CHAMBER ACTION

Senate		House
	.	

1 Representative Renner offered the following:

2

3 **Amendment to Amendment (640584) (with title amendment)**

4 Remove lines 5-556 of the amendment and insert:

5 Section 1. Paragraphs (c) and (h) of subsection (3) of
6 section 110.123, Florida Statutes, are amended to read:

7 110.123 State group insurance program.—

8 (3) STATE GROUP INSURANCE PROGRAM.—

9 (c) Notwithstanding any provision in this section to the
10 contrary, it is the intent of the Legislature that the
11 department shall be responsible for all aspects of the purchase
12 of health care for state employees under the state group health
13 insurance plan or plans, TRICARE supplemental insurance plans,

14 and the health maintenance organization plans. Responsibilities
15 shall include, but not be limited to, the development of
16 requests for proposals or invitations to negotiate for state
17 employee health benefits ~~services~~, the determination of health
18 care benefits to be provided, and the negotiation of contracts
19 for health care and health care administrative services. Prior
20 to the negotiation of contracts for health care services, the
21 Legislature intends that the department shall develop, with
22 respect to state collective bargaining issues, the health
23 benefits and terms to be included in the state group health
24 insurance program. The department shall adopt rules necessary to
25 perform its responsibilities pursuant to this section. ~~It is the~~
26 ~~intent of the Legislature that~~ The department is ~~shall be~~
27 responsible for the contract management and day-to-day
28 management of the state employee health insurance program,
29 including, but not limited to, employee enrollment, premium
30 collection, payment to health care providers, and other
31 administrative functions related to the program.
32 (h)1. A person eligible to participate in the state group
33 insurance program may be authorized by rules adopted by the
34 department, in lieu of participating in the state group health
35 insurance plan, to exercise an option to elect membership in a
36 health maintenance organization plan which is under contract
37 with the state in accordance with criteria established by this
38 section and by said rules. The offer of optional membership in a

39 health maintenance organization plan permitted by this paragraph
40 may be limited or conditioned by rule as may be necessary to
41 meet the requirements of state and federal laws.
42 2. The department shall contract with health maintenance
43 organizations seeking to participate in the state group
44 insurance program through a request for proposal or other
45 procurement process, as developed by the Department of
46 Management Services and determined to be appropriate.
47 a. The department shall establish a schedule of minimum
48 benefits for health maintenance organization coverage, and that
49 schedule shall include: physician services; inpatient and
50 outpatient hospital services; emergency medical services,
51 including out-of-area emergency coverage; diagnostic laboratory
52 and diagnostic and therapeutic radiologic services; mental
53 health, alcohol, and chemical dependency treatment services
54 meeting the minimum requirements of state and federal law;
55 skilled nursing facilities and services; prescription drugs;
56 age-based and gender-based wellness benefits; and other benefits
57 as may be required by the department. Additional services may be
58 provided subject to the contract between the department and the
59 HMO. As used in this paragraph, the term "age-based and gender-
60 based wellness benefits" includes aerobic exercise, education in
61 alcohol and substance abuse prevention, blood cholesterol
62 screening, health risk appraisals, blood pressure screening and
63 education, nutrition education, program planning, safety belt

64 education, smoking cessation, stress management, weight
65 management, and women's health education.
66 b. The department may establish uniform deductibles,
67 copayments, coverage tiers, or coinsurance schedules for all
68 participating HMO plans.
69 c. The department may require detailed information from
70 each health maintenance organization participating in the
71 procurement process, including information pertaining to
72 organizational status, experience in providing prepaid health
73 benefits, accessibility of services, financial stability of the
74 plan, quality of management services, accreditation status,
75 quality of medical services, network access and adequacy,
76 performance measurement, ability to meet the department's
77 reporting requirements, and the actuarial basis of the proposed
78 rates and other data determined by the director to be necessary
79 for the evaluation and selection of health maintenance
80 organization plans and negotiation of appropriate rates for
81 these plans. Upon receipt of proposals by health maintenance
82 organization plans and the evaluation of those proposals, the
83 department may enter into negotiations with all of the plans or
84 a subset of the plans, as the department determines appropriate.
85 ~~Nothing shall preclude~~ The department may negotiate ~~from~~
86 ~~negotiating~~ regional or statewide contracts with health
87 maintenance organization plans. Such plans must be ~~when this is~~

88 cost-effective and <u>must offer</u> ~~when the department determines~~
89 ~~that the plan offers~~ high value to enrollees.
90 d. The department may limit the number of HMOs that it
91 contracts with in each <u>region</u> ~~service area~~ based on the nature
92 of the bids the department receives, the number of state
93 employees in the <u>region</u> ~~service area~~, or any unique ~~geographical~~
94 characteristics of the <u>region</u> ~~service area~~. The department shall
95 establish <u>the regions throughout the state by rule. The</u>
96 <u>department must submit the rule to the President of the Senate</u>
97 <u>and the Speaker of the House of Representatives for ratification</u>
98 <u>no later than 30 days before the 2020 Regular Session of the</u>
99 <u>Legislature. The rule may not take effect until it is ratified</u>
100 <u>by the Legislature</u> ~~by rule service areas throughout the state~~.
101 e. All persons participating in the state group insurance
102 program may be required to contribute towards a total state
103 group health premium that may vary depending upon the plan,
104 coverage level, and coverage tier selected by the enrollee and
105 the level of state contribution authorized by the Legislature.
106 3. The department is authorized to negotiate and to
107 contract with specialty psychiatric hospitals for mental health
108 benefits, on a regional basis, for alcohol, drug abuse, and
109 mental and nervous disorders. The department may establish,
110 subject to the approval of the Legislature pursuant to
111 subsection (5), any such regional plan upon completion of an

112 actuarial study to determine any impact on plan benefits and
113 premiums.
114 4. In addition to contracting pursuant to subparagraph 2.,
115 the department may enter into contract with any HMO to
116 participate in the state group insurance program which:
117 a. Serves greater than 5,000 recipients on a prepaid basis
118 under the Medicaid program;
119 b. Does not currently meet the 25-percent non-
120 Medicare/non-Medicaid enrollment composition requirement
121 established by the Department of Health excluding participants
122 enrolled in the state group insurance program;
123 c. Meets the minimum benefit package and copayments and
124 deductibles contained in sub-subparagraphs 2.a. and b.;
125 d. Is willing to participate in the state group insurance
126 program at a cost of premiums that is not greater than 95
127 percent of the cost of HMO premiums accepted by the department
128 in each service area; and
129 e. Meets the minimum surplus requirements of s. 641.225.
130
131 The department is authorized to contract with HMOs that meet the
132 requirements of sub-subparagraphs a.-d. prior to the open
133 enrollment period for state employees. The department is not
134 required to renew the contract with the HMOs as set forth in
135 this paragraph more than twice. Thereafter, the HMOs shall be
136 eligible to participate in the state group insurance program

137 only through the request for proposal or invitation to negotiate
138 process described in subparagraph 2.
139 5. All enrollees in a state group health insurance plan, a
140 TRICARE supplemental insurance plan, or any health maintenance
141 organization plan have the option of changing to any other
142 health plan that is offered by the state within any open
143 enrollment period designated by the department. Open enrollment
144 shall be held at least once each calendar year.
145 6. When a contract between a treating provider and the
146 state-contracted health maintenance organization is terminated
147 for any reason other than for cause, each party shall allow any
148 enrollee for whom treatment was active to continue coverage and
149 care when medically necessary, through completion of treatment
150 of a condition for which the enrollee was receiving care at the
151 time of the termination, until the enrollee selects another
152 treating provider, or until the next open enrollment period
153 offered, whichever is longer, but no longer than 6 months after
154 termination of the contract. Each party to the terminated
155 contract shall allow an enrollee who has initiated a course of
156 prenatal care, regardless of the trimester in which care was
157 initiated, to continue care and coverage until completion of
158 postpartum care. This does not prevent a provider from refusing
159 to continue to provide care to an enrollee who is abusive,
160 noncompliant, or in arrears in payments for services provided.
161 For care continued under this subparagraph, the program and the

162 provider shall continue to be bound by the terms of the
163 terminated contract. Changes made within 30 days before
164 termination of a contract are effective only if agreed to by
165 both parties.
166 7. Any HMO participating in the state group insurance
167 program shall submit health care utilization and cost data to
168 the department, in such form and in such manner as the
169 department shall require, as a condition of participating in the
170 program. The department shall enter into negotiations with its
171 contracting HMOs to determine the nature and scope of the data
172 submission and the final requirements, format, penalties
173 associated with noncompliance, and timetables for submission.
174 These determinations shall be adopted by rule.
175 8. The department may establish and direct, with respect
176 to collective bargaining issues, a comprehensive package of
177 insurance benefits that may include supplemental health and life
178 coverage, dental care, long-term care, vision care, and other
179 benefits it determines necessary to enable state employees to
180 select from among benefit options that best suit their
181 individual and family needs. Beginning with the 2018 plan year,
182 the package of benefits may also include products and services
183 described in s. 110.12303.
184 a. Based upon a desired benefit package, the department
185 shall issue a request for proposal or invitation to negotiate
186 for providers interested in participating in the state group

187 insurance program, and the department shall issue a request for
188 proposal or invitation to negotiate for providers interested in
189 participating in the non-health-related components of the state
190 group insurance program. Upon receipt of all proposals, the
191 department may enter into contract negotiations with providers
192 submitting bids or negotiate a specially designed benefit
193 package. Providers offering or providing supplemental coverage
194 as of May 30, 1991, which qualify for pretax benefit treatment
195 pursuant to s. 125 of the Internal Revenue Code of 1986, with
196 5,500 or more state employees currently enrolled may be included
197 by the department in the supplemental insurance benefit plan
198 established by the department without participating in a request
199 for proposal, submitting bids, negotiating contracts, or
200 negotiating a specially designed benefit package. These
201 contracts shall provide state employees with the most cost-
202 effective and comprehensive coverage available; however, except
203 as provided in subparagraph (f)3., no state or agency funds
204 shall be contributed toward the cost of any part of the premium
205 of such supplemental benefit plans. With respect to dental
206 coverage, the division shall include in any solicitation or
207 contract for any state group dental program made after July 1,
208 2001, a comprehensive indemnity dental plan option which offers
209 enrollees a completely unrestricted choice of dentists. If a
210 dental plan is endorsed, or in some manner recognized as the
211 preferred product, such plan shall include a comprehensive

212 indemnity dental plan option which provides enrollees with a
213 completely unrestricted choice of dentists.
214 b. Pursuant to the applicable provisions of s. 110.161,
215 and s. 125 of the Internal Revenue Code of 1986, the department
216 shall enroll in the pretax benefit program those state employees
217 who voluntarily elect coverage in any of the supplemental
218 insurance benefit plans as provided by sub-subparagraph a.
219 c. Nothing herein contained shall be construed to prohibit
220 insurance providers from continuing to provide or offer
221 supplemental benefit coverage to state employees as provided
222 under existing agency plans.
223 Section 2. Section 110.12303, Florida Statutes, is amended
224 to read:
225 110.12303 State group insurance program; additional
226 benefits; price transparency program; reporting.~~ Beginning with~~
227 ~~the 2018 plan year:~~
228 (1) In addition to the comprehensive package of health
229 insurance and other benefits required or authorized to be
230 included in the state group insurance program, the package of
231 benefits may also include products and services offered by:
232 (a) Prepaid limited health service organizations
233 authorized pursuant to part I of chapter 636.
234 (b) Discount medical plan organizations authorized
235 pursuant to part II of chapter 636.
236 (c) Prepaid health clinics licensed under part II of

237 chapter 641.
238 (d) Licensed health care providers, including hospitals
239 and other health care facilities, health care clinics, and
240 health professionals, who sell service contracts and
241 arrangements for a specified amount and type of health services.
242 (e) Provider organizations, including service networks,
243 group practices, professional associations, and other
244 incorporated organizations of providers, who sell service
245 contracts and arrangements for a specified amount and type of
246 health services.
247 (f) Entities that provide specific health services in
248 accordance with applicable state law and sell service contracts
249 and arrangements for a specified amount and type of health
250 services.
251 (g) Entities that provide health services or treatments
252 through a bidding process.
253 (h) Entities that provide health services or treatments
254 through the bundling or aggregating of health services or
255 treatments.
256 (i) Entities that provide international prescription
257 services.
258 (j) Entities that provide optional participation in a
259 Medicare Advantage Prescription Drug Plan.
260 (k) Entities that provide other innovative and cost-
261 effective health service delivery methods.

262 (2)(a) The department shall contract with at least one
263 entity that provides comprehensive pricing and inclusive
264 services for surgery and other medical procedures which may be
265 accessed at the option of the enrollee. The contract shall
266 require the entity to:
267 1. Have procedures and evidence-based standards to ensure
268 the inclusion of only high-quality health care providers.
269 2. Provide assistance to the enrollee in accessing and
270 coordinating care.
271 3. Provide cost savings to the state group insurance
272 program to be shared with both the state and the enrollee. Cost
273 savings payable to an enrollee may be:
274 a. Credited to the enrollee's flexible spending account;
275 b. Credited to the enrollee's health savings account;
276 c. Credited to the enrollee's health reimbursement
277 account; or
278 d. Paid as additional health plan reimbursements not
279 exceeding the amount of the enrollee's out-of-pocket medical
280 expenses.
281 4. Provide an educational campaign for enrollees to learn
282 about the services offered by the entity.
283 (b) On or before January 15 of each year, the department
284 shall report to the Governor, the President of the Senate, and
285 the Speaker of the House of Representatives on the participation
286 level and cost-savings to both the enrollee and the state

287 resulting from the contract or contracts described in this
288 subsection.
289 (3) The department shall contract with an entity that
290 provides enrollees with online information on the cost and
291 quality of health care services and providers, allows an
292 enrollee to shop for health care services and providers, and
293 rewards the enrollee by sharing savings generated by the
294 enrollee's choice of services or providers. The contract shall
295 require the entity to:
296 (a) Establish an Internet-based, consumer-friendly
297 platform that educates and informs enrollees about the price and
298 quality of health care services and providers, including the
299 average amount paid in each county for health care services and
300 providers. The average amounts paid for such services and
301 providers may be expressed for service bundles, which include
302 all products and services associated with a particular treatment
303 or episode of care, or for separate and distinct products and
304 services.
305 (b) Allow enrollees to shop for health care services and
306 providers using the price and quality information provided on
307 the Internet-based platform.
308 (c) Permit a certified bargaining agent of state employees
309 to provide educational materials and counseling to enrollees
310 regarding the Internet-based platform.
311 (d) Identify the savings realized to the enrollee and

312 state if the enrollee chooses high-quality, lower-cost health
313 care services or providers, and facilitate a shared savings
314 payment to the enrollee. The amount of shared savings shall be
315 determined by a methodology approved by the department and shall
316 maximize value-based purchasing by enrollees. The amount payable
317 to the enrollee may be:
318 1. Credited to the enrollee's flexible spending account;
319 2. Credited to the enrollee's health savings account;
320 3. Credited to the enrollee's health reimbursement
321 account; or
322 4. Paid as additional health plan reimbursements not
323 exceeding the amount of the enrollee's out-of-pocket medical
324 expenses.
325 (e) On or before January 1 of 2019, 2020, and 2021, the
326 department shall report to the Governor, the President of the
327 Senate, and the Speaker of the House of Representatives on the
328 participation level, amount paid to enrollees, and cost-savings
329 to both the enrollees and the state resulting from the
330 implementation of this subsection.
331 (4) The department shall offer, as a voluntary
332 supplemental benefit option, international prescription services
333 that offer safe maintenance medications at a reduced cost to
334 enrollees and that meet the standards of the United States Food
335 and Drug Administration personal importation policy.

336 Section 3. Subsections (9) and (10) are added to section
337 110.12315, Florida Statutes, to read:
338 110.12315 Prescription drug program.—The state employees'
339 prescription drug program is established. This program shall be
340 administered by the Department of Management Services, according
341 to the terms and conditions of the plan as established by the
342 relevant provisions of the annual General Appropriations Act and
343 implementing legislation, subject to the following conditions:
344 (9)(a) Beginning with the 2020 plan year, the department
345 must implement formulary management for prescription drugs and
346 supplies. Such management practices must require prescription
347 drugs to be subject to formulary inclusion or exclusion but may
348 not restrict access to the most clinically appropriate,
349 clinically effective, and lowest net-cost prescription drugs and
350 supplies. Drugs excluded from the formulary must be available
351 for inclusion if a physician, advanced practice registered
352 nurse, or physician assistant prescribing a pharmaceutical
353 clearly states on the prescription that the excluded drug is
354 medically necessary. Prescription drugs and supplies first made
355 available in the marketplace after January 1, 2020, may not be
356 covered by the prescription drug program until specifically
357 included in the list of covered prescription drugs and supplies.
358 (b) No later than October 1, 2019, and by each October 1
359 thereafter, the department must submit to the Governor, the
360 President of the Senate, and the Speaker of the House of

361 Representatives the list of prescription drugs and supplies that
362 will be excluded from program coverage for the next plan year.
363 If the department proposes to exclude prescription drugs and
364 supplies after the plan year has commenced, the department must
365 provide notice to the Governor, the President of the Senate, and
366 the Speaker of the House of Representatives of such exclusions
367 at least 60 days before implementation of such exclusions.
368 (10) In addition to the comprehensive package of health
369 insurance and other benefits required or authorized to be
370 included in the state group insurance program, the program must
371 provide coverage for medically necessary prescription and
372 nonprescription enteral formulas and amino-acid-based elemental
373 formulas for home use, regardless of the method of delivery or
374 intake, which are ordered or prescribed by a physician. As used
375 in this subsection, the term "medically necessary" means the
376 formula to be covered represents the only medically appropriate
377 source of nutrition for a patient. Such coverage may not exceed
378 an amount of $20,000 annually for any insured individual.
379 Section 4. Effective December 31, 2019, section 8 of
380 chapter 99-255, Laws of Florida, is repealed.
381 Section 5. Effective January 1, 2020, section 627.6387,
382 Florida Statutes, is created to read:
383 627.6387 Shared savings incentive program.—
384 (1) This section and ss. 627.6648 and 641.31076 may be
385 cited as the "Patient Savings Act."

386 (2) As used in this section, the term:
387 (a) "Health care provider" means a hospital or facility
388 licensed under chapter 395; an entity licensed under chapter
389 400; a health care practitioner as defined in s. 456.001; a
390 blood bank, plasma center, industrial clinic, or renal dialysis
391 facility; or a professional association, partnership,
392 corporation, joint venture, or other association for
393 professional activity by health care providers. The term
394 includes entities and professionals outside of this state with
395 an active, unencumbered license for an equivalent facility or
396 practitioner type issued by another state, the District of
397 Columbia, or a possession or territory of the United States.
398 (b) "Health insurer" means an authorized insurer offering
399 health insurance as defined in s. 624.603.
400 (c) "Shared savings incentive" means a voluntary and
401 optional financial incentive that a health insurer may provide
402 to an insured for choosing certain shoppable health care
403 services under a shared savings incentive program and may
404 include, but is not limited to, the incentives described in s.
405 626.9541(4)(a).
406 (d) "Shared savings incentive program" means a voluntary
407 and optional incentive program established by a health insurer
408 pursuant to this section.
409 (e) "Shoppable health care service" means a lower-cost,
410 high-quality nonemergency health care service for which a shared

411 savings incentive is available for insureds under a health
412 insurer's shared savings incentive program. Shoppable health
413 care services may be provided within or outside this state and
414 include, but are not limited to:
415 1. Clinical laboratory services.
416 2. Infusion therapy.
417 3. Inpatient and outpatient surgical procedures.
418 4. Obstetrical and gynecological services.
419 5. Inpatient and outpatient nonsurgical diagnostic tests
420 and procedures.
421 6. Physical and occupational therapy services.
422 7. Radiology and imaging services.
423 8. Prescription drugs.
424 9. Services provided through telehealth.
425 (3) A health insurer may offer a shared savings incentive
426 program to provide incentives to an insured when the insured
427 obtains a shoppable health care service from the health
428 insurer's shared savings list. An insured may not be required to
429 participate in a shared savings incentive program. A health
430 insurer that offers a shared savings incentive program must:
431 (a) Establish the program as a component part of the
432 policy or certificate of insurance provided by the health
433 insurer and notify the insureds and the office at least 30 days
434 before program termination.
435 (b) File a description of the program on a form prescribed

436 by commission rule. The office must review the filing and
437 determine whether the shared savings incentive program complies
438 with this section.
439 (c) Notify an insured annually and at the time of renewal,
440 and an applicant for insurance at the time of enrollment, of the
441 availability of the shared savings incentive program and the
442 procedure to participate in the program.
443 (d) Publish on a webpage easily accessible to insureds and
444 to applicants for insurance a list of shoppable health care
445 services and health care providers and the shared savings
446 incentive amount applicable for each service. A shared savings
447 incentive may not be less than 25 percent of the savings
448 generated by the insured's participation in any shared savings
449 incentive offered by the health insurer. The baseline for the
450 savings calculation is the average in-network amount paid for
451 that service in the most recent 12-month period or some other
452 methodology established by the health insurer and approved by
453 the office.
454 (e) At least quarterly, credit or deposit the shared
455 savings incentive amount to the insured's account as a return or
456 reduction in premium, or credit the shared savings incentive
457 amount to the insured's flexible spending account, health
458 savings account, or health reimbursement account, such that the
459 amount does not constitute income to the insured.
460 (f) Submit an annual report to the office within 90

461 business days after the close of each plan year. At a minimum,
462 the report must include the following information:
463 1. The number of insureds who participated in the program
464 during the plan year and the number of instances of
465 participation.
466 2. The total cost of services provided as a part of the
467 program.
468 3. The total value of the shared savings incentive
469 payments made to insureds participating in the program and the
470 values distributed as premium reductions, credits to flexible
471 spending accounts, credits to health savings accounts, or
472 credits to health reimbursement accounts.
473 4. An inventory of the shoppable health care services
474 offered by the health insurer.
475 (4)(a) A shared savings incentive offered by a health
476 insurer in accordance with this section:
477 1. Is not an administrative expense for rate development
478 or rate filing purposes.
479 2. Does not constitute an unfair method of competition or
480 an unfair or deceptive act or practice under s. 626.9541 and is
481 presumed to be appropriate unless credible data clearly
482 demonstrates otherwise.
483 (b) A shared savings incentive amount provided as a return
484 or reduction in premium reduces the health insurer's direct
485 written premium by the shared savings incentive dollar amount

486 for the purposes of the taxes in ss. 624.509 and 624.5091.
487 (5) The commission may adopt rules necessary to implement
488 and enforce this section.
489 Section 6. Effective January 1, 2020, section 627.6648,
490 Florida Statutes, is created to read:
491 627.6648 Shared savings incentive program.—
492 (1) This section and ss. 627.6387 and 641.31076 may be
493 cited as the "Patient Savings Act."
494 (2) As used in this section, the term:
495 (a) "Health care provider" means a hospital or facility
496 licensed under chapter 395; an entity licensed under chapter
497 400; a health care practitioner as defined in s. 456.001; a
498 blood bank, plasma center, industrial clinic, or renal dialysis
499 facility; or a professional association, partnership,
500 corporation, joint venture, or other association for
501 professional activity by health care providers. The term
502 includes entities and professionals outside this state with an
503 active, unencumbered license for an equivalent facility or
504 practitioner type issued by another state, the District of
505 Columbia, or a possession or territory of the United States.
506 (b) "Health insurer" means an authorized insurer offering
507 health insurance as defined in s. 624.603. The term does not
508 include the state group health insurance program provided under
509 s. 110.123.
510 (c) "Shared savings incentive" means a voluntary and

511 optional financial incentive that a health insurer may provide
512 to an insured for choosing certain shoppable health care
513 services under a shared savings incentive program and may
514 include, but is not limited to, the incentives described in s.
515 626.9541(4)(a).
516 (d) "Shared savings incentive program" means a voluntary
517 and optional incentive program established by a health insurer
518 pursuant to this section.
519 (e) "Shoppable health care service" means a lower-cost,
520 high-quality nonemergency health care service for which a shared
521 savings incentive is available for insureds under a health
522 insurer's shared savings incentive program. Shoppable health
523 care services may be provided within or outside this state and
524 include, but are not limited to:
525 1. Clinical laboratory services.
526 2. Infusion therapy.
527 3. Inpatient and outpatient surgical procedures.
528 4. Obstetrical and gynecological services.
529 5. Inpatient and outpatient nonsurgical diagnostic tests
530 and procedures.
531 6. Physical and occupational therapy services.
532 7. Radiology and imaging services.
533 8. Prescription drugs.
534 9. Services provided through telehealth.
535 (3) A health insurer may offer a shared savings incentive

536 program to provide incentives to an insured when the insured
537 obtains a shoppable health care service from the health
538 insurer's shared savings list. An insured may not be required to
539 participate in a shared savings incentive program. A health
540 insurer that offers a shared savings incentive program must:
541 (a) Establish the program as a component part of the
542 policy or certificate of insurance provided by the health
543 insurer and notify the insureds and the office at least 30 days
544 before program termination.
545 (b) File a description of the program on a form prescribed
546 by commission rule. The office must review the filing and
547 determine whether the shared savings incentive program complies
548 with this section.
549 (c) Notify an insured annually and at the time of renewal,
550 and an applicant for insurance at the time of enrollment, of the
551 availability of the shared savings incentive program and the
552 procedure to participate in the program.
553 (d) Publish on a webpage easily accessible to insureds and
554 to applicants for insurance a list of shoppable health care
555 services and health care providers and the shared savings
556 incentive amount applicable for each service. A shared savings
557 incentive may not be less than 25 percent of the savings
558 generated by the insured's participation in any shared savings
559 incentive offered by the health insurer. The baseline for the
560 savings calculation is the average in-network amount paid for

561 that service in the most recent 12-month period or some other
562 methodology established by the health insurer and approved by
563 the office.
564 (e) At least quarterly, credit or deposit the shared
565 savings incentive amount to the insured's account as a return or
566 reduction in premium, or credit the shared savings incentive
567 amount to the insured's flexible spending account, health
568 savings account, or health reimbursement account, such that the
569 amount does not constitute income to the insured.
570 (f) Submit an annual report to the office within 90
571 business days after the close of each plan year. At a minimum,
572 the report must include the following information:
573 1. The number of insureds who participated in the program
574 during the plan year and the number of instances of
575 participation.
576 2. The total cost of services provided as a part of the
577 program.
578 3. The total value of the shared savings incentive
579 payments made to insureds participating in the program and the
580 values distributed as premium reductions, credits to flexible
581 spending accounts, credits to health savings accounts, or
582 credits to health reimbursement accounts.
583 4. An inventory of the shoppable health care services
584 offered by the health insurer.
585 (4)(a) A shared savings incentive offered by a health

586 insurer in accordance with this section:
587 1. Is not an administrative expense for rate development
588 or rate filing purposes.
589 2. Does not constitute an unfair method of competition or
590 an unfair or deceptive act or practice under s. 626.9541 and is
591 presumed to be appropriate unless credible data clearly
592 demonstrates otherwise.
593 (b) A shared savings incentive amount provided as a return
594 or reduction in premium reduces the health insurer's direct
595 written premium by the shared savings incentive dollar amount
596 for the purposes of the taxes in ss. 624.509 and 624.5091.
597 (5) The commission may adopt rules necessary to implement
598 and enforce this section.
599 Section 7. Effective January 1, 2020, section 641.31076,
600 Florida Statutes, is created to read:
601 641.31076 Shared savings incentive program.—
602 (1) This section and ss. 627.6387 and 627.6648 may be
603 cited as the "Patient Savings Act."
604 (2) As used in this section, the term:
605 (a) "Health care provider" means a hospital or facility
606 licensed under chapter 395; an entity licensed under chapter
607 400; a health care practitioner as defined in s. 456.001; a
608 blood bank, plasma center, industrial clinic, or renal dialysis
609 facility; or a professional association, partnership,
610 corporation, joint venture, or other association for

611 professional activity by health care providers. The term
612 includes entities and professionals outside this state with an
613 active, unencumbered license for an equivalent facility or
614 practitioner type issued by another state, the District of
615 Columbia, or a possession or territory of the United States.
616 (b) "Health maintenance organization" has the same meaning
617 as provided in s. 641.19. The term does not include the state
618 group health insurance program provided under s. 110.123.
619 (c) "Shared savings incentive" means a voluntary and
620 optional financial incentive that a health maintenance
621 organization may provide to a subscriber for choosing certain
622 shoppable health care services under a shared savings incentive
623 program and may include, but is not limited to, the incentives
624 described in s. 641.3903(15).
625 (d) "Shared savings incentive program" means a voluntary
626 and optional incentive program established by a health
627 maintenance organization pursuant to this section.
628 (e) "Shoppable health care service" means a lower-cost,
629 high-quality nonemergency health care service for which a shared
630 savings incentive is available for subscribers under a health
631 maintenance organization's shared savings incentive program.
632 Shoppable health care services may be provided within or outside
633 this state and include, but are not limited to:
634 1. Clinical laboratory services.
635 2. Infusion therapy.

636 3. Inpatient and outpatient surgical procedures.
637 4. Obstetrical and gynecological services.
638 5. Inpatient and outpatient nonsurgical diagnostic tests
639 and procedures.
640 6. Physical and occupational therapy services.
641 7. Radiology and imaging services.
642 8. Prescription drugs.
643 9. Services provided through telehealth.
644 (3) A health maintenance organization may offer a shared
645 savings incentive program to provide incentives to a subscriber
646 when the subscriber obtains a shoppable health care service from
647 the health maintenance organization's shared savings list. A
648 subscriber may not be required to participate in a shared
649 savings incentive program. A health maintenance organization
650 that offers a shared savings incentive program must:
651 (a) Establish the program as a component part of the
652 contract of coverage provided by the health maintenance
653 organization and notify the subscribers and the office at least
654 30 days before program termination.
655 (b) File a description of the program on a form prescribed
656 by commission rule. The office must review the filing and
657 determine whether the shared savings incentive program complies
658 with this section.
659 (c) Notify a subscriber annually and at the time of
660 renewal, and an applicant for coverage at the time of

661 enrollment, of the availability of the shared savings incentive
662 program and the procedure to participate in the program.
663 (d) Publish on a webpage easily accessible to subscribers
664 and to applicants for coverage a list of shoppable health care
665 services and health care providers and the shared savings
666 incentive amount applicable for each service. A shared savings
667 incentive may not be less than 25 percent of the savings
668 generated by the subscriber's participation in any shared
669 savings incentive offered by the health maintenance
670 organization. The baseline for the savings calculation is the
671 average in-network amount paid for that service in the most
672 recent 12-month period or some other methodology established by
673 the health maintenance organization and approved by the office.
674 (e) At least quarterly, credit or deposit the shared
675 savings incentive amount to the subscriber's account as a return
676 or reduction in premium, or credit the shared savings incentive
677 amount to the subscriber's flexible spending account, health
678 savings account, or health reimbursement account, such that the
679 amount does not constitute income to the subscriber.
680 (f) Submit an annual report to the office within 90
681 business days after the close of each plan year. At a minimum,
682 the report must include the following information:
683 1. The number of subscribers who participated in the
684 program during the plan year and the number of instances of
685 participation.

686 2. The total cost of services provided as a part of the
687 program.
688 3. The total value of the shared savings incentive
689 payments made to subscribers participating in the program and
690 the values distributed as premium reductions, credits to
691 flexible spending accounts, credits to health savings accounts,
692 or credits to health reimbursement accounts.
693 4. An inventory of the shoppable health care services
694 offered by the health maintenance organization.
695 (4) A shared savings incentive offered by a health
696 maintenance organization in accordance with this section:
697 (a) Is not an administrative expense for rate development
698 or rate filing purposes.
699 (b) Does not constitute an unfair method of competition or
700 an unfair or deceptive act or practice under s. 641.3903 and is
701 presumed to be appropriate unless credible data clearly
702 demonstrates otherwise.
703 (5) The commission may adopt rules necessary to implement
704 and enforce this section.
705 Section 8. Subsection (3) is added to section 287.056,
706 Florida Statutes, to read:
707 287.056 Purchases from purchasing agreements and state
708 term contracts.—
709 (3) The department must enter into and maintain one or
710 more state term contracts with benefits consulting companies.

711 Section 9. The Department of Management Services shall
712 conduct an analysis of the procurement timelines and terms of
713 contracts for state employee health benefits with health
714 maintenance organizations, preferred provider organizations, and
715 prescription drug programs to develop an implementation plan for
716 simultaneous procurement of such contracts for benefits offered
717 beginning plan year 2023. The analysis and any recommendations
718 from the department must identify any statutory changes and
719 additional budgetary resources, if any, that will be necessary
720 to implement the plan. The analysis and recommendations must be
721 submitted to the Governor, the President of the Senate, and the
722 Speaker of the House of Representatives no later than December
723 1, 2019.
724 Section 10. Except as otherwise expressly provided in this
725 act, this act shall take effect July 1, 2019.
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727 ---
728 **T I T L E A M E N D M E N T**
729 Remove lines 563-624 of the amendment and insert:
730 An act relating to health insurance; amending s.
731 110.123, F.S.; requiring health maintenance
732 organization to be cost-effective and to offer high
733 value; authorizing the Department of Management
734 Services to limit the number of HMOs that it contracts
735 with in each region; requiring the department to

736 establish regions by rule; requiring the department to
737 submit the rule to the Legislature for ratification;
738 providing requirements; amending s. 110.12303, F.S.;
739 removing an obsolete date; adding products and
740 services offered by certain entities to a list of
741 products and services that may be included in the
742 package of health insurance and other benefits under
743 the state group insurance program; requiring the
744 department to offer, as a voluntary supplemental
745 benefit option, certain international prescription
746 services; amending s. 110.12315, F.S.; requiring the
747 department to implement formulary management for
748 prescription drugs and supplies beginning with a
749 specified plan year; specifying requirements for such
750 management practices; providing that certain
751 prescription drugs and supplies may not be covered
752 until specifically included in the formulary;
753 requiring the department to report to the Governor and
754 the Legislature regarding formulary exclusions by a
755 specified date and annually thereafter; requiring the
756 state employees' prescription drug program to provide
757 coverage for certain enteral formulas and amino-acid-
758 based elemental formulas; defining the term "medically
759 necessary"; providing a cap on such coverage;
760 repealing s. 8 of chapter 99-255, Laws of Florida,

761 relating to a provision that prohibits the department
762 from implementing a prior authorization or a
763 restricted formulary program that restricts certain
764 non-HMO enrollees' access to specified prescription
765 drugs within the state employees' prescription drug
766 program; creating ss. 627.6387, 627.6648, and
767 641.31076, F.S.; providing a short title; defining
768 terms; authorizing individual and group health
769 insurers and health maintenance organizations to offer
770 shared savings incentive programs to insureds and
771 subscribers; providing that insureds and subscribers
772 are not required to participate in such programs;
773 specifying requirements for health insurers and health
774 maintenance organizations offering such programs;
775 requiring the Office of Insurance Regulation to review
776 filed descriptions of programs and make a certain
777 determination; providing notification and account
778 credit or deposit requirements for insurers and health
779 maintenance organizations; specifying the minimum
780 shared savings incentive and the basis for calculating
781 savings; specifying requirements for annual reports
782 submitted by health insurers and health maintenance
783 organizations to the office; providing construction;
784 providing that certain shared savings incentive
785 amounts reduce a health insurer's direct written

786 premium for purposes of the insurance premium tax and
787 the retaliatory tax; authorizing the Financial
788 Services Commission to adopt rules; amending s.
789 287.056, F.S.; requiring the department to enter into
790 contracts with benefits consulting companies;
791 requiring the department to conduct an analysis of the
792 procurement timelines and terms of certain contracts
793 with HMOs, preferred provider organizations, and
794 prescription drug programs for a specified purpose;
795 providing department analysis and recommendation
796 requirements; requiring the department to submit the
797 analysis and recommendations to the Governor and the
798 Legislature by a specified date; providing effective
799 dates.