FLORIDA HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: HB 5015 PCB BUC 25-08	**COMPANION BILL:** None
TITLE: State Group Insurance	**LINKED BILLS:** None
SPONSOR(S): Lopez, V.	**RELATED BILLS:** None

FINAL HOUSE FLOOR ACTION: 98 **Y's** 5 **N's** **GOVERNOR'S ACTION:** Pending

SUMMARY

Effect of the Bill:

The bill conforms law to the General Appropriations Act (GAA) for Fiscal Year 2025-2026. The bill requires the Department of Management Services (DMS) to submit recommendations on the implementation of formulary management for prescription drugs and supplies for the 2026 plan year to the Legislative Budget Commission (LBC) and the Governor. The LBC may consider these recommendations in total or in part; however, beginning in the 2026 plan year, DMS is required to only implement recommendations for formulary management of prescription drugs and supplies that have been approved by the LBC.

The bill provides a contingent repeal of the formulary recommendation requirements and the exception to the formulary exclusion in current law that allows for coverage of an excluded drug under certain circumstances. Specifically, effective January 1, 2026, these provisions will be repealed if the LBC approves at least one of the DMS formulary recommendations related to excluded prescription drugs and supplies.

The bill requires DMS by September 1, 2025, and annually thereafter, to submit a list of the prescription drugs and supplies that will be excluded from coverage from the next plan year to the Governor, President of the Senate and Speaker of the House. The bill requires LBC approval in order for DMS to implement this list.

Fiscal or Economic Impact:

The bill will provide significant savings to the State Group Insurance Program if formulary management for prescription drugs is approved by the LBC. See Fiscal Economic Impact.

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ANALYSIS

EFFECT OF THE BILL:

The bill requires Department of Management Services (DMS) to submit recommendations on the implementation of **formulary** management for prescription drugs and supplies in the **state employee prescription drug program** (Prescription Drug Plan) as a cost-saving measure. The recommendations will apply to the 2026 plan year which begins January 1, 2026. DMS must submit the recommendations to the Legislative Budget Commission[1] (LBC) and the Governor by September 1, 2025. The recommendations must, at a minimum, include:

- Lists of excluded prescription drugs and supplies for a recommended formulary, with a comparison to the formulary in effect during the 2025 plan year;
- Lists of included prescription drugs and supplies for a recommended formulary, with a comparison to the formulary in effect during the 2025 plan year;
- Prior authorization of specified prescription drugs and supplies; and
- Step therapy[2] of specified prescription drugs and supplies (Section 1).

[1] Pursuant to s. 19, Art. III of the State Constitution and s. 11.90, F.S., the LBC is authorized to develop the long-range financial outlook for the state and perform any other duties prescribed by the Legislature.

[2] Step therapy and prior authorization are enforcement mechanisms for an insurer's preferred drug list or formulary. They ensure that actual transaction volumes and manufacturer rebate levels align with the actuarial assumptions that generated the price of the insurance coverage, while accommodating clinically justified exceptions. Step therapy policies require an insured to try one drug first to treat his or her medical condition before they will cover another drug for that condition. In the prior

The bill expressly states that the recommended formulary is not subject to the exception to the formulary exclusion in current law which allows for coverage of an excluded drug if a prescribing practitioner writes clearly on the prescription that the excluded drug is medically necessary.[3] (Section 1).

The bill requires DMS to submit relevant information identifying the prescription drugs and supplies affected, the number of plan members and prescriptions affected for each identified drug or supply, and the cost savings expected for each recommended component. The LBC may consider these recommendations in total or in part; however, beginning in the 2026 plan year, DMS is required to only implement recommendations for formulary management of prescription drugs and supplies that have been approved by the LBC.

The bill provides a contingent repeal of the above formulary recommendation requirements and the exception to the formulary exclusion in current law that allows for coverage of an excluded drug if a prescribing practitioner writes clearly on the prescription that the excluded drug is medically necessary. Specifically, effective January 1, 2026, these provisions will be repealed if the LBC approves at least one of the DMS formulary recommendation related to excluded prescription drugs and supplies . (Section 2). The bill requires the LBC to notify the Division of Law Revision upon the LBC's approval of one or more of the DMS formulary implementation recommendations. (Section 3).

The bill also requires DMS, by September 1, 2025, and annually thereafter, to submit to the Governor, President of the Senate and Speaker of the House, a list of the prescription drugs and supplies that will be excluded from coverage from the next plan year and, for informational purposes only, the list of prescription drugs and supplies that are recommended to be subject to a higher copayment for the next plan year. The bill requires LBC approval in order for DMS to implement this list.

The bill prohibits prescription drugs and supplies first made available in the marketplace after January 1, 2026, from being covered by the Prescription Drug Program until specifically included in the list of covered prescription drugs and supplies.

Subject to the Governor's veto powers, the bill will be effective July 1, 2025, except where otherwise provided as contingent.

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The March 5, 2025, Revenue Estimating Conference estimated a deficit in the State Employees' Group Health Self-Insurance Trust Fund (Trust Fund) of $237.2 million for Fiscal Year 2025-26. For Fiscal Year 2026-27, the deficit is estimated at $803.8 million, and for Fiscal Year 2027-28, the estimate is a deficit of $1.1 billion.

The bill requires DMS to implement formulary management for prescription drugs which will provide savings to the State Group Insurance Program (SGI Program). A cost containment analysis study provided to DMS in 2023, estimated that a formulary may save an estimated $126 million per year.[4] Savings related to the formulary management required in the bill will depend on how such measures are implemented by DMS.

authorization process, a prescriber must obtain approval from an insurer before a patient may receive specified prescription drugs under the plan.

[3] *Id.*

[4] Cost Containment Analysis Study, State of Florida Department of Management Services, Division of State Group Insurance, January 9, 2023. On file with the State Administration Budget Subcommittee.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

The State Group Insurance Program

The State Group Insurance Program (SGI Program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS). The SGI Program is an optional benefit for most state employees employed by executive branch agencies, state universities, the Florida College System, the court system, and the Legislature and includes health, life, dental, vision, disability, and other supplemental insurance benefits. The SGI Program typically makes benefits changes on a plan year basis, January 1 through December 31.

For plan year 2025, SGI Program enrollment is estimated at 196,217 members.[5] In Fiscal Year 2024-25, the cost of the SGI program was $3.9 billion.[6] The Revenue Estimating Conference forecasts the SGI Program to cost $4.5 billion in Fiscal Year 2025-26.[7]

Eligible Employees

The SGI Program is open to the following individuals:

- All state officers;
- All state employees paid from "salaries and benefits" appropriation categories, regardless of the number of hours worked;
- Retired state officers and state employees;
- Surviving spouses of deceased state officers and state employees;
- Certain terminated state officers and state employees; and
- Certain state employees paid from Other Personal Services (OPS) appropriation categories.

For OPS employees hired after April 1, 2013, to be eligible to participate in the health insurance program, the employee must[8]:

- Be reasonably expected to work an average of at least 30 hours per week; and
- Have worked an average of at least 30 hours per week during the employee's measurement period (which is 12 consecutive months[9] of employment).

Employees enrolled in the SGI Program who separate from covered-employment are no longer covered by the benefits of the SGI Program. An exception would be continuation of SGI Program benefits under the federal COBRA (Consolidated Omnibus Reconciliation Act) law, which generally allows individuals who separate from employment to extend health care coverage for up to 18 months. Under COBRA, former employees must pay the full cost of insurance premiums, plus an administrative fee of 2 percent.

State Employee Prescription Drug Program

As part of the SGI program, DMS is required to maintain the State Employees' Prescription Drug Program (Prescription Drug Plan).[10] DMS contracts with Optum RX, a pharmacy benefits manager (PBM), to administer the Prescription Drug Plan.[11]

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[5] Florida Office of Economic and Demographic Research, https://edr.state.fl.us/content/conferences/healthinsurance/HealthInsuranceOutlook.pdf, at p.4 (last visited Mar. 25, 2025).
[6] *Id. at p. 5*
[7] *Id.*
[8] S. 110.123(2)(c)2., F.S.
[9] S. 110.123(13)(d), F.S.

The Prescription Drug Plan has three cost sharing categories for members: generic drugs, preferred brand name drugs - which are those brand name drugs on the preferred drug list[12], and non-preferred brand name drugs - which are those brand name drugs not on the preferred drug list. Contractually, the PBM updates the preferred drug list quarterly as brand name drugs enter the market and as the PBM negotiates pricing, including rebates with manufacturers.

Generic drugs are the least expensive and have the lowest member cost share, preferred brand name drugs have the middle cost share, and non-preferred brand name drugs are the most expensive and have the highest member cost share. As a general practice, prescriptions written for a brand name drug, preferred or non-preferred, will be substituted with a generic drug when available. If the prescribing health care provider states clearly on the prescription that the brand name drug is medically necessary over the generic equivalent, the member will pay only the brand name preferred or non- preferred cost share. If the member requests the brand name drug over the generic equivalent, without the provider's medically necessary request, then the member will pay the brand name preferred or non- preferred cost share, plus the difference between the actual cost of the generic drug and the brand name drug.

Prescription Drug Formulary

A formulary is a list of prescription drugs covered by a health plan's pharmacy benefit design. It dictates which drugs a health plan predetermines will be covered, and at what level, for reimbursement under the terms of its pharmacy benefit plan. Formularies distinguish between preferred or discouraged prescription drugs by dividing products into different tiers, designating different levels of patient out of pocket costs. A formulary may cover both generic and brand name prescription drugs. Formulary selection involves an assessment of both the clinical and financial elements of a prescription medication.[10] Formularies are utilized to implement cost-saving measures.

In 2019, the Legislature directed DMS to modify the State Group Insurance Program to use formulary management techniques to administer the Prescription Drug Plan beginning with the 2020 plan year.[11] Prescription drugs are to be subject to formulary inclusion or exclusion but may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescriptions drugs and supplies. Section 110.12315(9)(a), F.S., provides an exception to the formulary exclusion by authorizing excluded drugs to be made available for inclusion if a physician, advanced practice registered nurse, or physician assistant prescribing a pharmaceutical clearly states on the prescription that the excluded drug is medically necessary. This exception prevented the implementation of a traditional formulary, eliminating the potential for significant cost-savings to the program. To date, DMS has not implemented a formulary to manage the Prescription Drug Plan as required by law, because of the exception described above.

[10] *2025 Pharmacy Benefit Summary* available at https://dms-media.ccplatform.net/content/download/169648/file/Pharmacy%20Benefit%20Summary_V1.pdf and https://www.dms.myflorida.com/workforce_operations/state_group_insurance/mybenefits_faqs/frequently_asked_questions_prescription_drug_plan (last visited June 16, 2025).
[11] *January 2025 State of Florida Preferred Drug List* available at https://dms-media.ccplatform.net/content/download/162957/file/OptumRx_Jan_1_2025_StateofFlorida_PreferredDrugList.pdf (last visited June 16, 2024).