The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	SB 7046
INTRODUCER:	Governmental Oversight and Accountability Committee
SUBJECT:	State Group Insurance Program
DATE:	February 26, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	McVaney	McVaney		**GO Submitted as Committee Bill**
1.	McSwain	Kynoch	AP	**Pre-meeting**

I. Summary:

SB 7046 amends the State Group Insurance Program administered by the Department of Management Services.

For the State Group Insurance Program, the bill:
- Requires the department to establish an anti-fraud program.
- Defines particular instances that will be deemed to be fraudulent based on the acts of the providers and imposes civil and criminal penalties.
- Deletes obsolete language regarding employees paid from the other-personal-services appropriations categories and hired before April 1, 2013.

For the State Employee Health Insurance Program, the bill:
- Repeals the implementation of the metal tier health insurance plans, which had been scheduled for implementation during the 2020 plan year.
- Codifies the regions that must be used for any procurement of HMO services beginning in 2023. These regions are based on utilization and referral patterns studied by DMS recently and the rule recommended by the department.
- Requires an HMO option to be available to all enrollees of the program living in Florida.

For the Prescription Drug Program, the bill:
- Clarifies the implementation of a prescription drug formulary management. The department and the pharmacy benefit manager are not permitted to substitute their judgment over the judgment of the prescriber regarding whether a prescription drug is medically necessary for the treatment of a patient. The department or pharmacy benefit manager may ask specific questions of the prescriber to ensure the patient is served well.
- The bill requires the department to ensure that all rebates, fees and other charges related to pharmacy spend are remitted to the state for the benefit of the program.

The bill is expected to have a positive but indeterminate fiscal impact on the State Employees Group Self-Insurance Trust Fund.

This bill takes effect July 1, 2020.

II. Present Situation:

State Group Insurance Program

Overview

The State Group Insurance Program (SGI Program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS). The SGI Program is an optional benefit for most state employees employed by executive branch agencies, state universities, the court system, and the Legislature and includes health, life, dental, vision, disability, and other supplemental insurance benefits. The SGI Program typically makes benefits changes on a plan year basis, January 1 through December 31.

Eligible Employees

The SGI Program is open to the following individuals:
- All state officers;
- All state employees paid from "salaries and benefits" appropriation categories, regardless of the number of hours worked;
- Retired state officers and state employees;
- Surviving spouses of deceased state officers and state employees;
- Certain terminated state officers and state employees; and
- Certain state employees paid from "other-personal-services" (OPS) appropriation categories.

For OPS employees hired after April 1, 2013, to be eligible to participate in the health insurance program, the employee must[1]:
- Be reasonably expected to work an average of at least 30 hours per week; and
- Have worked an average of at least 30 hours per week during the person's measurement period (which is 12 consecutive months[2] of employment).

For OPS employees hired before April 1, 2013, the measurement period was the six-month period from April 1, 2013, through September 30, 2013.[3]

State Employee Health Insurance Program

Health Insurance Premiums and Revenues

Over 176,000 active and retired state employees and officers are expected to participate in the health insurance program during Fiscal Year 2020-2021. The health insurance benefit for active

[1] Section 110.123(2)(c)2., F.S.
[2] Section 110.123(13)(d), F.S.
[3] Section 110.123(13)(c), F.S.

employees has premium rates for single, spouse program,[4] or family coverage regardless of plan selection. These premiums cover both medical and pharmacy claims. The state will contribute approximately 92 percent toward the total annual premium for active employees and officers, or $2.08 billion out of total premium of $2.25 billion for active employees during Fiscal Year 2020-2021.[5] Retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants will contribute an additional $235.6 million in premiums, with $250.2 million in other revenue for a total of $2.74 billion in total revenues.[6]

State Employee Health Insurance (Medical Claims)

The DMS provides medical services to health plan members through a self-insured preferred provider organization (PPO), self-insured HMO plans, and a fully-insured HMO plan. Under current contracts, a single provider (Florida Blue) administers the statewide PPO plan. This contract expires December 2022. Three providers (Aetna, AvMed, and United Health Care) administer the self-insured HMO plans providing services in 60 counties combined. Capital Health Plan is a fully-insured HMO plan providing services in 7 counties. The current HMO contracts were awarded on a county-by-county basis with service based on the county in which the member works or resides. These contracts expire December 2020, but are eligible for three 1-year renewals.

Metal Tier Plans

During the 2017 Regular Session, the Legislature directed the DMS to offer health plans, beginning in the 2020 plan year, with specific actuarial values. The actuarial values represent the average cost sharing between the plan and the enrollee for a set of benefits. The cost sharing element includes premiums as well as deductibles and out-of-pocket coinsurance and copayments. Specifically, the DMS was directed to include in the health insurance program:

- A platinum level plan, which must have an actuarial value of at least 90 percent.
- A gold level plan, which must have an actuarial value of at least 80 percent.
- A silver level plan, which must have an actuarial value of at least 70 percent.
- A bronze level plan, which must have an actuarial value of at least 60 percent.[7]

The DMS was directed to contract with an independent benefits consultant to develop an implementation plan by January 1, 2019.[8] The DMS contracted with Foster & Foster to complete the report. [9]

The table below shows the current premiums by pay plan and by coverage type and the proposed platinum and bronze plans.[10] The report assumes that roughly 80 percent of the enrollees will

[4] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.
[5] Florida Legislature, Office of Economic and Demographic Research, Self-Insurance Estimating Conference, *State Employees' Group Health Self-Insurance Trust Fund – Report on the Financial Outlook for Fiscal Years Ending June 30, 2020 through June 30, 2025*, adopted January 8, 2020, page 6, available at http://edr.state.fl.us/content/conferences/healthinsurance/HealthInsuranceOutlook.pdf.
[6] *Id*.
[7] Section 110.123(3)(j), F.S.
[8] Section 110.123(3)(k), F.S.
[9] *Implementation of Metal Tier Health Plans in the State Group Health Insurance Program*, prepared by Foster & Foster for State of Florida Department of Management Services, Division of State Group Insurance.
[10] *Id*. at 161.

choose the platinum plans and another 6 percent will choose the bronze plans.[11] As shown in the columns for enrollee premiums, the enrollees choosing the platinum plans will pay significantly higher monthly premiums than they do under the current plans. On the other hand, enrollees selecting the bronze plans may experience lower premiums than under the current plans.

		2019 Standard Plan Premium Rates			2020 PPO/HMO Platinum Plan			2020 PPO/HMO Bronze Plan		
		Employer	Enrollee	Total	Employer	Enrollee	Total	Employer	Enrollee	Total
Career Service/ OPS	Single	$684.42	$50.00	$734.42	$685	$165	$850	$600	$5	$605
	Family	$1,473.18	$180.00	$1,653.18	$1,475	$395	$1,870	$1,300	$30	$1,330
	Spouse	$1,623.20	$30.00	$1,653.20	$1,625	$245	$1,870	$1,320	$10	$1,330
SES/ SMS	Single	$726.08	$8.34	$734.42	$730	$120	$850	$600	$5	$605
	Family	$1,623.20	$30.00	$1,653.20	$1,625	$245	$1,870	$1,300	$30	$1,330
Early Retirees	Single	n/a	$734.42	$734.42	n/a	$850	$850	n/a	$588	$588
	Family	n/a	$1,653.18	$1,653.18	n/a	$1,870	$1,870	n/a	$1,297	$1,297

A major concern regarding implementation of the metal plans is the opportunity for roughly 29,000 eligible employees who "opt-out" of coverage to enroll in the bronze plan. The report points out that if all of these employees enrolled in a family plan, the premiums paid by state agencies would increase by $464 million annually, the premiums paid by these employees would increase by $10 million annually, and newly authorized income supplements would increase by $61 million. Overall, state agencies would bear an additional $525 million of costs.[12]

State Employees Prescription Drug Program

Overview

As part of the SGI program, the DMS is required to maintain the State Employees' Prescription Drug Program (Prescription Drug Plan).[13] The DMS contracts with CVS/Caremark, a pharmacy benefits manager (PBM), to administer the Prescription Drug Plan. The Prescription Drug Plan has three cost sharing categories for members: generic drugs, preferred brand name drugs, which are those brand name drugs on the preferred drug list, and non-preferred brand name drugs, which are those brand name drugs not on the preferred drug list. Contractually, the PBM updates the preferred drug list quarterly as brand name drugs enter the market and as the PBM negotiates pricing, including rebates with manufacturers.

Typically, generic drugs are the least expensive and have the lowest member cost share, preferred brand name drugs have the middle cost share, and non-preferred brand name drugs are the most expensive and have the highest member cost share. As a general practice, prescriptions written for a brand name drug, preferred or non-preferred, will be substituted with a generic drug when available. If the prescribing health care provider states clearly on the prescription that the brand name drug is medically necessary over the generic equivalent, the member will pay only the brand name preferred or nonpreferred cost share. If the member requests the brand name drug over the generic equivalent, without the provider's medically necessary request, then the member will pay the brand name preferred or nonpreferred cost share plus the difference between the actual cost of the generic drug and the brand name drug.

[11] *Id*. at 155.
[12] *Id*. at 159.
[13] Section 110.12315, F.S.

Prescription drug costs differ depending on which health plan a member enrolls in and whether the prescription drug is a generic, a preferred brand-name, or a non-preferred brand-name. A member can get up to a 30-day supply at retail pharmacy in the Prescription Drug Plan network and up to a 90-day supply at a mail order pharmacy or at a participating 90-day retail pharmacy. The use of mail order pharmacy is optional, but Preferred Provider Organization (PPO) members must utilize the 90-day mail or retail option after three 30-day fills at a retail pharmacy for any maintenance medications. In addition, certain specialty medications are only available via delivery to a member's home or a participating pharmacy. The following chart shows the copayments for generics, mail order, or a participating 90-day retail pharmacy for maintenance medications.

	Standard HMO and Standard PPO		**High-Deductible HMO and PPO**
	Retail (30-day)	**Mail Order and Retail (90-day)**	**All Prescriptions**
Generic	$7	$14	30%
Preferred Brand Name	$30	$60	30%
Non-preferred Brand Name	$50	$100	30%

The Prescription Drug Plan also covers compound medications. Compound medications combine, mix, or alter the ingredients of one or more drugs or products to create another drug or product. The Prescription Drug Plan only covers the federal legend drug ingredient of a compounded medication when all of the following criteria are satisfied:

- The compounded medication is not used in place of a commercially available federal legend drug in the same strength and formulation, unless medically necessary;
- The compounded medication is specifically produced for use by a covered person to treat a covered condition; and
- The compounded medication, including all sterile compounded products, is made in compliance with Chapter 465, F.S.

Formulary Management

Prior to plan year 2020, the PBM employed only limited prescription drug formulary management in the form of reviews designed to ensure that drugs are being prescribed for appropriate medical conditions. There was, however, no use of utilization management protocols to incentivize the use of some drugs over others. The Prescription Drug Plan has an open formulary, which covers all federal legend drugs for covered medical conditions. However, the PBM each year announces in July the therapeutic classes of drugs that will be impacted by exclusion for the next plan year.

During the 2019 Regular Session, the Legislature amended s. 110.12315, F.S., to direct the DMS to implement formulary management for prescription drugs and supplies. The management practices are to include and exclude prescription drugs and supplies for coverage by the health insurance program. However, the formulary management could not restrict access to the most clinically appropriate, clinically effective, or the lowest new-cost prescription drugs and supplies.

If a prescription drug was otherwise excluded from the formulary, the drug must be made available for inclusion in the formulary (as a non-preferred drug) if the prescribing authority clearly states on the prescription that the drug is medically necessary in the treatment of the patient.

Pharmacy Spend and PBM Rebates

When a brand-name drug or supply is included in the formulary for coverage by the health insurance plan, the PBM may be successful in negotiating discounted prices, fees, or rebates from the various manufacturers. According to CVS/Caremark, none of the manufacturer payments associated drugs purchased on behalf of the state health insurance program are retained by CVS/Caremark. The table below shows the expected pharmacy spend and PBM rebates for Fiscal Years 2020-2021 through FY 2024-2025.[14]

	FY 2020-21	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**
PPO-PBM Rebates	$92.9 m	$100.5 m	$104.0 m	$107.7 m	$111.7 m
HMO-PBM Rebates	$81.5 m	$90.3 m	$95.6 m	$101.4 m	$107.6 m
Total PBM Rebates	$174.4 m	$193.8 m	$199.6 m	$209.1 m	$219.3 m
PPO-Pharmacy Spend	$430.2 m	$481.0 m	$539.4 m	$612.3 m	$701.1 m
HMO-Pharmacy Spend	$361.0 m	$402.6 m	$451.8 m	$510.0 m	$580.9 m
Total Pharmacy Spend	$791.2 m	$883.6 m	$991.2 m	$1,122.3 m	$1,282.0 m
% Growth in Total Spend	10.72%	11.68%	10.32%	13.23%	14.23%
Total Rebates as % of Total Spend	22.0%	21.9%	20.1%	18.6%	17.1%

Anti-Fraud Investigative Units

Section 626.9891, F.S., requires each insurer admitted to do business in Florida to establish and maintain a designated anti-fraud unit or contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services against policies held by insureds. Each insurer must also adopt an anti-fraud plan and submit the plan to the Division of Investigative and Forensic Services of the Department of Financial Services.

The State Group Health Insurance Program is not an insurer for purposes of this law, and DMS has not established or contracted for an anti-fraud investigative unit or adopted an anti-fraud plan.

Insurance Fraud

Section 817.234, F.S., defines, and imposes penalties for, insurance fraud. The criminal penalties for violations are as based on the value of the property involved as follows:

- If less than $20,000, the offender commits a 3rd degree felony;
- If $20,000 or more but less than $100,000, the offender commits a 2nd degree felony; and
- If $100,000 or more, the offender commits a 1st degree felony.

[14] *Supra* note 5.

False Claims Act

The Florida False Claims Act (FFCA)[15] authorizes civil actions by individuals and the state against persons who file false claims for payment or approval with a state agency. The FFCA is modeled after the Federal False Claims Act[16] that was enacted during the Civil War in response to widespread fraud among defense contractors.[17] The FFCA creates a right for the agency or any person to bring a civil action for violations of its provisions. Actions brought by private entities on behalf of the state are called *qui tam* actions.[18]

The FFCA has often been used to combat health care, nursing home, Medicaid, and Medicare fraud. An action under the FFCA can be brought either by the state itself or by a private individual on behalf of the state. The Department of Legal Affairs and then the Department of Financial Services are responsible for investigating and litigating actions brought under the FFCA. In addition to Florida, 28 states, the District of Columbia, New York City, and Chicago have a False Claims Act with *qui tam* provisions.[19]

Current law provides that when a *qui tam* action is filed in the circuit court of the Second Judicial Circuit, in and for Leon County, it must be identified on its face as a qui tam action and a copy of the complaint and disclosure of all material evidence must be served on the Attorney General, as head of the Department of Legal Affairs, and the Chief Financial Officer, as head of the Department of Financial Services.[20]

When a private individual brings a potential claim to the attention of the Department of Legal Affairs or the Department of Financial Services, these departments have 60 days to decide whether they are going to intervene, and take over litigating the FFCA action from the private individual.[21]

Actions that violate the FFCA include:
- Submitting a false claim for payment or approval;
- Making or using a false record to get a false or fraudulent claim paid or approved;
- Conspiring to make a false claim or to deceive an agency to get a false or fraudulent claim allowed or paid; or

[15] Sections 68.081-68.092, F.S.
[16] 31 U.S.C. §§ 3729 – 3732.
[17] *False Claims Amendments Act of 1986*, S. Rep. No. 99-345, at 8 (1986), reprinted in 1986 U.S.C.C.A.N 5266, 5273 ("The Claims Act was adopted in 1863 and signed into law by President Abraham Lincoln in order to combat rampant fraud in Civil War defense contracts."); see also *Rainwater v. United States*, 356 U.S. 590, 592 (1958) ("The Act was originally passed in 1863 after disclosure of widespread fraud against the Government during the War Between the States.").
[18] *Qui tam* cases usually arise from an employee of an institution such as a health care provider who discovers that violations of the FFCA are occurring. This is a type of whistleblower action. In a *qui tam* action under the FFCA, the employee will sue on behalf of the state to collect money that was illegally defrauded from the state. A private entity that brings a successful FFCA action on behalf of the state will receive an amount that the court decides is reasonable for collecting the civil penalty and damages. The amount must not be less than 25 percent and not more than 30 percent of the proceeds recovered under a judgment. Section 68.085(2), F.S.
[19] *See* State False Claims Acts, https://www.taf.org/state-laws (last visited January 24, 2020).
[20] Section 68.083(3), F.S.
[21] *Id*.

- Making or using a false record to conceal, avoid, or decrease payments owed to the state government.[22]

The penalty for violating the FFCA is $5,500 to $11,000 per claim, plus three times the amount of damages to the state government for FFCA violations.[23]

III. Effect of Proposed Changes:

Section 1 amends s. 110.123, F.S., to modify the health insurance program available to state employees and officers.

Subsections (2) and (13) are amended to delete obsolete language relating to OPS employees hired prior to April 1, 2013. This change has no impact on employees or the State Group Insurance Program.

Subsection (3) is amended to require at least one HMO option to be available for health insurance program enrollees residing in the state. Under the current HMO contracts, an HMO option is available throughout the state.

Statutory direction requiring the DMS to establish HMO regions by rule is deleted. This language is obsolete because a new subsection (14) is created to establish the HMO regions by law, beginning in the 2023 plan year. Although HMO regions are established, the DMS retains the authority to contract with HMOs on a statewide basis.

Statutory direction requiring the DMS to implement "metal tier" plans beginning in the 2020 plan year, as well as, the requirement for a report to the legislature, is deleted.

Section 2 creates s. 110.12305, F.S., to establish definitions and impose civil and criminal penalties for fraud committed against the State Group Insurance Program.

This section provides the following criminal penalties for violations. These penalties are identical to the penalties imposed for fraud committed against the Medicaid Program.

Penalties for Violations		
Valuation of Violation	**Penalty Type**	**Statutory Penalties**
A person may not knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact: • Any claim submitted, or commission or omission, to the department or its contracted vendors; or • Any claim submitted to the department or its contracted vendors for items or services that are not authorized to be reimbursed by the program. A provider may not knowingly: • Charge, solicit, accept, or receive anything of value, other than an authorized copayment from a health plan member; • Fail to credit the department or its contracted vendors for any payment received from a third-party source; and		

[22] Section 68.082(2), F.S.
[23] Section 68.082(2)(g), F.S.

Penalties for Violations		
Valuation of Violation	**Penalty Type**	**Statutory Penalties**
• Offer, solicit, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in-kind in return for a service, good, items under the program.		
$10,000 or less	3rd Degree Felony	Punishable by up to 5 years in prison If a habitual felony offender, for a term not exceeding 10 years
$10,000 or more, but less than $50,000	2nd Degree Felony	Punishable by up to 15 years in prison If a habitual felony offender, for a term not exceeding 30 years
$50,000 or more	1st Degree Felony	Punishable by up to 30 years in prison If a habitual felony offender may impose life sentence
Value of scheme or course of conduct	May be aggregated in determining degree of felony	
Any person who conspires to knowingly purchase, or knowingly attempt to purchase a legend drug that was paid for by the program		Commits a felony
If value of legend drug is less than $20,000	3rd Degree Felony	Punishable by up to 5 years in prison If a habitual felony offender, for a term not exceeding 10 years
If value of legend drug is more than $20,000 but less than $100,000	2nd Degree Felony	Punishable by up to 15 years in prison If a habitual felony offender, for a term not exceeding 30 years
If value of legend drug is greater than $100,000	1st Degree Felony	Punishable by up to 30 years in prison If a habitual felony offender may impose life sentence
Fines	Five times the pecuniary gain unlawfully received, or the value of the loss incurred by the program or the contracted vendor, whichever is greater	

Section 3 creates s. 110.12306, F.S., to direct the department to establish, or contract for, an anti-fraud investigative unit relating to the claims paid from the State Employees Health Insurance Trust Fund.

Section 4 amends s. 110.12315, F.S., relating to the prescription drug program. This section clarifies that, if the prescribing authority notes the drug as medically necessary, the drug must be covered by the program. The DMS or its PBM is not permitted to substitute its judgment over the judgement of the prescribing authority. The DMS or its PBM must ensure that each drug is being used appropriately (for a particular condition and appropriate dosage) and for a condition otherwise covered under the health insurance plan. For drugs that are not included on the formulary for program coverage but are prescribed as medically necessary, the DMS or its PBM must inquire about whether the prescribing authority has considered alternative prescription drugs that are included in the formulary. However, these inquiries must be completed within one business day after the pharmacist receives the prescription.

The DMS must ensure that any rebates, discounts, and other fees associated with the purchase or use of prescription drugs or supplies in the program are for the benefit of the program. The DMS must audit the amounts annually.

Section 5 amends s. 110.131, F.S., to correct a cross-reference.

Section 6 provides that the bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Not applicable. The bill does not require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

To establish an anti-fraud investigative unit, the department will incur costs either as additional personnel costs or as contracted services. However, with the investigative unit and the potential imposition of significant penalties for fraud committed against the

program, the program is expected to experience indeterminate savings for the State Employees Group Health Self-Insurance Trust Fund.

With the clarification relating to the implementation of formulary management in the prescription drug program, the DMS may experience reduced costs associated with pharmacy drug expenditures and potentially a higher volume of rebates for prescription drugs. Likewise, with the mandated audits of pharmacy rebates, discounts, and other fees, the DMS may see an increase in rebates remitted into the State Employees Group Health Self-Insurance Trust Fund.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 110.123 and 110.12315.

This bill creates the following sections of the Florida Statutes: 10.12305 and 110.12306.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.