HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5009 PCB APC 19-05 State Employees' Group Insurance Program
SPONSOR(S): Appropriations Committee, Magar
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Appropriations Committee	22 Y, 2 N	Delaney	Pridgeon

SUMMARY ANALYSIS

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 all state employees including all state agencies, state universities, 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. Benefit changes are subject to approval by the Legislature.

As part of the SGI Program, DMS procures contracts for insurance plans, health maintenance organization (HMOs) plans and pharmacy benefits plans. Currently, DMS procures these contracts at different times. The bill directs SGI to procure benefits contracts simultaneously, starting with contracts effective in plan year 2021. Currently, DMS procures with HMOs on a county-by-county basis. The bill requires DMS to contract with HMOs on a regional or statewide basis. The bill also requires DMS to require plans to accommodate any changes to law that occur during the terms of the contracts.

DSGI also maintains the State Employees' Prescription Drug Program (Prescription Drug Plan). DMS contracts with CVS/Caremark, a pharmacy benefits manager (PBM), to administer the Prescription Drug Plan. The PBM does not employ prescription drug formulary management or any other management protocols. The Prescription Drug Plan has an open formulary, which covers all federal legend drugs for covered medical conditions, and uses very limited utilization review for traditional or specialty prescription drugs.

The bill directs DMS to implement measures to manage the prescription drug formulary in the Prescription Drug Plan. The PBM must add drugs to the formulary and remove drugs from the formulary, as necessary, to implement cost-saving measures. However, any formulary management technique cannot restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs. The formulary is managed through an independent pharmacy and therapeutics committee as well as an internal review committee. In addition, an excluded drug may be available for inclusion, and thereby covered by the Prescription Drug Plan, if a member's, or her or his dependent's, prescribing practitioner writes clearly on the prescription that the excluded drug is medically necessary. The bill also requires DMS to offer international prescription services, as an optional benefit.

DMS procures state term contracts, which are contracts competitively procured by DMS for use by it and other state agencies to purchase services like accounting, consultation, maintenance and training programs. The bill directs DMS to enter into and maintain one or more state term contracts with benefits consulting companies.

The bill conforms the law to the House proposed 2019-20 General Appropriations Act (GAA) as the employer premium contributions are included in the GAA.

Based on a January 1, 2020 projected implementation date, the provisions of the bill result in a positive budgetary fiscal impact to the state of $13.7 million in General Revenue and $9.2 million in trust funds in fiscal year 2019-2020, and approximately twice that amount in future fiscal years.

The bill provides an effective date of July 1, 2019.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

State Group Insurance Program

Overview

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 all state employees including all state agencies, state universities, 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.

The health insurance benefit for active employees has premium rates for single, spouse program[1], or family coverage regardless of plan selection. The state will contribute approximately 92% toward the total annual premium for active employees, or $2.01 billion out of total premium of $2.19 billion for active employees during FY 2018-19[2]. Retirees and COBRA participants contributed an additional $233.1 million in premiums, with $251.3 million in other revenue for a total of $2.61 billion in total revenues.[3]

Health Plan Options

The SGI Program provides limited options for employees to choose as their health plan. The preferred provider organization (PPO) plan is the statewide, self-insured health plan administered by Florida Blue, whose current contract covers the 2019 through 2022 plan years. The administrator is responsible for processing health claims, providing access to a Preferred Provider Care Network, and managing customer service, utilization review, and case management functions. The standard health maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs.[4]

Prior to the 2011 plan year, the participating HMOs were fully insured; in other words, the HMOs assumed all financial risk for the covered benefits. During the 2010 session, the Legislature enacted s. 110.12302, F.S., which directed DMS to require costing options for both fully insured and self-insured plan designs as part of the department's solicitation for HMO contracts for the 2012 plan year and beyond. The department included these costing options in its Invitation to Negotiate[5] to HMOs for contracts for plans years beginning January 1, 2012. DMS entered into contracts for the 2012 and 2013 plan years with two HMOs with a fully insured plan design and four with a self-insured plan design. New contracts with the HMOs have subsequently been executed for plan years 2018-2020.

[1] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.
[2] Florida Legislature, Office of Economic and Demographic Research, Self-Insurance Estimating Conference, *State Employees' Group Health Self-Insurance Trust Fund- Report on the Financial Outlook for Fiscal Years Ending June 30, 2019 through June 30, 2023*4 adopted March 1, 2019, page 6, available at http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf
[3] Id.
[4] The HMOs include Aetna, AvMed, Capital Health Plan, Florida Health Care Plans and United Healthcare.
[5] ITN NO.: DMS 10/11-011

Additionally, the SGI Program offers two high-deductible health plans (HDHPs[6]) with health savings accounts (HSAs)[7]. The Health Investor PPO Plan is the statewide HDHP with an integrated HSA. It is also administered by Florida Blue. The Health Investor HMO Plan is an HDHP with an integrated HSA, for which the state has contracted with multiple state and regional HMOs. Both HDHPs have an individual deductible of $1,350 for individual coverage and $2,700 for family coverage for network providers.[8] The state makes an annual HSA contribution of $500 for single coverage and $1,000 for family coverage. The employee may make additional annual contributions[9] up to $3,400 for single coverage and $6,750 for family coverage. Both the employer and employee contributions are not subject to federal income tax. Unused funds roll over automatically every year. The HSA is owned by the employee and is portable. The following charts illustrate the benefit design of each of the plan choices.

	HMO Standard	**PPO Standard**	
	Network Only	*In-Network*	*Out-of-Network*
Deductible	None	$250 Single $500 Family	$750 Single $1,500 Family
Primary Care	$20 Copayment	$15 Copayment	40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist	$40 Copayment	$25 Copayment	
Urgent Care	$25 Copayment	$25 Copayment	
Emergency Room	$100 Copayment	$100 Copayment	
Hospital Stay	$250 Copayment	20% after $250 Copayment	40% after $500 copayment plus the amount between the charge and the allowance
Out-of-Pocket Max	$7,350 Single $14,700 Family	$7,350 Single $14,700 Family	NA

	PPO and HMO Health Investor	
	In-Network	*Out-of-Network (PPO Only)*
Deductible	$1,350 Single $2,700 Family	$2,500 Single $5,000 Family
Primary Care	After meeting deductible, 20% of network allowed amount	After meeting the deductible, 40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist		
Urgent Care		After meeting the deductible, 20% of the out-of-network allowance
Emergency Room		
Hospital Stay		After meeting the deductible, 40% after $1,000 copayment plus the amount between the charge and the allowance
Out-of-Pocket Max	HMO: $3,000 Single $6,000 Family PPO: $4,350 Single $8,700 Family	NA

[6] High-deductible health plans with linked HSAs are also call consumer-directed health plans (CDHP) because costs of health care are more visible to the enrollee.
[7] 26 USC sec. 223; to qualify as a high-deductible plan, the annual deductible must be at least $1,300 for single plans and $2,600 for family coverage, but annual out-of-pocket expenses cannot exceed $6,550 for individual and $13,100 for family coverage. These amounts are adjusted annually by the IRS.
[8] Department of Management Services, *myFlorida*, *2019 Benefits Guide*, available at https://www.mybenefits.myflorida.com/content/download/142647/951981/2019_Benefits_Guide_r11-19-18.pdf (last viewed March 6, 2019).
[9] Id. The IRS annually sets the contribution limit, as adjusted by inflation.

Health Benefits Contracts and Procurements

DMS currently uses a staggered procurement schedule for HMOs, insurers and pharmacy benefit managers (PBMs). Each type of contract therefore has different start and end dates. The department's current contract procurement schedule is below.

- PPO: Current contract ends December 31, 2022. Procurement of a new contract would begin September 2021, for plan year 2023.
- HMO: Current contracts end December 31, 2020, and may be renewed for up to 3 years. Procurement of new contracts, unless renewed, would begin September 2019 for plan year 2021.
- PBM: Current contract ends December 31, 2020. Procurement of a new contract would begin September 2019 for plan year 2021.

The lack of consolidated contract terms is inefficient. It prevents DMS from having a coordinated procurement strategy. DMS is unable to take advantage of changes in the market, impose uniform policies, or easily incorporate revisions of law into its procurement strategy. Aligning the contract terms so procurements for each contract can be done simultaneously would allow DSGI to incorporate benefit changes into the new contracts. Benefit changes are subject to approval by the Legislature.

Section 110.123(3)(h), F.S., gives the department the discretion to award its HMO contracts on a regional or statewide basis but does not require it to do so. DMS has chosen to award HMO contract on a county-by-county basis, with one HMO per county. These small procurements limit the department's negotiating power, and do not take into account service referral patterns.

State Employees 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 CVS/Caremark, a pharmacy benefits manager (PBM), to administer the Prescription Drug Plan.[11]

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.

[10] S. 110.12315, F.S.
[11] Department of Management Services, *myFlorida, Prescription Drug Plan*, available at http://mybenefits.myflorida.com/health/health_insurance_plans/prescription_drug_plan (last viewed March 6, 2019).
[12] The Prescription Drug Plan Preferred List for January 2019 is available at www.caremark.com/portal/asset/sof_preferred_dl.pdf (last viewed March 6, 2019).

Prescription drug costs differ depending on which health plan a member enrolls in and whether the prescription drug is a generic, a preferred brand-name or a non-preferred brand-name. A member can get up to a 30-day supply at retail pharmacy in the Prescription Drug Plan network and up to a 90-day supply at a mail order pharmacy or at a participating 90-day retail pharmacy. The use of mail order pharmacy is optional, but PPO members must utilize the 90-day mail or retail option after three 30-day fills at a retail pharmacy for any maintenance medications. In addition, certain specialty medications are only available via delivery to a member's home or a participating pharmacy. The following chart shows the cost savings of using generics, mail order or a participating 90-day retail pharmacy for maintenance medications.[13]

	Standard PPO and Standard HMOs		**High-Deductible HMO and PPO**
	Retail (30-day)	Mail Order and Retail (90-day)	Retail (30-day); Mail Order and Retail (90-Day)
Generic	$7	$14	30%
Preferred Brand Name	$30	$60	30%
Non-preferred Brand Name	$50	$100	50%

The Prescription Drug Plan also covers compound medications. Compound medications combine, mix, or alter the ingredients of one or more drugs or products to create another drug or product. The Prescription Drug Plan only covers the federal legend drug[14] ingredient of a compounded medication when all of the following criteria are satisfied:

- The compounded medication is not used in place of a commercially available federal legend drug in the same strength and formulation, unless medically necessary;
- The compounded medication is specifically produced for use by a covered person to treat a covered condition; and
- The compounded medication, including all sterile compounded products, is made in compliance with Chapter 465, F.S.[15]

Currently, the PBM employs only limited prescription drug formulary management in the form of reviews designed to ensure that drugs are being prescribed for appropriate medical conditions. There is, however, no use of utilization management protocols to incentivize the use of some drugs over others. The Prescription Drug Plan has an open formulary, which covers all federal legend drugs for covered medical conditions. However, the PBM each year announces in July the therapeutic classes of drugs that will be impacted by exclusion for the next plan year. For plan year 2019, the PBM excluded 179 drugs from the formulary.[16]

The formulary development process for the PBM is developed and managed through the Caremark National Pharmacy and Therapeutics Committee (P&T Committee) and the Formulary Review Committee (FRC). The P&T Committee is an external body of 22 independent health care professionals, including 18 physicians and 4 pharmacists, all with broad clinical backgrounds. The P&T Committee is charged with reviewing all drugs represented in the PBM's approved drug lists. The formulary is reviewed annually to recommend changes if advisable based on newly available pharmaceutical information. The P&T Committee evaluates medications from a clinical, not a financial, perspective.

[13] Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, on-going use of the drugs. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.
[14] Legend drug means drugs that are approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider. https://definitions.uslegal.com/l/legend-drug/.
[15] Department of Management Services, *myBenefits, Frequently Asked Questions-Prescription Drug Plan*, available at http://mybenefits.myflorida.com/health/forms_and_resources/faqs/frequently_asked_questions_prescription_drug_plan%20.
[16] CVSHealth, *Utilization and Spend for 2019 Standard Formulary Exclusions-State of Florida* (on file with Appropriation staff).

The FRC is an internal committee within the PBM. The FRC will consider additional factors that may affect the formulary, such as utilization trends, plan sponsor cost, potential impact on members and brand and generic pipeline. The FRC will make business recommendations to the P&T Committee. Any recommendations made by the FRC must be approved by the P&T Committee.

Drug Importation

The Federal Food, Drug and Cosmetic Act (FDCA) generally prohibits the importation of foreign drugs into the U.S. unless the drug was manufactured by a foreign facility registered with the Food and Drug Administration (FDA) and the foreign drug is specifically FDA-approved, or the drug was manufactured in the U.S., is FDA-approved, and is being reintroduced into the U.S. by the original manufacturer.

However, federal law does authorize the Department of Health and Human Services to grant individuals waivers to import drugs, exercise discretion in enforcing the law against individuals importing for personal use, and focus enforcement efforts on cases that pose a significant threat to public health.[17]

Personal Drug Importation

The FDA generally does not object to a person importing a drug from any country so long as it is for personal use.[18] The FDA recognizes there are situations where foreign medications may be appropriate for a particular individual consumer and that the FDA's resources are better served enforcing regulations against commercial shipments of foreign medication into the United States.[19]

The FDA does not examine personal baggage or mail, leaving that to the U.S. Customs and Border Protection (CPB). CPB is instructed to only notify the FDA when it appears that there is an FDA-regulated drug intended for commercial distribution, the FDA has specifically requested that drug be detained, or the drug appears to represent a health fraud or an unknown risk to health.[20]

A 2016 poll showed that 8 percent of U.S. households have bought prescription drugs from Canada or other countries in order to pay a lower price.[21]

International Prescription Services Providers

International prescription service providers assist individual health plan enrollees to obtain lower-cost prescription drugs. Employers make such providers available to employees as a voluntary benefit option for enrollees who choose to use it. International prescription service providers are not internet pharmacies; rather, they create direct contract relationships with licensed pharmacies in Canada and other FDA Tier-1 regulatory countries and negotiate prices for personal importation in compliance with the FDA personal importation policy. Enrollees can choose to work with the international prescription service provider directly to obtain such drugs, at a discount or without having a co-payment. Such providers offer transparent pricing, so enrollees can compare their pricing with that of their traditional prescription drug coverage and cost-sharing.[22]

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[17] 21 U.S.C. § 384(j).
[18] U.S. FOOD & DRUG ADMINISTRATION, *Person Importation*, https://www.fda.gov/ForIndustry/ImportProgram/ImportBasics/ucm432661.htm (last visited Mar. 10, 2019).
[19] U.S. FOOD & DRUG ADMINISTRATION, *Regulatory Procedures Manual, Chapter 9: Import Operations and Actions*, at 9-2, Dec. 2017, *available at* https://www.fda.gov/downloads/ICECI/ComplianceManuals/RegulatoryProceduresManual/UCM074300.pdf (last visited Mar. 10, 2019).
[20] Id.
[21] KAISER FAMILY FOUNDATION, *Kaiser Health Tracking Poll: November 2016*, http://files.kff.org/attachment/Kaiser-Health-Tracking-Poll-November-2016-Topline (last visited Mar. 8, 2019).
[22] See, e.g., CanaRx and The Canadian Medstore, which work with employees of local governments nationwide, including Flagler County and the Pasco County School Board (see, "Cities, Counties and Schools Sidestep FDA Canadian Drug Crackdown, Saving Millions". Kaiser Health News, Dec. 8, 2017, *available at* https://khn.org/news/cities-counties-and-schools-sidestep-fda-canadian-drug-crackdown-saving-millions/ (last viewed March 18, 2019); "U.S. Cities Skeptical Of FDA Warnings Against Medicine Imports From Canadian Firm", NPR, March 6, 2019, *available at* https://www.npr.org/sections/health-shots/2019/03/06/700374420/u-s-cities-skeptical-of-fda-warnings-against-medicine-imports-from-canadian-firm (last viewed March 19, 2019).

Effect of Proposed Changes

The bill directs DMS, to procure its insurance plans, health maintenance organization plans (HMOs) and pharmacy benefit plans simultaneously, beginning with the contracts for plan year 2021. Additionally, the bill requires DMS to ensure its contracts require the contractors to accommodate changes in law that occur during the contract terms. The bill also directs the department to contract with the HMOs on a regional or statewide basis to improve the state's negotiating power and gain efficiency.

The bill directs DMS to offer international prescription services as a voluntary supplemental benefit option for state employees who choose to use it. The option would offer safe maintenance medications at a reduced cost to state employees which meet the standards of the federal Food and Drug Administration personal importation policy.

The bill directs DMS to implement measures to manage the prescription drug formulary in the Prescription Drug Plan. Prescription drugs listed in the formulary must be subject to inclusion and exclusion, meaning the PBM must add drugs to the formulary and remove drugs from the formulary, at specified intervals, to implement cost-saving measures. However, any formulary management technique may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs.

The bill provides an exception to formulary exclusion of any prescription drug. An excluded drug may be available for inclusion, and thereby covered by the Prescription Drug Plan, if a member's, or her or his dependent's, prescribing physician, advanced registered nurse practitioner, or physician assistant writes clearly on the prescription that the excluded drug is medically necessary. The provision ensures a patient has access to a prescription drug that is effective in treating her or his disease or medical condition even if that drug is excluded from the formulary by the PBM.

In addition to the annual update to the formulary, the bill will allow the PBM to make changes quarterly to the formulary. Such changes could include:

- Identifying prescription drugs on the formulary that have unwarranted and substantial price increases. After complete review and ensuring adequate covered products remain on the formulary, the PBM could exclude such drugs.
- Adding prescription drugs to the formulary which are new to the market. According to the PBM, if the drug is not a breakthrough drug[23], it typically takes six months for clinical review and a decision to be made on formulary placement. If the new drug is a breakthrough drug, it typically takes thirty days for the same clinical review and decision-making process to be completed.

Formulary management techniques will give DMS, through its contracted PBM, greater influence over spending under the Prescription Drug Plan, while ensuring that members and their dependents have access to the most effective prescription drug therapies.

The bill directs DMS, through its Division of State Purchasing, to enter into and maintain one or more state term contracts with benefits consulting companies. This will allow DMS and other state agencies to purchase needed consulting services without additional procurements.

The bill provides an effective date of July 1, 2019.

[23] A breakthrough therapy is a drug intended alone or in combination with one or more other drugs to treat a serious or life threatening disease or condition and preliminary clinical evidence indicates that the drug may demonstrate substantial improvement over existing therapies on one or more clinically significant endpoints, such as substantial treatment effects observed early in clinical development. U.S. Department of Health and Human Services, Food and Drug Administration, *Fact Sheet: Breakthrough Therapies*, available at https://www.fda.gov/RegulatoryInformation/LawsEnforcedbyFDA/SignificantAmendmentstotheFDCAct/FDASIA/ucm329491.htm.

B. SECTION DIRECTORY:

Section 1: Amends s. 110.123, F.S., relating to procurements of insurance plans, health maintenance organizations, and pharmacy benefit plans.
Section 2: Amends s. 110.12303, F.S., relating to contracts with international prescription service providers.
Section 3: Amends s. 110.12315, F.S., relating to the prescription drug program.
Section 4: Repeals s. 8, ch. 99-255, Laws of Fla., prohibiting DMS from implementing a prior authorization program or a restricted formulary program that restricts a non-HMO enrollee's access to prescription drugs.
Section 5: Amends s. 287.056 relating to state term contracts.
Section 6: Provides an effective date of July 1, 2019.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   DMS is expected to realize annual savings to the state program of approximately $45.8 million (see Fiscal Comments) by employing various formulary management techniques. The July 1, 2019, effective date would allow DSGI to implement the formulary management protocols on January 1, 2020, which would generate a projected savings of $13.7 million in General Revenue Funds and $9.2 million in trust funds during the second half of FY 2019-20.[24]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None

D. FISCAL COMMENTS:

The projected annual savings[25], or cost avoidance, to the Prescription Drug Plan, from implementing formulary management techniques are:

- Total Gross Savings $46.8M or 5.4% of gross spend
- Net Plan Savings $45.8M or 5.6% of net cost
- Net Member Savings $ 1.0M or 1.9%[26] of member costs

[24] E-mail correspondence from DMS, dated February 11, 2019. On file with staff of the Appropriations Committee.
[25] Projected cost avoidance fluctuates quarterly based on utilization, inflation and formulary changes.
[26] Supra, FN 19.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to impact county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

DMS has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES