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 Health Policy

BILL:	SB 954
INTRODUCER:	Senator Passidomo
SUBJECT:	State Employees' Prescription Drug Program
DATE:	January 22, 2018
REVISED:	01/23/18

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**
2.			AGG	
3.			AP	

I. Summary:

SB 954 directs the Department of Management Services to implement formulary management cost-saving measures in the state employees' prescription drug program, including the inclusion and exclusion of prescription drugs. The cost-saving measures may not restrict access to the most clinically appropriate, clinically effective, lowest net-cost prescription drugs. The measures must also permit a specified prescribing practitioner to indicate when an excluded drug is medically necessary and cannot be substituted.

The bill removes a provision authorized in Chapter 99-255, Laws of Florida, which prohibits the implementation of a prior authorization program or a restricted formulary program on a non-HMO enrollee's access to certain prescription drugs.

Based on a January 1, 2019 implementation date, the bill has a projected positive 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 annualized savings are projected at a total $54.1 million.

The effective date of the bill is January 1, 2019.

II. Present Situation:

Cafeteria Plans

A cafeteria plan is a separate written plan maintained by an employer for employees that allows participants to receive certain benefits on a pre-tax basis. Participants must be permitted to

choose among at least one taxable benefit (cash) and one qualified benefit.[1] Employer contributions are usually made through a salary reduction agreement between the employer and employee on a pre-tax basis.

A qualified benefit does not confer compensation and it is excluded from an employee's gross income. Qualified benefits include benefits such as:

- Accident and health benefits;
- Adoption assistance;
- Dependent care assistance;
- Group life insurance coverage; and
- Health savings account, including distributions to pay long-term care services.[2]

In general, to qualify for the cafeteria plan as an employee, the employee must have had at least 1,000 hours of service in the prior year.[3] An employer may elect to exclude employees under the age of 21, those who have been in service for less than one year, those covered under a collective bargaining agreement with a cafeteria plan, or who are non-resident aliens working inside the United States.[4]

State Group Health Insurance Program Background

The State Group Health Insurance Program (SGI) 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 state group health insurance plan is administered as a cafeteria plan consistent with Section 125, Internal Revenue Code.[5]

The SGI 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. The SGI program typically makes program changes on a plan year basis, January 1 through December 31. Benefit changes are subject to approval of the Legislature.

The health insurance benefit for active employees has premium rates for single, spouse program,[6] or family coverage regardless of plan selection. The state contributes approximately 92 percent of the total annual premium for active employees, $1.87 billion out of a total premium of $2.04 billion for active employees during fiscal year 2017-2018.[7]

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[1] Internal Revenue Service, *FAQs for Government Entities regarding Cafeteria Plans* (last updated Nov. 11, 2017) https://www.irs.gov/government-entities/federal-state-local-governments/faqs-for-government-entities-regarding-cafeteria-plans (last visited Jan. 18, 2018).
[2] *Id*.
[3] 26 U.S.C. §125(4)(A).
[4] 26 U.S.C. §125(4)(B).
[5] Department of Management Services, *2018 Plan Year Benefits Guide*, pg. 9, https://www.mybenefits.myflorida.com/content/download/132894/826709/2018_102417_Benefits_Guide.pdf (last visited Jan. 19, 2018).
[6] The Spouse program provides discounted rates for family coverage when both spouses work for the state.
[7] 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,*

Health Plan Options

The SGI provides employees with two types of health plans: health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The PPO is the statewide, self-insured health plan administered by Florida Blue, whose current contract is effective from the 2015 through 2018 plan years. The administrator is responsible for processing health claims, providing access to a Preferred Provider Care Network, 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.[8]

Prior to the 2011 plan year, the participating HMOs were fully insured, meaning 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 for the 2012 plan year and beyond for HMOs.[9] The department included these costing options in its *Invitation to Negotiate* to HMOs for plan years beginning January 1, 2012.[10]

Currently, there are four vendors participating who were awarded contracts with initial terms of three years (January 1, 2018 through December 2020) with annual renewal options for up to three additional years.[11] The number of HMO vendors per county was limited to one. Three of the HMOs vendors were contracted under a self-insured financial model and two HMOs were contracted under a fully-insured model.[12] Approximately 52 percent of all participants in the plan are enrolled in HMO plans.[13]

The SGI program also includes two high deductible health plans (HDHPs) with health savings accounts (HSAs). The Health Investor PPO is the statewide HDHP with the integrated HSA. The plan is administered by Florida Blue.[14] The Health Investor HMO Plan is an HDHP with an integrated HSA for which employees can combine with one of several state or regional HMOs.[15]

2018 through June 30, 2023, adopted December 13, 2017, p 6, *available at* http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf (last visited Jan. 19, 2018).

[8] Department of Management Services, MyBenefits, *2018 Health Plan Options,* https://www.mybenefits.myflorida.com/health/2018_benefit_options/2018_health_plan_options (last visited Jan 22, 2018). The current contracted HMOs are: Aetna, AvMed, Capital Health Plan, and United Healthcare.

[9] *See* Chapter 2010-150, s. 3, Laws of Fla.

[10] Department of Management Services, *Invitation to Negotiate, No.: DMS 10/11-011*, pg. 7, http://www.myflorida.com/apps/vbs/adoc/F4568_HMORFPWordWrap_Final.pdf (last visited Jan. 19, 2018).

[11] State Employees' Group Health Self-Insurance Trust Fund, *Report on Financial Outlook for the Fiscal Years Ending June 30, 2018 through June 30, 2023,* Adopted at the August 3, 2017 Self-Insurance Estimating Conference, pg. 1, http://edr.state.fl.us/Content/conferences/healthinsurance/archives/170803healthins.pdf (last visited Jan. 19, 2018).

[12] *Id.*

[13] *Id.*

[14] Department of Management Services, *MyBenefits, Health Insurance Plans,* https://www.mybenefits.myflorida.com/health/health_insurance_plans (last visited Jan. 19, 2018).

[15] Department of Management Services, State Group Insurance, *2018 Plan Year – 2018 Benefits Guide,* https://www.mybenefits.myflorida.com/content/download/132894/826709/2018_102417_Benefits_Guide.pdf (last visited Jan. 19, 2018).

Flexible Spending and Savings Accounts

A flexible spending account (FSA) is also a form of a cafeteria plan benefit funded through salary reductions that reimburses employees for qualified expenses. An FSA may be created for dependent care assistance, adoption assistance, and medical care reimbursement.[16] Pre-tax dollars are deposited into an FSA account through payroll deduction. The employee uses either a prepaid card or submits claims for reimbursement for eligible expenses.
Florida offers its employees four types of accounts:

- Health Care Flexible Spending Accounts (FSA);
- Limited Purpose Flexible Spending Accounts (FSA);
- Dependent Care Flexible Spending Accounts; and
- Health Savings Accounts (HSAs).

The limited purpose flexible spending account and health savings account (HSA) require the employee to pair the account with a high deductible/health savings account plan (HDHP/HSA).[17]

Three of these four savings and spending accounts (Healthcare FSA, Limited purpose FAS, and Health Savings Account) allow the employee to use pre-tax dollars for eligible medical, prescription, dental, or vision care services that are not otherwise covered by the employee's insurance plan.[18] The chart below compares the different savings and spending accounts for health benefits with the High Deductible Health Plans.

The high deductible health plan HMO has the same in-network requirements as the standard HMO; however, the member must meet a higher deductible before anything except certain preventive services are covered. Once the member has met the deductible, the member is responsible for coinsurance for all services and prescription drugs which is 20 percent in-network and 40 percent out-of-network, plus the cost difference between the charge and out-of-network allowance.[19]

Additionally, employers are permitted, at their option, to amend their cafeteria plans, to allow employees to carryover up to $500 of any unused amount under a Healthcare Flexible Spending Account (FSA) to the following plan year. Healthcare FSA funds can be used to pay for healthcare expenses not covered by insurance such as contact lenses, deductibles, dental treatment, or a private hospital room.[20] The carry-over amount does not count against the annual

[16] *Id.*
[17] Department of Management Services, MyBenefits, *Savings and Spending Accounts,* https://www.mybenefits.myflorida.com/health/savings_and_spending_accounts (last visited Jan. 19, 2018).
[18] Department of Management Services, *My Benefits – Savings and Spending Accounts,* https://www.mybenefits.myflorida.com/health/savings_and_spending_accounts (last visited Jan. 19, 2018).
[19] Department of Management Services, *Health Plan Summary Comparison Chart,* p 19, https://www.mybenefits.myflorida.com/content/download/132894/826709/2018_102417_Benefits_Guide.pdf (last visited Jan 19, 2018).
[20] Chard Snyder Benefit Solutions, *2018 Savings and Spending Accounts Guide,* https://www.mybenefits.myflorida.com/content/download/134963/849052/SOF_2018_S&SA_Guide_FINAL_VERSION_-_APPROVED_10-6.pdf (last visited Jan. 19, 2018).

salary reduction limit.[21] For those age 55 and over, participants are permitted to make annual "catch up" contributions of up to $1,000.[22]

State Employee Health Care Options- 2018[23]					
	HDHP (HMO or PPO)		Health Savings Account (HSA	Limited Purpose FSA	Healthcare FSA
	Deductible (Minimum)	Out of Pocket (Maximum)	Contribution (Maximum)	Contribution (Maximum)	Contribution (Maximum)
Self	$1,350	$3,000 (HMO) $4,350 (PPO)	$3,450	$2,650	$2,650
Family	$2,700	$6,000 (HMO) $8,700 (PPO)	$6,900	$2,650	$2,650
Other Plan Required?	Pair with HSA	Pair with HSA	Pair with HDHP	Pair with HDHP	NA
Catch-Up for 55+?	No	No	$1,000/year	No	No
Carryover?	NA	NA	Rolls over every year; can take with you when you leave	$500	$500

Current State Prescription Drug Plan

The DMS contracts with third party administrators for self-insured health plans, insured health maintenance organizations (HMOs), and a pharmacy benefits manager (PBM) for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.[24] In fiscal year 2016-2017, the total pharmacy claims expenses were $611.7 million.[25]

The pharmacy benefits manager for the State Employees' Prescription Drug Plan is CVS/caremark. The cost to a member for a drug varies depending on which health plan a member is enrolled in and whether the prescription is generic, a preferred brand-name, or a non-preferred brand-name.[26] The following chart depicts the member's cost.

[21] Department of Treasury, Internal Revenue Service, *Notice 2013-71: Modification of "Use or Lose" Rule for Health Flexible Spending Arrangements (FSAs) and Clarification Regarding 2013-2014 Non-Calendar Year Salary Reduction Elections Under §125 Cafeteria Plans*, https://www.irs.gov/pub/irs-drop/n-13-71.pdf (last visited Jan. 19, 2018).
[22] Department of Management Services, *Health Savings Account*, https://www.mybenefits.myflorida.com/health/savings_and_spending_accounts/health_savings_account (last visited Jan. 18, 2018.)
[23] *Supra* note 19.
[24] Department of Management Services, *House Bill 517 Analysis* (November 27, 2017) (on file with the Senate Committee on Health Policy).
[25] *Supra* note 13, at 5.
[26] Department of Management Services, *MyBenefits, Prescription Drug Plan*, https://www.mybenefits.myflorida.com/health/health_insurance_plans/prescription_drug_plan (last visited Jan. 18, 2018).

Copayments or Coinsurance for State Employee Prescriptions and 90-Day Maintenance Medications[27]						
	Standard PPO[28] Standard HMO			High Deductible HMO High Deductible PPO		
	Retail (30 day)	***Mail Order (90 days)***	***Retail (90 days)***	***Retail 30 day***	***Mail Order 90 day***	***Retail 90 day***
Generic						
Preferred Brand Name[29]	$7	$14		30%		
Non-Preferred Brand Name	$30	$60		30%		
	$50	$100		30%		

The plan currently covers all federal legend drugs[30] (open formulary) for covered medical conditions, and provides very limited utilization review and clinical review for traditional or specialty prescription drugs.[31] However, the PBM announces each July the therapeutic classes of drugs that will be excluded from the next plan year.

The current plan also covers compounded medications. Compounded medications combine, mix, or alter the ingredients of one or more drugs or products to create another drug or product. The plan only covers the federal legend drug ingredient of a compounded medication when all of the following criteria are met:

- 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 ch. 465, F.S., the Florida Pharmacy Act.[32]

[27] Maintenance medications are considered those prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions require regular or on-going use of the drugs. Some examples include those medications that treat heart disease, diabetes, asthma, or heart disease.
[28] Members enrolled in a state employee PPO plan must fill their maintenance medications through the mail order pharmacy or a participating 90-day retail pharmacy after three fills at a 30-day retail pharmacy. *See* Department of Management Services, Prescription Drug Plan https://www.mybenefits.myflorida.com/health/health_insurance_plans/prescription_drug_plan (last visited Jan. 18, 2018).
[29] Members who request a preferred brand-name drug when a generic is available, must pay the difference between the generic cost and the preferred name-brand cost, plus the appropriate copayment or coinsurance. If the prescribing physician writes on the prescription that the preferred brand is medically necessary or to "dispense as written" and the reason, the member pays only the appropriate brand copayment or coinsurance. *See* Department of Management Services, *Frequently Asked Questions*, https://www.mybenefits.myflorida.com/health/resources/faq_s/frequently_asked_questions_prescription_drug_plan (last visited Jan. 19, 2018).
[30] A legend drug is defined as any drug approved by the U.S. Food and Drug Administration 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.
[31] *Supra*, note 19 at 19.
[32] Department of Management Services, *My Benefits, Frequently Asked Questions – Prescription Drug Plan*, https://www.mybenefits.myflorida.com/health/resources/faq_s/frequently_asked_questions_prescription_drug_plan (last visited Jan. 19, 2018).

Currently, the law prohibits the program from implementing a restricted formulary or prior authorization process on the non-HMO component of the state employees' prescription drug program.[33] In August 2017, the state's Revenue Estimating Conference (REC) projected gross costs related to prescription drug coverage to increase by 55 percent over the next three years or nearly $693 billion for fiscal year 2017-2018 to $1.1 billion in fiscal year 2020-2021.[34] These estimates were reduced slightly in December, 2017, with reductions in enrollment and projected claims experience; however, the Self-Insurance Estimating Conference revised upwards the HMO pharmacy growth factor slightly from 15.9 percent to 16 percent for fiscal year 2018-2019 through 2022-2023.[35] This adjustment in the growth factor indicates a forecast for continued increases year after year in pharmacy costs beyond what had been predicted in December 2017.

National health spending on prescription drugs is projected to peak in 2018 at 7.6 percent, as fewer brand-name drugs are expected to lose patent protection and is expected to grow at an average of 6.3 percent a year in the private marketplace for 2016 through 2025.[36]

Formulary Development

Formularies are developed by a pharmacy and therapeutics (P&T) committee or an equivalent entity within health plans, PBMs, hospitals, government agencies, and Medicare and Medicaid programs. The P&T committee determines which medications and related products should be listed on the formulary. The committee is composed of primary care and specialty care physicians, pharmacists and other professionals in the health care field and can also include nurses, legal experts, and administrators.[37] In order to keep up to date on newly approved medications from the United States Food and Drug Administration the P&T committee should meet regularly to review newly released drugs and classes of drugs. As part of that review process, the P&T committee reviews some or all of the following:

- Medical and clinical literature including clinical trials and treatment guidelines, comparative effectiveness reports, pharmacoeconomic studies and outcomes data;
- FDA-approved prescribing information and related FDA information including safety data;
- Relevant information on use of medications by patients and experience with specific medications;
- Current therapeutic use and access guidelines and the need for revised or new guidelines;
- Economic data, such as total health care costs, including drug costs;
- Drug and other health care cost data (not all P&T committees review drug specific economic data); and

[33] Ch. 99-255, s. 8, Laws of Fla.
[34] Department of Management Services, *Executive Briefing Paper – Formulary Management* (on file with the Senate Health Policy Committee).
[35] State Employee's Group Health Self-Insurance Trust Fund, *Report on Financial Outlook (For the Fiscal Years Ending June 30, 2018 through June 30, 2023)*, pg. 3, Adopted at the December 13, 2017 Self-Insurance Estimating Conference, http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf (last visited Jan. 19, 2018).
[36] Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2016-2025, *Forecast Summary*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf (last visited Jan. 19, 2018).
[37] Academy of Managed Care Pharmacy, *Formulary Management*, http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=9298 (last visited Jan. 19, 2018).

- Health care provider recommendations.[38]

Florida uses a P&T committee in its Medicaid program.[39] Membership on its committee includes physicians, pharmacists, and a consumer. The Medicaid preferred drug list is a listing of cost-effective, safe, and clinically efficient medications for each of the therapeutic classes on the list and is posted on the Agency for Health Care Administration's website.[40] Medicaid recipients may appeal any drug formulary decisions using the Medicaid fair hearing process.[41]

III. Effect of Proposed Changes:

Section 1 directs the Department of Management Services to implement formulary management cost saving measures in the state employees' prescription drug program as established in s. 110.12315, F.S. The measures must require that the prescription drugs be subject to formulary inclusion or exclusion, but may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs.

The formulary program must allow for an excluded drug to be included if a physician, an advanced registered nurse practitioner, or a physician assistant prescribing a pharmaceutical clearly states that the excluded drug is medically necessary and cannot be substituted.

According to the DMS, the CVS/caremark[42] formulary for 2018 covers the majority of generic drugs on the market as well as approximately 5,400 brand name drugs (preferred, non-preferred, and specialty). The 2019 formulary also excludes 159 drugs, test strips, insulin syringes, and pen needles which, as exclusions, require prior authorization or clinical review for members to receive.[43]

By October of each year, CVS/caremark would announces the therapeutic classes and the specific drugs that will be impacted by formulary changes.

Section 2 deletes Section 8 of Chapter 99-255, Laws of Florida, to remove a provision that prohibits the DMS from implementing a restricted prescription drug formulary or prior authorization program in the state employees' prescription drug program.

Section 3 provides an effective date of January 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[38] *Id.*
[39] Section 409.9119(1), F.S.
[40] *See Florida Medicaid Preferred Drug List (PDL),* http://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml (last visited Jan. 19, 2018).
[41] Section 409.9119(11), F.S.
[42] CVS/caremark is the state's contracted PBM for the state employee prescription drug program.
[43] *Supra* note 29, at 6.

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:

If CVS/caremark's 2018 Standard Control Formulary[44] were implemented, the projected impacts on current prescriptions filled and members are:

Non-Specialty Prescriptions:	84,043
Specialty Prescriptions:	513
Total:	84,556 or 1.9% of all prescriptions
Non-Specialty Members:	30,917
Specialty Members:	130
Total:	31,047 or 8.6% of all members

With a restricted formulary or prior authorization process, prescribers in the private sector or public sector need to indicate that a drug is "medically necessary" or to engage in a prior authorization process if a member needs an excluded drugs. This may create an administrative burden on the health care community, depending on the volume of members who seek exceptions.

Taxpayers may experience savings from the implementation of a restricted formulary and prior authorization process as the bill is projected to reduce state expenditures by $54 million on an annual basis.

C. Government Sector Impact:

The DMS estimates that the implementation of a standard formulary would result in a cost avoidance to the state of approximately $27 million in the first half of the fiscal year and $54 million annually thereafter.[45] The estimate is based on 2017 member utilization, the program's current Preferred Drug list, and the 2018 CVS/caremark Standard Control Formulary.

[44] CVS/caremark, *Prescribing Guide – Standard Control 2018* (January 2018) https://www.caremark.com/portal/asset/prescribing_guide.pdf (last visited Jan. 19, 2018).
[45] *Supra* note 33.

The DMS projects the annual fiscal year savings from the proposed changes in SB 954 at $55.6 million or a net plan savings of $54 million. The net savings projected to the SGI members is $1.5 million.[46]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 110.12315 of the Florida Statutes and 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.

[46] *Supra*, note 24 at 6.