FOR CONSIDERATION By the Committee on Governmental Oversight and Accountability

585-02369A-20 20207046pb

1 A bill to be entitled
2 An act relating to the state group insurance program;
3 amending s. 110.123, F.S.; revising the definition of
4 “full-time state employees” to conform to changes made
5 by the act; authorizing persons eligible to
6 participate in the program to elect membership with
7 certain health maintenance organization plans;
8 requiring at least one health maintenance organization
9 plan be made available to each enrollee residing in
10 the state; deleting provisions providing for the
11 establishment of health maintenance organization plan
12 regions by Department of Management Services rule;
13 deleting the requirement that health plans be offered
14 in specified benefit levels; deleting obsolete
15 language regarding eligibility for participation in
16 the program for other-personal-services employees;
17 establishing regions for health maintenance
18 organizations for specified purposes; providing for
19 construction; creating s. 110.12305, F.S.; defining
20 terms; prohibiting specified fraudulent acts in
21 connection with the program, including the submission
22 of fraudulent insurance claims, making false
23 statements in claims, and the acceptance of certain
24 payments; providing criminal penalties; specifying
25 that the repayment, or attempted repayments, of any
26 unlawful payments does not constitute a defense or a
27 ground for dismissal for a violation of the act;
28 specifying which property is deemed to be paid for by
29 the program; specifying application of the business

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

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59 judgment over the judgment of a prescriber in
60 determining whether a drug excluded from the formulary
61 is medically necessary; requiring the department or
62 its pharmacy benefit manager to take specified action
63 regarding formulary management; removing a limitation
64 for the annual maximum amount for coverage for
65 medically necessary prescription and nonprescription
66 enteral formulas and amino-acid-based elemental
67 formulas for home use; requiring the department to
68 ensure that the prescription drug program receives
69 certain benefits, and to perform annual audits of such
70 benefits; amending s. 110.131, F.S.; conforming a
71 cross-reference; providing an effective date.
72
73 Be It Enacted by the Legislature of the State of Florida:
74
75 Section 1. Paragraph (c) of subsection (2), paragraphs (h),
76 (j), and (k) of subsection (3), and paragraphs (c) and (d) of
77 subsection (13) of section 110.123, Florida Statutes, are
78 amended, and subsection (14) is added to that section, to read:
79 110.123 State group insurance program.—
80 (2) DEFINITIONS.—As used in ss. 110.123-110.1239, the term:
81 (c) “Full-time state employees” means employees of all
82 branches or agencies of state government holding salaried
83 positions who are paid by state warrant or from agency funds and
84 who work or are expected to work an average of at least 30 or
85 more hours per week; employees paid from regular salary
86 appropriations for 8 months’ employment, including university
87 personnel on academic contracts; and employees paid from other-

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88 personal-services (OPS) funds who are reasonably expected to
89 work an average of at least 30 hours or more per week or have
90 worked an average of at least 30 hours or more per week during
91 the employee's measurement period ~~as described in subparagraphs~~
92 ~~1. and 2~~. The term includes all full-time employees of the state
93 universities. The term does not include seasonal workers who are
94 paid from OPS funds.
95 ~~1. For persons hired before April 1, 2013, the term~~
96 ~~includes any person paid from OPS funds who:~~
97 ~~a. Has worked an average of at least 30 hours or more per~~
98 ~~week during the initial measurement period from April 1, 2013,~~
99 ~~through September 30, 2013; or~~
100 ~~b. Has worked an average of at least 30 hours or more per~~
101 ~~week during a subsequent measurement period.~~
102 ~~2. For persons hired after April 1, 2013, the term includes~~
103 ~~any person paid from OPS funds who:~~
104 ~~a. Is reasonably expected to work an average of at least 30~~
105 ~~hours or more per week; or~~
106 ~~b. Has worked an average of at least 30 hours or more per~~
107 ~~week during the person's measurement period.~~
108 (3) STATE GROUP INSURANCE PROGRAM.—
109 (h)1. A person eligible to participate in the state group
110 insurance program ~~may be authorized by rules adopted by the~~
111 ~~department~~, in lieu of participating in the state group health
112 insurance plan, may ~~to~~ exercise an option to elect membership in
113 a health maintenance organization plan which is under contract
114 with the state in accordance with criteria established by this
115 section and by ~~said~~ rules adopted by the department. The offer
116 of optional membership in a health maintenance organization plan

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117 permitted by this paragraph may be limited or conditioned by
118 rule as may be necessary to meet the requirements of state and
119 federal laws.
120 2. The department shall contract with health maintenance
121 organizations seeking to participate in the state group
122 insurance program through a request for proposal or other
123 procurement process, as developed by the Department of
124 Management Services and determined to be appropriate.
125 a. The department shall establish a schedule of minimum
126 benefits for health maintenance organization coverage, and that
127 schedule shall include~~:~~ physician services; inpatient and
128 outpatient hospital services; emergency medical services,
129 including out-of-area emergency coverage; diagnostic laboratory
130 and diagnostic and therapeutic radiologic services; mental
131 health, alcohol, and chemical dependency treatment services
132 meeting the minimum requirements of state and federal law;
133 skilled nursing facilities and services; prescription drugs;
134 age-based and gender-based wellness benefits; and other benefits
135 as may be required by the department. Additional services may be
136 provided subject to the contract between the department and the
137 HMO. As used in this paragraph, the term “age-based and gender-
138 based wellness benefits” includes aerobic exercise, education in
139 alcohol and substance abuse prevention, blood cholesterol
140 screening, health risk appraisals, blood pressure screening and
141 education, nutrition education, program planning, safety belt
142 education, smoking cessation, stress management, weight
143 management, and women’s health education.
144 b. The department may establish uniform deductibles,
145 copayments, coverage tiers, or coinsurance schedules for all

146 participating HMO plans.
147 c. The department may require detailed information from
148 each health maintenance organization participating in the
149 procurement process, including information pertaining to
150 organizational status, experience in providing prepaid health
151 benefits, accessibility of services, financial stability of the
152 plan, quality of management services, accreditation status,
153 quality of medical services, network access and adequacy,
154 performance measurement, ability to meet the department's
155 reporting requirements, and the actuarial basis of the proposed
156 rates and other data determined by the director to be necessary
157 for the evaluation and selection of health maintenance
158 organization plans and negotiation of appropriate rates for
159 these plans. Upon receipt of proposals by health maintenance
160 organization plans and the evaluation of those proposals, the
161 department may enter into negotiations with all of the plans or
162 a subset of the plans, as the department determines appropriate.
163 The department may negotiate regional or statewide contracts
164 with health maintenance organization plans. Such plans must be
165 cost-effective and must offer high value to enrollees.
166 d. The department may limit the number of HMOs that it
167 contracts with in each region based on the nature of the bids
168 the department receives, the number of state employees in the
169 region, or any unique characteristics of the region. <u>At least</u>
170 <u>one HMO plan must be available to each enrollee residing in the</u>
171 <u>state</u> ~~The department shall establish the regions throughout the~~
172 ~~state by rule~~. ~~The department must submit the rule to the~~
173 ~~President of the Senate and the Speaker of the House of~~
174 ~~Representatives for ratification no later than 30 days before~~

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175 ~~the 2020 Regular Session of the Legislature. The rule may not~~
176 ~~take effect until it is ratified by the Legislature.~~
177 e. All persons participating in the state group insurance
178 program may be required to contribute towards a total state
179 group health premium that may vary depending upon the plan,
180 coverage level, and coverage tier selected by the enrollee and
181 the level of state contribution authorized by the Legislature.
182 3. The department is authorized to negotiate and to
183 contract with specialty psychiatric hospitals for mental health
184 benefits, on a regional basis, for alcohol, drug abuse, and
185 mental and nervous disorders. The department may establish,
186 subject to the approval of the Legislature pursuant to
187 subsection (5), any such regional plan upon completion of an
188 actuarial study to determine any impact on plan benefits and
189 premiums.
190 4. In addition to contracting pursuant to subparagraph 2.,
191 the department may enter into contract with any HMO to
192 participate in the state group insurance program which:
193 a. Serves greater than 5,000 recipients on a prepaid basis
194 under the Medicaid program;
195 b. Does not currently meet the 25-percent non-Medicare/non-
196 Medicaid enrollment composition requirement established by the
197 Department of Health excluding participants enrolled in the
198 state group insurance program;
199 c. Meets the minimum benefit package and copayments and
200 deductibles contained in sub-subparagraphs 2.a. and b.;
201 d. Is willing to participate in the state group insurance
202 program at a cost of premiums that is not greater than 95
203 percent of the cost of HMO premiums accepted by the department

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204 in each service area; and
205 e. Meets the minimum surplus requirements of s. 641.225.
206
207 The department is authorized to contract with HMOs that meet the
208 requirements of sub-subparagraphs a.-d. prior to the open
209 enrollment period for state employees. The department is not
210 required to renew the contract with the HMOs as set forth in
211 this paragraph more than twice. Thereafter, the HMOs shall be
212 eligible to participate in the state group insurance program
213 only through the request for proposal or invitation to negotiate
214 process described in subparagraph 2.
215 5. All enrollees in a state group health insurance plan, a
216 TRICARE supplemental insurance plan, or any health maintenance
217 organization plan have the option of changing to any other
218 health plan that is offered by the state within any open
219 enrollment period designated by the department. Open enrollment
220 shall be held at least once each calendar year.
221 6. When a contract between a treating provider and the
222 state-contracted health maintenance organization is terminated
223 for any reason other than for cause, each party shall allow any
224 enrollee for whom treatment was active to continue coverage and
225 care when medically necessary, through completion of treatment
226 of a condition for which the enrollee was receiving care at the
227 time of the termination, until the enrollee selects another
228 treating provider, or until the next open enrollment period
229 offered, whichever is longer, but no longer than 6 months after
230 termination of the contract. Each party to the terminated
231 contract shall allow an enrollee who has initiated a course of
232 prenatal care, regardless of the trimester in which care was

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233 initiated, to continue care and coverage until completion of
234 postpartum care. This does not prevent a provider from refusing
235 to continue to provide care to an enrollee who is abusive,
236 noncompliant, or in arrears in payments for services provided.
237 For care continued under this subparagraph, the program and the
238 provider shall continue to be bound by the terms of the
239 terminated contract. Changes made within 30 days before
240 termination of a contract are effective only if agreed to by
241 both parties.
242 7. Any HMO participating in the state group insurance
243 program shall submit health care utilization and cost data to
244 the department, in such form and in such manner as the
245 department shall require, as a condition of participating in the
246 program. The department shall enter into negotiations with its
247 contracting HMOs to determine the nature and scope of the data
248 submission and the final requirements, format, penalties
249 associated with noncompliance, and timetables for submission.
250 These determinations shall be adopted by rule.
251 8. The department may establish and direct, with respect to
252 collective bargaining issues, a comprehensive package of
253 insurance benefits that may include supplemental health and life
254 coverage, dental care, long-term care, vision care, and other
255 benefits it determines necessary to enable state employees to
256 select from among benefit options that best suit their
257 individual and family needs. Beginning with the 2018 plan year,
258 the package of benefits may also include products and services
259 described in s. 110.12303.
260 a. Based upon a desired benefit package, the department
261 shall issue a request for proposal or invitation to negotiate

262 for providers interested in participating in the state group
263 insurance program, and the department shall issue a request for
264 proposal or invitation to negotiate for providers interested in
265 participating in the non-health-related components of the state
266 group insurance program. Upon receipt of all proposals, the
267 department may enter into contract negotiations with providers
268 submitting bids or negotiate a specially designed benefit
269 package. Providers offering or providing supplemental coverage
270 as of May 30, 1991, which qualify for pretax benefit treatment
271 pursuant to s. 125 of the Internal Revenue Code of 1986, with
272 5,500 or more state employees currently enrolled may be included
273 by the department in the supplemental insurance benefit plan
274 established by the department without participating in a request
275 for proposal, submitting bids, negotiating contracts, or
276 negotiating a specially designed benefit package. These
277 contracts shall provide state employees with the most cost-
278 effective and comprehensive coverage available; however, except
279 as provided in subparagraph (f)3., no state or agency funds
280 shall be contributed toward the cost of any part of the premium
281 of such supplemental benefit plans. With respect to dental
282 coverage, the division shall include in any solicitation or
283 contract for any state group dental program made after July 1,
284 2001, a comprehensive indemnity dental plan option which offers
285 enrollees a completely unrestricted choice of dentists. If a
286 dental plan is endorsed, or in some manner recognized as the
287 preferred product, such plan shall include a comprehensive
288 indemnity dental plan option which provides enrollees with a
289 completely unrestricted choice of dentists.
290 b. Pursuant to the applicable provisions of s. 110.161, and

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291 s. 125 of the Internal Revenue Code of 1986, the department
292 shall enroll in the pretax benefit program those state employees
293 who voluntarily elect coverage in any of the supplemental
294 insurance benefit plans as provided by sub-subparagraph a.
295 c. Nothing herein contained shall be construed to prohibit
296 insurance providers from continuing to provide or offer
297 supplemental benefit coverage to state employees as provided
298 under existing agency plans.
299 ~~(j) For the 2020 plan year and each plan year thereafter,~~
300 ~~health plans shall be offered in the following benefit levels:~~
301 ~~1. Platinum level, which shall have an actuarial value of~~
302 ~~at least 90 percent.~~
303 ~~2. Gold level, which shall have an actuarial value of at~~
304 ~~least 80 percent.~~
305 ~~3. Silver level, which shall have an actuarial value of at~~
306 ~~least 70 percent.~~
307 ~~4. Bronze level, which shall have an actuarial value of at~~
308 ~~least 60 percent.~~
309 ~~(k) In consultation with the independent benefits~~
310 ~~consultant described in s. 110.12304, the department shall~~
311 ~~develop a plan for implementation of the benefit levels~~
312 ~~described in paragraph (j). The plan shall be submitted to the~~
313 ~~Governor, the President of the Senate, and the Speaker of the~~
314 ~~House of Representatives by January 1, 2019, and include~~
315 ~~recommendations for:~~
316 ~~1. Employer and employee contribution policies.~~
317 ~~2. Steps necessary for maintaining or improving total~~
318 ~~employee compensation levels when the transition is initiated.~~
319 ~~3. An education strategy to inform employees of the~~

320 ~~additional choices available in the state group insurance~~
321 ~~program.~~
322
323 ~~This paragraph expires July 1, 2019.~~
324 (13) OTHER-PERSONAL-SERVICES EMPLOYEES (OPS).—
325 (c) The ~~initial~~ measurement period used to determine
326 whether an employee ~~hired before April 1, 2013, and~~ paid from
327 OPS funds is a full-time employee described in ~~subparagraph~~
328 ~~(2)(c)1. is the 6-month period from April 1, 2013, through~~
329 ~~September 30, 2013.~~
330 ~~(d) All other measurement periods used to determine whether~~
331 ~~an employee paid from OPS funds is a full-time employee~~
332 ~~described in~~ paragraph (2)(c) must be for 12 consecutive months.
333 (14) REGIONS FOR HEALTH MAINTENANCE ORGANIZATIONS.—
334 (a) The following regions are established for purposes of
335 the department entering into contracts with HMOs to provide
336 services on a regional basis on or after January 1, 2023,
337 pursuant to paragraph (3)(h):
338 1. Region 1 consists of Bay, Calhoun, Escambia, Gulf,
339 Holmes, Jackson, Okaloosa, Santa Rosa, Walton, and Washington
340 Counties.
341 2. Region 2 consists of Franklin, Gadsden, Jefferson, Leon,
342 Liberty, Madison, Taylor, and Wakulla Counties.
343 3. Region 3 consists of Alachua, Bradford, Columbia, Dixie,
344 Gilchrist, Hamilton, Lafayette, Levy, Marion, Suwannee, and
345 Union Counties.
346 4. Region 4 consists of Baker, Clay, Duval, Flagler,
347 Nassau, Putnam, St. Johns, and Volusia Counties.
348 5. Region 5 consists of Brevard, Indian River, Lake,

349 Orange, Osceola, and Seminole Counties.
350 6. Region 6 consists of Citrus, DeSoto, Hardee, Hernando,
351 Highlands, Hillsborough, Manatee, Pasco, Pinellas, Polk,
352 Sarasota, and Sumter Counties.
353 7. Region 7 consists of Martin, Okeechobee, Palm Beach, and
354 St. Lucie Counties.
355 8. Region 8 consists of Charlotte, Collier, Glades, Hendry,
356 and Lee Counties.
357 9. Region 9 consists of Broward, Miami-Dade, and Monroe
358 Counties.
359 (b) The establishment of these regions does not limit the
360 department's authority to contract for HMO services on a
361 statewide basis.
362 Section 2. Section 110.12305, Florida Statutes, is created
363 to read:
364 110.12305 Provider fraud.—
365 (1) As used in this section, the term:
366 (a) "Item or service" includes:
367 1. Any particular item, device, medical supply, or service
368 claimed to have been provided to a health plan member and listed
369 in an itemized claim for payment; or
370 2. In the case of a claim based on costs, any entry in the
371 cost report, books of account, or other documents supporting
372 such claim.
373 (b) "Knowingly" means that the act was done voluntarily and
374 intentionally and not because of mistake or accident. As used in
375 this section, the term also includes the word "willfully" or
376 "willful," which means that an act was committed voluntarily and
377 purposely, with the specific intent to do something prohibited

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378 by law, and that the act was committed with bad purpose, either
379 to disobey or disregard the law.
380 (c) "Prescription drug" means any drug, including, but not
381 limited to, finished dosage forms or active ingredients that are
382 subject to, defined in, or described in s. 503(b) of the Federal
383 Food, Drug, and Cosmetic Act or in s. 465.003(8), s.
384 499.003(17), s. 499.007(13), or s. 499.82(10).
385 (d) "Provider" means any person providing health care
386 services or prescription drugs and supplies funded by the
387 program.
388 (e) "Value" means the amount billed to the program for the
389 property dispensed or the market value of a legend drug or goods
390 or services at the time and place of the offense. If the market
391 value cannot be determined, the term means the replacement cost
392 of the legend drug or goods or services within a reasonable time
393 after the offense.
394 (2)(a) A person may not:
395 1. Knowingly make, cause to be made, or aid and abet in the
396 making of any false statement or false representation of a
397 material fact, by commission or omission, in any claim submitted
398 to the department or its contracted vendors for payment.
399 2. Knowingly make, cause to be made, or aid and abet in the
400 making of a claim for items or services that are not authorized
401 to be reimbursed by the program.
402 3. Knowingly charge, solicit, accept, or receive anything
403 of value, other than an authorized copayment from a health plan
404 member, from any source in addition to the amount legally
405 payable for an item or service provided to a health plan member
406 under the program or knowingly fail to credit the department or

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407 its contracted vendors for any payment received from a third-
408 party source.
409 4. Knowingly solicit, offer, pay, or receive any
410 remuneration, including any kickback, bribe, or rebate, directly
411 or indirectly, overtly or covertly, in cash or in kind, in
412 return for referring an individual to a person for the
413 furnishing or arranging of any item or service for which payment
414 may be made, in whole or in part, under the program, or in
415 return for obtaining, purchasing, leasing, ordering, or
416 arranging for or recommending, obtaining, purchasing, leasing,
417 or ordering any goods, facility, item, or service for which
418 payment may be made, in whole or in part, under the program.
419 (b)1. A person who violates this subsection and receives or
420 endeavors to receive anything of value of:
421 a. Ten thousand dollars or less commits a felony of the
422 third degree, punishable as provided in s. 775.082, s. 775.083,
423 or s. 775.084.
424 b. More than $10,000, but less than $50,000, commits a
425 felony of the second degree, punishable as provided in s.
426 775.082, s. 775.083, or s. 775.084.
427 c. Fifty thousand dollars or more commits a felony of the
428 first degree, punishable as provided in s. 775.082, s. 775.083,
429 or s. 775.084.
430 2. The value of separate funds, goods, or services that a
431 person received or attempted to receive pursuant to a scheme or
432 course of conduct may be aggregated in determining the degree of
433 the offense.
434 3. In addition to the sentence authorized by law, a person
435 who is convicted of a violation of this subsection shall pay a

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436 fine in an amount equal to five times the pecuniary gain
437 unlawfully received or the loss incurred by the program or
438 contracted vendor, whichever amount is greater.
439 (3) The repayment of any payments wrongfully obtained, or
440 the offer or endeavor to repay funds wrongfully obtained, does
441 not constitute a defense to or a ground for dismissal of
442 criminal charges brought under this section.
443 (4) Property paid for by the program includes all property
444 furnished or intended to be furnished to any health plan member
445 of benefits under the program, regardless of whether
446 reimbursement is ever actually made by the program.
447 (5) All records in the custody of the department or its
448 contracted vendors which relate to provider fraud are business
449 records within the meaning of s. 90.803(6).
450 (6) Proof that a claim was submitted to the department or
451 its contracted vendors which contained a false statement or a
452 false representation of a material fact, by commission or
453 omission, unless satisfactorily explained, gives rise to an
454 inference that the person whose signature appears as the
455 provider's authorizing signature on the claim form, or whose
456 signature appears on an electronic claim submission agreement
457 submitted for claims made to the contracted vendor by electronic
458 means, had knowledge of the false statement or false
459 representation. This subsection applies whether the signature
460 appears on the claim form or the electronic claim submission
461 agreement by means of handwriting, typewriting, facsimile
462 signature stamp, computer impulse, initials, or otherwise.
463 (7) Any person who knowingly sells, who knowingly attempts
464 or conspires to sell, or who knowingly causes any other person

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465 to sell or attempt or conspire to sell a legend drug that was
466 paid for by the program commits a felony.
467 (a) If the value of the legend drug involved is less than
468 $20,000, the crime is a felony of the third degree, punishable
469 as provided in s. 775.082, s. 775.083, or s. 775.084.
470 (b) If the value of the legend drug involved is $20,000 or
471 more but less than $100,000, the crime is a felony of the second
472 degree, punishable as provided in s. 775.082, s. 775.083, or s.
473 775.084.
474 (c) If the value of the legend drug involved is $100,000 or
475 more, the crime is a felony of the first degree, punishable as
476 provided in s. 775.082, s. 775.083, or s. 775.084.
477 (8) Any person who knowingly purchases, or who knowingly
478 attempts or conspires to purchase, a legend drug that was paid
479 for by the program and intended for use by another person
480 commits a felony.
481 (a) If the value of the legend drug is less than $20,000,
482 the crime is a felony of the third degree, punishable as
483 provided in s. 775.082, s. 775.083, or s. 775.084.
484 (b) If the value of the legend drug is $20,000 or more but
485 less than $100,000, the crime is a felony of the second degree,
486 punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
487 (c) If the value of the legend drug is $100,000 or more,
488 the crime is a felony of the first degree, punishable as
489 provided in s. 775.082, s. 775.083, or s. 775.084.
490 (9) Any person who knowingly makes or knowingly causes to
491 be made, or who attempts or conspires to make, any false
492 statement or representation to any person for the purpose of
493 obtaining goods or services from the program commits a felony.

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494 (a) If the value of the goods or services is less than
495 $20,000, the crime is a felony of the third degree, punishable
496 as provided in s. 775.082, s. 775.083, or s. 775.084.
497 (b) If the value of the goods or services is $20,000 or
498 more but less than $100,000, the crime is a felony of the second
499 degree, punishable as provided in s. 775.082, s. 775.083, or s.
500 775.084.
501 (c) If the value of the goods or services involved is
502 $100,000 or more, the crime is a felony of the first degree,
503 punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
504
505 The value of individual items of the legend drugs or goods or
506 services involved in distinct transactions committed during a
507 single scheme or course of conduct, whether involving a single
508 person or several persons, may be aggregated when determining
509 the punishment for the offense.
510 (10) A person who provides the state, any state agency, or
511 any political subdivision of the state or an agency thereof with
512 information about fraud or suspected fraudulent acts by a
513 provider is immune from civil liability for libel, slander, or
514 any other relevant tort for providing such information unless
515 the person acted with knowledge that the information was false
516 or with reckless disregard for the truth or falsity of the
517 information. Such immunity extends to reports of fraudulent acts
518 or suspected fraudulent acts conveyed to or from the department
519 in any manner, including any forum and with any audience as
520 directed by the department, and includes all discussions
521 subsequent to the report and subsequent inquiries from the
522 department, unless the person acted with knowledge that the

523 information was false or with reckless disregard for the truth
524 or falsity of the information. As used in this subsection, the
525 term “fraudulent acts” includes actual or suspected fraud and
526 abuse, insurance fraud, or licensure fraud, including any fraud-
527 related matters that a provider or health plan is required to
528 report to the department or a law enforcement agency.
529 (11) The department must publicize to state employees and
530 the public the ability of persons to bring a civil action under
531 the provisions of the Florida False Claims Act and the potential
532 for the persons bringing a civil action under the act to obtain
533 a monetary award.
534 Section 3. Section 110.12306, Florida Statutes, is created
535 to read:
536 110.12306 Anti-fraud investigative units.—
537 (1) As used in this section, the term “designated anti-
538 fraud unit” means a distinct unit within the division which is
539 made up of employees whose principal responsibilities are the
540 investigation and disposition of claims and who are also
541 assigned investigation of fraud.
542 (2) By December 31, 2020, the division:
543 (a)1. Shall establish and maintain a designated anti-fraud
544 unit to investigate and report possible fraudulent insurance
545 acts by insureds, persons making claims for services against the
546 State Employees Health Insurance Trust Fund, or vendors under
547 contract with the division.
548 2. May contract with others to investigate and report
549 possible fraudulent insurance acts by insureds, persons making
550 claims for services against the State Employees Health Insurance
551 Trust Fund, or vendors under contract with the division.

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552 (b) Shall adopt an anti-fraud plan.
553 (c) Shall designate at least one employee with the primary
554 responsibility of implementing the requirements of this section.
555 Section 4. Paragraph (a) of subsection (9) and subsection
556 (10) of section 110.12315, Florida Statutes, are amended, and
557 subsection (11) is added to that section, to read:
558 110.12315 Prescription drug program.—The state employees'
559 prescription drug program is established. This program shall be
560 administered by the Department of Management Services, according
561 to the terms and conditions of the plan as established by the
562 relevant provisions of the annual General Appropriations Act and
563 implementing legislation, subject to the following conditions:
564 (9)(a)1. Beginning with the 2020 plan year, the department
565 must implement formulary management for prescription drugs and
566 supplies. Such management practices must require prescription
567 drugs to be subject to formulary inclusion or exclusion but may
568 not restrict access to the most clinically appropriate,
569 clinically effective, and lowest net-cost prescription drugs and
570 supplies. Drugs excluded from the formulary must be available
571 for inclusion if a physician, an advanced practice registered
572 nurse, or a physician assistant prescribing a pharmaceutical
573 clearly states on the prescription, or otherwise in the manner
574 specified in s. 465.025(2), that the excluded drug is medically
575 necessary. The department or its pharmacy benefit manager may
576 not substitute its judgment over the judgment of the prescriber
577 of a prescription drug as to whether the drug is medically
578 necessary.
579 2. The department or its pharmacy benefit manager must
580 ensure that:

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581 a. The condition for which the patient is being treated is
582 covered under the program;
583 b. The prescribed drug is approved by the Federal Drug
584 Administration or supported in the compendia of current
585 literature for the treatment of the patient's condition; and
586 c. The prescribed dosage falls within the Federal Drug
587 Administration approved labeling or within dosing guidelines
588 found in the compendia of current literature as treatment for
589 the patient's condition.
590 3. If the prescription drug or supply is not included on
591 the formulary but is prescribed as medically necessary for the
592 treatment of the patient, the department or its pharmacy benefit
593 manager must inquire of the prescribing authority as to whether:
594 a. The prescribing authority has considered alternative
595 prescription drugs and supplies that are included on the
596 formulary;
597 b. The patient has tried and had inadequate treatment
598 response or intolerance to alternative prescription drugs that
599 are included on the formulary; and
600 c. The patient has a contraindication to the alternative
601 prescription drugs that are included on the formulary.
602
603 Such inquiries must be made as soon as practicable but no later
604 than the next business day after the pharmacist received the
605 prescription.
606 4. Prescription drugs and supplies first made available in
607 the marketplace after January 1, 2020, may not be covered by the
608 prescription drug program until specifically included in the
609 list of covered prescription drugs and supplies.

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610 (10) In addition to the comprehensive package of health
611 insurance and other benefits required or authorized to be
612 included in the state group insurance program, the program must
613 provide coverage for medically necessary prescription and
614 nonprescription enteral formulas and amino-acid-based elemental
615 formulas for home use, regardless of the method of delivery or
616 intake, which are ordered or prescribed by a physician. As used
617 in this subsection, the term "medically necessary" means the
618 formula to be covered represents the only medically appropriate
619 source of nutrition for a patient. ~~Such coverage may not exceed~~
620 ~~an amount of $20,000 annually for any insured individual.~~
621 (11) The department must ensure that the prescription drug
622 program receives the benefits of all discounts, rebates, and
623 other fees associated with the prescription drugs and supplies
624 provided through the program. The department shall annually
625 audit the amounts of discounts, rebates, and other fees received
626 by the department or its pharmacy benefit manager for the
627 prescription drugs and supplies provided through the program.
628 Section 5. Subsection (5) of section 110.131, Florida
629 Statutes, is amended to read:
630 110.131 Other-personal-services employment.—
631 (5) Beginning January 1, 2014, an other-personal-services
632 (OPS) employee who has worked an average of at least 30 or more
633 hours per week during the measurement period described in s.
634 110.123(13)(c) ~~s. 110.123(13)(c) or (d)~~, or who is reasonably
635 expected to work an average of at least 30 or more hours per
636 week following his or her employment, is eligible to participate
637 in the state group insurance program as provided under s.
638 110.123.

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

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