CHAPTER 2017-127

Senate Bill No. 2508

An act relating to the Division of State Group Insurance; amending s. 110.12301, F.S.; removing a requirement that a contract for dependent eligibility verification services for the state group insurance program be a contingency-based contract; requiring the division to notify subscribers of dependent eligibility rules by a certain date; requiring the division to hold a subscriber harmless for past claims of ineligible dependents for a specified timeframe; providing for applicability; removing a requirement that the Department of Management Services submit budget amendments pursuant to ch. 216, F.S., regarding vendor payments for dependent eligibility verification services; authorizing the contractor providing dependent eligibility verification services to request certain information from subscribers; requiring the division and the contractor to disclose to subscribers that dependent eligibility verification information may be subject to disclosure and inspection under public records requirements under certain circumstances; specifying requirements for marriage licenses or certificates or birth certificates submitted for dependent eligibility verification; authorizing foreign-born subscribers to submit an affidavit in lieu of documentation under certain circumstances; specifying that original or photocopied documentation may be submitted; authorizing a subscriber to redact unnecessary information before submitting documentation; requiring the contractor to retain documentation obtained for dependent eligibility verification services for a specified timeframe; requiring the department and the contractor to destroy such documentation after a specified date; amending s. 110.12315, F.S.; providing that retail, mail order, and specialty pharmacies participating in the state employees' prescription drug program shall be reimbursed as established by contract; revising supply limitations under the program; requiring that the pharmacy dispensing fee be negotiated by the department; revising provisions governing the reimbursement schedule for prescription drugs and supplies dispensed under the program; requiring the department to maintain certain lists; establishing supply limitations for maintenance drugs and supplies; specifying pricing of certain copayments by health plan members; deleting a provision requiring the department to implement additional cost-saving measures and adjustments; revising copayment and coinsurance amounts for the State Group Health Insurance Standard Plan and the State Group Health Insurance High Deductible Plan; providing an effective date.

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

Section 1. Section 110.12301, Florida Statutes, is amended to read:

110.12301 Competitive procurement of postpayment claims review services and dependent eligibility verification services.—The Division of State Group Insurance is directed to competitively procure:

(1) Postpayment claims review services for the state group health insurance plans established pursuant to s. 110.123. Compensation under the contract shall be paid from amounts identified as claim overpayments that are made by or on behalf of the health plans and that are recovered by the vendor. The vendor may retain that portion of the amount recovered as provided in the contract. The contract must require the vendor to maintain all necessary documentation supporting the amounts recovered, retained, and remitted to the division; and

(2) A ~~contingency-based~~ contract for dependent eligibility verification services for the state group insurance program; however, compensation under the contract may not exceed historical claim costs for the prior 12 months for the dependent populations disenrolled as a result of the contractor's ~~vendor's~~ services.

(a)1. By September 1, 2017, the division shall notify all subscribers regarding the eligibility rules for dependents. Through November 30, 2017, the division must ~~may establish a 3-month grace period and~~ hold subscribers harmless for past claims of ineligible dependents if such dependents are removed from plan membership before December 1, 2017.

2. Subparagraph 1. does not apply to any dependent identified as ineligible before July 1, 2017, for which the department has notified the state agency employing the associated subscriber ~~The Department of Management Services shall submit budget amendments pursuant to chapter 216 in order to obtain budget authority necessary to expend funds from the State Employees' Group Health Self-Insurance Trust Fund for payments to the vendor as provided in the contract~~.

(b) The contractor providing dependent eligibility verification services may request the following information from subscribers:

1. To prove a spouse's eligibility:

a. If married less than 12 months and the subscriber and his or her spouse have not filed a joint federal income tax return, a government-issued marriage certificate; or

b. If married for 12 or more months, a transcript of the most recently filed federal income tax return.

2. To prove a biological child's or a newborn grandchild's eligibility, a government-issued birth certificate.

3. To prove an adopted child's eligibility:

a. An adoption certificate; or

b. An adoption placement agreement and a petition for adoption.

4. To prove a stepchild's eligibility:

a. A government-issued birth certificate for the stepchild; and

b. The transcript of the subscriber's most recently filed federal income tax return.

5. Any other information necessary to verify the dependent's eligibility for enrollment in the state group insurance program.

(c) If a document requested from a subscriber is not confidential or exempt from public records requirements, the division and the contractor shall disclose to all subscribers that such information submitted to verify the eligibility of dependents may be subject to disclosure and inspection under chapter 119.

(d) A government-issued marriage license or marriage certificate submitted for dependent eligibility verification must include the date of the marriage between the subscriber and the spouse.

(e) A government-issued birth certificate submitted for dependent eligibility verification must list the parents' names.

(f) Foreign-born subscribers unable to obtain the necessary documentation within the specified time period of producing verification documentation may execute a signed affidavit attesting to eligibility requirements.

(g) Documentation submitted to verify eligibility may be an original or a photocopy of an original document. Before submitting a document, the subscriber may redact any information on a document which is not necessary to verify the eligibility of the dependent.

(h) All documentation obtained by the contractor to conduct the dependent eligibility verification services must be retained until June 30, 2019. The department or the contractor is not required to retain such documentation after June 30, 2019, and shall destroy such documentation as soon as practicable after such date.

Section 2. Upon the expiration and reversion of the amendments made to section 110.12315, Florida Statutes, pursuant to section 123 of chapter 2016-62, Laws of Florida, section 110.12315, Florida Statutes, is amended 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:

(1) The department shall allow prescriptions written by health care providers under the plan to be filled by any licensed pharmacy and reimbursed pursuant to subsection (2) ~~contractual claims-processing provisions~~. ~~Nothing in~~ This section may not be construed as prohibiting a mail

order prescription drug program distinct from the service provided by retail pharmacies.

(2) In providing for reimbursement of pharmacies for prescription drugs and supplies ~~medicines~~ dispensed to members of the state group health insurance plan and their dependents under the state employees' prescription drug program:

(a) Retail, mail order, and specialty pharmacies participating in the program must be reimbursed as established by contract and ~~at a uniform rate and subject to uniform conditions,~~ according to the terms and conditions of the plan.

(b) There is ~~shall be~~ a 30-day supply limit for retail pharmacy fills, a 90-day supply limit for mail order fills, and a 90-day supply limit for maintenance drug fills by retail pharmacies ~~prescription card purchases and 90-day supply limit for mail order or mail order prescription drug purchases~~. This paragraph may not be construed to prohibit fills at any amount less than the applicable supply limit.

(c) The ~~current~~ pharmacy dispensing fee shall be negotiated by the department ~~remains in effect~~.

(d)~~(3)~~ The department ~~of Management Services~~ shall establish the reimbursement schedule for prescription drugs and supplies ~~pharmaceuticals~~ dispensed under the program. Reimbursement rates for a prescription drug or supply ~~pharmaceutical~~ must be based on the cost of the generic equivalent drug or supply if a generic equivalent exists, unless the physician, advanced registered nurse practitioner, or physician assistant prescribing the drug or supply ~~pharmaceutical~~ clearly states on the prescription that the brand name drug or supply is medically necessary or that the drug or supply ~~product~~ is included on the formulary of drugs and supplies ~~drug products~~ that may not be interchanged as provided in chapter 465, in which case reimbursement must be based on the cost of the brand name drug or supply as specified in the reimbursement schedule adopted by the department ~~of Management Services~~.

(3) The department shall maintain the generic, preferred brand name, and the nonpreferred brand name lists of drugs and supplies to be used in the administration of the state employees' prescription drug program.

(4) The department shall maintain a list of maintenance drugs and supplies.

(a) Preferred provider organization health plan members may have prescriptions for maintenance drugs and supplies filled up to three times as a supply for up to 30 days through a retail pharmacy; thereafter, prescriptions for the same maintenance drug or supply must be filled for up to 90 days either through the department's contracted mail order pharmacy or through a retail pharmacy.

(b) Health maintenance organization health plan members may have prescriptions for maintenance drugs and supplies filled for up to 90 days either through a mail order pharmacy or through a retail pharmacy.

(5) Copayments made by health plan members for a supply for up to 90 days through a retail pharmacy shall be the same as copayments made for a similar supply through the department's contracted mail order pharmacy.

(6)~~(4)~~ The department ~~of Management Services~~ shall conduct a prescription utilization review program. In order to participate in the state employees' prescription drug program, retail pharmacies dispensing prescription drugs and supplies ~~medicines~~ to members of the state group health insurance plan or their covered dependents, or to subscribers or covered dependents of a health maintenance organization plan under the state group insurance program, shall make their records available for this review.

~~(5) The Department of Management Services shall implement such additional cost-saving measures and adjustments as may be required to balance program funding within appropriations provided, including a trial or starter dose program and dispensing of long-term-maintenance medication in lieu of acute therapy medication.~~

(7)~~(6)~~ Participating pharmacies must use a point-of-sale device or an online computer system to verify a participant's eligibility for coverage. The state is not liable for reimbursement of a participating pharmacy for dispensing prescription drugs and supplies to any person whose current eligibility for coverage has not been verified by the state's contracted administrator or by the department ~~of Management Services~~.

~~(7) Under the state employees' prescription drug program copayments must be made as follows:~~

(8)(a) Effective July 1, 2017 ~~January 1, 2006~~, for the State Group Health Insurance Standard Plan, copayments must be made as follows:

1. For a supply for up to 30 days from a retail pharmacy:

a. For generic drug ~~with card~~..... $7 ~~$10~~.

b.~~2.~~ For preferred brand name drug ~~with card~~..... $30 ~~$25~~.

c.~~3.~~ For nonpreferred brand name drug ~~with card~~..... $50 ~~$40~~.

2. For a supply for up to 90 days from a mail order pharmacy or a retail pharmacy:

a.~~4.~~ For generic ~~mail order~~ drug.....$14 ~~$20~~.

b.~~5.~~ For preferred brand name ~~mail order~~ drug.....$60 ~~$50~~.

c.~~6.~~ For nonpreferred brand name ~~mail order~~ drug.....$100 ~~$80~~.

(b) Effective July 1, 2017 ~~January 1, 2006~~, for the State Group Health Insurance High Deductible Plan, coinsurance must be paid as follows:

1. For a supply for up to 30 days from a retail pharmacy:

a. ~~Retail coinsurance~~ For generic drug ~~with card~~..... 30%.

b.~~2.~~ ~~Retail coinsurance~~ For preferred brand name drug ~~with card~~..... 30%.

c.~~3.~~ ~~Retail coinsurance~~ For nonpreferred brand name drug ~~with card~~..... 50%.

2. For a supply for up to 90 days from a mail order pharmacy or a retail pharmacy:

a.~~4. Mail order coinsurance~~ For generic drug.....30%.

b.~~5. Mail order coinsurance~~ For preferred brand name drug.....30%.

c.~~6. Mail order coinsurance~~ For nonpreferred brand name drug.....50%.

~~(c) The Department of Management Services shall create a preferred brand name drug list to be used in the administration of the state employees' prescription drug program.~~

Section 3. This act shall take effect July 1, 2017.

Approved by the Governor June 16, 2017.

Filed in Office Secretary of State June 16, 2017.