An act relating to health insurance; amending s. 110.123, F.S.; requiring health maintenance organization to be cost-effective and to offer high value; authorizing the Department of Management Services to limit the number of HMOs that it contracts with in each region; requiring the department to establish regions by rule; requiring the department to submit the rule to the Legislature for ratification; providing requirements; amending s. 110.12303, F.S.; removing an obsolete date; adding products and services offered by certain entities to a list of products and services that may be included in the package of health insurance and other benefits under the state group insurance program; requiring the department to offer, as a voluntary supplemental benefit option, certain international prescription services; amending s. 110.12315, F.S.; requiring the department to implement formulary management for prescription drugs and supplies beginning with a specified plan year; specifying requirements for such management practices; providing that certain prescription drugs and supplies may not be covered until specifically included in the formulary; requiring the department to report to the Governor and

the Legislature regarding formulary exclusions by a specified date and annually thereafter; requiring the state employees' prescription drug program to provide coverage for certain enteral formulas and amino-acid-based elemental formulas; defining the term "medically necessary"; providing a cap on such coverage; repealing s. 8 of chapter 99-255, Laws of Florida, relating to a provision that prohibits the department from implementing a prior authorization or a restricted formulary program that restricts certain non-HMO enrollees' access to specified prescription drugs within the state employees' prescription drug program; creating ss. 627.6387, 627.6648, and 641.31076, F.S.; providing a short title; defining terms; authorizing individual and group health insurers and health maintenance organizations to offer shared savings incentive programs to insureds and subscribers; providing that insureds and subscribers are not required to participate in such programs; specifying requirements for health insurers and health maintenance organizations offering such programs; requiring the Office of Insurance Regulation to review filed descriptions of programs and make a certain determination; providing notification and account credit or deposit requirements for insurers and health

maintenance organizations; specifying the minimum shared savings incentive and the basis for calculating savings; specifying requirements for annual reports submitted by health insurers and health maintenance organizations to the office; providing construction; providing that certain shared savings incentive amounts reduce a health insurer's direct written premium for purposes of the insurance premium tax and the retaliatory tax; authorizing the Financial Services Commission to adopt rules; amending s. 287.056, F.S.; requiring the department to enter into contracts with benefits consulting companies; requiring the department to conduct an analysis of the procurement timelines and terms of certain contracts with HMOs, preferred provider organizations, and prescription drug programs for a specified purpose; providing department analysis and recommendation requirements; requiring the department to submit the analysis and recommendations to the Governor and the Legislature by a specified date; providing effective dates.

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

Section 1. Paragraphs (c) and (h) of subsection (3) of

section 110.123, Florida Statutes, are amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(c) Notwithstanding any provision in this section to the contrary, it is the intent of the Legislature that the department shall be responsible for all aspects of the purchase of health care for state employees under the state group health insurance plan or plans, TRICARE supplemental insurance plans, and the health maintenance organization plans. Responsibilities shall include, but not be limited to, the development of requests for proposals or invitations to negotiate for state employee health benefits ~~services~~, the determination of health care benefits to be provided, and the negotiation of contracts for health care and health care administrative services. Prior to the negotiation of contracts for health care services, the Legislature intends that the department shall develop, with respect to state collective bargaining issues, the health benefits and terms to be included in the state group health insurance program. The department shall adopt rules necessary to perform its responsibilities pursuant to this section. ~~It is the intent of the Legislature that~~ The department is ~~shall be~~ responsible for the contract management and day-to-day management of the state employee health insurance program, including, but not limited to, employee enrollment, premium collection, payment to health care providers, and other

administrative functions related to the program.

(h)1. A person eligible to participate in the state group insurance program may be authorized by rules adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The department shall contract with health maintenance organizations seeking to participate in the state group insurance program through a request for proposal or other procurement process, as developed by the Department of Management Services and determined to be appropriate.

a. The department shall establish a schedule of minimum benefits for health maintenance organization coverage, and that schedule shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs;

age-based and gender-based wellness benefits; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO. As used in this paragraph, the term "age-based and gender-based wellness benefits" includes aerobic exercise, education in alcohol and substance abuse prevention, blood cholesterol screening, health risk appraisals, blood pressure screening and education, nutrition education, program planning, safety belt education, smoking cessation, stress management, weight management, and women's health education.

b. The department may establish uniform deductibles, copayments, coverage tiers, or coinsurance schedules for all participating HMO plans.

c. The department may require detailed information from each health maintenance organization participating in the procurement process, including information pertaining to organizational status, experience in providing prepaid health benefits, accessibility of services, financial stability of the plan, quality of management services, accreditation status, quality of medical services, network access and adequacy, performance measurement, ability to meet the department's reporting requirements, and the actuarial basis of the proposed rates and other data determined by the director to be necessary for the evaluation and selection of health maintenance organization plans and negotiation of appropriate rates for

these plans. Upon receipt of proposals by health maintenance organization plans and the evaluation of those proposals, the department may enter into negotiations with all of the plans or a subset of the plans, as the department determines appropriate. ~~Nothing shall preclude~~ The department may negotiate ~~from negotiating~~ regional or statewide contracts with health maintenance organization plans. Such plans must be ~~when this is~~ cost-effective and must offer ~~when the department determines that the plan offers~~ high value to enrollees.

d. The department may limit the number of HMOs that it contracts with in each region ~~service area~~ based on the nature of the bids the department receives, the number of state employees in the region ~~service area~~, or any unique ~~geographical~~ characteristics of the region ~~service area~~. The department shall establish the regions throughout the state by rule. The department must submit the rule to the President of the Senate and the Speaker of the House of Representatives for ratification no later than 30 days before the 2020 Regular Session of the Legislature. The rule may not take effect until it is ratified by the Legislature ~~by rule service areas throughout the state~~.

e. All persons participating in the state group insurance program may be required to contribute towards a total state group health premium that may vary depending upon the plan, coverage level, and coverage tier selected by the enrollee and the level of state contribution authorized by the Legislature.

3. The department is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The department may establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the department may enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25-percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a.-d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal or invitation to negotiate process described in subparagraph 2.

5. All enrollees in a state group health insurance plan, a TRICARE supplemental insurance plan, or any health maintenance organization plan have the option of changing to any other health plan that is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year.

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 months after termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of

prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

7. Any HMO participating in the state group insurance program shall submit health care utilization and cost data to the department, in such form and in such manner as the department shall require, as a condition of participating in the program. The department shall enter into negotiations with its contracting HMOs to determine the nature and scope of the data submission and the final requirements, format, penalties associated with noncompliance, and timetables for submission. These determinations shall be adopted by rule.

8. The department may establish and direct, with respect to collective bargaining issues, a comprehensive package of insurance benefits that may include supplemental health and life coverage, dental care, long-term care, vision care, and other benefits it determines necessary to enable state employees to select from among benefit options that best suit their

individual and family needs. Beginning with the 2018 plan year, the package of benefits may also include products and services described in s. 110.12303.

a. Based upon a desired benefit package, the department shall issue a request for proposal or invitation to negotiate for providers interested in participating in the state group insurance program, and the department shall issue a request for proposal or invitation to negotiate for providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the department may enter into contract negotiations with providers submitting bids or negotiate a specially designed benefit package. Providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, except as provided in subparagraph (f)3., no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans. With respect to dental

coverage, the division shall include in any solicitation or contract for any state group dental program made after July 1, 2001, a comprehensive indemnity dental plan option which offers enrollees a completely unrestricted choice of dentists. If a dental plan is endorsed, or in some manner recognized as the preferred product, such plan shall include a comprehensive indemnity dental plan option which provides enrollees with a completely unrestricted choice of dentists.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the department shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental insurance benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

Section 2. Section 110.12303, Florida Statutes, is amended to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting. ~~Beginning with the 2018 plan year:~~

(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:

(a) Prepaid limited health service organizations authorized pursuant to part I of chapter 636.

(b) Discount medical plan organizations authorized pursuant to part II of chapter 636.

(c) Prepaid health clinics licensed under part II of chapter 641.

(d) Licensed health care providers, including hospitals and other health care facilities, health care clinics, and health professionals, who sell service contracts and arrangements for a specified amount and type of health services.

(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.

(f) Entities that provide specific health services in accordance with applicable state law and sell service contracts and arrangements for a specified amount and type of health services.

(g) Entities that provide health services or treatments through a bidding process.

(h) Entities that provide health services or treatments through the bundling or aggregating of health services or treatments.

(i) Entities that provide international prescription services.

(j) Entities that provide optional participation in a Medicare Advantage Prescription Drug Plan.

(k) Entities that provide other innovative and cost-effective health service delivery methods.

(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. Paid as 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.

(b) On or before January 15 of each year, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level and cost-savings to both the enrollee and the state resulting from the contract or contracts described in this subsection.

(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:

(a) Establish an Internet-based, consumer-friendly platform that educates and informs enrollees about the price and quality of health care services and providers, including the average amount paid in each county for health care services and providers. The average amounts paid for such services and providers may be expressed for service bundles, which include all products and services associated with a particular treatment or episode of care, or for separate and distinct products and services.

(b) Allow enrollees to shop for health care services and

providers using the price and quality information provided on the Internet-based platform.

(c) Permit a certified bargaining agent of state employees to provide educational materials and counseling to enrollees regarding the Internet-based platform.

(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. Paid as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

(e) On or before January 1 of 2019, 2020, and 2021, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level, amount paid to enrollees, and cost-savings to both the enrollees and the state resulting from the implementation of this subsection.

(4) The department shall offer, as a voluntary supplemental benefit option, 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.

Section 3. Subsections (9) and (10) are 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:

(9)(a) Beginning with the 2020 plan year, the department must implement formulary management for prescription drugs and supplies. Such management practices must require prescription drugs to be subject to formulary inclusion or exclusion but may not restrict access to the most clinically appropriate, clinically effective, and lowest net-cost prescription drugs and supplies. Drugs excluded from the formulary must be available for inclusion if a physician, advanced practice registered nurse, or physician assistant prescribing a pharmaceutical clearly states on the prescription that the excluded drug is medically necessary. Prescription drugs and supplies first made available in the marketplace after January 1, 2020, may not be

covered by the prescription drug program until specifically included in the list of covered prescription drugs and supplies.

(b) No later than October 1, 2019, and by each October 1 thereafter, the department must submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives the list of prescription drugs and supplies that will be excluded from program coverage for the next plan year. If the department proposes to exclude prescription drugs and supplies after the plan year has commenced, the department must provide notice to the Governor, the President of the Senate, and the Speaker of the House of Representatives of such exclusions at least 60 days before implementation of such exclusions.

(10) 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 program must provide coverage for medically necessary prescription and nonprescription enteral formulas and amino-acid-based elemental formulas for home use, regardless of the method of delivery or intake, which are ordered or prescribed by a physician. As used in this subsection, the term "medically necessary" means the formula to be covered represents the only medically appropriate source of nutrition for a patient. Such coverage may not exceed an amount of $20,000 annually for any insured individual.

Section 4. Effective December 31, 2019, section 8 of chapter 99-255, Laws of Florida, is repealed.

Section 5. Effective January 1, 2020, section 627.6387, Florida Statutes, is created to read:

627.6387 Shared savings incentive program.—

(1) This section and ss. 627.6648 and 641.31076 may be cited as the "Patient Savings Act."

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

(a) "Health care provider" means a hospital or facility licensed under chapter 395; an entity licensed under chapter 400; a health care practitioner as defined in s. 456.001; a blood bank, plasma center, industrial clinic, or renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers. The term includes entities and professionals outside of this state with an active, unencumbered license for an equivalent facility or practitioner type issued by another state, the District of Columbia, or a possession or territory of the United States.

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health insurer 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 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.

(3) A health insurer 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 notify the insureds and the office at least 30 days before program termination.

(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.

(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.

(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.

(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, such that the amount does not constitute income to the insured.

(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.

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is

presumed to be appropriate unless credible data clearly demonstrates otherwise.

(b) A shared savings incentive amount provided as a return or reduction in premium reduces the health insurer's direct written premium by the shared savings incentive dollar amount for the purposes of the taxes in ss. 624.509 and 624.5091.

(5) The commission may adopt rules necessary to implement and enforce this section.

Section 6. Effective January 1, 2020, section 627.6648, Florida Statutes, is created to read:

627.6648 Shared savings incentive program.—

(1) This section and ss. 627.6387 and 641.31076 may be cited as the "Patient Savings Act."

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

(a) "Health care provider" means a hospital or facility licensed under chapter 395; an entity licensed under chapter 400; a health care practitioner as defined in s. 456.001; a blood bank, plasma center, industrial clinic, or renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers. The term includes entities and professionals outside this state with an active, unencumbered license for an equivalent facility or practitioner type issued by another state, the District of Columbia, or a possession or territory of the United States.

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603. The term does not include the state group health insurance program provided under s. 110.123.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health insurer 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 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.

(3) A health insurer 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 notify the insureds and the office at least 30 days before program termination.

(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.

(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.

(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.

(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, such that the amount does not constitute income to the insured.

(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.

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

(b) A shared savings incentive amount provided as a return or reduction in premium reduces the health insurer's direct written premium by the shared savings incentive dollar amount for the purposes of the taxes in ss. 624.509 and 624.5091.

(5) The commission may adopt rules necessary to implement and enforce this section.

Section 7. Effective January 1, 2020, section 641.31076, Florida Statutes, is created to read:

641.31076 Shared savings incentive program.—

(1) This section and ss. 627.6387 and 627.6648 may be cited as the "Patient Savings Act."

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

(a) "Health care provider" means a hospital or facility

licensed under chapter 395; an entity licensed under chapter 400; a health care practitioner as defined in s. 456.001; a blood bank, plasma center, industrial clinic, or renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers. The term includes entities and professionals outside this state with an active, unencumbered license for an equivalent facility or practitioner type issued by another state, the District of Columbia, or a possession or territory of the United States.

(b) "Health maintenance organization" has the same meaning as provided in s. 641.19. The term does not include the state group health insurance program provided under s. 110.123.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health maintenance organization 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 a voluntary and optional incentive program established by a health 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.

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

(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.

(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.

(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.

(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, such that the amount does not constitute income to the subscriber.

(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.

(4) A shared savings incentive offered by a health maintenance organization in accordance with this section:

(a) Is not an administrative expense for rate development or rate filing purposes.

(b) Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 641.3903 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

(5) The commission may adopt rules necessary to implement and enforce this section.

Section 8. Subsection (3) is added to section 287.056,

Florida Statutes, to read:

287.056 Purchases from purchasing agreements and state term contracts.—

(3) The department must enter into and maintain one or more state term contracts with benefits consulting companies.

Section 9. The Department of Management Services shall conduct an analysis of the procurement timelines and terms of contracts for state employee health benefits with health maintenance organizations, preferred provider organizations, and prescription drug programs to develop an implementation plan for simultaneous procurement of such contracts for benefits offered beginning plan year 2023. The analysis and any recommendations from the department must identify any statutory changes and additional budgetary resources, if any, that will be necessary to implement the plan. The analysis and recommendations must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 1, 2019.

Section 10. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2019.