A bill to be entitled

An act relating to state employees' group insurance program; amending s. 110.123, F.S.; requiring the procurement of contracts for insurance plans, health maintenance organization plans, and pharmacy benefit plans to be conducted simultaneously beginning in a certain year; providing requirements for such contracts; requiring, rather than authorizing, health maintenance organization plans to be negotiated on a regional or statewide basis; removing obsolete language; amending s. 110.12303, F.S.; authorizing international prescription services to be included in the state group insurance program; requiring the department to offer international prescription services; amending s. 110.12315, F.S.; requiring the Department of Management Services to use varying plan and network designs in the state employees' prescription drug program; requiring the department to implement formulary management cost-saving measures; providing requirements for such measures; amending s. 287.056, F.S.; requiring the department to enter into contracts with benefits consulting companies; amending ch. 99-255, Laws of Florida; removing a provision that prohibits the department from implementing a restricted prescription drug formulary or prior

authorization program in the state employees' prescription drug program; providing an effective date.

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

Section 1. Paragraphs (c) and (h) of subsection (3) of section 110.123, Florida Statutes, are amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(c) Notwithstanding any provision in this section to the contrary, ~~it is the intent of the Legislature that~~ the department is ~~shall be~~ responsible for all aspects of the purchase of health care for state employees under the state group health insurance plan or plans, TRICARE supplemental insurance plans, and the health maintenance organization plans. Responsibilities shall include, but not be limited to, the development of requests for proposals or invitations to negotiate for state employee health benefits ~~services~~, the determination of health care benefits to be provided, and the negotiation of contracts for health care benefits and health care administrative services. Beginning with the 2021 plan year, the department must simultaneously procure contracts for insurance plans, health maintenance organization plans, and pharmacy benefit plans. Such contracts must require contractors

to accommodate changes to the law that occur during the terms of the contracts. Before ~~Prior to~~ the negotiation of contracts for health care benefits ~~services~~, ~~the Legislature intends that~~ the department shall develop, with respect to state collective bargaining issues, the health benefits and terms to be included in the state group health insurance program. The department shall adopt rules necessary to perform its responsibilities pursuant to this section. ~~It is the intent of the Legislature that~~ The department is ~~shall be~~ responsible for the contract management and day-to-day management of the state employee health insurance program, including, but not limited to, employee enrollment, premium collection, payment to health care providers, and other administrative functions related to the 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, 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. The offer of optional membership in a health maintenance organization plan 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

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. ~~Nothing shall preclude~~ The department shall negotiate ~~from negotiating~~ regional or statewide contracts with health maintenance organization plans. Such plans must be ~~when this is~~ cost-effective and offer ~~when the department determines that the plan offers~~ high value to enrollees.

d. The department may limit the number of HMOs that it contracts with in each region ~~service area~~ based on the nature of the bids the department receives, the number of state

employees in the region ~~service area~~, or any unique ~~geographical~~ characteristics of the region ~~service area~~. ~~The department shall establish by rule service areas throughout the state.~~

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 region ~~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. before ~~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 are ~~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 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 may not ~~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 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.

Section 2. Section 110.12303, Florida Statutes, is amended to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting. ~~Beginning with the 2018 plan year:~~

(1) 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 package of benefits may also include products and services offered by:

(a) Prepaid limited health service organizations authorized pursuant to part I of chapter 636.

(b) Discount medical plan organizations authorized pursuant to part II of chapter 636.

(c) Prepaid health clinics licensed under part II of chapter 641.

(d) Licensed health care providers, including hospitals and other health care facilities, health care clinics, and health professionals, who sell service contracts and arrangements for a specified amount and type of health services.

(e) Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, who sell service contracts and arrangements for a specified amount and type of health services.

(f) Entities that provide specific health services in

accordance with applicable state law and sell service contracts and arrangements for a specified amount and type of health services.

(g) Entities that provide health services or treatments through a bidding process.

(h) Entities that provide health services or treatments through the bundling or aggregating of health services or treatments.

(i) Entities that provide international prescription services.

(j) Entities that provide other innovative and cost-effective health service delivery methods.

(2)(a) The department shall contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures which may be accessed at the option of the enrollee. The contract shall require the entity to:

1. Have procedures and evidence-based standards to ensure the inclusion of only high-quality health care providers.

2. Provide assistance to the enrollee in accessing and coordinating care.

3. Provide cost savings to the state group insurance program to be shared with both the state and the enrollee. Cost savings payable to an enrollee may be:

a. Credited to the enrollee's flexible spending account;

b. Credited to the enrollee's health savings account;

c. Credited to the enrollee's health reimbursement account; or

d. Paid as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

4. Provide an educational campaign for enrollees to learn about the services offered by the entity.

(b) On or before January 15 of each year, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level and cost-savings to both the enrollee and the state resulting from the contract or contracts described in this subsection.

(3) The department shall contract with an entity that provides enrollees with online information on the cost and quality of health care services and providers, allows an enrollee to shop for health care services and providers, and rewards the enrollee by sharing savings generated by the enrollee's choice of services or providers. The contract shall require the entity to:

(a) Establish an Internet-based, consumer-friendly platform that educates and informs enrollees about the price and quality of health care services and providers, including the average amount paid in each county for health care services and

providers. The average amounts paid for such services and providers may be expressed for service bundles, which include all products and services associated with a particular treatment or episode of care, or for separate and distinct products and services.

(b) Allow enrollees to shop for health care services and providers using the price and quality information provided on the Internet-based platform.

(c) Permit a certified bargaining agent of state employees to provide educational materials and counseling to enrollees regarding the Internet-based platform.

(d) Identify the savings realized to the enrollee and state if the enrollee chooses high-quality, lower-cost health care services or providers, and facilitate a shared savings payment to the enrollee. The amount of shared savings shall be determined by a methodology approved by the department and shall maximize value-based purchasing by enrollees. The amount payable to the enrollee may be:

1. Credited to the enrollee's flexible spending account;

2. Credited to the enrollee's health savings account;

3. Credited to the enrollee's health reimbursement account; or

4. Paid as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

(e) On or before January 1 of 2019, 2020, and 2021, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level, amount paid to enrollees, and cost-savings to both the enrollees and the state resulting from the implementation of this subsection.

(4) The department must offer international prescription services as a voluntary supplemental benefit option that offers safe maintenance medications at a reduced cost to enrollees and that meets the standards of the United States Food and Drug Administration personal importation policy.

Section 3. Section 110.12315, Florida Statutes, is amended 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. The department may use varying plan and network designs in the program, and shall administer it~~,~~ 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:

(1) The department shall allow prescriptions written by health care providers under the plan to be filled by any licensed pharmacy and reimbursed pursuant to subsection (2). This section may not be construed as prohibiting a mail order

prescription drug program distinct from the service provided by retail pharmacies.

(2) In providing for reimbursement of pharmacies for prescription drugs and supplies dispensed to members of the state group health insurance plan and their dependents under the state employees' prescription drug program:

(a) Retail, mail order, and specialty pharmacies participating in the program must be reimbursed as established by contract and according to the terms and conditions of the plan.

(b) There is a 30-day supply limit for retail pharmacy fills, a 90-day supply limit for mail order fills, and a 90-day supply limit for maintenance drug fills by retail pharmacies. This paragraph may not be construed to prohibit fills at any amount less than the applicable supply limit.

(c) The pharmacy dispensing fee shall be negotiated by the department.

(d) The department shall establish the reimbursement schedule for prescription drugs and supplies dispensed under the program. Reimbursement rates for a prescription drug or supply must be based on the cost of the generic equivalent drug or supply if a generic equivalent exists, unless the physician, advanced registered nurse practitioner ~~advanced practice registered nurse~~, or physician assistant prescribing the drug or supply clearly states on the prescription that the brand name

drug or supply is medically necessary or that the drug or supply is included on the formulary of drugs and supplies that may not be interchanged as provided in chapter 465, in which case reimbursement must be based on the cost of the brand name drug or supply as specified in the reimbursement schedule adopted by the department.

(3) The department shall maintain the generic, preferred brand name, and the nonpreferred brand name lists of drugs and supplies to be used in the administration of the state employees' prescription drug program.

(4) The department shall maintain a list of maintenance drugs and supplies.

(a) Preferred provider organization health plan members may have prescriptions for maintenance drugs and supplies filled up to three times as a supply for up to 30 days through a retail pharmacy; thereafter, prescriptions for the same maintenance drug or supply must be filled for up to 90 days either through the department's contracted mail order pharmacy or through a retail pharmacy.

(b) Health maintenance organization health plan members may have prescriptions for maintenance drugs and supplies filled for up to 90 days either through a mail order pharmacy or through a retail pharmacy.

(5) Copayments made by health plan members for a supply for up to 90 days through a retail pharmacy shall be the same as

copayments made for a similar supply through the department's contracted mail order pharmacy.

(6) The department shall conduct a prescription utilization review program. In order to participate in the state employees' prescription drug program, retail pharmacies dispensing prescription drugs and supplies to members of the state group health insurance plan or their covered dependents, or to subscribers or covered dependents of a health maintenance organization plan under the state group insurance program, shall make their records available for this review.

(7) Participating pharmacies must use a point-of-sale device or an online computer system to verify a participant's eligibility for coverage. The state is not liable for reimbursement of a participating pharmacy for dispensing prescription drugs and supplies to any person whose current eligibility for coverage has not been verified by the state's contracted administrator or by the department.

(8)(a) Effective July 1, 2017, for the State Group Health Insurance Standard Plan, copayments must be made as follows:

1. For a supply for up to 30 days from a retail pharmacy:

a. For generic drug .....$7.

b. For preferred brand name drug .....$30.

c. For nonpreferred brand name drug .....$50.

2. For a supply for up to 90 days from a mail order pharmacy or a retail pharmacy:

a. For generic drug.....$14.

b. For preferred brand name drug.....$60.

c. For nonpreferred brand name drug.....$100.

(b) Effective July 1, 2017, for the State Group Health Insurance High Deductible Plan, coinsurance must be paid as follows:

1. For a supply for up to 30 days from a retail pharmacy:

a. For generic drug .....30%.

b. For preferred brand name drug .....30%.

c. For nonpreferred brand name drug .....50%.

2. For a supply for up to 90 days from a mail order pharmacy or a retail pharmacy:

a. For generic drug.....30%.

b. For preferred brand name drug.....30%.

c. For nonpreferred brand name drug.....50%.

(9) The department shall implement formulary management cost-savings measures. Such measures must require prescription drugs to be subject to formulary inclusion or exclusion and may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs. However, excluded drugs may be 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.

Section 4. Subsection (3) is added to section 287.056,

Florida Statutes, to read:

287.056 Purchases from purchasing agreements and state term contracts.—

(3) The department shall enter into and maintain one or more state term contracts with benefits consulting companies.

Section 5. Section 8 of chapter 99-255, Laws of Florida, is amended to read:

Section 8. ~~The Department of Management Services shall not implement a prior authorization program or a restricted formulary program that restricts a non-HMO enrollee's access to prescription drugs beyond the provisions of paragraph (b) related specifically to generic equivalents for prescriptions and the provisions in paragraph (d) related specifically to starter dose programs or the dispensing of long-term maintenance medications. The prior authorization program expanded pursuant to section 8 of the 1998-1999 General Appropriations Act is hereby terminated. If this section conflicts with any General Appropriations Act or any act implementing a General Appropriations Act, the Legislature intends that the provisions of this section shall prevail. This section shall take effect upon becoming law.~~

Section 6. This act shall take effect July 1, 2019.