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 Governmental Oversight and Accountability

BILL: SB 1836

INTRODUCER: Senator Bean

SUBJECT: Health Insurance and Prescription Drug Coverage

DATE: February 14, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McVaney	McVaney	GO	**Pre-meeting**
2.			AEG	
3.			AP	

I. Summary:

SB 1836 modifies the State Group Insurance Program (SGI program) to:

- Allow enrollees to obtain covered services and covered prescription drugs from non-network providers and non-network pharmacies at a cost that is the same or less than the in-network average paid by the enrollee's health plan;
- Require the enrollee's health plan to apply the same deductible and cost sharing maximums towards the enrollee's deductible within a reasonable time, not to exceed one year as if the service or prescription drug had been provided by an in-network provider;
- Apply the costs of any prescription drug purchased through a prescription drug card, manufacturer rebate program, other discount, other rebate program, or direct from a provider and it results than a lower cost than if purchased from an in-network provider within a reasonable time period, not the exceed one year towards an enrollee's deductible or cost sharing maximum;
- Inform its enrollees through its website and benefits materials about the ability to use non-network providers and how to access the option;
- Include of subscription based medical services and other medical care as a supplemental benefit option;
- Require the health care transparency and bundled services programs to offer enrollees the option of receiving credits as premium or out of pocket cost reductions and the option of being paid cash or cash equivalents as rewards;
- Require infusion therapy to be included in the Shared Savings Incentive Program; and
- Prohibit the pharmacy benefit manager from imposing a copayment or cost share amount that is greater than the cost of the drug or to penalize the pharmacist for providing the enrollee with certain educational materials.

Beginning on January 1, 2021, and after approval of a health insurer's rate filing, health insurers and health maintenance organizations:

- Must allow an insured or a subscriber to obtain a covered service from an out of network provider or out of network pharmacy if the cost is the same or less than the average cost of the insured's or the subscriber's health plan cost for the same service and to have that service count towards the insured's or the subscriber's deductible or cost sharing maximum;
- May not deny a claim for payment because an insured or subscriber received a covered service from an in-network provider based on a referral from an out-of-network provider;
- May not impose on an insured or a subscriber a copayment or other charge that is greater than the claim cost of the prescription drug;
- Are required to inform insureds and subscribers of the availability of non-network provides and non-network pharmacies and how to access these options and file claims;
- Shall provide a downloadable, interactive claims form for filing non-network provider claims; and
- Must notify insureds and subscribers if in a plan where a provider claim was in the highest third for an in-network provider and provide resources for other lower cost options.

The Shared Savings Program is modified to include additional options and to require health insurers and health maintenance organizations (HMOs) to offer a Shared Savings Program. Health insurers and HMOs would also be newly required to offer a toll-free number for insureds and subscribers to check their qualifications for incentives under the Shared Savings Program. Incentives involving premium and copayment reductions or cash and cash equivalent options are added to the list possible rewards.

The Department of Management Services and its contractors under the State Group Insurance Program are expected to experience significant fiscal impacts.

The bill takes effect January 1, 2021.

II. Present Situation:

State Group Insurance Program

Under the authority of section 110.123, Florida Statutes, the Department of Management Services (department), through the Division of State Group Insurance (DSGI), administers the State Group Insurance Program under a cafeteria plan consistent with section 125 of the Internal Revenue Code.

The department contracts with third-party administrators for self-insured health plans, fully insured health maintenance organizations (HMOs), and a pharmacy benefits manager (PBM) for the self-insured State Employees' Prescription Drug Program (Prescription Drug Program) pursuant to s.110.12315, F.S.

The state offers also a self-insured, standard preferred provider option (PPO) plan and a high-deductible health plan (HDHP) option. Both PPOs are offered on a statewide basis. The HMO options are offered on a county by county basis. Each health plan is responsible for the development and maintenance of its own network, including credentialing its own providers within the SGI program's access and appointment standards.

The Prescription Drug Program has four dispensing avenues: participating 30-day retail pharmacies, participating 90-day retail pharmacies, the PBM's mail order pharmacies, and the PBM's specialty pharmacies. The retail network provides 3,961 pharmacies within the state of Florida and 59,520 nationally. The only chain pharmacy not included in the Prescription Drug Program's retail network is Walgreens. During the ITN process it has been determined that using a slightly less broad network provided significant savings to the Program while having zero access disruption to members.

While the Prescription Drug Program does offer a mail order pharmacy network which in the case of the contract with the current PBM, members are not required to use mail order and may fill their prescriptions for up to a 90-day supply at network retail pharmacies that agree to the same pricing as the mail order.

Contractually, and as stated in the benefit documents, specialty drugs, as defined by the PBM, must be dispensed by the PBM's specialty pharmacies. However, the first fill of oncology specialty drugs may be covered when dispensed by a network retail pharmacy. This process allows the patient to get on the medication as soon as possible while providing time for the prescriber to get the patient set up at the PBM's specialty pharmacy. To assist members and prescribers, the PBM's specialty pharmacies have clinicians trained in each of the clinical disciplines, conditions, and/or specialties corresponding to the specialty drugs being dispended.

The Prescription Drug Program covers all federal legend drugs unless specifically excluded or if prescribed to treat a non-covered medical condition. The Prescription Drug Program does not have prior authorization or step therapy requirements.

Price Transparency in Florida

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center), housed within the Agency for Health Care Administration (AHCA), provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.[1]

The Florida Center identifies existing health-related data and collects data for use in the information system, including information on health care costs and financing, trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.[2]

Florida Consumer Price Portal

The Florida Center maintains www.FloridaHealthFinder.gov, which was established by law in 2016[3], to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ambulatory surgery centers,

[1] Section 408.05(1), F.S.
[2] Section 408.05(2), F.S.
[3] Chapter 2016-234, L.O.F.; *see also* s. 408.05(3), F.S.

emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida.

The cost information on the website is searchable, and based on descriptive bundles of commonly performed procedures and services. Consumers can view typical payments[4] for common medical procedures and diagnostic tests, with information presented at both statewide and local levels. In other words, a patient in Tampa can see recent prices paid for a chest x-ray at local facilities and a statewide average price. The consumer search tool is accessible at https://pricing.floridahealthfinder.gov/#!.

The website also provides tools to researchers and professionals allowing for specialized data queries, but requires users to have some knowledge of medical coding and terminology.[5] Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.[6]

Patient Savings Act

In 2019, the Legislature enacted the Patient Savings Act[7] (Act), which allows (but does not mandate) health insurers and health maintenance organizations (HMOs) to create a shared savings incentive program (Shared Savings 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 Act authorizes implementation of these incentive programs for plan years beginning January 1, 2020.

Health insurers and HMOs that choose to offer a Shared Savings Program must develop a website outlining the range of shoppable health care services available to insureds. This website must provide patients with an inventory of participating health care providers and an accounting of the shared savings incentives available for each shoppable service. The Act 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.

[4] The website provides information on *payments* for services, and not facility *charges*. Very few patients or insurers actually pay the full charge for a service, so reporting of payments provides a more accurate estimate of costs that patients and/or their health plans can expect to incur.
[5] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, *2017 Annual Report*, pgs. 4-8, available at https://fhfstore.blob.core.windows.net/documents/researchers/documents/2017%20FL%20Center%20Annual%20Report%20FINAL.PDF (last accessed February 13, 2020).
[6] *Id.*, pgs. 6-8.
[7] Sections 627.6387, 627.6648, and 641.31076, F.S.

- Prescription drugs.
- Services provided through telehealth.

The Act 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 Shared Savings Program. When a patient 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 patient. A patient 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 patient's participation.

The law provides a range of methods by which a Shared Savings Program may financially reward patients who save money by shopping for health care services. Patients may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.[8]

III. Effect of Proposed Changes:

Section 1 amends s. 110.123, F.S. to require the State Group Insurance Program to allow its enrollees to obtain services from out-of-network providers at a cost equal to or less than the in-network average for the same service. Within one year, the program shall apply the payment made by, or required of a participant of that health plan for that covered health care service or covered prescription drug toward that participant's deductible and out-of-pocket maximum as if the service had been provided by an in-service provider or in-network pharmacy.

Section 2 amends s. 110.12303, F.S., to allow the DMS may include benefits offered by direct primary or other medical care provided on a subscription basis. In terms of the comprehensive surgery benefit, the contract must allow the savings to be credited to the enrollee as a premium or out-of-pocket cost reduction or paid directly to the enrollee as cash or a cash equivalent.

The section allows the amount payable to the enrollee under the shared savings plan to be credited to the enrollee as a premium or out-of-pocket cost reduction, or paid directly to the enrollee as cash or a cash equivalent.

Infusion services are required to be included in the shared savings incentive program.

Section 3 amends s. 110.12315, F.S., to require the DMS to apply any payment made by an enrollee using a pharmacy discount program, drug manufacturer rebate, or other discount or rebate program including purchasing a prescription from a prescriber such as a direct primary care provider to the enrollee's deductible and out-of-pocket maximum within one year.

Section 4 amends s. 110.1238, F.S., to require the state group health insurance plan to allow participants to obtain covered health care services from an out-of-network provider at a cost equal to or less than the in-network average for the participant's plan. Any out-of-network out-of-pocket payment by the participant must be treated as part of the participant's deductible and out-of-pocket maximum.

[8] *Id.*

At a minimum, the program must also inform its enrollees through its website and benefit material about the out-of-network option, application of deductibles and out-of-pocket maximums, and how to utilize the option.

Section 5 creates s. 465.203, F.S., to prohibit a pharmacy benefit manager (PBM) from imposing a copayment or other charge that exceeds the claim cost of a prescription drug. The PBM may not penalize a pharmacy provider for providing information to a covered individual.

Section 6 creates s. 627.4435, F.S, to require, effective January 1, 2021 and upon approval of a health insurer's rate filing, a health insurer meeting the statutory definition to allow its insureds to receive health care services from an out-of-network provider at the same or lesser cost than the in-network average that an insured's insurance plan pays for that health care service.

Payments made by an insured which results in a lower cost than would have been paid if the insured had stayed in the network, shall be applied towards the insured's deductible and out of pocket maximum within a reasonable time period, not to exceed one (1) year, as if the drugs had been provided by an in-network provider such as:

- An out-of-network provider;
- Prescription drugs purchased from an out-of-network pharmacy; or
- Prescription drugs purchased with a discount card, directly from a provider, or through the use of manufacturer's rebate, discount, or other rebate program.

A health insurer is prohibited from denying payment for any in-network, covered service on the basis that the referral came from non-network provider for the covered service. The health insurer may not apply a deductible, co-insurance, or copayment greater than the applicable cost sharing amount that would have applied to the same service if the health care service was referred by an in-network provider.
At a minimum, a health insurer is required to provide information on its website and in its benefits documents with its insureds, including the following:

- The options for obtaining benefits and prescription drugs from out-of-network providers and pharmacies with payments being eligible for application against deductibles and out of pocket maximum calculations;
- How to use out-of-network provider and out-of-network pharmacy options;
- How to obtain information about the average amount paid to an in-network provider or in-network pharmacy for a procedure, service, or prescription drug; and
- Provide an interactive, downloadable form to submit proof of payment to an out-of-network provider or out-of-network pharmacy.

If the insured is in a group health plan, policy, or contract that has paid for a health care service or for a provider that was in the highest third for in-network providers, the insured's health plan is required to provide notification to the insured that he/she has overpaid for a service and identify tools that the insured can use next time to elect a lower cost option.

Section 7 amends s. 627.6387, F.S, to require an insurer to offer a shared savings incentive program to an insured who obtains a shoppable health care service from the insurer's shared

savings list. An insured or subscriber is not required to participate in the shared savings program. The list of shoppable health care services is expanded to include any additional services identified by the Florida Center for Health Information and Transparency which commonly have a wide price variation. Health insurers will be required to offer a toll-free number that an insured or subscriber may call to compare and qualify for incentives under the program.

Section 8 amends s. 627.6648, F.S., to require an insurer to offer a shared savings incentive program to an insured who obtains a shoppable health care service from the insurer's shared savings list. An insured or subscriber is not required to participate in the shared savings program. The list of shoppable health care services is expanded to include any additional services identified by the Florida Center for Health Information and Transparency which commonly have a wide price variation. Health insurers will be required to offer a toll-free number that an insured or subscriber may call to compare and qualify for incentives under the program.

Section 9 amends s. 641.31076, F.S., to require an HMO to offer a shared savings incentive program to an insured who obtains a shoppable health care service from the HMO's shared savings list. An insured or subscriber is not required to participate in the shared savings program. The list of shoppable health care services is expanded to include any additional services identified by the Florida Center for Health Information and Transparency which commonly have a wide price variation. HMOs will be required to offer a toll-free number that an insured or subscriber may call to compare and qualify for incentives under the program.

The bill takes effect July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Not applicable. The bill does not require counties or municipalities to take action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

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:

None.

B. Private Sector Impact:

Persons insured in Florida for health insurance purposes may receive financial incentives under the terms of the bill. However, the insurers may realize less profits under the bill.

C. Government Sector Impact:

The DMS has noted a significant fiscal impact on the State Group Insurance Program. The DMS notes:

> "All of the contracted health plans and insurers with the State Group Insurance program have indicated either a fiscal or operational impact, or both. For the statewide PPO plan, an out-of-network plan administered as an in-network plan cannot be administered to alter the cost sharing differently than the plan design. Altering the claims in this manner does not maintain the integrity of the original claims data elements submitted by either the member or the provider. According to the PPO administrator, even if this could be manually administered, it has the potential for multiple claims, impacting quality audit findings, accumulator exchangers with PBMs and vendors. Concerns that such changes will raise serious concerns with any auditing entity attempting to track appropriate deductible, cost sharing, and accumulators. There are also concerns about degradation of the network if the out of network provider charges is the same or less than the in-network provider charges. The changes in these sections of the bill also create an administrative burden on all affected parties.
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> The PPO Plan administrator estimated a minimum fiscal impact of $1.8 million by adding the noted changes specific to out-of-network services and member cost share. Another plan has estimated that by adding out-of-network benefits, plus some of the other changes to the Program, this change would have an estimated impact of $545 per member per month for their plan alone totaling to $2 to $3 million annually in costs."[9]

VI. Technical Deficiencies:

None.

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[9] *See* Department of Management Services, *Senate Bill 1873 Agency Legislative Analysis* (January 31, 2020) (on file with the Senate Committee on Governmental Oversight and Accountability).

VII. Related Issues:

The State Employee Group Insurance Plan is a cafeteria plan which is regulated by, and meets the specific requirements of, section 125 of the Internal Revenue Code (IRC). Employees and employers who participate under a Section 125 cafeteria plan receive their benefits on a pre-tax basis; however, only certain qualified benefits meet the requirements. Requiring the reimbursement of direct primary care subscription fees as a supplemental benefit option does not appear to meet the requirements for federal tax exceptions under the rules and regulations for cafeteria plans.

For treatment as a pre-tax benefit under Section 125, the IRS identifies specific "Qualified Benefits" which are:

- Accident and health benefits (but not Archer medical savings accounts or long-term care insurance);
- Adoption assistance;
- Dependent care assistance;
- Group-term life insurance; and
- Health savings accounts[10], including distributions to pay long-term care services.[11]

Multiple issues arise if the rewards lose their tax-free status and become marked as income for both the Program's active and retiree populations, especially for those participating under the deferred compensations provisions of IRS Code 409A (Inclusion of gross income of deferred compensation under nonqualified deferred compensation plans). According to the Code, the penalties include taxation of compensation deferred during the tax year with a risk of forfeiture among other actions. At that time, consultants to DSGI suggested that payments could be structured in ways to avoid being taxable, including:

- Limit any shared savings to the individual's out of pocket medical expenses;
- Characterize the payments as non-taxable benefits to the extent they reduce out of pocket expenses such as copayments, co-insurance, deductibles;
- Provide that the shared savings are deposited into an account subject to federal requirements such as an HRA, FSA, or HSA;
- Limit shared savings to where the deductible has been met for the underlying health plan; and
- Structure the shared savings contribution to deposit in an HSA or limited purpose (vision/dental) FSA.

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[10] A health savings account is owned by a qualified employee and contributions may be made by the employee and the employer. Contributions to the account are used to pay current or future medical expenses of the account holder, his or her spouse, and any qualified dependent. The expenses must not reimbursable by insurance or other source and cannot be deductible on the individual's tax return. See Employer's Tax Guide to Fringe Benefits (2020), Department of Treasury, Internal Revenue Service, Publication 15-B, https://www.irs.gov/publications/p15b#en_US_2020_publink1000193660 (last visited February 13, 2020).

[11] Internal Revenue Service, FAQs for government entities regarding Cafeteria Plans, https://www.irs.gov/government-entities/federal-state-local-governments/faqs-for-government-entities-regarding-cafeteria-plans (last visited February 13, 2020).

Some of these safeguards exist in state law, state rule, or program guidelines of the Shared Savings Program today. Rewards are specifically deposited into an HRA account and all enrollees with a HDHP are required to also have an HRA account.

VIII. Statutes Affected:

This bill substantially amends sections 110.123, 110.12303, 110.12315, 110.1238, 627.6387, 627.6648, and 641.31076 of the Florida Statutes.

This bill creates sections 465.203 and 627.4435 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.