The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	SPB 2508
INTRODUCER:	For consideration by the Appropriations Committee
SUBJECT:	State Group Insurance Program
DATE:	April 4, 2017
REVISED:	

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
McVaney	Hansen		**Pre-meeting**

I. Summary:

SPB 2508 authorizes the Department of Management Services (DMS) to implement certain cost-savings measures related to the State Group Insurance Program. The two main cost-savings measures are the contract for a dependent eligibility verification audit and the implementation of formulary management practices of the State Employees' Prescription Drug Program.

In terms of the dependent eligibility audit, the DMS is required to put all enrollees of the State Group Health Insurance Plan on notice regarding the eligibility requirements for dependents. Through the next open enrollment period for the plan, enrollees can remove dependents who are no longer eligible for coverage. Beginning in December 2017, a contractor will begin the eligibility audits, requesting and reviewing documents on each dependent to ensure eligibility requirements have been met. The documents submitted for this audit must be retained until June 30, 2019. After that date, the documents are no longer useful and may be destroyed.

In terms of the implementation of formulary management, the DMS is permitted to submit recommendations to exclude prescription drugs and supplies from coverage during the next plan year. The DMS may also propose to move prescription drugs and supplies between copayment tiers each quarter. Each proposed change is subject to the notice, review, and objection procedures pursuant to section 216.177, Florida Statutes, which allows legislative oversight of budgetary actions.

The fiscal impact of this bill is indeterminate; however, the DMS anticipates that significant costs may be avoided by eliminating ineligible dependents, excluding certain high cost drugs when suitable lower cost alternatives exist, and implementing a managed formulary that may result in more rebates paid by pharmaceutical manufacturers.

II. Present Situation:

State Group Insurance Program

Overview

The State Group Insurance Program (state program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the DMS. The state program is an optional benefit for all state employees including all state agencies, state universities, the court system, and the Legislature. The program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

State Health Insurance Plans

The state program provides four options for employees and retirees to choose as their health plan. The first two are the PPO Standard Health Plan and the PPO High Deductible Health Plan. These PPO plans are administered by Florida Blue as the third party administrator. The second two are the HMO Standard Health Plan and the HMO High Deductible Health Plan. The HMO plans are administered by Aetna, AvMed, and United Health Care as self-insured plans based on geographic regions of the state with two fully-insured HMO plans (Capital Health Plan and Florida Health Plan) offered in other areas of the state.

Florida Blue, as the third party administrator of the PPO Plans, receives an administrative services organization (ASO) fee for its work. For the 2016-2017 fiscal year, $17.6 million is appropriated to pay this fee. With 83,829 enrollees and 77,594 covered dependents, this fee equates to roughly $17.50 per enrollee per month.

Likewise, the HMOs (Aetna, AvMed, and United Health Care) that administer the self-insured HMO plans also receive an ASO fee. For the 2016-2017 fiscal year, $28.1 million is appropriated for these providers. With a combined membership of 59,731 enrollees and 77,349 covered dependents, this combined fee equates to an average of $39.20 per enrollee per month for these providers.

Capital Health Plan and Florida Health Plan administer fully-insured HMO plans where those entities bear the health claims risk. Their premiums charged to the DMS include the costs of administration. Combined, the membership of the fully-insured HMOs is 32,714 enrollees and 36,464 covered dependents.

Pharmacy Benefit

The state program also has a pharmacy benefit for members of the plan. The program covers all federal legend drugs (open formulary) for covered medical conditions, and employs very limited utilization review and clinical review for traditional or specialty prescription drugs. Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions such as cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling (e.g., refrigeration during shipping) and administration (such as injection or infusion).

The federal out-of-pocket limit applies to members of the state group self-insured health plans and insured HMOs, all of which include prescription drug coverage. The prescription drugs and

supplies are placed in copayment tiers to determine the amount of the out-of-pocket costs the members must bear. The tiers are shown in the table below:

	Standard Plans		High Deductible Plans	
Tier	**Copayment for Retail[1] Pharmacy**	**Copayment for Mail Order[2] Pharmacy**	**Coinsurance for Retail Pharmacy**	**Coinsurance for Mail Order Pharmacy**
Generic	$7	$14	30%	30%
Preferred brand name drugs	$30	$60	30%	30%
Nonpreferred brand name drugs	$50	$100	50%	50%

CVS Caremark has contracted with the DMS to be the pharmacy benefit manager for most members of the state program. CVS Caremark receives about $4.4 million annually to manage the prescription drug program. The table below shows the financial impact of the prescription drug program.

	2016-17	2017-18	2018-19	2019-20	2020-21
PPO-PBM Rebates	$54.0	$56.2	$57.8	$59.6	$61.4
HMO-PBM Rebates	$43.2	$50.2	$53.4	$56.9	$60.7
Total Rebates	$97.2	$106.4	$111.2	$116.5	$122.1
PPO Pharmacy Claims	$337.7	$373.5	$426.3	$491.3	$566.1
HMO Pharmacy Claims	$261.8	$301.8	$354.9	$423.5	$505.2
Total Pharmacy Claims	$599.5	$675.3	$781.2	$914.8	$1,071.3

Employer and Employee Contributions

The monthly premium contributions paid by the employing state agencies and employees are established in the General Appropriations Act each year. The following chart shows the monthly contributions of the state and the employee for health insurance premium as of January 1, 2017. These premiums cover the cost of health claims as well as pharmacy claims.

		Standard Health Plan			High Deductible Health Plan		
Subscriber Category	Coverage Type	Employer	Enrollee	Total	Employer	Employee	Total
Career Service	Single	$642.84	$50.00	$692.84	$642.84	$15.00	$657.84
	Family	$1,379.60	$180.00	$1,559.60	$1,379.60	$64.30	$1,443.90
	Spouse	$1,529.60	$30.00	$1,559.60	$1,413.92	$30.00	$1,443.92
SES/SMS	Single	$684.50	$8.34	$692.84	$649.50	$8.34	$657.84
	Family	$1,529.60	$30.00	$1,559.60	$1,413.90	$30.00	$1,443.90
COBRA	Single	0	$706.70	$706.70	0	$628.50	$628.50
	Family	0	$1,590.79	$1,590.79	0	$1,387.78	$1,387.78
Early Retiree	Single	0	$692.84	$692.84	0	$616.18	$616.18
	Family	0	$1,559.60	$1,559.60	0	$1,360.57	$1,360.57
Over-age Dependents	Single	0	$692.84	$692.84	0	$616.18	$616.18

[1] For up to a 30-day supply of prescription drugs and supplies.
[2] For up to a 90-day supply of prescription drugs and supplies.

Plan Enrollment

The state program has 366,681 covered lives and 176,274 policyholders. According to data submitted by the DMS, there are 78,806 spouses and 112,601 other covered dependents listed as covered dependents in the state plan's records.

Dependent Eligibility

The state program covers employees and retirees of state agencies and their eligible dependents. Based on the relationship to the member, a dependent may be eligible for coverage as:

- A current spouse to whom the member is legally married;
- A biological child or adopted child of the member through the calendar year in which the child turns age 26;
- A child of the member who is permanently mentally or physically disabled. The member's child may continue health insurance coverage after reaching 26 years of age if the child is unmarried and dependent on the member for care and financial support;
- A stepchild – a child of the member's current spouse through the calendar year in which the child turns age 26;
- A foster child placed in the member's home through the calendar year in which the child turns age 26;
- A newborn dependent of a member's covered child for up to 18 months of age as long as the newborn's parent remains covered; and
- An over-age dependent until the calendar year in which the child turns age 30, if unmarried.

Dependents may be added as covered dependents during open enrollment each year or in the event of a qualifying status change. Minimal information is collected by the DMS to determine eligibility.

III. Effect of Proposed Changes:

Section 1 amends s. 110.12301, F.S., to direct the DMS to contract with a vendor to verify the eligibility of all dependents participating in the state program. The DMS must notify all members of the Health Insurance Plan regarding the eligibility criteria for dependents. During the 2017 Open Enrollment period, members will have the opportunity to update their dependents – eliminating any that are no longer eligible for participation in the program.

Beginning December 2017 (after open enrollment has closed), the DMS' vendor will begin asking for documents to verify dependent eligibility. This section specifies certain information that the vendor may request to verify certain dependent relationships. The vendor is allowed to request additional records if the records are exempt from public inspection and copying. The section requires the submitted documents to be retained until July 1, 2019, but destroyed as soon as practicable thereafter.

Section 2 amends s. 110.12315, F.S., to update the state employee Prescription Drug Program. This section makes various changes to codify permanently changes made to the program since 2010 on an annual basis in the bill implementing the general appropriations act. These updates:

- Allow a retail pharmacy to fill 90-day supply for prescription drugs and supplies;

- Require the pharmacy dispensing fee to be negotiated by the DMS; and
- Continue the current drug copayment tiers and amounts at the current year levels rather than the higher copayment levels that would be applicable beginning July 1, 2017.

Section 2 also makes a major policy change to the prescription drug program by directing the DMS to formulary management. The section:

- Codifies the current DMS practice of moving drugs among the copayment tiers as necessary on a quarterly basis. However, under the bill, the DMS is required to provide information to the Governor and Legislature regarding the impacts to members and the health insurance plan. Adjustments to copayment tiers are allowed quarterly.
- Allows the DMS to implement a closed formulary, which allows some prescription drugs and supplies to be excluded from coverage under the program.
- To exclude a drug, the DMS must propose the exclusion and provide information regarding the impact on employees and the health insurance plan. The exclusion must be approved by the Governor's Office and is subject to objection by the presiding officers or the Legislative Budget Commission (LBC) chair and vice chair. New exclusions are allowed once a year unless the Legislature directs otherwise.

Section 3 repeals s. 8 of ch. 99-255, L.O.F., which had prohibited the use of a prior authorization program or a restricted formulary for members in the PPO Plan.

Section 4 provides that the act takes effect July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The fiscal impact of SPB 2508 is indeterminate; however, the DMS anticipates that significant costs may be avoided by eliminating ineligible dependents, excluding certain high cost drugs when suitable lower cost alternatives exist, and implementing a managed formulary that may result in more rebates paid by pharmaceutical manufacturers.

SB 2500, the Senate's proposed General Appropriations Act for the 2017-2018 fiscal year, appropriates up to $1 million to contract for the dependent eligibility audits. The DMS has suggested that it would require a "claw back" provision in the contract to ensure that the savings resulting from the audit exceeds the $1 million appropriation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 110.12301 and 110.12315.

This bill repeals section 8 of chapter 99-255, Laws of Florida.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.