HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/CS/HB 1191	**FINAL HOUSE FLOOR ACTION:**	
SUBJECT/SHORT TITLE	Medication Synchronization	120 **Y's** 0 **N's**	
SPONSOR(S):	Health & Human Services Committee; Commerce Committee; Health Innovation Subcommittee; Cruz and others	**GOVERNOR'S ACTION:**	Approved
COMPANION BILLS:	CS/CS/SB 800		

SUMMARY ANALYSIS

CS/CS/CS/HB 1191 passed the House on May 3, 2017, as CS/CS/SB 800.

Medication synchronization is the process of a pharmacy coordinating all of a patient's prescription medications to fill them on the same date each month. In order to achieve this, some medications may need an early or short refill to align all of the prescription medications. Currently, Florida does not require health plans to make partial supplies of prescriptions available to consumers at a reduced cost-sharing amount for medication synchronization.

CS/CS/CS/HB 1191 requires certain health insurers and health maintenance organizations (HMOs) to offer medication synchronization services on all policies and contracts entered into or renewed on or after January 1, 2018. The medication synchronization services must allow an insured or subscriber to align refill dates of covered prescription drugs at least once per year. The bill prohibits a partial fill to align refill dates for controlled substances, prescription drugs dispensed in unbreakable packages, and multi-dose units of prescription drugs.

Health insurance policies and HMO contracts that provide prescription drug coverage must cover a partial supply of a covered prescription medication dispensed by a network pharmacy with prorated cost-sharing obligations for medication synchronization. Insurers and HMOs must also pay the pharmacy a full dispensing fee for each prescription dispensed, unless otherwise agreed to at the time an insured or subscriber requests medication synchronization. Notwithstanding these requirements, the bill deems existing medication synchronization programs that allow for early refills and refill overrides as complying with the bill's requirements.

The bill will have an indeterminate insignificant negative fiscal impact on the State Group Insurance Program and no fiscal impact on local governments.

The bill was approved by the Governor on June 14, 2017, ch. 2017-94, L.O.F., and will become effective on January 1, 2018.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Current Situation

Medication Synchronization

Medication synchronization is the process of a pharmacy coordinating all of a patient's prescription medications to fill them on the same date each month.[1] In order to achieve this, some medications may need an early or short refill to align all of the patient's prescription medications.[2] Without medication synchronization, pharmacy workflow operates around patients bringing in new prescriptions, calling for medication refills, and picking up their mediations at their convenience. Patients who are on multiple medications often visit the pharmacy many times a month, which is inefficient for the patient and the pharmacy.[3] Medication synchronization programs can reduce the administrative burden on patients who take multiple medications by centering all prescription refills to a common monthly or quarterly fill date.[4] While patients may realize a savings from a medication synchronization program, insurers may incur additional dispensing fees and administrative costs to reprogram their systems, which may be passed on to patients in the form of higher premiums or cost sharing.

Medication Synchronization in Other States

Recently, several states have enacted laws that require health insurance plans to make partial supplies of prescriptions available to consumers at a reduced cost-sharing amount for medication synchronization purposes. In 2015, Arizona enacted a law that requires pharmacies to dispense an early refill or a short fill and to prorate the cost for a refill for less than the standard refill amount if such a refill is for medication synchronization.[5] Maine,[6] New Mexico,[7] and Washington[8] enacted similar measures in 2015. Kentucky[9] and Oregon[10] also enacted similar measures in 2015; however, they placed limits on which medications were subject to the new laws, prohibiting early and short refills of Schedule II and certain Schedule III controlled substances.

Missouri enacted similar medication synchronization legislation, in 2016, which also required the health insurance carrier or managed care plan to pay a full dispensing fee to the pharmacy for any prescription dispensed in a quantity less than the prescribed amount to align prescriptions.[11] Ohio enacted a medication synchronization law in 2016. In addition to prohibitions on Schedule II controlled substances, the Ohio law also limits the number of times a consumer may synchronize medications to once per year.[12]

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[1] National Community Pharmacist Association, *Model Legislation: Patient Protection & Medication Synchronization*, available at: http://www.ncpa.co/pdf/state/med-synch-model-legislation.pdf (last visited May 3, 2017).
[2] Id.
[3] American Pharmacists Association Foundation, *Pharmacy's Appointment Based Model: A prescription synchronization program that improves adherence*, Jul. 2015, available at: https://naspa.us/wp-content/uploads/2015/07/ABMWhitePaper-FINAL-201309233.pdf (last visited May 3, 2017).
[4] Academy of Managed Care Pharmacy, *Medication Synchronization*, 2015, p. 1, available at: http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=20019 (last visited May 3, 2017).
[5] Ariz. Rev. Stat. ss. 20-848; 20-1057.15; 20-1376.07; 20-1406.07.
[6] Me. Rev. Stat. tit. 24-A s. 2769.
[7] N.M. Stat. ss. 59A-22-1978; 59A-23-1978.
[8] Wash. Rev. Code ss. 48.43; 41.05.
[9] Ky. Rev. Stat. s. 304.17A-165.
[10] 2014 Or. Laws ch. 25, ss. 2; 4.
[11] Mo. Rev. Stat. s. 376.379.
[12] Oh. Rev. Stat. ss. 1751.68 and 3923.602.

Medication Synchronization in Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003[13] established a voluntary, outpatient, prescription drug benefit under Medicare Part D, effective January 1, 2006. Medicare Part D provides coverage through private prescription drug plans that offer only drug coverage, or through Medicare Advantage plans that offer prescription drug coverage as part of broader managed care benefits.

Beginning in 2014, the Centers for Medicare and Medicaid Services required health plans administering Medicare Part D plans use a daily cost-sharing rate for prescriptions that are dispensed for less than a 30-day supply.[14] Prior to the rule change, an enrollee's cost sharing was the same whether he or she received a 7-, 14-, or 30-day supply of a medication.[15] The maximum amount that can be charged to the enrollee is based on the one-month copayment amount divided by the actual number of days entered for that one-month supply for that specific tier.[16] The Centers for Medicare and Medicaid Services (CMS) noted that this could be beneficial for enrollees seeking to synchronize their medications, but that savings from the daily cost sharing could be partly offset by additional dispensing fees and administrative costs to plan sponsors.[17]

CMS noted the daily cost-sharing requirement does not address how dispensing fees are to be negotiated, calculated, or paid; however, it discouraged sponsors from using a pro-rated dispensing fee that would discourage pharmacies from dispensing less than a 30-day supply.[18]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk bearing entities. OIR regulates health insurer provider contracts under parts IV, VI, and VII of ch. 627, F.S. and HMO contracts and rates under part I of ch. 641, F.S. To operate in Florida, an HMO must obtain a certificate of authority from OIR.[19] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[20]

Section 641.31(4), F.S., requires each contract, certificate, or member handbook of an HMO to delineate the services to which a subscriber is entitled under the contract and any limitations on the services or kinds of services to be provided.

Pharmacy Benefit Managers

Health insurers and HMOs contract with pharmacy benefit managers (PBMs) to help manage prescription drug benefits. PBMs act as intermediaries between health plan sponsors and drug

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[13] P.L. 108-173.
[14] 42 C.F.R. s. 423.104(i) and s. 423.153(b)(4); *see also,* Centers for Medicare and Medicaid Services, *Medicare Part D Overutilization Monitoring System – Updates*, (Oct. 25, 2013), available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoMedicare-Part-D-OMS-Updates-10-25-13.pdf (last visited May 3, 2017); Centers for Medicare and Medicaid Services, *Copayment/coinsurance in drug plans*, available at: https://www.medicare.gov/part-d/costs/copayment-coinsurance/drug-plan-copayments.html (last visited May 3, 2017).
[15] 77 Fed. Reg. 22072.
[16] Centers for Medicare and Medicaid Services, *Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, (Apr. 1, 2013), available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2014.pdf (last visited May 15, 2017).
[17] Supra, FN 15.
[18] Supra, FN 16.
[19] S. 641.21(1) and 641.49, F.S.
[20] S. 641.21(1) and 641.48, F.S.

manufacturers and pharmacies.[21] PBMs develop and manage pharmacy networks, develop drug formularies, provide mail order and specialty pharmacy services, provide support services for physicians and beneficiaries, and process claims.[22] PBMs' contracts with pharmacies also establish how pharmacies will be reimbursed for prescriptions they dispense to health plan members.[23]

State Employees' Prescription Drug Program

The State Group Insurance Program (SGI Program) was created by s. 110.123, F.S., and is administered by the Division of State Group Insurance 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.

As part of the SGI Program, DMS maintains the State Employees' Prescription Drug Program (Prescription Drug Plan).[24] DMS contracts with CVS/Caremark, a PBM, to administer the Prescription Drug Plan.[25] A member can receive up to a 30-day supply of prescription medication at a 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.

Currently, the SGI Program does not allow medication synchronization if it would require an early refill.

Effect of Proposed Changes

CS/CS/CS/HB 1191 requires certain health insurers and HMOs to offer medication synchronization services on all policies and contracts entered into or renewed on or after January 1, 2018. The bill applies to individual, small group, and large group health insurance policies and HMO contracts that offer prescription drug coverage. The medication synchronization services must allow an insured or subscriber to align refill dates of covered prescription drugs at least once per year; however, health insurers and HMOs may elect to offer this service more frequently if they choose. Health insurance policies and HMO contracts that provide prescription drug coverage must cover a partial supply of a covered prescription medication dispensed by a network pharmacy with prorated cost-sharing obligations for medication synchronization.

This will allow patients, at least once per year, to obtain a partial refill to align their medications, without incurring any additional costs for refilling too soon or having to pay more than the prorated rate for a partial refill. Aligning prescription refill dates will necessitate fewer trips to the pharmacy for refills, which may improve patient adherence to prescription medication regimens.

The bill prohibits a partial fills for the following prescription drugs:

- Controlled substances;
- Prescription drugs dispensed in unbreakable packages; and
- Multi-dose units of prescription drugs.

Additionally, the bill requires a health insurer or HMO to pay the pharmacy a full dispensing fee for each prescription dispensed, unless otherwise agreed to at the time an insured or subscriber requests medication synchronization. Health insurers and HMOs may have to amend their multiyear contracts

[21] Office of Program Policy Analysis & Government Accountability, *Legislature Could Consider Options to Address Pharmacy Benefit Manager Business Practices*, Report No. 07-08 (Feb. 2007), available at: http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0708rpt.pdf (last visited May 3, 2017).
[22] Id.
[23] Id.
[24] S. 110.12315, F.S.
[25] Department of Management Services, *myFlorida, Prescription Drug Plan*, available at: http://mybenefits.myflorida.com/health/health_insurance_plans/prescription_drug_plan (last visited May 3, 2017).

with pharmacies or PBMs to allow a full dispensing fee for partial refills due to medication synchronization.

Notwithstanding these requirements for medication synchronization, the bill deems existing medication synchronization programs that provide for early refills and refill overrides as complying with the bill's requirements.

The bill provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   For each partial refill made for the purpose of medication synchronization, DMS expects an initial low-cost negative fiscal impact to the SGI Program. However, DMS anticipates greater member adherence to prescription medication regimens for chronic conditions, which may result in overall lower medical spending in the SGI Program.

   DMS will need to make changes to the summary plan description currently used by the SGI Program's PBM to allow prescriptions to be filled at any point for medication synchronization.[26] DMS would also need to develop and incorporate a proration schedule outlining and creating prorated copayment amounts for medication synchronization.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There may be new administrative costs for insurers and pharmacies to institute daily cost-sharing rates for partial fills and refills.[27] Some insurers may also incur costs to revise their forms to comply with the bill.[28] Insurers may have to renegotiate or amend their contracts with PBMs to take into account the bill's requirements.

The bill's default requirement of a full dispensing fee for partial fills will have a negative fiscal impact on insurers and health plans, which may be passed on to patients in the form of higher premiums or cost-sharing.

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[26] Department of Management Services, *Agency Analysis of 2017 House Bill 1191* (Mar. 12, 2017) (on file with Health and Human Services Committee staff).
[27] Office of Insurance Regulation, *Agency Analysis of 2017 House Bill 1191* (Mar. 7, 2017) (on file with Health and Human Services Committee staff).
[28] Id.

D. FISCAL COMMENTS:

For SGI Program members with a Preferred Provider Organization plan filling maintenance medications at a retail pharmacy, any "partial" fill would count as one of their three 30-day fills at retail before being required to use 90-day retail refill or 90-day mail order refill.[29]

The bill's default requirement of a full dispensing fee for partial fills will have a negative fiscal impact on the SGI Program, which may be passed on to members in the form of higher premiums or cost-sharing.

[29] Supra, FN 26.