indicated by * are statistically different from groups indicated by † at the p<.05 level.

The individuals who compared prices stated that such research impacted their health care choices and saved them money.²⁰ In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher price imparts a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.²¹ Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.²² Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.²³

Florida Price Transparency: Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).²⁴ The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.²⁵ The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

²⁰ Id., pg. 4.

²¹ Supra note 14.

²² American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, page 4, available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126 (last accessed January 4, 2019).

²³ Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, *Health Affairs* 2012; 31(3): 560-568.

²⁴ S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.; The Florida Patient's Bill of Rights and Responsibilities is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility. The rights of patients include standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.

²⁵ S. 381.026(3), F.S.

Under s. 381.026(4)(c), F.S., a patient has the right to request certain financial information from health care providers and facilities.²⁶ Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.²⁷ Estimates must be written in language “comprehensible to an ordinary layperson.”²⁸ The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient’s needs or medical condition warrant.²⁹ A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.³⁰

Currently, under the Patient’s Bill of Rights financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider’s office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient’s Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the AHCA.
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient’s charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.³¹

The Patient’s Bill of Rights also authorizes, but does not require, primary care providers³² to publish a schedule of charges for the medical services offered to patients.³³ The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.³⁴ The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider’s office and at least 15 square feet in size.³⁵ A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.³⁶

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.³⁷ This applies to any entity that holds itself out to the general public, in any manner,

²⁶ S. 381.026(4)(c), F.S.

²⁷ S. 381.026(4)(c)3., F.S.

²⁸ Id.

²⁹ Id.

³⁰ S. 381.026(4)(c)5., F.S.

³¹ S. 381.0261, F.S.

³² S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.

³³ S. 381.026(4)(c)3., F.S.

³⁴ Id.

³⁵ Id.

³⁶ S. 381.026(4)(c)4., F.S.

³⁷ S. 395.107(1), F.S.

as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.³⁸ The schedule must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than \$1,000 per day (until the schedule is published and posted).³⁹

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility⁴⁰ must provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined \$500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.⁴¹ Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.⁴² Hospitals and other facilities post a link to this site - <https://pricing.floridahealthfinder.gov/> - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and

³⁸ S. 395.107(2), F.S.

³⁹ In 2012, the Legislature considered, but did not pass, HB 1329. The bill required ambulatory surgical centers and diagnostic-imaging centers to comply with the provisions of s. 395.107, F.S., established by HB 935 in 2011, and required physicians to publish, in writing, a schedule of medical charges. The bill would have imposed a fine of \$1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges subjected the practitioner to discipline under the applicable practice act and s. 456.072, F.S. Lastly, the bill addressed balance billing by requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or services, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. Failure to provide disclosure to the insured as required by this provision of the bill resulted in a \$500 fine, per occurrence, to be imposed by the AHCA.

⁴⁰ The term "health care facilities" refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under part I of Chapter 395, F.S.

⁴¹ S. 395.301, F.S.

⁴² S. 408.05(3)(c), F.S.

the estimated range of payment from all non-governmental payers for the bundles available at the facility.⁴³

Health Reimbursement Arrangements

As a way to support transparency initiatives and encourage employee engagement, many employers now offer a range of health reimbursement arrangements (HRAs). HRAs are defined contribution benefits established by an employer for the benefit of 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.⁴⁴ Unlike an FSA, an HRA is not a "use it or lose it" arrangement, but the employer may cap the rollover amount.

The following chart shows the distinctions among FSAs, HSAs, and HRAs.

	FSA	HSA	HRA
Who funds the account?	Employee and employer (optional)	Employee, employer, and other individuals	Employer
How is it funded?	Employee payroll deduction; employer direct contribution - money is held by employer in "fund"	Cash contributions to bank account owned by employee	Employer pays up to promised amount
Account Owner	Employer	Employee	Employer
Contribution Limits	\$2,600 annually	Single - \$3,400 Family - \$6,750 Over 55 - additional \$1,000 for single coverage	Set by employer
Rollover of Funds?	Up to \$500 (federal law)	Yes	Yes, as determined by employer
Medical Expenses Allowed	IRC 213(d) expenses ⁴⁵	IRC 213(d) expenses	Post-tax health insurance premiums and IRC 213(d) expenses
High Deductible Health Plan Required?	No	Yes Minimum deductible: Single - \$1,300 Family - \$2,600 Max out-of-pocket: Single - \$6,550 Family - \$13,100	No

Shoppable Health Care Services

As Americans are given greater access to health care cost information, they will be faced with decisions on how to use the cost information. Shopping for health care services can be very difficult due to the structure of our current health care system. A patient's need for health care services can be unpredictable and patients can be in a vulnerable position and unable to negotiate.

⁴³ Id.

⁴⁴ 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.

⁴⁵ 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.

There are many factors that impact the “shoppability” of services – how complex the service is, how urgent it is, if the patient knows what they need versus if they need a recommendation from a doctor. Physicians have a growing role in the price conversation, but evidence suggests they are not engaging in the discussion of price as much as they could be. Furthermore, doctors may have a wider influence on costs, extending beyond the prices they charge their patients. Patients who visit doctors with lower-cost office visits have lower spending, on average, than those who visit high-cost doctors.⁴⁶

The New Hampshire State Employee SmartShopper Incentive Program

In 2010, the State of New Hampshire began offering state employees a new pilot program called Compass SmartShopper.⁴⁷ The program was designed to lower healthcare costs by providing consumers cost information for common elective procedures, and providing cash incentives when they chose to receive care from a cost-effective provider as identified by Compass Healthcare Advisers.⁴⁸ The program rewarded employees for being more engaged in the cost of their healthcare decisions, while also helping the state avoid unnecessary claims costs.⁴⁹ The incentives are tied to choosing the “most cost-effective”, “2nd most cost-effective,” or “3rd most cost-effective” option for a list of particular services. The chart below provides an example of the options available for a variety of services within the program:⁵⁰

Incentive Reward Services	Incentive Amount		
	Most Cost-Effective	2 nd Most Cost-Effective	3 rd Most Cost-Effective
Back Surgery (inpatient laminectomy)	\$500	\$250	n/a
CT Scan	\$150	\$75	\$50
Hernia Repair	\$250	\$100	\$50
Mammogram	\$50	\$25	n/a
Tonsillectomy	\$150	\$75	\$50
Ultrasound (non-maternity)	\$50	\$25	n/a

With three years of education and outreach, the program had produced \$12 million in savings and over \$1 million paid in incentives.⁵¹ The data shows that:

- Consumers are 11 times more likely to use a transparency program when incentives are included;
- Roughly 90 percent of enrollees have shopped at least once, and 66 percent repeatedly shop and earn incentives;
- The program averages approximately \$650 in savings each time an employee shops; and,
- In 2015, the program achieved a 13:1 return on investment.

⁴⁶ “From The Archives: Prices And Consumer Shopping,” Health Affairs Blog, July 19, 2017, available at <https://www.healthaffairs.org/doi/10.1377/hblog20170719.061105/full/> (last accessed March 7, 2019).

⁴⁷ State of New Hampshire, Department of Administrative Services, Vitals SmartShopper Program, available at https://das.nh.gov/hr/Vitals_SmartShopper.html (last accessed March 8, 2019).

⁴⁸ Id.

⁴⁹ Compass SmartShopper Program Personnel Memo, June 28, 2010, available at <https://das.nh.gov/hr/documents/compass%20memo.pdf> (last accessed March 8, 2019).

⁵⁰ State of New Hampshire, Department of Administrative Services, Incentive List, available at <https://das.nh.gov/hr/documents/VitalsSmartShopperIncentiveList.pdf> (last accessed March 8, 2019).

⁵¹ Right to Shop: The Next Big Thing in Health Care, Forbes: The Apothecary, August 5, 2016, available at <http://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/> (last accessed March 8, 2019).

Regulation of Health Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.⁵² The Agency for Health Care Administration (agency) regulates the quality of care by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.⁵³ As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.⁵⁴

All persons who transact insurance in the state must comply with the Code.⁵⁵ OIR has the power to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,⁵⁶ and may investigate any matter relating to insurance.⁵⁷

Unfair Insurance Practices

The Unfair Insurance Trade Practices Act,⁵⁸ among other things, defines unfair methods of competition and unfair or deceptive acts in the business of insurance.⁵⁹ It provides an extensive list of prohibited methods and acts. Among these are prohibitions on certain inducements to the purchase of insurance, including rebates, dividends, stock, and contracts that promise to return profits to the prospective insurance purchaser. The law also describes prohibited discrimination. However, there are also many exceptions to the prohibitions defined by law.

Insurance Premiums Tax on Insurance

Florida imposes an annual tax on premiums collected by insurance companies doing business in the state.⁶⁰ This tax applies to life, health, property and casualty, title insurance, and most other types of policies at a rate of 1.75 percent, with deductions allowed for reinsurance accepted, return premiums and assessments.⁶¹ It applies to self-insurance funds at a rate of 1.6 percent.⁶² It applies to annuities at a rate of 1 percent.⁶³

Health insurers and health maintenance organizations providing coverage in Florida pay the premium tax based on the gross amount of premiums they receive from covered individuals each year.

⁵² S. 20.121(3)(a), F.S.

⁵³ S. 641.21(1), F.S.

⁵⁴ S. 641.495, F.S.

⁵⁵ S. 624.11, F.S.

⁵⁶ S. 624.307(4), F.S.

⁵⁷ S. 624.307(3), F.S.

⁵⁸ part IX, ch. 626, F.S.

⁵⁹ s. 626.9541, F.S.

⁶⁰ s. 624.509, F.S.

⁶¹ s. 624.509(1)(a), F.S.

⁶² s. 624.4625(4), F.S.

⁶³ s. 624.509(1)(b), F.S.

Effect of the Bill – Health Insurance Savings Programs

HB 1113 creates the Patient Savings Act, which allows health insurers to create a shared savings incentive program (Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice. The bill authorizes implementation of these incentive programs for plan years beginning January 1, 2020.

Program Structure

The bill permits an issuer of individual and group health insurance policies, as well as an HMO, to establish a Program. An established program may offer a shared savings incentive payment to an insured who receives treatment from a comprehensive list of more than 25 individual entities or groups that provide a health care service; this includes hospitals, physicians, nursing homes, pharmacies, and others.

The bill directs health insurers who choose to offer a Program to develop a website outlining the range of shoppable health care services available to insureds. This website must provide insureds with an inventory of participating health care providers and an accounting of the shared savings incentives available for each shoppable service. The bill provides a list of nonemergency services that qualify as "shoppable health care services". These include, but are not limited to:

- Clinical laboratory services.
- Infusion therapy.
- Inpatient and outpatient surgical procedures.
- Obstetrical and gynecological services.
- Outpatient nonsurgical diagnostic tests and procedures.
- Physical and occupational therapy services.
- Radiology and imaging services.
- Prescription drugs.
- Services provided through telehealth.

A Program must be a component part of the policy, contract, or certificate of insurance provided by each participating health insurer, and the insurer must notify its insureds of the Program annually and at the time of enrollment and renewal.

Shared Savings Incentives

The bill defines a "shared savings incentive" as an optional financial incentive that may be paid to an insured for choosing certain shoppable health care services under a Program. When an insured obtains a shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the insured. An insured is entitled to a financial incentive that is no less than 25 percent of the savings that accrue to the insurer as a result of the insured's participation.

The bill provides a range of methods by which a Program may financially reward insureds who use shoppable health care services. Insureds may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.

Reporting Requirements

The bill requires a health insurer to file a description of its Program for review by OIR, on a form prescribed by OIR, and requires an annual report to OIR that must include the:

- Total number of insureds who participated in the program and the number of instances of participation;
- Total costs of services provided as part of the program;
- Total value of incentive payments made to participating insureds and the amounts distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, and credits to health reimbursement accounts; and,
- Inventory of shoppable health care services offered by the insurer.

Exemption from Unfair Insurance Practices

The bill specifies that shared savings incentives are not administrative expenses for rate development and do not constitute an unfair method of competition under the Florida Unfair Insurance Trade Practices Act.

Insurance Premium Tax Impact

The bill specifies that a shared savings incentive amount provided to an insured is treated as a reduction in the health insurer's written premium for purposes of insurance premiums tax under ss. 624.509 and 624.5091, F.S. In other words, if a shared savings incentive reduces an insured's premium, it will also reduce the amount of premiums collected by an insurer for purposes of calculating that insurer's premium tax due to the state.

Background – State Group Insurance Program

Overview

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 all state employees including all state 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.

The health insurance benefit for active employees has premium rates for single, spouse program⁶⁴, or family coverage regardless of plan selection. The state will contribute approximately 92% toward the total annual premium for active employees, or \$2.01 billion out of total premium of \$2.19 billion for active employees during FY 2018-19⁶⁵. Retirees and COBRA participants contributed an additional \$233.1 million in premiums, with \$251.3 million in other revenue for a total of \$2.61 billion in total revenues.⁶⁶

⁶⁴ The Spouse Program provides discounted rates for family coverage when both spouses work for the state.

⁶⁵ 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, 2019 through June 30, 2023* adopted March 1, 2019, page 6, available at <http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf>

⁶⁶ Id.

Health Plan Options

The SGI 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 covers the 2019 through 2022 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.⁶⁷

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 Negotiate⁶⁸ to HMOs for contracts for plans years beginning January 1, 2012. DMS 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. New contracts with the HMOs have subsequently been executed for plan years 2018-2020.

Additionally, the SGI Program offers two high-deductible health plans (HDHPs⁶⁹) with health savings accounts (HSAs)⁷⁰. 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, for which the state has contracted with multiple state and regional HMOs. Both HDHPs have an individual deductible of \$1,350 for individual coverage and \$2,700 for family coverage for network providers.⁷¹ The state makes an annual HSA contribution of \$500 for single coverage and \$1,000 for family coverage. The employee may make additional annual contributions⁷² up to \$3,400 for single coverage and \$6,750 for family coverage. The following charts illustrate the benefit design of each of the plan choices.

	HMO Standard	PPO Standard	
	<i>Network Only</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Deductible	None	\$250 Single \$500 Family	\$750 Single \$1,500 Family
Primary Care	\$20 Copayment	\$15 Copayment	40% of the out-of-network allowance plus the amount between the charge and the allowance
Specialist	\$40 Copayment	\$25 Copayment	
Urgent Care	\$25 Copayment	\$25 Copayment	
Emergency Room	\$100 Copayment	\$100 Copayment	
Hospital Stay	\$250 Copayment	20% after \$250 Copayment	40% after \$500 copayment plus the amount between the charge and the allowance
Out-of-Pocket Max	\$7,350 Single \$14,700 Family	\$7,350 Single \$14,700 Family	

⁶⁷ The HMOs include Aetna, AvMed, Capital Health Plan, Florida Health Care Plans and United Healthcare.

⁶⁸ ITN NO.: DMS 10/11-011.

⁶⁹ 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.

⁷⁰ 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.

⁷¹ Department of Management Services, *myFlorida, 2019 Benefits Guide*, available at https://www.mybenefits.myflorida.com/content/download/142647/951981/2019_Benefits_Guide_r11-19-18.pdf (last accessed March 6, 2019).

⁷² *Id.* The IRS annually sets the contribution limit, as adjusted by inflation.

PPO and HMO Health Investor			
		In-Network	Out-of-Network (PPO Only)
Deductible		\$1,350 Single \$2,700 Family	\$2,500 Single \$5,000 Family
Primary Care		After meeting deductible, 20% of network allowed amount	After meeting the deductible, 40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist			After meeting the deductible, 20% of the out-of-network allowance
Urgent Care			After meeting the deductible, 40% after \$1,000 copayment plus the amount between the charge and the allowance
Emergency Room			
Hospital Stay			
Out-of-Pocket Max		HMO: \$3,000 Single \$6,000 Family	PPO: \$4,350 Single \$8,700 Family

Health Benefits Contracts and Procurements

DMS currently uses a staggered procurement schedule for HMOs, insurers and pharmacy benefit managers (PBMs). Each type of contract therefore has different start and end dates. The department's current contract procurement schedule is below.

- PPO: Current contract ends December 31, 2022. Procurement of a new contract would begin September 2021, for plan year 2023.
- HMO: Current contracts end December 31, 2020, and may be renewed for up to 3 years. Procurement of new contracts, unless renewed, would begin September 2019 for plan year 2021.
- PBM: Current contract ends December 31, 2020. Procurement of a new contract would begin September 2019 for plan year 2021.

Section 110.123(3)(h), F.S., gives the department the discretion to award its HMO contracts on a regional or statewide basis but does not require it to do so. DMS has chosen to award HMO contract on a county-by-county basis, with one HMO per county. These small procurements may limit the department's negotiating power, and do not take into account service referral patterns.

State Employee Prescription Drug Program

As part of the SGI program, DMS is required to maintain the State Employee Prescription Drug Program (Prescription Drug Plan).⁷³ DMS contracts with CVS/Caremark, a pharmacy benefits manager (PBM), to administer the Prescription Drug Plan.⁷⁴

The Prescription Drug Plan has three cost sharing categories for members: generic drugs, preferred brand name drugs - which are those brand name drugs on the preferred drug list⁷⁵, and non-preferred brand name drugs - which are those brand name drugs not on the preferred drug list. Contractually, the

⁷³ S. 110.12315, F.S.

⁷⁴ Department of Management Services, *myFlorida, Prescription Drug Plan*, available at http://mybenefits.myflorida.com/health/health_insurance_plans/prescription_drug_plan (last accessed March 6, 2019).

⁷⁵ The Prescription Drug Plan Preferred List for January 2019 is available at www.caremark.com/portal/asset/sof_preferred_dl.pdf (last accessed March 6, 2019).

PBM updates the preferred drug list quarterly as brand name drugs enter the market and as the PBM negotiates pricing, including rebates with manufacturers.

Generic drugs are the least expensive and have the lowest member cost share, preferred brand name drugs have the middle cost share, and non-preferred brand name drugs are the most expensive and have the highest member cost share. As a general practice, prescriptions written for a brand name drug, preferred or non-preferred, will be substituted with a generic drug when available. If the prescribing health care provider states clearly on the prescription that the brand name drug is medically necessary over the generic equivalent, the member will pay only the brand name preferred or non-preferred cost share. If the member requests the brand name drug over the generic equivalent, without the provider’s medically necessary request, then the member will pay the brand name preferred or non-preferred cost share, plus the difference between the actual cost of the generic drug and the brand name drug.

Prescription drug costs differ depending on which health plan a member enrolls in and whether the prescription drug is a generic, a preferred brand-name or a non-preferred brand-name. A member can get up to a 30-day supply at retail pharmacy in the Prescription Drug Plan network and up to a 90-day supply at a mail order pharmacy or at a participating 90-day retail pharmacy. The use of mail order pharmacy is optional, but PPO members must utilize the 90-day mail or retail option after three 30-day fills at a retail pharmacy for any maintenance medications. In addition, certain specialty medications are only available via delivery to a member’s home or a participating pharmacy. The following chart shows the cost savings of using generics, mail order or a participating 90-day retail pharmacy for maintenance medications.⁷⁶

	Standard PPO and Standard HMOs		High-Deductible HMO and PPO
	Retail (30-day)	Mail Order and Retail (90-day)	Retail (30-day); Mail Order and Retail (90-Day)
Generic	\$7	\$14	30%
Preferred Brand Name	\$30	\$60	30%
Non-preferred Brand Name	\$50	\$100	50%

The Prescription Drug Plan also covers compound medications. Compound medications combine, mix, or alter the ingredients of one or more drugs or products to create another drug or product. The Prescription Drug Plan only covers the federal legend drug⁷⁷ ingredient of a compounded medication when all of the following criteria are satisfied:

- The compounded medication is not used in place of a commercially available federal legend drug in the same strength and formulation, unless medically necessary;
- The compounded medication is specifically produced for use by a covered person to treat a covered condition; and

⁷⁶ Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, on-going use of the drugs. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

⁷⁷ Legend drug means drugs that are approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider. <https://definitions.uslegal.com/legend-drug/>.

- The compounded medication, including all sterile compounded products, is made in compliance with Chapter 465, F.S.⁷⁸

Currently, the state's Prescription Drug Plan has an open formulary, which covers all federal legend drugs for covered medical conditions. The PBM employs only limited prescription drug formulary management in the form of reviews designed to ensure that drugs are being prescribed for appropriate medical conditions. The PBM does not use utilization management protocols to incentivize the use of some drugs over others. For other client employers, the PBM each year announces in July the therapeutic classes of drugs that will be impacted by exclusion for the next plan year. For plan year 2019, the PBM excluded 179 drugs from its standard formulary.⁷⁹ However, with its open formulary, these drugs were not excluded from the state's Prescription Drug Plan.

The formulary development process for the PBM is developed and managed through the Caremark National Pharmacy and Therapeutics Committee (P&T Committee) and the Formulary Review Committee (FRC). The P&T Committee is an external body of 22 independent health care professionals, including 18 physicians and 4 pharmacists, all with broad clinical backgrounds. The P&T Committee is charged with reviewing all drugs represented in the PBM's approved drug lists. The formulary is reviewed annually to recommend changes if advisable based on newly available pharmaceutical information. The P&T Committee evaluates medications from a clinical, not a financial, perspective.

The FRC is an internal committee within the PBM. The FRC will consider additional factors that may affect the formulary, such as utilization trends, plan sponsor cost, potential impact on members and brand and generic pipeline. The FRC will make business recommendations to the P&T Committee. Any recommendations made by the FRC must be approved by the P&T Committee.

Drug Importation

The Federal Food, Drug and Cosmetic Act (FDCA) generally prohibits the importation of foreign drugs into the U.S. unless the drug was manufactured by a foreign facility registered with the Food and Drug Administration (FDA) and the foreign drug is specifically FDA-approved, or the drug was manufactured in the U.S., is FDA-approved, and is being reintroduced into the U.S. by the original manufacturer.

Personal Drug Importation

The FDA generally does not object to a person importing a drug from any country so long as it is for personal use.⁸⁰ The FDA guidance states that it should consider not taking enforcement action under certain circumstances, including, but not limited to, when the product does not represent an unreasonable risk, the person seeking to import the product affirms in writing that it is for the patient's own use and is generally not more than a 3 month supply.⁸¹ The FDA recognizes there are situations where foreign medications may be appropriate for a particular individual consumer and that the FDA's resources are better served enforcing regulations against commercial shipments of foreign medication into the United States.⁸²

⁷⁸ Department of Management Services, *myBenefits, Frequently Asked Questions-Prescription Drug Plan*, available at http://mybenefits.myflorida.com/health/forms_and_resources/faqs/frequently_asked_questions_prescription_drug_plan%20.

⁷⁹ CVSHealth, *Utilization and Spend for 2019 Standard Formulary Exclusions-State of Florida* (on file with Appropriation staff).

⁸⁰ U.S. FOOD & DRUG ADMINISTRATION, *Personal Importation*, <https://www.fda.gov/ForIndustry/ImportProgram/ImportBasics/ucm432661.htm> (last accessed Mar. 10, 2019).

⁸¹ Information on Importation of Drugs Prepared by the Division of Import Operations and Policy, Food and Drug Administration, <https://www.fda.gov/industry/import-program-food-and-drug-administration-fda/importations-drugs> (last accessed May 14, 2019).

⁸² U.S. FOOD & DRUG ADMINISTRATION, *Regulatory Procedures Manual, Chapter 9: Import Operations and Actions*, at 9-2, Dec. 2017, available at <https://www.fda.gov/downloads/ICECI/ComplianceManuals/RegulatoryProceduresManual/UCM074300.pdf> (last accessed Mar. 10, 2019).

The FDA does not examine personal baggage or mail, leaving that to the U.S. Customs and Border Protection (CPB). CPB is instructed to only notify the FDA when it appears that there is an FDA-regulated drug intended for commercial distribution, the FDA has specifically requested that drug be detained, or the drug appears to represent a health fraud or an unknown risk to health.⁸³

A 2016 poll showed that 8 percent of U.S. households have bought prescription drugs from Canada or other countries in order to pay a lower price.⁸⁴

International Prescription Services Providers

International prescription service providers assist individual health plan enrollees to obtain lower-cost prescription drugs. Employers make such providers available to employees as a voluntary benefit option for enrollees who choose to use it. According to media reports, Pasco County School Board, City of Sarasota, Flagler County, Indian River County, City of St. Cloud, Palm Beach County and Highlands County Board of County Commissioners, are a few of the governmental entities. Also, according to media reports, Nextran Corporation, Tower Hill Insurance Group, LLC, Pritchett Trucking and Westgate Resorts are examples of private entities using these programs.⁸⁵

International prescription service providers are not internet pharmacies; rather, they create direct contract relationships with licensed pharmacies in Canada and other FDA Tier-1 regulatory countries and negotiate prices for personal importation in compliance with the FDA personal importation policy. Enrollees can choose to work with the international prescription service provider directly to obtain such drugs, at a discount or without having a co-payment. Such providers offer transparent pricing, so enrollees can compare their pricing with that of their traditional prescription drug coverage and cost-sharing.⁸⁶

Medicare Advantage Plans

Florida law requires that the same health insurance coverage offered to its employees be offered to retirees under the same premium conditions.⁸⁷ However, the state does not provide any contribution to the cost of any part of the premium for its retirees under the state group insurance plan, except under certain conditions.⁸⁸ This means the retiree is responsible for the full amount of the premium for health insurance coverage. According to the Division of State Group Insurance's Report on Financial Outlook, presented to the Self-Insurance Estimating Conference, December 7, 2018, the monthly premium for the PPO or HMO standard plan for a Medicare eligible retiree and his or her spouse is \$776.76. Among retirees in the SGI program, only those enrolled in Capital Health Plan currently have access to a state-sponsored Medicare Advantage plan which has a monthly premium of \$565.24 for a Medicare eligible retiree and his or her spouse.

⁸³ Id.

⁸⁴ KAISER FAMILY FOUNDATION, *Kaiser Health Tracking Poll: November 2016*, <http://files.kff.org/attachment/Kaiser-Health-Tracking-Poll-November-2016-Topline> (last accessed Mar. 8, 2019).

⁸⁵ See, e.g., Kaiser Health News, "Cities, Counties and Schools Sidestep FDA Canadian Drug Crackdown, Saving Millions," December 8, 2017. Available at <https://khn.org/news/cities-counties-and-schools-sidestep-fda-canadian-drug-crackdown-saving-millions/> (last accessed May 15, 2019).

⁸⁶ See, e.g., CanaRx and The Canadian Medstore, which work with employees of local governments nationwide, including Flagler County and the Pasco County School Board (see, "Cities, Counties and Schools Sidestep FDA Canadian Drug Crackdown, Saving Millions". Kaiser Health News, Dec. 8, 2017, available at <https://khn.org/news/cities-counties-and-schools-sidestep-fda-canadian-drug-crackdown-saving-millions/> (last accessed March 18, 2019); "U.S. Cities Skeptical Of FDA Warnings Against Medicine Imports From Canadian Firm", NPR, March 6, 2019, available at <https://www.npr.org/sections/health-shots/2019/03/06/700374420/u-s-cities-skeptical-of-fda-warnings-against-medicine-imports-from-canadian-firm> (last accessed March 19, 2019).

⁸⁷ S. 110.12312, F.S.

⁸⁸ S. 110.123(4)(e), F.S.

For many years, private health plans have provided benefits to Medicare enrollees as an alternative to traditional Medicare participation. Such private plans, now known as Medicare Advantage plans, operate under risk-based contracts in which the plans agree to assume liability for beneficiaries' health expenses in exchange for a monthly, per-person (also known as capitated) sum.⁸⁹

Medicare Advantage Plans must cover all of the services that traditional Medicare covers except hospice care. Sponsors of Medicare Advantage plans have significant flexibility in designing the benefits to be offered to enrollees. In this regard, Medicare Advantage plans operate much like commercial PPO or HMO plans by providing enrollees with a defined set of benefits and a defined network in which to access those benefits.⁹⁰

Proponents of Medicare Advantage plans argue that the efficiencies of managed care can reduce government expenditures, improve quality, and provide additional benefits beyond those offered by traditional Medicare. They also assert that plans can provide beneficiaries with greater choice and promote innovations in health care delivery.⁹¹ There is some evidence to support these claims; some Medicare Advantage plans provide auxiliary benefits, such as dental or vision care, while others may set caps on out-of-pocket costs that are borne by enrollees.⁹²

Medicare Advantage plans have become an increasingly popular alternative for many Medicare-eligible individuals. As of 2017, one in three people with Medicare (33% or 19.0 million beneficiaries) is enrolled in a Medicare Advantage plan.⁹³ To some extent, the increasing prevalence of Medicare Advantage plans is a reflection of the low premiums often associated with the plans. In 2019, the average monthly premium for Medicare Advantage enrollees was \$28 and 46 percent of the Medicare Advantage population was enrolled in plans with \$0 monthly premiums.⁹⁴

Effect of the Bill – State Group Insurance Program

Prescription Drug Program

The bill directs DMS to implement measures to manage the prescription drug formulary in the Prescription Drug Plan. Beginning October 1, 2019, and by each October 1 thereafter, DMS must submit to the Governor, the President of the Senate, and the Speaker of the House of Representative, the list of prescription drugs and supplies that will be excluded from program coverage for the next plan year. If DMS proposes to exclude prescription drugs and supplies after the plan year has commenced, it must provide 60 days notice to the Governor, the President of the Senate, and the Speaker of the House of Representatives, before implementation of such exclusion.

The bill provides an exception to formulary exclusion of any prescription drug. An excluded drug may be available for inclusion, and thereby covered by the Prescription Drug Plan, if a member's, or her or his dependent's, prescribing physician, advanced registered nurse practitioner, or physician assistant

⁸⁹ The Commonwealth Fund, "The Evolution of Private Plans in Medicare," December 8, 2017. Available at <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>.

⁹⁰ U.S. Department of Health and Human Services, "What's a Medicare Advantage Plan?," April 2015. Available at <https://www.medicare.gov/Pubs/pdf/11474.pdf> (last accessed May 7, 2019).

⁹¹ R. A. Berenson and B. E. Dowd, "Medicare Advantage Plans at a Crossroads — Yet Again," *Health Affairs Web Exclusive*, published online Nov. 2008. Available at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.28.1.w29> (last accessed May 7, 2019).

⁹² Henry J. Kaiser Family Foundation, "A Dozen Facts about Medicare Advantage," November 13, 2018. Available at <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/> (last accessed May 7, 2019).

⁹³ Henry J. Kaiser Family Foundation, "Medicare Advantage 2017 Spotlight: Enrollment Market Update," June 6, 2017. Available at <https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/> (last accessed May 7, 2019).

⁹⁴ Centers for Medicare and Medicaid Services, "Medicare Advantage premiums continue to decline while plan choices and benefits increase in 2019," September 28, 2018. Available at <https://www.cms.gov/newsroom/press-releases/medicare-advantage-premiums-continue-decline-while-plan-choices-and-benefits-increase-2019> (last accessed May 9, 2019).

writes clearly on the prescription that the excluded drug is medically necessary. The provision ensures a patient has access to a prescription drug that is effective in treating her or his disease or medical condition even if that drug is excluded from the formulary by the PBM.

Formulary management techniques will give DMS, through its contracted PBM, greater influence over spending under the Prescription Drug Plan, while ensuring that members and their dependents have access to the most effective prescription drug therapies

Drug Importation

The bill directs DMS to offer international prescription services as a voluntary supplemental benefit option for state employees who choose to use it. The option would offer safe maintenance medications at a reduced cost to state employees which meet the standards of the federal Food and Drug Administration personal importation policy.

Enteral Formulas

The bill requires the state group program to provide coverage for prescription and nonprescription enteral formulas when those products represent the only medically appropriate form of nutrition for an insured patient. Coverage of these products is limited to \$20,000 annually for each insured.

Medicare Advantage Plans

The bill also authorizes DMS to offer a voluntary Medicare Advantage plan option for Medicare-eligible retirees who are insured by the state group program. Eligible enrollees would be offered the choice between maintaining existing retiree health benefits or enrolling in the Medicare Advantage offering, which would provide comprehensive medical and pharmacy benefits. The availability of the Medicare Advantage Plan option would allow retirees to choose a lower monthly premium for coverage similar to that provided under the state's standard plan.

Health Benefits Contracts and Procurements

The bill directs DMS to conduct an analysis of existing contract procurement timelines to develop an implementation plan for the simultaneous procurement of vendor contracts beginning in advance of plan year 2023. The analysis must identify any additional statutory changes or budget resources that would be necessary to allow for implementation of simultaneous procurement. The analysis and recommendations must be submitted to the Governor and Legislature by December 1, 2019.

The department is directed to establish regions throughout the state for the procurement of HMOs. The regions must be established by rule. The rule must be submitted to the Legislature for ratification no later than 30 days before the beginning of the 2020 legislative session. Currently, the HMO contracts are procured on a county-by-county basis which is inefficient and puts the department at a significant negotiating disadvantage.

The bill directs DMS, through its Division of State Purchasing, to enter into and maintain one or more state term contracts with benefits consulting companies. This will allow DMS and other state agencies to purchase needed consulting services without additional procurements.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill has a negative fiscal impact to the Department of Revenue. The bill requires any reduction in premium resulting from shared savings incentives provided to insureds to be reflected as a reduction in premium for the insurance premium tax calculation under ss. 624.509 and 624.5091, F.S. The Revenue Estimating Conference indicates this will lead to a reduction in premium taxes paid by insurers and collected by the state. The Conference estimates a negative recurring impact on General Revenue of \$0.1 million in FY 2019-20 rising to \$0.2 million in FY 2021-22 and thereafter.

2. Expenditures:

The broadening of coverage of enteral formulas for enrollees in the state group plan will have a negative impact on the State Employee Group Health Trust Fund of approximately \$2.8 million annually.

Based on a January 1, 2020 projected implementation date, the bill's changes to prescription drug formulary management in the state group plan will result in a positive budgetary fiscal impact to the state of \$13.7 million in General Revenue and \$9.2 million in trust funds in Fiscal Year 2019-2020, and approximately twice that amount in future fiscal years.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health insurers may develop and implement a Program beginning with the 2020 plan year. Each participating health insurer must include specific information on their website that allows an insured to research certain cost and quality information associated with health care providers, such as the average price for a shoppable health care services. With this in mind, the implementation of a Program may be associated with increased costs to insurers in the form of administrative expenses.

Health insurers are required to share any savings realized as a result of the treatment options chosen by their insureds for shoppable health care services. This aspect of Program participation may result in financial benefits to insurers and insureds. Insureds would benefit from receipt of shared savings incentives, whereas insurers could incur lower treatment costs when insureds choose cost-effective treatment options.

D. FISCAL COMMENTS:

None.