By Senator Bean

4-01734-20 20201836__

A bill to be entitled

An act relating to health insurance and prescription drug coverage; amending s. 110.123, F.S.; requiring the state group insurance program to allow enrollees to obtain health care services and prescription drugs from out-of-network providers and pharmacies if certain conditions are met; providing for the payment to be applied towards the enrollee's deductible and out-of-pocket maximum; providing notice requirements; amending s. 110.12303, F.S.; revising provider organizations included in benefit packages for the state group insurance program; revising requirements for the contracts between the Department of Management Services and health insurers; requiring the department to offer specified reimbursement as a voluntary supplemental benefit option in the state group insurance program; amending s. 110.12315, F.S.; requiring the state employees' prescription drug program to allow members and members' dependents to obtain prescription drugs from out-of-network pharmacies if certain conditions are met; providing for the payment to be applied towards the deductible and out-of-pocket maximum; providing notice requirements; amending s. 110.1238, F.S.; requiring state group health insurance plans to allow participants to obtain health care services and prescription drugs from out-of-network providers and pharmacies if certain conditions are met; providing for the payment to be applied towards the deductible

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and out-of-pocket maximum; providing notice requirements; creating s. 465.203, F.S.; defining the term "covered individual"; prohibiting pharmacy benefit managers from engaging in specified acts under certain circumstances; creating s. 627.4435, F.S.; defining the term "health insurer"; requiring health insurers to apply certain payments toward deductibles and out-of-pocket maximums within a specified timeframe under certain circumstances; prohibiting health insurers from engaging in specified acts under certain circumstances; providing construction; providing publication and notification requirements; amending ss. 627.6387, 627.6648, and 641.31076, F.S.; revising definitions; requiring, rather than authorizing, health insurers and health maintenance organizations to offer shared savings incentive programs; revising duties of health insurers and health maintenance organizations with respect to shared savings incentive programs; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (14) is added to section 110.123, Florida Statutes, to read:

110.123 State group insurance program.—

(14) OUT-OF-NETWORK PROVIDERS.—

(a) The state group insurance program shall allow its enrollees to obtain a covered health care service from an out-

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of-network provider at a cost that is the same or less than the in-network average that an enrollee's insurance plan pays for that health care service. The state group insurance program shall apply, within a reasonable timeframe not to exceed 1 year, the payment made by, or required of, an enrollee for that health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's insurance plan as if the health care service had been provided by an in-network provider.

(b) If an enrollee uses a pharmacy discount program, drug manufacturer rebate, or other discount or rebate program, including purchasing a prescription drug from a licensed prescribing provider such as a direct primary care provider, and such use results in a lower cost than would have been paid for a covered prescription drug had the enrollee used the enrollee's insurance plan to purchase the prescription drug, the state group insurance program shall apply, within a reasonable timeframe not to exceed 1 year, the payment made by the enrollee for that covered prescription drug toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's insurance plan as if the prescription drug had been purchased from an in-network pharmacy.

(c) At a minimum, the state group insurance program shall inform enrollees on its website and in its benefit plan materials of the options of obtaining covered health care services from out-of-network providers and prescription drugs from out-of-network pharmacies under paragraphs (a) and (b), respectively, with the enrollees' payments applied to deductibles and out-of-pocket maximums. On its website and in its benefit plan materials, the state group insurance program

shall also provide information on how to use the options under paragraphs (a) and (b) if an enrollee is interested in doing so.

Section 2. Present paragraph (e) of subsection (3) and present subsection (4) of section 110.12303, Florida Statutes, are redesignated as subsections (4) and (5), respectively, a new paragraph (e) is added to subsection (3) of that section, and paragraph (e) of subsection (1), paragraph (a) of subsection (2), paragraph (d) of subsection (3), and present subsection (4) of that section are amended, to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—

(1) In addition to the comprehensive package of health insurance and other benefits required or authorized to be included in the state group insurance program, the package of benefits may also include products and services offered by:

(e) Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, who sell service contracts and arrangements for a specified amount and type of health services, including direct primary or other medical care provided on a subscription basis.

(2)(a) The department shall contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures which may be accessed at the option of the enrollee. The contract shall require the entity to:

1. Have procedures and evidence-based standards to ensure the inclusion of only high-quality health care providers.

2. Provide assistance to the enrollee in accessing and

coordinating care.

3. Provide cost savings to the state group insurance program to be shared with both the state and the enrollee. Cost savings payable to an enrollee may be:

a. Credited to the enrollee's flexible spending account;

b. Credited to the enrollee's health savings account;

c. Credited to the enrollee's health reimbursement account; ~~or~~

d. Credited to the enrollee as a premium or out-of-pocket cost reduction; or

e. Paid directly to the enrollee as cash or a cash equivalent ~~additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses~~.

4. Provide an educational campaign for enrollees to learn about the services offered by the entity.

(3) The department shall contract with an entity that provides enrollees with online information on the cost and quality of health care services and providers, allows an enrollee to shop for health care services and providers, and rewards the enrollee by sharing savings generated by the enrollee's choice of services or providers. The contract shall require the entity to:

(d) Identify the savings realized to the enrollee and state if the enrollee chooses high-quality, lower-cost health care services or providers, and facilitate a shared savings payment to the enrollee. The amount of shared savings shall be determined by a methodology approved by the department and shall maximize value-based purchasing by enrollees. The amount payable to the enrollee may be:

1. Credited to the enrollee's flexible spending account;

2. Credited to the enrollee's health savings account;

3. Credited to the enrollee's health reimbursement account; ~~or~~

4. Credited to the enrollee as a premium or out-of-pocket cost reduction; or

5. Paid directly to the enrollee as cash or a cash equivalent ~~additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses~~.

(e) Include infusion therapy in the shared savings incentive program.

(5)~~(4)~~ The department shall offer, as a voluntary supplemental benefit option:~~,~~

(a) International prescription services that offer safe maintenance medications at a reduced cost to enrollees and that meet the standards of the United States Food and Drug Administration personal importation policy.

(b) At a minimum, reimbursement of direct primary care subscription fees.

Section 3. Subsection (11) is added to section 110.12315, Florida Statutes, to read:

110.12315 Prescription drug program.—The state employees' prescription drug program is established. This program shall be administered by the Department of Management Services, according to the terms and conditions of the plan as established by the relevant provisions of the annual General Appropriations Act and implementing legislation, subject to the following conditions:

(11)(a) If a member or a member's dependent uses a pharmacy discount program, drug manufacturer rebate, or other discount or

rebate program, including purchasing a prescription drug from a licensed prescribing provider such as a direct primary care provider, and such use results in a lower cost than would have been paid for a covered prescription drug had the member or member's dependent used the state group health insurance plan or a pharmacy participating in the state employees' prescription drug program to purchase the prescription drug, the department must apply the payments made by the member or member's dependent for that covered prescription drug toward the member's deductible and out-of-pocket maximum as specified in the state group health insurance plan or state employees' prescription drug program as if the prescription drug had been purchased from a pharmacy participating in the state employees' prescription drug program.

(b) At a minimum, the department, on its website and in its materials, shall inform the program's members on the program benefits of the option of obtaining prescription drugs from nonparticipating pharmacies under paragraph (a) and shall provide information on how to use such option to a member or a member's dependent.

Section 4. Section 110.1238, Florida Statutes, is amended to read:

110.1238 State group health insurance plans; refunds with respect to overcharges by providers; out-of-network providers.—

(1) A participant in a state group health insurance plan who discovers that he or she was overcharged by a health care provider shall receive a refund of 50 percent of any amount recovered as a result of such overcharge, up to a maximum of $1,000.

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(2) A state group health insurance plan shall allow its participants to obtain a covered health care service from an out-of-network provider at a cost that is the same or less than the in-network average that the state group health insurance plan pays for that health care service. The state group health insurance plan shall apply, within a reasonable timeframe not to exceed 1 year, the payment made by, or required of, a participant for that health care service toward the participant's deductible and out-of-pocket maximum as specified in the state group health insurance plan as if the health care service had been provided by an in-network provider.

(3) If a participant uses a pharmacy discount program, drug manufacturer rebate, or other discount or rebate program, including purchasing a prescription drug from a licensed prescribing provider such as a direct primary care provider, and such use results in a lower cost than would have been paid for a covered prescription drug had the participant used the state group health insurance plan to purchase the prescription drug, the state group health insurance plan must apply the payment made by the participant for that covered prescription drug toward the participant's deductible and out-of-pocket maximum as specified in the state group health insurance plan as if the prescription drug had been purchased from an in-network pharmacy.

(4) At a minimum, a state group health insurance plan shall inform participants on its website and in its benefit plan materials of the options of obtaining covered health care services from out-of-network providers and prescription drugs from out-of-network pharmacies under subsections (2) and (3),

respectively, with the participants' payments applied to deductibles and out-of-pocket maximums. On its website and in its benefit plan materials, a state group health insurance plan shall also provide information on how to use the options under subsections (2) and (3) if a participant is interested in doing so.

Section 5. Section 465.203, Florida Statutes, is created to read:

465.203 Pharmacy benefit managers; prohibited acts.—

(1) As used in this section, the term "covered individual" means a member, a participant, an enrollee, a contract holder, a policyholder, or a beneficiary of a health plan, health plan sponsor, health plan provider, health insurer, health maintenance organization, or any other payor that uses pharmacy benefit management services in this state.

(2) A pharmacy benefit manager may not impose on a covered individual a copayment or any other charge that exceeds the claim cost of a prescription drug. If information related to a covered individual's out-of-pocket cost, the clinical efficacy of a prescription drug, or alternative medication is available to a pharmacy provider, a pharmacy benefit manager may not penalize the pharmacy provider for providing that information to the covered individual.

Section 6. Section 627.4435, Florida Statutes, is created to read:

627.4435 Coverage for out-of-network providers and prescription drugs.—

(1) DEFINITION.—As used in this section, the term "health insurer" has the same meaning as provided in s. 408.07.

(2) HEALTH CARE SERVICES FROM OUT-OF-NETWORK PROVIDERS.—Beginning on January 1, 2021, upon approval of a health insurer's rate filings:

(a) If an insured obtains a covered health care service from an out-of-network provider at a cost that is the same or less than the in-network average that the health insurer pays for that health care service, the health insurer must apply, within a reasonable timeframe not to exceed 1 year, the payment made by, or required of, an insured for that health care service toward the insured's deductible and out-of-pocket maximum as specified in the insured's health insurance policy, plan, or contract as if the health care service had been provided by an in-network provider.

(b) A health insurer may not deny payment for any in-network health care service covered under an insured's health insurance policy, plan, or contract based solely on the basis that the insured's referral was made by an out-of-network provider. The health insurer may not apply a deductible, coinsurance, or copayment greater than the applicable deductible, coinsurance, or copayment that would apply to the same health care service if the health care service was referred by an in-network provider.

(3) PRESCRIPTION DRUGS.—

(a) A health insurer or a pharmacy benefit manager on behalf of a health insurer may not impose on an insured a copayment or other charge that exceeds the claim cost of a prescription drug. If information related to an insured's out-of-pocket cost, the clinical efficacy of a prescription drug, or alternative medication is available to a pharmacy provider, a

health insurer or a pharmacy benefit manager on behalf of a health insurer may not penalize the pharmacy provider for providing that information to the insured.

(b) If an insured uses a pharmacy discount program, drug manufacturer rebate, or other discount or rebate program, including purchasing a prescription drug from a licensed prescribing provider such as a direct primary care provider, and such use results in a lower cost than would have been paid for a covered prescription drug had the insured used the health insurance policy, plan, or contract to purchase the prescription drug, the health insurer or the pharmacy benefit manager on behalf of a health insurer shall apply the payment made by the insured for that covered prescription drug toward the insured's deductible and out-of-pocket maximum as specified in the insured's health insurance policy, plan, or contract as if the prescription drug had been purchased from an in-network pharmacy.

(c) This section does not restrict a health insurer from requiring standard preauthorization or other precertification requirements, such as the use of a formulary, that would otherwise be required under the insured's health insurance policy, plan, or contract.

(4) NOTIFICATION TO INSUREDS.—

(a) At a minimum, a health insurer shall inform insureds on its website and in its benefit policy, plan, or contract materials of the options of obtaining health care services from out-of-network providers and prescription drugs from out-of-network pharmacies under subsections (2) and (3), respectively, with the insureds' payments applied to deductibles and out-of-

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pocket maximums. On its website and in its benefit policy, plan, or contract materials, the health insurer shall also inform insureds on the process to obtain information on the average amount paid to an in-network provider or in-network pharmacy for a procedure, service, or prescription drug. The health insurer shall provide on its website a downloadable or interactive form for insureds to submit proof of payment to an out-of-network provider or out-of-network pharmacy.

(b) If an insured who is in a group health insurance policy, plan, or contract has paid for a health care service and the paid contracted rate for the provider was in the highest third for in-network providers for that insured's group health insurance policy, plan, or contract, the health insurer must inform the insured, by mail, electronic transmission, or telephone, that the insured has overpaid for the health care service, and the health insurer must also inform the insured of tools or methods the insured could use next time to elect a lower-cost option if the insured is interested in doing so.

Section 7. Paragraphs (c), (d), and (e) of subsection (2) and subsection (3) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

(2) As used in this section, the term:

(c) "Shared savings incentive" means a ~~voluntary and optional~~ financial incentive that a health insurer provides ~~may provide~~ to an insured for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(d) "Shared savings incentive program" means an ~~a voluntary and optional~~ incentive program established by a health insurer pursuant to this section.

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services identified by the Florida Center for Health Information and Transparency which commonly have a wide price variation.

(3) A health insurer shall ~~may~~ offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer ~~that offers a shared savings incentive program~~ must:

~~(a) Establish the program as a component part of the policy~~

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~~or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.~~

(a) ~~(b)~~ File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(b) ~~(c)~~ Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(c) ~~(d)~~ Publish on a webpage easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office. The health insurer must also offer a toll-free telephone number that an insured may call to compare services that qualify for a shared savings incentive.

(d) ~~(e)~~ At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the

insured directly with cash or a cash equivalent ~~such that the amount does not constitute income to the insured~~.

(e)~~(f)~~ Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

Section 8. Paragraphs (c), (d), and (e) of subsection (2) and subsection (3) of section 627.6648, Florida Statutes, are amended to read:

627.6648 Shared savings incentive program.—

(2) As used in this section, the term:

(c) "Shared savings incentive" means a ~~voluntary and optional~~ financial incentive that a health insurer provides ~~may provide~~ to an insured for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(d) "Shared savings incentive program" means an ~~a voluntary~~

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~~and optional~~ incentive program established by a health insurer pursuant to this section.

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services identified by the Florida Center for Health Information and Transparency which commonly have a wide price variation.

(3) A health insurer shall ~~may~~ offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer ~~that offers a shared savings incentive program~~ must:

~~(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and~~

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~~notify the insureds and the office at least 30 days before program termination.~~

(a)~~(b)~~ File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(b)~~(c)~~ Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(c)~~(d)~~ Publish on a webpage easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office. The health insurer must also offer a toll-free telephone number that an insured may call to compare services that qualify for a shared savings incentive.

(d)~~(e)~~ At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent ~~such that the~~

~~amount does not constitute income to the insured~~.

(e) ~~(f)~~ Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

Section 9. Paragraphs (c), (d), and (e) of subsection (2) and subsection (3) of section 641.31076, Florida Statutes, are amended to read:

641.31076 Shared savings incentive program.—

(2) As used in this section, the term:

(c) "Shared savings incentive" means a ~~voluntary and optional~~ financial incentive that a health maintenance organization provides ~~may provide~~ to a subscriber for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 641.3903(15).

(d) "Shared savings incentive program" means an ~~a voluntary and optional~~ incentive program established by a health

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maintenance organization pursuant to this section.

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. Any additional services identified by the Florida Center for Health Information and Transparency which commonly have a wide price variation.

(3) A health maintenance organization shall ~~may~~ offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared savings incentive program. A health maintenance organization ~~that offers a shared savings incentive program~~ must:

~~(a) Establish the program as a component part of the~~

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~~contract of coverage provided by the health maintenance organization and notify the subscribers and the office at least 30 days before program termination.~~

(a) ~~(b)~~ File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(b) ~~(c)~~ Notify a subscriber annually and at the time of renewal, and an applicant for coverage at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(c) ~~(d)~~ Publish on a webpage easily accessible to subscribers and to applicants for coverage a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the subscriber's participation in any shared savings incentive offered by the health maintenance organization. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health maintenance organization and approved by the office. The health maintenance organization must also offer a toll-free telephone number that a subscriber may call to compare services that qualify for a shared savings incentive.

(d) ~~(e)~~ At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return or reduction in premium, or credit the shared savings incentive amount to the subscriber's flexible spending account, health

savings account, or health reimbursement account, or reward the subscriber directly with cash or a cash equivalent ~~such that the amount does not constitute income to the subscriber~~.

(e)~~(f)~~ Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of subscribers who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to subscribers participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health maintenance organization.

Section 10. This act shall take effect January 1, 2021.

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