HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 993 State Employees' Prescription Drug Program
SPONSOR(S): Health Innovation Subcommittee, Magar
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 0 N, As CS	Poche	Poche
2) Appropriations Committee	24 Y, 0 N	Delaney	Leznoff
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The State Group Insurance Program (SGI Program) is created by s. 110.123, F.S., and 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 1st through December 31st. Benefit changes are subject to approval by the Legislature.

As part of the SGI program, DMS is required to maintain 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 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, 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 drugs enter the market and as the PBM negotiates pricing and rebates with manufacturers.

Currently, 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.

HB 933 directs DMS to implement cost-saving measures in the Prescription Drug Plan. Specifically, the bill requires DMS to implement prescription drug formulary management techniques to manage the drugs that are included and excluded from the formulary. However, any formulary management technique cannot restrict a plan member's, or her or his dependent's, access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs. The DSGI expects full implementation to occur on January 1, 2017. 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, following a medical necessity review. 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. The bill also requires DSGI to make any necessary adjustments to the Prescription Drug Plan to balance program funding within appropriations made by the Legislature. Finally, the bill makes changes to authorizing statute for the Prescription Drug Plan, s. 110.12315, F.S., to reflect the current administration and operations.

The bill conforms to the law to HB 5001 General Appropriations Act (GAA) as health insurance premiums are included in the GAA.

Based on a January 1, 2018 projected implementation date, the provisions in the bill result in a positive budgetary fiscal impact to the state of $15.9 million in General Revenue and $13.3 million in trust funds in fiscal year 2017-2018.

The bill provides an effective date of July 1, 2017.

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. Benefit changes are subject to approval by the Legislature.

The health insurance benefit for active employees has premium rates for single, spouse program[1], or family coverage regardless of plan selection. The state contributed approximately 92% toward the total annual premium for active employees, or $1.80 billion out of total premium of $1.95 billion for active employees during FY 2016-17[2]. Retirees and COBRA participants contributed an additional $233.3 million in premiums, with $158.9 million in other revenue for a total of $2.34 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 2015 through 2018 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. The department 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. The contracts with the HMOs had been renewed for the 2015 plan year.[6]

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[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, 2017 through June 30, 2022*, adopted December 9, 2016, 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 UnitedHealthcare.
[5] ITN NO.: DMS 10/11-011
[6] After extending the existing HMO contracts for the 2016 and 2017 plan years, DMS is currently procuring HMOs for the next contract period and expects to complete the procurement process and award contracts to the HMOs during or after the 2017 Regular Legislative Session.

Additionally, the SGI Program offers two high-deductible health plans (HDHPs[7]) with health savings accounts (HSAs)[8]. 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 $1,300 for individual coverage and $2,600 for family coverage for network providers.[9] The state makes an annual HAS contribution of $500 for single coverage and $1,000 for family coverage. The employee may make additional annual contributions[10] 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	Network	Out-of-Network
Deductible	None	$250 | $500 Single | Family	$750 | $1,500 Single | 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 Maximum	$1,500 | $3,000 Single | Family	$2,500 | $5,000 (coinsurance only) Single | Family	

[7] 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.
[8] 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.
[9] Internal Revenue Service, *Revenue Procedure 2016-28*, April 29, 2016 (setting contribution limits for 2017 calendar year) available at https://www.irs.gov/pub/irs-drop/rp-16-28.pdf (last viewed March 16, 2017).
[10] Id., The IRS annually sets the contribution limit, as adjusted by inflation.

	PPO and HMO Health Investor	
	Network	Out-of-Network (PPO Only)
Deductible	$1,300 | $2,600 Single | Family	$2,500 | $5,000 Single | Family
Primary Care	After meeting deductible, 20% of network allowed amount	After meeting deductible, 40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist		
Urgent Care		After meeting deductible, 20% of out-of-network allowance
Emergency Room		
Hospital Stay		After meeting deductible, 40% after $1,000 copayment plus the amount between the charge and the allowance
Out-of-Pocket Maximum	$3,000 | $6,000 (coinsurance only) Single | Family	$7,500 | $15,000 (coinsurance only) Single | Family

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).[11] DMS contracts with CVS/Caremark, a pharmacy benefits manager (PBM), to administer the Prescription Drug Plan.[12]

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[13], 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 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. Generally, 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 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

[11] S. 110.12315, F.S.
[12] Department of Management Services, *myFlorida, Prescription Drug Plan*, available at http://mybenefits.myflorida.com/health/health_insurance_plans/prescription_drug_plan (last viewed March 16, 2017).
[13] The Prescription Drug Plan Preferred List for January 2017 is available at www.caremark.com/portal/asset/sof_preferred_dl.pdf (last viewed March 16, 2017).

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 following chart shows the cost savings of using generics, mail order or a participating 90-day retail pharmacy for maintenance medications.[14]

	Standard PPO and Standard HMOs		High Deductible HMO and PPO
	Retail (30-day)	Mail Order (90-day) and Retail (90-day)	Retail (30-day); Mail Order (90-day) 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 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 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. However, the PBM each year announces in July the therapeutic classes of drugs that will be impacted by exclusion for the next plan year. In August, the PBM announces the specific drugs which will be excluded from the open formulary. In 2017, the PBM excluded 131 drugs from the formulary.[16]

Effect of Proposed Changes

HB 933 directs DMS to implement cost-saving measures in the Prescription Drug Plan. Specifically, the bill requires DMS to implement prescription drug formulary management techniques to manage the drugs that are included and excluded from the formulary. However, any formulary management technique cannot restrict a plan member's, or her or his dependent's, access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs.

[14] 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.
[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 (last viewed March 16, 2017).
[16] CVSHealth, *Utilization and Spend for 2017 Standard Formulary Exclusions-State of Florida* (on file with Health Innovation Subcommittee staff).

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, following a medical necessity review. 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. The bill also requires DSGI to make any necessary adjustments to the Prescription Drug Plan to balance program funding within appropriations made by the Legislature.

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[17], 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 allow the PBM to contain the prescription drug spend in the Prescription Drug Plan, while ensuring that members and their dependents have access to the most effective prescription drug therapies.

The bill makes the following changes to s. 110.12315, F.S., to reflect the current administration and operation of the Prescription Drug Plan:

- Clarifies that retail, mail order, and specialty pharmacies participating in the network receive reimbursement at a rate established by contract.
- Requires DSGI to maintain the generic, preferred brand name, and nonpreferred brand name drug lists, and the maintenance drug and supply list, for administrating the Prescription Drug Plan. Currently, DSGI contracts with the PBM to maintain the lists.
- Permits members enrolled in a preferred provider organization health plan in the SGI Program to have prescriptions for maintenance drugs or supplies filled three times at a retail pharmacy as an up to 30-day supply. Each prescription for maintenance drugs or supplies thereafter must be filled either through a mail order pharmacy or a 90-day retail pharmacy. The option is also provided to HMO plan members in the SGI Program.
- Requires co-payments for drugs and supplies filled at a mail order pharmacy to be the same as co-payments for drugs and supplies filled at a 90-day retail pharmacy.
- Details the current co-payments for drugs and supplies filled under the SGI Program Standard Plan and the current coinsurance rates for drugs and supplies filled under the SGI Program Health Insurance High Deductible Plan.

Finally, the bill repeals section 8 of chapter 99-255, Laws of Florida, which prohibits DMS from implementing a prior authorization program or a restricted formulary program in the Prescription Drug Plan that restricts a non-HMO enrollee in the SGI Program from accessing certain prescription drugs. The restriction created by the chapter law is reflected in a statutory footnote to s. 110.12315, F.S. The footnote must be repealed to allow DMS to implement formulary management techniques as required by the bill.

The bill provides an effective date of July 1, 2017.

[17] 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* (last viewed March 16, 2017).

B. SECTION DIRECTORY:

Section 1: Amends s. 110.12315, F.S., relating to prescription drug program.
Section 2: 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 3: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

DMS projects annual savings to the state program of approximately $55 million (see Fiscal Comments) annually by employing various formulary management techniques. Members of the plan are expected to realize $2 million in savings from reduced cost-sharing obligations. The DSGI expects January 1, 2018 implementation date, which generates a savings of $15.9 million in General Revenue Funds and $13.3 million in trust funds.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Based on implementing CVS/Caremark's standard prescription drug formulary with exclusions and prior authorization, the projected impacts to members and the number of prescriptions are:

- Non-Specialty Prescriptions 102,687
- Specialty Prescriptions 597
- Total (4,081,887 prescriptions in FY2015-2016) 103,284 or 2.3%

- Non-Specialty Members 36,071
- Specialty Members 149

- Total (366,080 total members) 36,220 or 10.1%[18]

The projected savings[19], or cost avoidance to the Prescription Drug Plan, from implementing formulary management techniques are:

- Total Goss Savings $57M or 7.2%
- Net Plan Savings $55M or 7.4%
- Net Member Savings $2.0M or 3.9%[20]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not to affect county or municipal government.

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

On March 14, 2017, the Health Innovation Subcommittee adopted a strike-all amendment to the bill. The amendment:

- Deleted a footnote to s. 110.12315, F.S., which prohibited DMS from implementing prior authorization program or a restricted prescription drug formulary program which restricts a non-HMO enrollee's access to prescriptions drugs;
- Clarified that a drug excluded from the formulary is available for inclusion for a member or her or his dependent by medical necessity review and authorization;
- Detailed how retail, mail order, and specialty pharmacies are reimbursed;
- Permitted prescription refills for less than a 30-day supply or 90-day supply;
- Required DMS to maintain all drug lists used by the Prescription Drug Plan; and
- Made technical changes to reflect current administration of the Prescription Drug Plan by DMS.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.

[18] Department of Management Services, *2017 Agency Legislative Bill Analysis for HB 993*, March 7, 2017, pg. 6 (on file with Health Innovation Subcommittee staff). Member impact for subsequent years is expected to be approximately 1-2%.
[19] Projected cost avoidance fluctuates quarterly based on utilization, inflation and formulary changes.
[20] Supra, FN 18.