HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 517 State Employees' Prescription Drug Program
SPONSOR(S): Magar
TIED BILLS: **IDEN./SIM. BILLS:** SB 954

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Committee	19 Y, 0 N	Grabowski	Calamas
2) Appropriations Committee	28 Y, 0 N	Delaney	Leznoff

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 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.

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 517 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.

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.

Based on a January 1, 2019 projected implementation date, the provisions of the bill result in a positive budgetary fiscal impact to the state of $15.3 million in General Revenue and $11.7 million in trust funds in fiscal year 2018-2019.

The bill provides an effective date of July 1, 2018.

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 $1.87 billion out of total premium of $2.04 billion for active employees during FY 2017-18[2]. Retirees and COBRA participants contributed an additional $239.2 million in premiums, with $168.7 million in other revenue for a total of $2.45 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. New contracts with the HMOs have subsequently been executed for plan years 2018-2020.[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, 2018 through June 30, 2023*, adopted December 13, 2017, 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
[6] Beginning in 2018, Florida Health Care Plans is no longer a participating HMO in the SGI program.

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 $1,350 for individual coverage and $2,700 for family coverage for network providers.[9] 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[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	*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

[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] Department of Management Services, *myFlorida*, *2018 Benefits Guide*, available at https://www.mybenefits.myflorida.com/content/download/132894/826709/2018_102417_Benefits_Guide.pdf (last viewed November 21, 2017).
[10] Id., The IRS annually sets the contribution limit, as adjusted by inflation.

	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

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 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

[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 November 21, 2017).
[13] The Prescription Drug Plan Preferred List for October 2017 is available at www.caremark.com/portal/asset/sof_preferred_dl.pdf (last viewed November 21, 2017).

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.

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.[14]

	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[15] 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.[16]

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

[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] 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/ (last accessed November 22, 2017).
[16] 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 November 21, 2017).

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 2017, the PBM excluded 131 drugs from the formulary.[17]

Effect of Proposed Changes

HB 517 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[18], 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 provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Amends s. 110.12315, F.S., relating to the 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, 2018.

[17] CVSHealth, *Utilization and Spend for 2017 Standard Formulary Exclusions-State of Florida* (on file with Health Innovation Subcommittee staff).
[18] 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 (last viewed November 21, 2017).

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 $54.1 million (see Fiscal Comments) by employing various formulary management techniques. The July 1, 2018, effective date would allow DSGI to implement the formulary management protocols on January 1, 2019, which would generate a projected savings of $15.3 million in General Revenue Funds and $11.7 million in trust funds during the second half of FY 2018-19.[19]

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[20] are:

Non-Specialty Prescriptions	84,043
Specialty Prescriptions	513
Total (4,450,316 prescriptions in FY2016-2017)	84,556 or 1.9%
Non-Specialty Use - Members	30,917
Specialty Use - Members	130
Total (361,012)	31,047 or 8.6%

The projected savings[21], or cost avoidance to the Prescription Drug Plan, from implementing formulary management techniques are:

- Total Gross Savings — $55.6M or 7.1% of gross costs
- Net Plan Savings — $54.1M or 7.4% of net costs
- Net Member Savings — $ 1.5M or 3.2%[22] of member costs

[19] E-mail correspondence from DMS, dated December 1, 2017. On file with staff of the Committee on Health and Human Services.
[20] Department of Management Services, *2018 Agency Legislative Bill Analysis for HB 517*, November 27, 2017, pgs. 5-6 (on file with Health Innovation Subcommittee staff). Member impact for subsequent years is expected to be approximately 1-2%.
[21] Projected cost avoidance fluctuates quarterly based on utilization, inflation and formulary changes.
[22] 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 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