

By Senator Bean

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1                   A bill to be entitled  
2           An act relating to health insurance and prescription  
3           drug coverage; amending s. 110.123, F.S.; requiring  
4           the state group insurance program to allow enrollees  
5           to obtain health care services and prescription drugs  
6           from out-of-network providers and pharmacies if  
7           certain conditions are met; providing for the payment  
8           to be applied towards the enrollee's deductible and  
9           out-of-pocket maximum; providing notice requirements;  
10          amending s. 110.12303, F.S.; revising provider  
11          organizations included in benefit packages for the  
12          state group insurance program; revising requirements  
13          for the contracts between the Department of Management  
14          Services and health insurers; requiring the department  
15          to offer specified reimbursement as a voluntary  
16          supplemental benefit option in the state group  
17          insurance program; amending s. 110.12315, F.S.;  
18          requiring the state employees' prescription drug  
19          program to allow members and members' dependents to  
20          obtain prescription drugs from out-of-network  
21          pharmacies if certain conditions are met; providing  
22          for the payment to be applied towards the deductible  
23          and out-of-pocket maximum; providing notice  
24          requirements; amending s. 110.1238, F.S.; requiring  
25          state group health insurance plans to allow  
26          participants to obtain health care services and  
27          prescription drugs from out-of-network providers and  
28          pharmacies if certain conditions are met; providing  
29          for the payment to be applied towards the deductible

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30 and out-of-pocket maximum; providing notice  
31 requirements; creating s. 465.203, F.S.; defining the  
32 term "covered individual"; prohibiting pharmacy  
33 benefit managers from engaging in specified acts under  
34 certain circumstances; creating s. 627.4435, F.S.;  
35 defining the term "health insurer"; requiring health  
36 insurers to apply certain payments toward deductibles  
37 and out-of-pocket maximums within a specified  
38 timeframe under certain circumstances; prohibiting  
39 health insurers from engaging in specified acts under  
40 certain circumstances; providing construction;  
41 providing publication and notification requirements;  
42 amending ss. 627.6387, 627.6648, and 641.31076, F.S.;  
43 revising definitions; requiring, rather than  
44 authorizing, health insurers and health maintenance  
45 organizations to offer shared savings incentive  
46 programs; revising duties of health insurers and  
47 health maintenance organizations with respect to  
48 shared savings incentive programs; providing an  
49 effective date.

50  
51 Be It Enacted by the Legislature of the State of Florida:

52  
53 Section 1. Subsection (14) is added to section 110.123,  
54 Florida Statutes, to read:

55 110.123 State group insurance program.—

56 (14) OUT-OF-NETWORK PROVIDERS.—

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

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

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

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

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

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

97 110.12303 State group insurance program; additional  
98 benefits; price transparency program; reporting.—

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

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

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

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

116 2. Provide assistance to the enrollee in accessing and

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117 coordinating care.

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

- 121 a. Credited to the enrollee's flexible spending account;
- 122 b. Credited to the enrollee's health savings account;
- 123 c. Credited to the enrollee's health reimbursement account;

124 ~~or~~

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

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

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

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

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

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- 146 1. Credited to the enrollee's flexible spending account;  
147 2. Credited to the enrollee's health savings account;  
148 3. Credited to the enrollee's health reimbursement account;

149 ~~or~~

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

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

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

157 (5)-(4) The department shall offer, as a voluntary  
158 supplemental benefit option:7

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

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

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

167 110.12315 Prescription drug program.—The state employees'  
168 prescription drug program is established. This program shall be  
169 administered by the Department of Management Services, according  
170 to the terms and conditions of the plan as established by the  
171 relevant provisions of the annual General Appropriations Act and  
172 implementing legislation, subject to the following conditions:

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

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

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

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

197 110.1238 State group health insurance plans; refunds with  
198 respect to overcharges by providers; out-of-network providers.-

199 (1) A participant in a state group health insurance plan  
200 who discovers that he or she was overcharged by a health care  
201 provider shall receive a refund of 50 percent of any amount  
202 recovered as a result of such overcharge, up to a maximum of  
203 \$1,000.

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

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

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



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

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

241 465.203 Pharmacy benefit managers; prohibited acts.-

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

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

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

258 627.4435 Coverage for out-of-network providers and  
259 prescription drugs.-

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

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262 (2) HEALTH CARE SERVICES FROM OUT-OF-NETWORK PROVIDERS.—

263 Beginning on January 1, 2021, upon approval of a health  
264 insurer's rate filings:

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

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

284 (3) PRESCRIPTION DRUGS.—

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

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

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

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

313 (4) NOTIFICATION TO INSUREDS.—

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

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

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

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

341 627.6387 Shared savings incentive program.-

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

343 (c) "Shared savings incentive" means a ~~voluntary and~~  
344 ~~optional~~ financial incentive that a health insurer provides ~~may~~  
345 ~~provide~~ to an insured for choosing certain shoppable health care  
346 services under a shared savings incentive program and may  
347 include, but is not limited to, the incentives described in s.  
348 626.9541(4)(a).

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

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

- 358 1. Clinical laboratory services.
- 359 2. Infusion therapy.
- 360 3. Inpatient and outpatient surgical procedures.
- 361 4. Obstetrical and gynecological services.
- 362 5. Inpatient and outpatient nonsurgical diagnostic tests  
363 and procedures.
- 364 6. Physical and occupational therapy services.
- 365 7. Radiology and imaging services.
- 366 8. Prescription drugs.
- 367 9. Services provided through telehealth.
- 368 10. Any additional services identified by the Florida  
369 Center for Health Information and Transparency which commonly  
370 have a wide price variation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

427 627.6648 Shared savings incentive program.—

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

429 (c) "Shared savings incentive" means a ~~voluntary and~~  
 430 ~~optional~~ financial incentive that a health insurer provides ~~may~~  
 431 ~~provide~~ to an insured for choosing certain shoppable health care  
 432 services under a shared savings incentive program and may  
 433 include, but is not limited to, the incentives described in s.  
 434 626.9541(4)(a).

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

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

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

- 444 1. Clinical laboratory services.
- 445 2. Infusion therapy.
- 446 3. Inpatient and outpatient surgical procedures.
- 447 4. Obstetrical and gynecological services.
- 448 5. Inpatient and outpatient nonsurgical diagnostic tests  
449 and procedures.
- 450 6. Physical and occupational therapy services.
- 451 7. Radiology and imaging services.
- 452 8. Prescription drugs.
- 453 9. Services provided through telehealth.
- 454 10. Any additional services identified by the Florida  
455 Center for Health Information and Transparency which commonly  
456 have a wide price variation.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

513 641.31076 Shared savings incentive program.—

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

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

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

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523 maintenance organization pursuant to this section.

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

- 530 1. Clinical laboratory services.
- 531 2. Infusion therapy.
- 532 3. Inpatient and outpatient surgical procedures.
- 533 4. Obstetrical and gynecological services.
- 534 5. Inpatient and outpatient nonsurgical diagnostic tests  
535 and procedures.
- 536 6. Physical and occupational therapy services.
- 537 7. Radiology and imaging services.
- 538 8. Prescription drugs.
- 539 9. Services provided through telehealth.
- 540 10. Any additional services identified by the Florida  
541 Center for Health Information and Transparency which commonly  
542 have a wide price variation.

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

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

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552 ~~contract of coverage provided by the health maintenance~~  
553 ~~organization and notify the subscribers and the office at least~~  
554 ~~30 days before program termination.~~

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

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

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

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

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

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

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

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

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

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

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