The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/CS/SB 524
INTRODUCER:	Appropriations Committee; Banking and Insurance Committee; and Senators Diaz, Farmer, and Bean
SUBJECT:	Health Insurance
DATE:	April 19, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	McVaney	McVaney	GO	**Favorable**
3.	Sanders	Kynoch	AP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 524 requires the Department of Management Services to implement formulary management for the State Group Insurance Program for the 2020 plan year. A formulary may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs and supplies. If a prescription drug is excluded from the formulary, the drug may be available to the patient if a physician prescribing the medication writes clearly on the prescription that the drug is medically necessary.

The bill creates the Patient Savings Act, which allows health insurers and health maintenance organizations (HMOs) to create a shared savings incentive program that may provide financial incentives to insureds with individual policies or contracts when they obtain shoppable health care services offered by their health insurer or HMO through their shared savings list. The shoppable health care services are lower-cost, high-quality non-emergency services for which a shared savings incentive is available for insureds under the program. The insurer's shared savings incentive list may include shoppable health care services within and outside of Florida. The program is voluntary for insurers, HMOs, policyholders, and subscribers. Health insurers offering a shared savings incentive program must submit an annual report to the Office of Insurance Regulation (OIR) regarding the performance of the program.

The DMS has estimated that implementation of formulary management may produce annual savings of $40 million to the State Group Health Self-Insurance Trust Fund. The Revenue

Estimating Conference determined Section 4 of the bill has a negative $100,000 recurring impact to the General Revenue fund, based on the analysis for CS/HB 1113, the House companion.[1]

The effective date of the bill is January 1, 2020.

II. Present Situation:

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 program,[2] 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 Fiscal Year 2018-2019.[3] Retirees and Consolidated Omnibus Budget Reconciliation Act (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.[4]

State Employees Prescription Drug Program

As part of the SGI program, the DMS is required to maintain the State Employees' Prescription Drug Program (Prescription Drug Plan).[5] The DMS contracts with CVS/Caremark, a pharmacy benefits manager (PBM), to administer the Prescription Drug Plan. 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 list, and non-preferred brand name drugs, which are those brand name drugs not on the preferred drug list. Contractually, the PBM updates the preferred drug list quarterly as brand name drugs enter the market and as the PBM negotiates pricing, including rebates with manufacturers.

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[1] Revenue Estimating Conference (March 15, 2019) http://edr.state.fl.us/Content/conferences/revenueimpact/archives/2019/_pdf/Impact0315.pdf (last visited April 8, 2019).
[2] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.
[3] 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, 2024*, adopted March 1, 2019, page 6, available at http://edr.state.fl.us/content/conferences/healthinsurance/HealthInsuranceOutlook.pdf.
[4] Id.
[5] Section 110.12315, F.S.

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 nonpreferred 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 nonpreferred 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 Preferred Provider Organization (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.

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

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

Currently, 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. There is, however, no use of utilization management protocols to incentivize the use of some

drugs over others. The Prescription Drug Plan has an open formulary, which covers all federal legend drugs for covered medical conditions. However, the PBM each year announces in July the therapeutic classes of drugs that will be impacted by exclusion for the next plan year.

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 four 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.

Medicare Advantage Prescription Drug Plans

The SGI Program covers retirees who are Medicare-eligible. For their coverage, Medicare provides primary coverage for standard hospitalization and medical coverage. The SGI Program offers secondary coverage after the Medicare coverage and, typically, primary coverage for prescription drugs. Medicare-eligible retirees may purchase a Medicare Part D plan (prescription drugs) for an additional premium.

Medicare Advantage plans are offered by private insurance companies. These plans provide standard hospitalization and medical coverage similar to Medicare Part A and Part B. Companies that offer these plans receive a monthly per member subsidy from the federal government and are the primary payer of all medical and pharmacy claims. If the retiree opts for a Medicare Advantage plan, the SGI Program does not pay the claims directly and is not at risk for the claims.

A Medicare Advantage Prescription Drug (MAPD) Plan allows a Medicare-eligible retiree to purchase a policy that covers Part A (standard hospitalization), Part B (medical), and Part D (prescription drug coverage). Similar to the Medicare Advantage plans, these MAPD plans receive a federal subsidy. If the retiree opts for a MAPD plan, the SGI Program will not pay claims directly and will not be at risk for any claims.

Shared Savings Program

On January 1, 2019, the Division of State Group Insurance of the Department of Management Services instituted a voluntary shared savings program to reward policyholders, subscribers, or their dependents for making informed and cost-effective decisions about health care spending,

thereby reducing healthcare costs.[6] The program allows participants to earn rewards by receiving rewardable healthcare services through two state vendors. Rewards are credited to a select pretax savings or spending account of the participant, and funds can be used to pay for eligible medical, dental, and vision expenses. Rewards are earned after the participant shops for a rewardable healthcare service on the website, receives the service, and the claim has been paid.[7]

Health Care Spending

Health care spending in the United States is expected to grow an average of 5.5 percent annually from 2018-2027, reaching nearly $6.0 trillion by 2027.[8] Consumers are becoming responsible for a growing proportion of this spending, as demonstrated in the increased use of high deductible health plans and other forms of cost sharing. Since 2012, the percentage of workers covered by a plan with a deductible of $1,000 or greater has grown from 34 to 51 percent.[9]

Price transparency and quality transparency enable consumers to obtain more value out of the health care system. Greater awareness and access by consumers to pricing information before obtaining health care services may result in lower overall payments for health care services and higher quality providers. A recent study concluded that the use of private price transparency platforms was associated with lower claims payments for common medical services. [10] According to a 2017 survey, 98 percent of health plans around the country indicated that they have cost calculator tools, but only two percent of policyholders or subscribers use them.[11] Financial incentives may encourage consumers to access price information. Incentives may include reductions in premiums, cash payments, or lower out-of-pocket costs for their members if they select low-price, high quality providers.

Regulation of Health Insurance

The OIR is responsible for the regulation of insurers and other risk-bearing entities.[12] Rates and forms of individual and small group policies and contracts are subject to prior approval. The Insurance Code[13] does not address a shared savings program.

Section 627.6385, F.S., requires health insurers writing individual policies to make available on their website a method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities for health care services and procedures.[14] Insurers are required to

[6] Ch. 2017-70, L.O.F.
[7] MyBenefits, Shared Savings Program, available at https://www.mybenefits.myflorida.com/health/shared_savings_program (last viewed March 2, 2019).
[8] Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Projections 2018-2027, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf (last viewed March 2, 2019).
[9] North Carolina Medical Journal, 79. 1.34.
[10] JAMA. 2014:312(16):1670-1676.
[11] Catalyst for Payment Reform Survey available at http://www.catalyzepaymentreform.org/wp-content/uploads/2017/04/National-Scorecard.png (last viewed March 2, 2019).
[12] Section 20.121, F.S. The Financial Services Commission, composed of the Governor, Attorney General, Commissioner of Agriculture, and the Chief Financial Officer, are the agency head for purposes of rulemaking.
[13] Ch. 624, F.S.
[14] The Agency for Healthcare Administration, available at http://www.floridahealthfinder.gov/index.html (last viewed March 2, 2019).

provide a hyperlink to health information, including service bundles and quality of care information, developed by the Agency for Health Care Administration. Likewise, the federal Patient Protection and Affordable Care Act[15] requires insurance policies and contracts to provide price and coverage information to enrollees, including cost sharing and payments with respect to out-of-network coverage.[16]

III. Effect of Proposed Changes:

Section 1 allows the DMS to contract with entities that offer an optional participation Medicare Advantage Prescription Drug Plan. Under these contracts, the retiree will pay a premium to the SGI Program that will be passed through as the premium for the MAPD plan. All health insurance claims will be payable under the MAPD plan, and the SGI Program will have no direct claims risk.

Section 2 requires the DMS to implement prescription drug formulary management for the 2020 plan year. The formulary may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs and supplies. If a prescription drug is excluded from the formulary, the drug may be available to the patient if a physician prescribing the medication writes clearly on the prescription that the drug is medically necessary.

By October 1 of each year, the DMS must notify the Governor and the Legislature of the prescription drugs and supplies to be excluded during the next plan year. If the DMS proposes additional exclusions during the plan year, the DMS must give 60 days' notice to the Governor and Legislature prior to the implementation of those new exclusions.

Section 3 repeals section 8 of ch. 99-255, L.O.F., effective December 31, 2019, which prohibits use of a prescription drug formulary management plan for the State Group Insurance PPO Plan.

Section 4 creates s. 627.6387, F.S., the "Patient Saving Act." This section establishes the shared savings incentive program, which is a voluntary incentive program a health insurer may establish to provide incentives when the insured who has an individual policy, contract, or certificate of insurance obtains a shoppable health care service from a health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. For purposes of this section, the terms "health care provider," health insurer," "shared savings incentive," "shared "savings incentive program," and "shoppable health care service" are defined.

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

[15] Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010; and amended by the Health Care and Education Reconciliation Act, Public Law 111–152, was enacted on March 30, 2010.
[16] 45 CFR Part 147 and Section 2715A Public Health Service Act.

A "health insurer" is an authorized insurer offering health insurance as defined in s. 624.603, F.S., or a health maintenance organization as defined in s. 641.19, F.S. The term does not include the state group health insurance program.

A "shared savings incentive," is a voluntary and optional financial incentive that a health insurer may provide to an insured for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 626.9541(4)(a), F.S., which relate to participation in a wellness or health improvement program. The term, "shared savings incentive program," means a voluntary and optional incentive program established by a health insurer pursuant to this section.

A "shoppable health care service" is a lower-cost, high quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside of this state and include, but are not limited to:

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

A health insurer that offers a shared savings incentive program must:

- Establish the program as a component part of the policy, contract, or certificate of insurance provided by the health insurer.
- File a description of the program with the OIR on a form prescribed by the Financial Services Commission[17] (commission). The OIR must determine if the program complies with the statutory requirements.
- Notify each insured about the program annually, and at the time of renewal, and notify an applicant for insurance of the availability of the program at the time of enrollment.
- Publish on a webpage easily accessible to insureds and to applicants for insurance coverage a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service.
- Notify insureds and the OIR 30 days before program termination.

A shared saving incentive:

- May not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings

[17] Section 624.05, F.S., defines "Commission" as the Financial Services Commission. The commission is comprised of four members: the Governor, the Attorney General, the Chief Financial Officer and the Commissioner of Agriculture and is responsible for final approval of rules developed by the Office of Financial Regulation and the Office of Insurance Regulation. Financial Services Commission, https://www.flofr.com/sitepages/financialservicescommission.htm (last visited April 2, 2019).

calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the OIR.
- Must be credited or deposited quarterly to an insured's account as a return or reduction in premium, or credited to the insured flexible spending account, health savings account, or health reimbursement account, such that the amount does not constitute income for the insured.

A health insurer offering a shared savings program must submit an annual report to the OIR after the end of each plan year. At a minimum, the report must include the following information:
- Number of insureds who participated in the program and the number of instances of participation;
- The total cost of services provided as a part of the program;
- The total value of the incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending, health savings, or health reimbursement accounts; and
- An inventory of the shoppable health care services offered by the health insurer.

A shared savings incentive offered by a health insurer:
- Is not an administrative expense for rate development or rate filing purposes; and
- Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541, F.S., and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

A shared savings incentive amount provided as a return or reduction in premium reduces the health insurer's direct written premium by the shared savings incentive dollar amount for purposes of ss. 624.509 and 624.5091, F.S. (insurance premium tax and retaliatory tax).

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

Section 5 provides the bill takes effect July 1, 2019, except as otherwise provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill allows an insurer to reduce its direct written premiums by the dollar amount of the shared savings incentives provided to insureds, thereby reducing its tax liabilities relating to Florida's insurance premium tax and the retaliatory tax. The fiscal impact is indeterminate. The Revenue Estimating Conference determined that Section 4 of the bill has a negative $100,000 recurring impact to the General Revenue fund, based on the analysis for CS/HB 1113, the House companion.[18]

B. Private Sector Impact:

The implementation of a shared savings incentive program may encourage insureds to obtain high quality health care services at lower prices.

C. Government Sector Impact:

The DMS has estimated that implementation of prescription drug formulary management may produce annual savings of $40 million for the State Group Health Self-Insurance Trust Fund.

The OIR indicates Section 4 of the bill does not have a fiscal impact to state government; however, the OIR also indicates it will need to update "its computer system to allow for carriers to submit a description of the shared savings incentive program".[19] The OIR did not provide an estimate of the cost associated with this system upgrade.

The bill provides the Financial Services Commission with rulemaking authority to implement the provisions of the bill.

The bill allows an insurer to reduce its direct written premiums, which also reduces the insurer's tax liabilities related to Florida's insurance premium tax and the retaliatory tax. The effect of this reduction is unknown and indeterminate. *See* Tax/Fee Issues above.

[18] Revenue Estimating Conference (March 15, 2019) http://edr.state.fl.us/Content/conferences/revenueimpact/archives/2019/_pdf/Impact0315.pdf (last visited April 8, 2019).
[19] The Office of Insurance Regulation, *Senate Bill 524 2019 Agency Legislative Bill Analysis* (February 18, 2019) (on file with the Senate Committee on Appropriations).

VI. Technical Deficiencies:

It is unclear whether the shared savings incentives provided to an insured could exceed the annual limits on contributions to pretax savings or spending accounts, such as the health savings account, or the amount of premiums paid by the insured during a plan year.

The term, "health insurer," is defined to mean insurance as defined in s. 624.603, F.S., which includes major medical health insurance, as well as excepted benefit, limited benefit, indemnity benefit, and supplemental benefit policies. Generally, pretax savings or spending accounts, such as the health savings account, provide tax advantages to offset health care costs. To be eligible for a health savings account, an individual is required to be covered under a high deductible health plan, which provides major medical coverage.[20]

VII. Related Issues:

The bill applies to individual policies or contracts only because the bill amends Part VI of ch. 627, F.S. Section 627.601(2), F.S., provides that nothing in this part applies to or affects any group or blanket policy.

VIII. Statutes Affected:

This bill amends the following sections of the Florida Statutes: 110.12303 and 110.12315.

This bill creates section 627.6387 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Appropriations on April 18, 2019:
The committee substitute:

- Modifies the State Group Health Insurance Program by requiring the Department of Management Services (DMS) to implement a managed formulary for prescription drugs for participating state employees and retirees.
  - The formulary may not restrict access to a drug if the drug is the most clinically effective and lowest net-cost drug.
  - For a particular patient, a drug that is otherwise excluded from the formulary must be available if a physician prescribing the drug clearly states on the prescription that the drug is medically necessary.
- Changes the dates upon which the DMS is to notify the Governor and Legislature of changes to the formulary.
- Permits the DMS to contract with entities that provide Medicare Advantage Prescription Drug Costs.
- Revises the effective date of the bill.

[20] Internal Revenue Service, Health Savings Accounts and Other Tax-Favored Health Plan**s**, (May 4, 2019) https://www.irs.gov/pub/irs-pdf/p969.pdf (last visited Mar. 12, 2019).

CS by Banking and Insurance on March 11, 2019:
The CS:

- Revises definitions.
- Revises and clarifies requirements of the shared savings program.
- Provides technical changes.
- Requires health insurers to submit an annual report to the Office of Insurance Regulation.

B. Amendments:

None.