1 A bill to be entitled
2 An act relating to health insurance; amending s.
3 110.123, F.S.; requiring health maintenance
4 organization to be cost-effective and to offer high
5 value; authorizing the Department of Management
6 Services to limit the number of HMOs that it contracts
7 with in each region; requiring the department to
8 establish regions by rule; requiring the department to
9 submit the rule to the Legislature for ratification;
10 providing requirements; amending s. 110.12303, F.S.;
11 removing an obsolete date; adding products and
12 services offered by certain entities to a list of
13 products and services that may be included in the
14 package of health insurance and other benefits under
15 the state group insurance program; requiring the
16 department to offer, as a voluntary supplemental
17 benefit option, certain international prescription
18 services; amending s. 110.12315, F.S.; requiring the
19 department to implement formulary management for
20 prescription drugs and supplies beginning with a
21 specified plan year; specifying requirements for such
22 management practices; providing that certain
23 prescription drugs and supplies may not be covered
24 until specifically included in the formulary;
25 requiring the department to report to the Governor and

26 the Legislature regarding formulary exclusions by a
27 specified date and annually thereafter; requiring the
28 state employees' prescription drug program to provide
29 coverage for certain enteral formulas and amino-acid-
30 based elemental formulas; defining the term "medically
31 necessary"; providing a cap on such coverage;
32 repealing s. 8 of chapter 99-255, Laws of Florida,
33 relating to a provision that prohibits the department
34 from implementing a prior authorization or a
35 restricted formulary program that restricts certain
36 non-HMO enrollees' access to specified prescription
37 drugs within the state employees' prescription drug
38 program; creating ss. 627.6387, 627.6648, and
39 641.31076, F.S.; providing a short title; defining
40 terms; authorizing individual and group health
41 insurers and health maintenance organizations to offer
42 shared savings incentive programs to insureds and
43 subscribers; providing that insureds and subscribers
44 are not required to participate in such programs;
45 specifying requirements for health insurers and health
46 maintenance organizations offering such programs;
47 requiring the Office of Insurance Regulation to review
48 filed descriptions of programs and make a certain
49 determination; providing notification and account
50 credit or deposit requirements for insurers and health

51 maintenance organizations; specifying the minimum
52 shared savings incentive and the basis for calculating
53 savings; specifying requirements for annual reports
54 submitted by health insurers and health maintenance
55 organizations to the office; providing construction;
56 providing that certain shared savings incentive
57 amounts reduce a health insurer's direct written
58 premium for purposes of the insurance premium tax and
59 the retaliatory tax; authorizing the Financial
60 Services Commission to adopt rules; amending s.
61 287.056, F.S.; requiring the department to enter into
62 contracts with benefits consulting companies;
63 requiring the department to conduct an analysis of the
64 procurement timelines and terms of certain contracts
65 with HMOs, preferred provider organizations, and
66 prescription drug programs for a specified purpose;
67 providing department analysis and recommendation
68 requirements; requiring the department to submit the
69 analysis and recommendations to the Governor and the
70 Legislature by a specified date; providing effective
71 dates.
72
73 Be It Enacted by the Legislature of the State of Florida:
74
75 Section 1. Paragraphs (c) and (h) of subsection (3) of

76 section 110.123, Florida Statutes, are amended to read:
77 110.123 State group insurance program.—
78 (3) STATE GROUP INSURANCE PROGRAM.—
79 (c) Notwithstanding any provision in this section to the
80 contrary, it is the intent of the Legislature that the
81 department shall be responsible for all aspects of the purchase
82 of health care for state employees under the state group health
83 insurance plan or plans, TRICARE supplemental insurance plans,
84 and the health maintenance organization plans. Responsibilities
85 shall include, but not be limited to, the development of
86 requests for proposals or invitations to negotiate for state
87 employee health benefits ~~services~~, the determination of health
88 care benefits to be provided, and the negotiation of contracts
89 for health care and health care administrative services. Prior
90 to the negotiation of contracts for health care services, the
91 Legislature intends that the department shall develop, with
92 respect to state collective bargaining issues, the health
93 benefits and terms to be included in the state group health
94 insurance program. The department shall adopt rules necessary to
95 perform its responsibilities pursuant to this section. ~~It is the~~
96 ~~intent of the Legislature that~~ The department is ~~shall be~~
97 responsible for the contract management and day-to-day
98 management of the state employee health insurance program,
99 including, but not limited to, employee enrollment, premium
100 collection, payment to health care providers, and other

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101 administrative functions related to the program.
102 (h)1. A person eligible to participate in the state group
103 insurance program may be authorized by rules adopted by the
104 department, in lieu of participating in the state group health
105 insurance plan, to exercise an option to elect membership in a
106 health maintenance organization plan which is under contract
107 with the state in accordance with criteria established by this
108 section and by said rules. The offer of optional membership in a
109 health maintenance organization plan permitted by this paragraph
110 may be limited or conditioned by rule as may be necessary to
111 meet the requirements of state and federal laws.
112 2. The department shall contract with health maintenance
113 organizations seeking to participate in the state group
114 insurance program through a request for proposal or other
115 procurement process, as developed by the Department of
116 Management Services and determined to be appropriate.
117 a. The department shall establish a schedule of minimum
118 benefits for health maintenance organization coverage, and that
119 schedule shall include: physician services; inpatient and
120 outpatient hospital services; emergency medical services,
121 including out-of-area emergency coverage; diagnostic laboratory
122 and diagnostic and therapeutic radiologic services; mental
123 health, alcohol, and chemical dependency treatment services
124 meeting the minimum requirements of state and federal law;
125 skilled nursing facilities and services; prescription drugs;

126 age-based and gender-based wellness benefits; and other benefits
127 as may be required by the department. Additional services may be
128 provided subject to the contract between the department and the
129 HMO. As used in this paragraph, the term "age-based and gender-
130 based wellness benefits" includes aerobic exercise, education in
131 alcohol and substance abuse prevention, blood cholesterol
132 screening, health risk appraisals, blood pressure screening and
133 education, nutrition education, program planning, safety belt
134 education, smoking cessation, stress management, weight
135 management, and women's health education.
136 b. The department may establish uniform deductibles,
137 copayments, coverage tiers, or coinsurance schedules for all
138 participating HMO plans.
139 c. The department may require detailed information from
140 each health maintenance organization participating in the
141 procurement process, including information pertaining to
142 organizational status, experience in providing prepaid health
143 benefits, accessibility of services, financial stability of the
144 plan, quality of management services, accreditation status,
145 quality of medical services, network access and adequacy,
146 performance measurement, ability to meet the department's
147 reporting requirements, and the actuarial basis of the proposed
148 rates and other data determined by the director to be necessary
149 for the evaluation and selection of health maintenance
150 organization plans and negotiation of appropriate rates for

151 these plans. Upon receipt of proposals by health maintenance
152 organization plans and the evaluation of those proposals, the
153 department may enter into negotiations with all of the plans or
154 a subset of the plans, as the department determines appropriate.
155 ~~Nothing shall preclude~~ The department may negotiate ~~from~~
156 ~~negotiating~~ regional or statewide contracts with health
157 maintenance organization plans. Such plans must be ~~when this is~~
158 cost-effective and must offer ~~when the department determines~~
159 ~~that the plan offers~~ high value to enrollees.
160 d. The department may limit the number of HMOs that it
161 contracts with in each region ~~service area~~ based on the nature
162 of the bids the department receives, the number of state
163 employees in the region ~~service area~~, or any unique ~~geographical~~
164 characteristics of the region ~~service area~~. The department shall
165 establish the regions throughout the state by rule. The
166 department must submit the rule to the President of the Senate
167 and the Speaker of the House of Representatives for ratification
168 no later than 30 days before the 2020 Regular Session of the
169 Legislature. The rule may not take effect until it is ratified
170 by the Legislature ~~by rule service areas throughout the state~~.
171 e. All persons participating in the state group insurance
172 program may be required to contribute towards a total state
173 group health premium that may vary depending upon the plan,
174 coverage level, and coverage tier selected by the enrollee and
175 the level of state contribution authorized by the Legislature.

176 3. The department is authorized to negotiate and to
177 contract with specialty psychiatric hospitals for mental health
178 benefits, on a regional basis, for alcohol, drug abuse, and
179 mental and nervous disorders. The department may establish,
180 subject to the approval of the Legislature pursuant to
181 subsection (5), any such regional plan upon completion of an
182 actuarial study to determine any impact on plan benefits and
183 premiums.
184 4. In addition to contracting pursuant to subparagraph 2.,
185 the department may enter into contract with any HMO to
186 participate in the state group insurance program which:
187 a. Serves greater than 5,000 recipients on a prepaid basis
188 under the Medicaid program;
189 b. Does not currently meet the 25-percent non-
190 Medicare/non-Medicaid enrollment composition requirement
191 established by the Department of Health excluding participants
192 enrolled in the state group insurance program;
193 c. Meets the minimum benefit package and copayments and
194 deductibles contained in sub-subparagraphs 2.a. and b.;
195 d. Is willing to participate in the state group insurance
196 program at a cost of premiums that is not greater than 95
197 percent of the cost of HMO premiums accepted by the department
198 in each service area; and
199 e. Meets the minimum surplus requirements of s. 641.225.
200

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201 The department is authorized to contract with HMOs that meet the
202 requirements of sub-subparagraphs a.-d. prior to the open
203 enrollment period for state employees. The department is not
204 required to renew the contract with the HMOs as set forth in
205 this paragraph more than twice. Thereafter, the HMOs shall be
206 eligible to participate in the state group insurance program
207 only through the request for proposal or invitation to negotiate
208 process described in subparagraph 2.
209 5. All enrollees in a state group health insurance plan, a
210 TRICARE supplemental insurance plan, or any health maintenance
211 organization plan have the option of changing to any other
212 health plan that is offered by the state within any open
213 enrollment period designated by the department. Open enrollment
214 shall be held at least once each calendar year.
215 6. When a contract between a treating provider and the
216 state-contracted health maintenance organization is terminated
217 for any reason other than for cause, each party shall allow any
218 enrollee for whom treatment was active to continue coverage and
219 care when medically necessary, through completion of treatment
220 of a condition for which the enrollee was receiving care at the
221 time of the termination, until the enrollee selects another
222 treating provider, or until the next open enrollment period
223 offered, whichever is longer, but no longer than 6 months after
224 termination of the contract. Each party to the terminated
225 contract shall allow an enrollee who has initiated a course of

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226 prenatal care, regardless of the trimester in which care was
227 initiated, to continue care and coverage until completion of
228 postpartum care. This does not prevent a provider from refusing
229 to continue to provide care to an enrollee who is abusive,
230 noncompliant, or in arrears in payments for services provided.
231 For care continued under this subparagraph, the program and the
232 provider shall continue to be bound by the terms of the
233 terminated contract. Changes made within 30 days before
234 termination of a contract are effective only if agreed to by
235 both parties.
236 7. Any HMO participating in the state group insurance
237 program shall submit health care utilization and cost data to
238 the department, in such form and in such manner as the
239 department shall require, as a condition of participating in the
240 program. The department shall enter into negotiations with its
241 contracting HMOs to determine the nature and scope of the data
242 submission and the final requirements, format, penalties
243 associated with noncompliance, and timetables for submission.
244 These determinations shall be adopted by rule.
245 8. The department may establish and direct, with respect
246 to collective bargaining issues, a comprehensive package of
247 insurance benefits that may include supplemental health and life
248 coverage, dental care, long-term care, vision care, and other
249 benefits it determines necessary to enable state employees to
250 select from among benefit options that best suit their

251 individual and family needs. Beginning with the 2018 plan year,
252 the package of benefits may also include products and services
253 described in s. 110.12303.
254 a. Based upon a desired benefit package, the department
255 shall issue a request for proposal or invitation to negotiate
256 for providers interested in participating in the state group
257 insurance program, and the department shall issue a request for
258 proposal or invitation to negotiate for providers interested in
259 participating in the non-health-related components of the state
260 group insurance program. Upon receipt of all proposals, the
261 department may enter into contract negotiations with providers
262 submitting bids or negotiate a specially designed benefit
263 package. Providers offering or providing supplemental coverage
264 as of May 30, 1991, which qualify for pretax benefit treatment
265 pursuant to s. 125 of the Internal Revenue Code of 1986, with
266 5,500 or more state employees currently enrolled may be included
267 by the department in the supplemental insurance benefit plan
268 established by the department without participating in a request
269 for proposal, submitting bids, negotiating contracts, or
270 negotiating a specially designed benefit package. These
271 contracts shall provide state employees with the most cost-
272 effective and comprehensive coverage available; however, except
273 as provided in subparagraph (f)3., no state or agency funds
274 shall be contributed toward the cost of any part of the premium
275 of such supplemental benefit plans. With respect to dental

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276 coverage, the division shall include in any solicitation or
277 contract for any state group dental program made after July 1,
278 2001, a comprehensive indemnity dental plan option which offers
279 enrollees a completely unrestricted choice of dentists. If a
280 dental plan is endorsed, or in some manner recognized as the
281 preferred product, such plan shall include a comprehensive
282 indemnity dental plan option which provides enrollees with a
283 completely unrestricted choice of dentists.
284 b. Pursuant to the applicable provisions of s. 110.161,
285 and s. 125 of the Internal Revenue Code of 1986, the department
286 shall enroll in the pretax benefit program those state employees
287 who voluntarily elect coverage in any of the supplemental
288 insurance benefit plans as provided by sub-subparagraph a.
289 c. Nothing herein contained shall be construed to prohibit
290 insurance providers from continuing to provide or offer
291 supplemental benefit coverage to state employees as provided
292 under existing agency plans.
293 Section 2. Section 110.12303, Florida Statutes, is amended
294 to read:
295 110.12303 State group insurance program; additional
296 benefits; price transparency program; reporting.~~ Beginning with~~
297 ~~the 2018 plan year:~~
298 (1) In addition to the comprehensive package of health
299 insurance and other benefits required or authorized to be
300 included in the state group insurance program, the package of

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301 benefits may also include products and services offered by:
302 (a) Prepaid limited health service organizations
303 authorized pursuant to part I of chapter 636.
304 (b) Discount medical plan organizations authorized
305 pursuant to part II of chapter 636.
306 (c) Prepaid health clinics licensed under part II of
307 chapter 641.
308 (d) Licensed health care providers, including hospitals
309 and other health care facilities, health care clinics, and
310 health professionals, who sell service contracts and
311 arrangements for a specified amount and type of health services.
312 (e) Provider organizations, including service networks,
313 group practices, professional associations, and other
314 incorporated organizations of providers, who sell service
315 contracts and arrangements for a specified amount and type of
316 health services.
317 (f) Entities that provide specific health services in
318 accordance with applicable state law and sell service contracts
319 and arrangements for a specified amount and type of health
320 services.
321 (g) Entities that provide health services or treatments
322 through a bidding process.
323 (h) Entities that provide health services or treatments
324 through the bundling or aggregating of health services or
325 treatments.

326 (i) Entities that provide international prescription
327 services.
328 (j) Entities that provide optional participation in a
329 Medicare Advantage Prescription Drug Plan.
330 (k) Entities that provide other innovative and cost-
331 effective health service delivery methods.
332 (2)(a) The department shall contract with at least one
333 entity that provides comprehensive pricing and inclusive
334 services for surgery and other medical procedures which may be
335 accessed at the option of the enrollee. The contract shall
336 require the entity to:
337 1. Have procedures and evidence-based standards to ensure
338 the inclusion of only high-quality health care providers.
339 2. Provide assistance to the enrollee in accessing and
340 coordinating care.
341 3. Provide cost savings to the state group insurance
342 program to be shared with both the state and the enrollee. Cost
343 savings payable to an enrollee may be:
344 a. Credited to the enrollee's flexible spending account;
345 b. Credited to the enrollee's health savings account;
346 c. Credited to the enrollee's health reimbursement
347 account; or
348 d. Paid as additional health plan reimbursements not
349 exceeding the amount of the enrollee's out-of-pocket medical
350 expenses.

351 4. Provide an educational campaign for enrollees to learn
352 about the services offered by the entity.
353 (b) On or before January 15 of each year, the department
354 shall report to the Governor, the President of the Senate, and
355 the Speaker of the House of Representatives on the participation
356 level and cost-savings to both the enrollee and the state
357 resulting from the contract or contracts described in this
358 subsection.
359 (3) The department shall contract with an entity that
360 provides enrollees with online information on the cost and
361 quality of health care services and providers, allows an
362 enrollee to shop for health care services and providers, and
363 rewards the enrollee by sharing savings generated by the
364 enrollee's choice of services or providers. The contract shall
365 require the entity to:
366 (a) Establish an Internet-based, consumer-friendly
367 platform that educates and informs enrollees about the price and
368 quality of health care services and providers, including the
369 average amount paid in each county for health care services and
370 providers. The average amounts paid for such services and
371 providers may be expressed for service bundles, which include
372 all products and services associated with a particular treatment
373 or episode of care, or for separate and distinct products and
374 services.
375 (b) Allow enrollees to shop for health care services and

376 providers using the price and quality information provided on
377 the Internet-based platform.
378 (c) Permit a certified bargaining agent of state employees
379 to provide educational materials and counseling to enrollees
380 regarding the Internet-based platform.
381 (d) Identify the savings realized to the enrollee and
382 state if the enrollee chooses high-quality, lower-cost health
383 care services or providers, and facilitate a shared savings
384 payment to the enrollee. The amount of shared savings shall be
385 determined by a methodology approved by the department and shall
386 maximize value-based purchasing by enrollees. The amount payable
387 to the enrollee may be:
388 1. Credited to the enrollee's flexible spending account;
389 2. Credited to the enrollee's health savings account;
390 3. Credited to the enrollee's health reimbursement
391 account; or
392 4. Paid as additional health plan reimbursements not
393 exceeding the amount of the enrollee's out-of-pocket medical
394 expenses.
395 (e) On or before January 1 of 2019, 2020, and 2021, the
396 department shall report to the Governor, the President of the
397 Senate, and the Speaker of the House of Representatives on the
398 participation level, amount paid to enrollees, and cost-savings
399 to both the enrollees and the state resulting from the
400 implementation of this subsection.

401 (4) The department shall offer, as a voluntary
402 supplemental benefit option, international prescription services
403 that offer safe maintenance medications at a reduced cost to
404 enrollees and that meet the standards of the United States Food
405 and Drug Administration personal importation policy.
406 Section 3. Subsections (9) and (10) are added to section
407 110.12315, Florida Statutes, to read:
408 110.12315 Prescription drug program.—The state employees'
409 prescription drug program is established. This program shall be
410 administered by the Department of Management Services, according
411 to the terms and conditions of the plan as established by the
412 relevant provisions of the annual General Appropriations Act and
413 implementing legislation, subject to the following conditions:
414 (9)(a) Beginning with the 2020 plan year, the department
415 must implement formulary management for prescription drugs and
416 supplies. Such management practices must require prescription
417 drugs to be subject to formulary inclusion or exclusion but may
418 not restrict access to the most clinically appropriate,
419 clinically effective, and lowest net-cost prescription drugs and
420 supplies. Drugs excluded from the formulary must be available
421 for inclusion if a physician, advanced practice registered
422 nurse, or physician assistant prescribing a pharmaceutical
423 clearly states on the prescription that the excluded drug is
424 medically necessary. Prescription drugs and supplies first made
425 available in the marketplace after January 1, 2020, may not be

426 covered by the prescription drug program until specifically
427 included in the list of covered prescription drugs and supplies.
428 (b) No later than October 1, 2019, and by each October 1
429 thereafter, the department must submit to the Governor, the
430 President of the Senate, and the Speaker of the House of
431 Representatives the list of prescription drugs and supplies that
432 will be excluded from program coverage for the next plan year.
433 If the department proposes to exclude prescription drugs and
434 supplies after the plan year has commenced, the department must
435 provide notice to the Governor, the President of the Senate, and
436 the Speaker of the House of Representatives of such exclusions
437 at least 60 days before implementation of such exclusions.
438 (10) In addition to the comprehensive package of health
439 insurance and other benefits required or authorized to be
440 included in the state group insurance program, the program must
441 provide coverage for medically necessary prescription and
442 nonprescription enteral formulas and amino-acid-based elemental
443 formulas for home use, regardless of the method of delivery or
444 intake, which are ordered or prescribed by a physician. As used
445 in this subsection, the term "medically necessary" means the
446 formula to be covered represents the only medically appropriate
447 source of nutrition for a patient. Such coverage may not exceed
448 an amount of $20,000 annually for any insured individual.
449 Section 4. Effective December 31, 2019, section 8 of
450 chapter 99-255, Laws of Florida, is repealed.

451 Section 5. Effective January 1, 2020, section 627.6387,
452 Florida Statutes, is created to read:
453 627.6387 Shared savings incentive program.—
454 (1) This section and ss. 627.6648 and 641.31076 may be
455 cited as the "Patient Savings Act."
456 (2) As used in this section, the term:
457 (a) "Health care provider" means a hospital or facility
458 licensed under chapter 395; an entity licensed under chapter
459 400; a health care practitioner as defined in s. 456.001; a
460 blood bank, plasma center, industrial clinic, or renal dialysis
461 facility; or a professional association, partnership,
462 corporation, joint venture, or other association for
463 professional activity by health care providers. The term
464 includes entities and professionals outside of this state with
465 an active, unencumbered license for an equivalent facility or
466 practitioner type issued by another state, the District of
467 Columbia, or a possession or territory of the United States.
468 (b) "Health insurer" means an authorized insurer offering
469 health insurance as defined in s. 624.603.
470 (c) "Shared savings incentive" means a voluntary and
471 optional financial incentive that a health insurer may provide
472 to an insured for choosing certain shoppable health care
473 services under a shared savings incentive program and may
474 include, but is not limited to, the incentives described in s.
475 626.9541(4)(a).

476 (d) "Shared savings incentive program" means a voluntary
477 and optional incentive program established by a health insurer
478 pursuant to this section.
479 (e) "Shoppable health care service" means a lower-cost,
480 high-quality nonemergency health care service for which a shared
481 savings incentive is available for insureds under a health
482 insurer's shared savings incentive program. Shoppable health
483 care services may be provided within or outside this state and
484 include, but are not limited to:
485 1. Clinical laboratory services.
486 2. Infusion therapy.
487 3. Inpatient and outpatient surgical procedures.
488 4. Obstetrical and gynecological services.
489 5. Inpatient and outpatient nonsurgical diagnostic tests
490 and procedures.
491 6. Physical and occupational therapy services.
492 7. Radiology and imaging services.
493 8. Prescription drugs.
494 9. Services provided through telehealth.
495 (3) A health insurer may offer a shared savings incentive
496 program to provide incentives to an insured when the insured
497 obtains a shoppable health care service from the health
498 insurer's shared savings list. An insured may not be required to
499 participate in a shared savings incentive program. A health
500 insurer that offers a shared savings incentive program must:

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501 (a) Establish the program as a component part of the
502 policy or certificate of insurance provided by the health
503 insurer and notify the insureds and the office at least 30 days
504 before program termination.
505 (b) File a description of the program on a form prescribed
506 by commission rule. The office must review the filing and
507 determine whether the shared savings incentive program complies
508 with this section.
509 (c) Notify an insured annually and at the time of renewal,
510 and an applicant for insurance at the time of enrollment, of the
511 availability of the shared savings incentive program and the
512 procedure to participate in the program.
513 (d) Publish on a webpage easily accessible to insureds and
514 to applicants for insurance a list of shoppable health care
515 services and health care providers and the shared savings
516 incentive amount applicable for each service. A shared savings
517 incentive may not be less than 25 percent of the savings
518 generated by the insured's participation in any shared savings
519 incentive offered by the health insurer. The baseline for the
520 savings calculation is the average in-network amount paid for
521 that service in the most recent 12-month period or some other
522 methodology established by the health insurer and approved by
523 the office.
524 (e) At least quarterly, credit or deposit the shared
525 savings incentive amount to the insured's account as a return or

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526 reduction in premium, or credit the shared savings incentive
527 amount to the insured's flexible spending account, health
528 savings account, or health reimbursement account, such that the
529 amount does not constitute income to the insured.
530 (f) Submit an annual report to the office within 90
531 business days after the close of each plan year. At a minimum,
532 the report must include the following information:
533 1. The number of insureds who participated in the program
534 during the plan year and the number of instances of
535 participation.
536 2. The total cost of services provided as a part of the
537 program.
538 3. The total value of the shared savings incentive
539 payments made to insureds participating in the program and the
540 values distributed as premium reductions, credits to flexible
541 spending accounts, credits to health savings accounts, or
542 credits to health reimbursement accounts.
543 4. An inventory of the shoppable health care services
544 offered by the health insurer.
545 (4)(a) A shared savings incentive offered by a health
546 insurer in accordance with this section:
547 1. Is not an administrative expense for rate development
548 or rate filing purposes.
549 2. Does not constitute an unfair method of competition or
550 an unfair or deceptive act or practice under s. 626.9541 and is

551 presumed to be appropriate unless credible data clearly
552 demonstrates otherwise.
553 (b) A shared savings incentive amount provided as a return
554 or reduction in premium reduces the health insurer's direct
555 written premium by the shared savings incentive dollar amount
556 for the purposes of the taxes in ss. 624.509 and 624.5091.
557 (5) The commission may adopt rules necessary to implement
558 and enforce this section.
559 Section 6. Effective January 1, 2020, section 627.6648,
560 Florida Statutes, is created to read:
561 627.6648 Shared savings incentive program.—
562 (1) This section and ss. 627.6387 and 641.31076 may be
563 cited as the "Patient Savings Act."
564 (2) As used in this section, the term:
565 (a) "Health care provider" means a hospital or facility
566 licensed under chapter 395; an entity licensed under chapter
567 400; a health care practitioner as defined in s. 456.001; a
568 blood bank, plasma center, industrial clinic, or renal dialysis
569 facility; or a professional association, partnership,
570 corporation, joint venture, or other association for
571 professional activity by health care providers. The term
572 includes entities and professionals outside this state with an
573 active, unencumbered license for an equivalent facility or
574 practitioner type issued by another state, the District of
575 Columbia, or a possession or territory of the United States.

576 (b) "Health insurer" means an authorized insurer offering
577 health insurance as defined in s. 624.603. The term does not
578 include the state group health insurance program provided under
579 s. 110.123.
580 (c) "Shared savings incentive" means a voluntary and
581 optional financial incentive that a health insurer may provide
582 to an insured for choosing certain shoppable health care
583 services under a shared savings incentive program and may
584 include, but is not limited to, the incentives described in s.
585 626.9541(4)(a).
586 (d) "Shared savings incentive program" means a voluntary
587 and optional incentive program established by a health insurer
588 pursuant to this section.
589 (e) "Shoppable health care service" means a lower-cost,
590 high-quality nonemergency health care service for which a shared
591 savings incentive is available for insureds under a health
592 insurer's shared savings incentive program. Shoppable health
593 care services may be provided within or outside this state and
594 include, but are not limited to:
595 1. Clinical laboratory services.
596 2. Infusion therapy.
597 3. Inpatient and outpatient surgical procedures.
598 4. Obstetrical and gynecological services.
599 5. Inpatient and outpatient nonsurgical diagnostic tests
600 and procedures.

601 6. Physical and occupational therapy services.
602 7. Radiology and imaging services.
603 8. Prescription drugs.
604 9. Services provided through telehealth.
605 (3) A health insurer may offer a shared savings incentive
606 program to provide incentives to an insured when the insured
607 obtains a shoppable health care service from the health
608 insurer's shared savings list. An insured may not be required to
609 participate in a shared savings incentive program. A health
610 insurer that offers a shared savings incentive program must:
611 (a) Establish the program as a component part of the
612 policy or certificate of insurance provided by the health
613 insurer and notify the insureds and the office at least 30 days
614 before program termination.
615 (b) File a description of the program on a form prescribed
616 by commission rule. The office must review the filing and
617 determine whether the shared savings incentive program complies
618 with this section.
619 (c) Notify an insured annually and at the time of renewal,
620 and an applicant for insurance at the time of enrollment, of the
621 availability of the shared savings incentive program and the
622 procedure to participate in the program.
623 (d) Publish on a webpage easily accessible to insureds and
624 to applicants for insurance a list of shoppable health care
625 services and health care providers and the shared savings

626 incentive amount applicable for each service. A shared savings
627 incentive may not be less than 25 percent of the savings
628 generated by the insured's participation in any shared savings
629 incentive offered by the health insurer. The baseline for the
630 savings calculation is the average in-network amount paid for
631 that service in the most recent 12-month period or some other
632 methodology established by the health insurer and approved by
633 the office.
634 (e) At least quarterly, credit or deposit the shared
635 savings incentive amount to the insured's account as a return or
636 reduction in premium, or credit the shared savings incentive
637 amount to the insured's flexible spending account, health
638 savings account, or health reimbursement account, such that the
639 amount does not constitute income to the insured.
640 (f) Submit an annual report to the office within 90
641 business days after the close of each plan year. At a minimum,
642 the report must include the following information:
643 1. The number of insureds who participated in the program
644 during the plan year and the number of instances of
645 participation.
646 2. The total cost of services provided as a part of the
647 program.
648 3. The total value of the shared savings incentive
649 payments made to insureds participating in the program and the
650 values distributed as premium reductions, credits to flexible

651 spending accounts, credits to health savings accounts, or
652 credits to health reimbursement accounts.
653 4. An inventory of the shoppable health care services
654 offered by the health insurer.
655 (4)(a) A shared savings incentive offered by a health
656 insurer in accordance with this section:
657 1. Is not an administrative expense for rate development
658 or rate filing purposes.
659 2. Does not constitute an unfair method of competition or
660 an unfair or deceptive act or practice under s. 626.9541 and is
661 presumed to be appropriate unless credible data clearly
662 demonstrates otherwise.
663 (b) A shared savings incentive amount provided as a return
664 or reduction in premium reduces the health insurer's direct
665 written premium by the shared savings incentive dollar amount
666 for the purposes of the taxes in ss. 624.509 and 624.5091.
667 (5) The commission may adopt rules necessary to implement
668 and enforce this section.
669 Section 7. Effective January 1, 2020, section 641.31076,
670 Florida Statutes, is created to read:
671 641.31076 Shared savings incentive program.—
672 (1) This section and ss. 627.6387 and 627.6648 may be
673 cited as the "Patient Savings Act."
674 (2) As used in this section, the term:
675 (a) "Health care provider" means a hospital or facility

676 licensed under chapter 395; an entity licensed under chapter
677 400; a health care practitioner as defined in s. 456.001; a
678 blood bank, plasma center, industrial clinic, or renal dialysis
679 facility; or a professional association, partnership,
680 corporation, joint venture, or other association for
681 professional activity by health care providers. The term
682 includes entities and professionals outside this state with an
683 active, unencumbered license for an equivalent facility or
684 practitioner type issued by another state, the District of
685 Columbia, or a possession or territory of the United States.
686 (b) "Health maintenance organization" has the same meaning
687 as provided in s. 641.19. The term does not include the state
688 group health insurance program provided under s. 110.123.
689 (c) "Shared savings incentive" means a voluntary and
690 optional financial incentive that a health maintenance
691 organization may provide to a subscriber for choosing certain
692 shoppable health care services under a shared savings incentive
693 program and may include, but is not limited to, the incentives
694 described in s. 641.3903(15).
695 (d) "Shared savings incentive program" means a voluntary
696 and optional incentive program established by a health
697 maintenance organization pursuant to this section.
698 (e) "Shoppable health care service" means a lower-cost,
699 high-quality nonemergency health care service for which a shared
700 savings incentive is available for subscribers under a health

701 maintenance organization's shared savings incentive program.
702 Shoppable health care services may be provided within or outside
703 this state and include, but are not limited to:
704 1. Clinical laboratory services.
705 2. Infusion therapy.
706 3. Inpatient and outpatient surgical procedures.
707 4. Obstetrical and gynecological services.
708 5. Inpatient and outpatient nonsurgical diagnostic tests
709 and procedures.
710 6. Physical and occupational therapy services.
711 7. Radiology and imaging services.
712 8. Prescription drugs.
713 9. Services provided through telehealth.
714 (3) A health maintenance organization may offer a shared
715 savings incentive program to provide incentives to a subscriber
716 when the subscriber obtains a shoppable health care service from
717 the health maintenance organization's shared savings list. A
718 subscriber may not be required to participate in a shared
719 savings incentive program. A health maintenance organization
720 that offers a shared savings incentive program must:
721 (a) Establish the program as a component part of the
722 contract of coverage provided by the health maintenance
723 organization and notify the subscribers and the office at least
724 30 days before program termination.
725 (b) File a description of the program on a form prescribed

726 by commission rule. The office must review the filing and
727 determine whether the shared savings incentive program complies
728 with this section.
729 (c) Notify a subscriber annually and at the time of
730 renewal, and an applicant for coverage at the time of
731 enrollment, of the availability of the shared savings incentive
732 program and the procedure to participate in the program.
733 (d) Publish on a webpage easily accessible to subscribers
734 and to applicants for coverage a list of shoppable health care
735 services and health care providers and the shared savings
736 incentive amount applicable for each service. A shared savings
737 incentive may not be less than 25 percent of the savings
738 generated by the subscriber's participation in any shared
739 savings incentive offered by the health maintenance
740 organization. The baseline for the savings calculation is the
741 average in-network amount paid for that service in the most
742 recent 12-month period or some other methodology established by
743 the health maintenance organization and approved by the office.
744 (e) At least quarterly, credit or deposit the shared
745 savings incentive amount to the subscriber's account as a return
746 or reduction in premium, or credit the shared savings incentive
747 amount to the subscriber's flexible spending account, health
748 savings account, or health reimbursement account, such that the
749 amount does not constitute income to the subscriber.
750 (f) Submit an annual report to the office within 90

751 business days after the close of each plan year. At a minimum,
752 the report must include the following information:
753 1. The number of subscribers who participated in the
754 program during the plan year and the number of instances of
755 participation.
756 2. The total cost of services provided as a part of the
757 program.
758 3. The total value of the shared savings incentive
759 payments made to subscribers participating in the program and
760 the values distributed as premium reductions, credits to
761 flexible spending accounts, credits to health savings accounts,
762 or credits to health reimbursement accounts.
763 4. An inventory of the shoppable health care services
764 offered by the health maintenance organization.
765 (4) A shared savings incentive offered by a health
766 maintenance organization in accordance with this section:
767 (a) Is not an administrative expense for rate development
768 or rate filing purposes.
769 (b) Does not constitute an unfair method of competition or
770 an unfair or deceptive act or practice under s. 641.3903 and is
771 presumed to be appropriate unless credible data clearly
772 demonstrates otherwise.
773 (5) The commission may adopt rules necessary to implement
774 and enforce this section.
775 Section 8. Subsection (3) is added to section 287.056,

776 Florida Statutes, to read:
777 287.056 Purchases from purchasing agreements and state
778 term contracts.—
779 (3) The department must enter into and maintain one or
780 more state term contracts with benefits consulting companies.
781 Section 9. The Department of Management Services shall
782 conduct an analysis of the procurement timelines and terms of
783 contracts for state employee health benefits with health
784 maintenance organizations, preferred provider organizations, and
785 prescription drug programs to develop an implementation plan for
786 simultaneous procurement of such contracts for benefits offered
787 beginning plan year 2023. The analysis and any recommendations
788 from the department must identify any statutory changes and
789 additional budgetary resources, if any, that will be necessary
790 to implement the plan. The analysis and recommendations must be
791 submitted to the Governor, the President of the Senate, and the
792 Speaker of the House of Representatives no later than December
793 1, 2019.
794 Section 10. Except as otherwise expressly provided in this
795 act, this act shall take effect July 1, 2019.

CODING: Words stricken are deletions; words underlined are additions.