By the Committee on Governmental Oversight and Accountability

585-02629-20 20207046__

A bill to be entitled

An act relating to the state group insurance program; amending s. 110.123, F.S.; revising the definition of "full-time state employees" to conform to changes made by the act; authorizing persons eligible to participate in the program to elect membership with certain health maintenance organization plans; requiring at least one health maintenance organization plan be made available to each enrollee residing in the state; deleting provisions providing for the establishment of health maintenance organization plan regions by Department of Management Services rule; deleting the requirement that health plans be offered in specified benefit levels; deleting obsolete language regarding eligibility for participation in the program for other-personal-services employees; establishing regions for health maintenance organizations for specified purposes; providing for construction; creating s. 110.12305, F.S.; defining terms; prohibiting specified fraudulent acts in connection with the program, including the submission of fraudulent insurance claims, making false statements in claims, and the acceptance of certain payments; providing criminal penalties; specifying that the repayment, or attempted repayments, of any unlawful payments does not constitute a defense or a ground for dismissal for a violation of the act; specifying which property is deemed to be paid for by the program; specifying application of the business

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records hearsay exception to certain records in the custody of the department or a contracted vendor; specifying factors that establish an inference that a person had knowledge of a false statement or false representation regarding a claim; prohibiting the sale or purchase of a legend drug paid for by the program; providing criminal penalties; prohibiting a person from knowingly making or causing to be made, or attempting or conspiring to make, any false statement or representation in order to obtain goods or services from the program; providing criminal penalties; providing immunity for certain persons who provide information regarding provider fraud to governmental entities; specifying the scope of such immunity; defining the term "fraudulent acts"; requiring the department to publicize certain terms of the Florida False Claims Act to state employees and the public; creating s. 110.12306, F.S.; defining a term; requiring the Division of State Group Insurance to establish an anti-fraud unit for certain purposes by a specified date; authorizing the division to contract with other parties to perform certain anti-fraud measures; requiring the division to adopt an anti-fraud plan and designate at least one employee to implement anti-fraud measures; amending s. 110.12315, F.S.; modifying requirements for identifying a medically necessary drug excluded from the formulary on a prescription; prohibiting the department or its pharmacy benefit manager from substituting its

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judgment over the judgment of a prescriber in determining whether a drug excluded from the formulary is medically necessary; requiring the department or its pharmacy benefit manager to take specified action regarding formulary management; removing a limitation for the annual maximum amount for coverage for medically necessary prescription and nonprescription enteral formulas and amino-acid-based elemental formulas for home use; requiring the department to ensure that the prescription drug program receives certain benefits, and to perform annual audits of such benefits; amending s. 110.131, F.S.; conforming a cross-reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) of subsection (2), paragraphs (h), (j), and (k) of subsection (3), and paragraphs (c) and (d) of subsection (13) of section 110.123, Florida Statutes, are amended, and subsection (14) is added to that section, to read:

110.123 State group insurance program.—

(2) DEFINITIONS.—As used in ss. 110.123-110.1239, the term:

(c) "Full-time state employees" means employees of all branches or agencies of state government holding salaried positions who are paid by state warrant or from agency funds and who work or are expected to work an average of at least 30 or more hours per week; employees paid from regular salary appropriations for 8 months' employment, including university personnel on academic contracts; and employees paid from other-

personal-services (OPS) funds who are reasonably expected to work an average of at least 30 hours or more per week or have worked an average of at least 30 hours or more per week during the employee's measurement period ~~as described in subparagraphs 1. and 2~~. The term includes all full-time employees of the state universities. The term does not include seasonal workers who are paid from OPS funds.

~~1. For persons hired before April 1, 2013, the term includes any person paid from OPS funds who:~~

~~a. Has worked an average of at least 30 hours or more per week during the initial measurement period from April 1, 2013, through September 30, 2013; or~~

~~b. Has worked an average of at least 30 hours or more per week during a subsequent measurement period.~~

~~2. For persons hired after April 1, 2013, the term includes any person paid from OPS funds who:~~

~~a. Is reasonably expected to work an average of at least 30 hours or more per week; or~~

~~b. Has worked an average of at least 30 hours or more per week during the person's measurement period.~~

(3) STATE GROUP INSURANCE PROGRAM.—

(h)1. A person eligible to participate in the state group insurance program ~~may be authorized by rules adopted by the department~~, in lieu of participating in the state group health insurance plan, may ~~to~~ exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by ~~said~~ rules adopted by the department. The offer of optional membership in a health maintenance organization plan

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permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The department shall contract with health maintenance organizations seeking to participate in the state group insurance program through a request for proposal or other procurement process, as developed by the Department of Management Services and determined to be appropriate.

a. The department shall establish a schedule of minimum benefits for health maintenance organization coverage, and that schedule shall include~~:~~ physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; age-based and gender-based wellness benefits; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO. As used in this paragraph, the term "age-based and gender-based wellness benefits" includes aerobic exercise, education in alcohol and substance abuse prevention, blood cholesterol screening, health risk appraisals, blood pressure screening and education, nutrition education, program planning, safety belt education, smoking cessation, stress management, weight management, and women's health education.

b. The department may establish uniform deductibles, copayments, coverage tiers, or coinsurance schedules for all

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participating HMO plans.

c. The department may require detailed information from each health maintenance organization participating in the procurement process, including information pertaining to organizational status, experience in providing prepaid health benefits, accessibility of services, financial stability of the plan, quality of management services, accreditation status, quality of medical services, network access and adequacy, performance measurement, ability to meet the department's reporting requirements, and the actuarial basis of the proposed rates and other data determined by the director to be necessary for the evaluation and selection of health maintenance organization plans and negotiation of appropriate rates for these plans. Upon receipt of proposals by health maintenance organization plans and the evaluation of those proposals, the department may enter into negotiations with all of the plans or a subset of the plans, as the department determines appropriate. The department may negotiate regional or statewide contracts with health maintenance organization plans. Such plans must be cost-effective and must offer high value to enrollees.

d. The department may limit the number of HMOs that it contracts with in each region based on the nature of the bids the department receives, the number of state employees in the region, or any unique characteristics of the region. <u>At least one HMO plan must be available to each enrollee residing in the state</u> ~~The department shall establish the regions throughout the state by rule~~. ~~The department must submit the rule to the President of the Senate and the Speaker of the House of Representatives for ratification no later than 30 days before~~

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~~the 2020 Regular Session of the Legislature. The rule may not take effect until it is ratified by the Legislature.~~

e. All persons participating in the state group insurance program may be required to contribute towards a total state group health premium that may vary depending upon the plan, coverage level, and coverage tier selected by the enrollee and the level of state contribution authorized by the Legislature.

3. The department is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The department may establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the department may enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25-percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department

in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a.-d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal or invitation to negotiate process described in subparagraph 2.

5. All enrollees in a state group health insurance plan, a TRICARE supplemental insurance plan, or any health maintenance organization plan have the option of changing to any other health plan that is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year.

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 months after termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of prenatal care, regardless of the trimester in which care was

initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

7. Any HMO participating in the state group insurance program shall submit health care utilization and cost data to the department, in such form and in such manner as the department shall require, as a condition of participating in the program. The department shall enter into negotiations with its contracting HMOs to determine the nature and scope of the data submission and the final requirements, format, penalties associated with noncompliance, and timetables for submission. These determinations shall be adopted by rule.

8. The department may establish and direct, with respect to collective bargaining issues, a comprehensive package of insurance benefits that may include supplemental health and life coverage, dental care, long-term care, vision care, and other benefits it determines necessary to enable state employees to select from among benefit options that best suit their individual and family needs. Beginning with the 2018 plan year, the package of benefits may also include products and services described in s. 110.12303.

a. Based upon a desired benefit package, the department shall issue a request for proposal or invitation to negotiate

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for providers interested in participating in the state group insurance program, and the department shall issue a request for proposal or invitation to negotiate for providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the department may enter into contract negotiations with providers submitting bids or negotiate a specially designed benefit package. Providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, except as provided in subparagraph (f)3., no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans. With respect to dental coverage, the division shall include in any solicitation or contract for any state group dental program made after July 1, 2001, a comprehensive indemnity dental plan option which offers enrollees a completely unrestricted choice of dentists. If a dental plan is endorsed, or in some manner recognized as the preferred product, such plan shall include a comprehensive indemnity dental plan option which provides enrollees with a completely unrestricted choice of dentists.

b. Pursuant to the applicable provisions of s. 110.161, and

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s. 125 of the Internal Revenue Code of 1986, the department shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental insurance benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

~~(j) For the 2020 plan year and each plan year thereafter, health plans shall be offered in the following benefit levels:~~

~~1. Platinum level, which shall have an actuarial value of at least 90 percent.~~

~~2. Gold level, which shall have an actuarial value of at least 80 percent.~~

~~3. Silver level, which shall have an actuarial value of at least 70 percent.~~

~~4. Bronze level, which shall have an actuarial value of at least 60 percent.~~

~~(k) In consultation with the independent benefits consultant described in s. 110.12304, the department shall develop a plan for implementation of the benefit levels described in paragraph (j). The plan shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2019, and include recommendations for:~~

~~1. Employer and employee contribution policies.~~

~~2. Steps necessary for maintaining or improving total employee compensation levels when the transition is initiated.~~

~~3. An education strategy to inform employees of the~~

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~~additional choices available in the state group insurance program.~~

~~This paragraph expires July 1, 2019.~~

(13) OTHER-PERSONAL-SERVICES EMPLOYEES (OPS).—

(c) The ~~initial~~ measurement period used to determine whether an employee ~~hired before April 1, 2013, and~~ paid from OPS funds is a full-time employee described in ~~subparagraph (2)(c)1. is the 6-month period from April 1, 2013, through September 30, 2013.~~

~~(d) All other measurement periods used to determine whether an employee paid from OPS funds is a full-time employee described in~~ paragraph (2)(c) must be for 12 consecutive months.

(14) REGIONS FOR HEALTH MAINTENANCE ORGANIZATIONS.—

(a) The following regions are established for purposes of the department entering into contracts with HMOs to provide services on a regional basis on or after January 1, 2023, pursuant to paragraph (3)(h):

1. Region 1 consists of Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, and Washington Counties.

2. Region 2 consists of Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties.

3. Region 3 consists of Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Suwannee, and Union Counties.

4. Region 4 consists of Baker, Clay, Duval, Flagler, Nassau, Putnam, St. Johns, and Volusia Counties.

5. Region 5 consists of Brevard, Indian River, Lake,

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Orange, Osceola, and Seminole Counties.

6. Region 6 consists of Citrus, DeSoto, Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas, Polk, Sarasota, and Sumter Counties.

7. Region 7 consists of Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

8. Region 8 consists of Charlotte, Collier, Glades, Hendry, and Lee Counties.

9. Region 9 consists of Broward, Miami-Dade, and Monroe Counties.

(b) The establishment of these regions does not limit the department's authority to contract for HMO services on a statewide basis.

Section 2. Section 110.12305, Florida Statutes, is created to read:

110.12305 Provider fraud.—

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

(a) "Item or service" includes:

1. Any particular item, device, medical supply, or service claimed to have been provided to a health plan member and listed in an itemized claim for payment; or

2. In the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim.

(b) "Knowingly" means that the act was done voluntarily and intentionally and not because of mistake or accident. As used in this section, the term also includes the word "willfully" or "willful," which means that an act was committed voluntarily and purposely, with the specific intent to do something prohibited

by law, and that the act was committed with bad purpose, either to disobey or disregard the law.

(c) "Prescription drug" means any drug, including, but not limited to, finished dosage forms or active ingredients that are subject to, defined in, or described in s. 503(b) of the Federal Food, Drug, and Cosmetic Act or in s. 465.003(8), s. 499.003(17), s. 499.007(13), or s. 499.82(10).

(d) "Provider" means any person providing health care services or prescription drugs and supplies funded by the program.

(e) "Value" means the amount billed to the program for the property dispensed or the market value of a legend drug or goods or services at the time and place of the offense. If the market value cannot be determined, the term means the replacement cost of the legend drug or goods or services within a reasonable time after the offense.

(2)(a) A person may not:

1. Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to the department or its contracted vendors for payment.

2. Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the program.

3. Knowingly charge, solicit, accept, or receive anything of value, other than an authorized copayment from a health plan member, from any source in addition to the amount legally payable for an item or service provided to a health plan member under the program or knowingly fail to credit the department or

its contracted vendors for any payment received from a third-party source.

4. Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging of any item or service for which payment may be made, in whole or in part, under the program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service for which payment may be made, in whole or in part, under the program.

(b)1. A person who violates this subsection and receives or endeavors to receive anything of value of:

a. Ten thousand dollars or less commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. More than $10,000, but less than $50,000, commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

c. Fifty thousand dollars or more commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. The value of separate funds, goods, or services that a person received or attempted to receive pursuant to a scheme or course of conduct may be aggregated in determining the degree of the offense.

3. In addition to the sentence authorized by law, a person who is convicted of a violation of this subsection shall pay a

fine in an amount equal to five times the pecuniary gain unlawfully received or the loss incurred by the program or contracted vendor, whichever amount is greater.

(3) The repayment of any payments wrongfully obtained, or the offer or endeavor to repay funds wrongfully obtained, does not constitute a defense to or a ground for dismissal of criminal charges brought under this section.

(4) Property paid for by the program includes all property furnished or intended to be furnished to any health plan member of benefits under the program, regardless of whether reimbursement is ever actually made by the program.

(5) All records in the custody of the department or its contracted vendors which relate to provider fraud are business records within the meaning of s. 90.803(6).

(6) Proof that a claim was submitted to the department or its contracted vendors which contained a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to an inference that the person whose signature appears as the provider's authorizing signature on the claim form, or whose signature appears on an electronic claim submission agreement submitted for claims made to the contracted vendor by electronic means, had knowledge of the false statement or false representation. This subsection applies whether the signature appears on the claim form or the electronic claim submission agreement by means of handwriting, typewriting, facsimile signature stamp, computer impulse, initials, or otherwise.

(7) Any person who knowingly sells, who knowingly attempts or conspires to sell, or who knowingly causes any other person

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to sell or attempt or conspire to sell a legend drug that was paid for by the program commits a felony.

(a) If the value of the legend drug involved is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the legend drug involved is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the legend drug involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8) Any person who knowingly purchases, or who knowingly attempts or conspires to purchase, a legend drug that was paid for by the program and intended for use by another person commits a felony.

(a) If the value of the legend drug is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the legend drug is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the legend drug is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(9) Any person who knowingly makes or knowingly causes to be made, or who attempts or conspires to make, any false statement or representation to any person for the purpose of obtaining goods or services from the program commits a felony.

(a) If the value of the goods or services is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) If the value of the goods or services is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) If the value of the goods or services involved is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

The value of individual items of the legend drugs or goods or services involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated when determining the punishment for the offense.

(10) A person who provides the state, any state agency, or any political subdivision of the state or an agency thereof with information about fraud or suspected fraudulent acts by a provider is immune from civil liability for libel, slander, or any other relevant tort for providing such information unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information. Such immunity extends to reports of fraudulent acts or suspected fraudulent acts conveyed to or from the department in any manner, including any forum and with any audience as directed by the department, and includes all discussions subsequent to the report and subsequent inquiries from the department, unless the person acted with knowledge that the

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information was false or with reckless disregard for the truth or falsity of the information. As used in this subsection, the term "fraudulent acts" includes actual or suspected fraud and abuse, insurance fraud, or licensure fraud, including any fraud-related matters that a provider or health plan is required to report to the department or a law enforcement agency.

(11) The department must publicize to state employees and the public the ability of persons to bring a civil action under the provisions of the Florida False Claims Act and the potential for the persons bringing a civil action under the act to obtain a monetary award.

Section 3. Section 110.12306, Florida Statutes, is created to read:

110.12306 Anti-fraud investigative units.—

(1) As used in this section, the term "designated anti-fraud unit" means a distinct unit within the division which is made up of employees whose principal responsibilities are the investigation and disposition of claims and who are also assigned investigation of fraud.

(2) By December 31, 2020, the division:

(a)1. Shall establish and maintain a designated anti-fraud unit to investigate and report possible fraudulent insurance acts by insureds, persons making claims for services against the State Employees Health Insurance Trust Fund, or vendors under contract with the division.

2. May contract with others to investigate and report possible fraudulent insurance acts by insureds, persons making claims for services against the State Employees Health Insurance Trust Fund, or vendors under contract with the division.

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(b) Shall adopt an anti-fraud plan.

(c) Shall designate at least one employee with the primary responsibility of implementing the requirements of this section.

Section 4. Paragraph (a) of subsection (9) and subsection (10) of section 110.12315, Florida Statutes, are amended, and subsection (11) is added to that section, to read:

110.12315 Prescription drug program.—The state employees' prescription drug program is established. This program shall be administered by the Department of Management Services, according to the terms and conditions of the plan as established by the relevant provisions of the annual General Appropriations Act and implementing legislation, subject to the following conditions:

(9)(a)1. Beginning with the 2020 plan year, the department must implement formulary management for prescription drugs and supplies. Such management practices must require prescription drugs to be subject to formulary inclusion or exclusion but may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs and supplies. Drugs excluded from the formulary must be available for inclusion if a physician, an advanced practice registered nurse, or a physician assistant prescribing a pharmaceutical clearly states on the prescription, or otherwise in the manner specified in s. 465.025(2), that the excluded drug is medically necessary. The department or its pharmacy benefit manager may not substitute its judgment over the judgment of the prescriber of a prescription drug as to whether the drug is medically necessary.

2. The department or its pharmacy benefit manager must ensure that:

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a. The condition for which the patient is being treated is covered under the program;

b. The prescribed drug is approved by the Federal Drug Administration or supported in the compendia of current literature for the treatment of the patient's condition; and

c. The prescribed dosage falls within the Federal Drug Administration approved labeling or within dosing guidelines found in the compendia of current literature as treatment for the patient's condition.

3. If the prescription drug or supply is not included on the formulary but is prescribed as medically necessary for the treatment of the patient, the department or its pharmacy benefit manager must inquire of the prescribing authority as to whether:

a. The prescribing authority has considered alternative prescription drugs and supplies that are included on the formulary;

b. The patient has tried and had inadequate treatment response or intolerance to alternative prescription drugs that are included on the formulary; and

c. The patient has a contraindication to the alternative prescription drugs that are included on the formulary.

Such inquiries must be made as soon as practicable but no later than the next business day after the pharmacist received the prescription.

4. Prescription drugs and supplies first made available in the marketplace after January 1, 2020, may not be covered by the prescription drug program until specifically included in the list of covered prescription drugs and supplies.

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

(11) The department must ensure that the prescription drug program receives the benefits of all discounts, rebates, and other fees associated with the prescription drugs and supplies provided through the program. The department shall annually audit the amounts of discounts, rebates, and other fees received by the department or its pharmacy benefit manager for the prescription drugs and supplies provided through the program.

Section 5. Subsection (5) of section 110.131, Florida Statutes, is amended to read:

110.131 Other-personal-services employment.—

(5) Beginning January 1, 2014, an other-personal-services (OPS) employee who has worked an average of at least 30 or more hours per week during the measurement period described in s. 110.123(13)(c) ~~s. 110.123(13)(c) or (d)~~, or who is reasonably expected to work an average of at least 30 or more hours per week following his or her employment, is eligible to participate in the state group insurance program as provided under s. 110.123.

639 Section 6. This act shall take effect July 1, 2020.

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