Subcommittee on Health and Human Services
Government Efficiency Task Force
401 Senate Office Building
May 17, 2012
1:30 p.m. – 3:30 p.m.

1) Call to Order

2) Roll Call

3) Recommendations on Drug Repackaging and Workers' Compensation

4) Recommendations on Criminal Justice

5) Presentation on Health Insurance Procurement
   Don Fisher, Osceola County Manager

6) Q & A on State Group Health Insurance
   Barbara Crosier, Director of State Group Insurance, Department of Management Services

7) Member discussion of Health Insurance Procurement

8) Adjourn

Florida Government Efficiency Task Force

Subcommittee on Health and Human Services ***Recommendation Analysis***

Subject Matter: Pharmaceutical Repackaging and Workers' Compensation

Subcommittee Members: Bob Rohrlack (Chair), Frank Attkisson, Larry Cretul, Julie Fess, and Bob Stork

RECOMMENDATION SUMMARY

The Subcommittee on Health and Human Services met on April 26th and makes the following recommendations to the Government Efficiency Task Force:

- Adjust workers' compensation pharmaceutical reimbursement to the original manufacturer's AWP plus a $4.18 dispensing fee. This will provide the same rate of reimbursement for repackaged drugs as for non-repackaged drugs, creating parity in reimbursement throughout the workers' compensation system. HB 511, filed during the 2012 regular Legislative session, should serve as models for these reforms.

- Retain physician dispensing within the workers' compensation system. Physician dispensing can provide certain benefits, including increased patient access to care and more convenient and timely patient access to medication. Physician dispensing should continue to be offered to patients seeking care under the workers' compensation system.

- Implementation of these recommendations is estimated to reduce workers' compensation system costs by 2.5%. The resulting rate reduction for the workers' compensation system would save Florida employers at least **$62 million** annually and promote a business friendly climate in the state.

FULL RECOMMENTION(S) ANALYSIS

I. BACKGROUND

A. Prescription Drugs:

Regulation of Repackaged Prescription Drugs

The term "repackaged" drugs refers to pharmaceuticals that have been purchased in bulk by a wholesaler/repackager from a manufacturer, relabeled, and repackaged into individual prescription sizes that can be dispensed directly by physicians or pharmacies to patients.[1] A "repackager" means a person who repackages a drug, device, or cosmetic, but specifically excludes pharmacies operating in compliance with pharmacy practice standards set out in chapter 465, F.S., and rules adopted under that chapter.[2]

Rule 64F-12, F.A.C., defines "repackaging or otherwise changing the container, wrapper, or labeling to further the distribution" to mean:

- Altering a packaging component that is or may be in direct contact with the drug, device, or cosmetic, for example, repackaging from bottles of 1,000 to bottles of 100.
- Altering a manufacturer's package for sale under a label different from the manufacturer, for example packaging together a kit that contains an injectable vaccine from manufacturer A; a syringe from manufacturer B; alcohol from manufacturer C; and sterile gauze from manufacturer D; and marketing as an immunization kit under a label of manufacturer Z.
- Altering a package of multiple-units, which the manufacturer intended to be distributed as one unit, for sale or transfer to a person engaged in the further distribution of the product.

Dispensing Practitioners

Section 465.0276(1), F.S., authorizes physicians and pharmacies to dispense, as provided below:

> A person may not dispense medicinal drugs unless licensed as a pharmacist or otherwise authorized under this chapter to do so, except that a practitioner authorized by law to prescribe drugs may dispense such drugs to her or his patients in the regular course of her or his practice in compliance with this section.

To become a dispensing practitioner in Florida, a practitioner is required to register pursuant to s. 465.0276, F.S., with the applicable professional licensing board as a dispensing practitioner and pay a $100 fee.[3] Dispensing practitioners must comply with all laws and rules applicable to pharmacists and pharmacies including undergoing inspections.[4] In addition, the physician must comply with all applicable statutes found in chapter 465, chapter 499, and chapter 893, F. S., all applicable rules, and federal laws regarding the dispensing of medicinal drugs.[5] Lastly, a physician must provide the patient with a written prescription and

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[1] In Florida, the Department of Business and Professional Regulation (DBPR) regulates prescription drug repackagers. A permit as a prescription drug repackager is required for any person that repackages a prescription drug in Florida. The permit authorizes the wholesale distribution of prescription drugs repackaged at the establishment. Section 499.01(2)(b), F.S.
[2] Section 499.003(50), F.S.
[3] *See* s. 465.0276(2)(a), F.S.; Rule 64B8-3.006, F.A.C.; Registration is not required for dispensing complimentary medications in the normal course of practice without payment or remuneration.
[4] Section 465.0276(2)(b), F.S.
[5] *See* s. 465.0276(2)(b), F.S.; chapter 499, F.S., contains the Florida Drug and Cosmetic Act, administered by the DBPR; chapter 893, F.S., contains the Florida Comprehensive Drug Abuse Prevention and Control Act; *see also* chapter 2011-141, L.O.F.

advise him or her, orally or in writing, that there is an option to have the prescription filled at the doctor's office or at a pharmacy.[6] Physician dispensing is regulated by the relevant licensing boards with the Department of Health.

Workers' Compensation

Chapter 440, F.S., is Florida's workers' compensation law. The Division of Workers' Compensation within the Department of Financial Services (DFS) is responsible for administering ch. 440, F.S. For work-related injuries, workers' compensation provides:

- Medically necessary remedial treatment, care, and attendance, including medicines, medical supplies, durable medical equipment, and prosthetics.[7]
- Compensation for disability when the injury causes an employee to miss more than 7 days of work.[8]

For such compensable injuries, an employer/carrier is responsible for providing medical treatment, which includes, but is not limited to, medically necessary care and treatment and prescription drugs.[9] To be eligible for payment under the workers' compensation law, health care providers who treat injured employees, except for emergency treatment, must apply for and be certified by DFS and receive authorization from the insurer before providing treatment.[10]

The majority of repackaged drugs in Florida's workers' compensation system are dispensed by physicians who are authorized to dispense drugs at their offices.[11] According to the Division of Risk Management (division) within DFS, since 2009, physicians have dispensed nearly 90% repackaged drugs.[12]

Reimbursement for Prescription Drugs in Workers' Compensation

The reimbursement method for a prescription medication to pharmacies and dispensing physicians is found in s. 440.13(12)(c), F.S. The reimbursement amount is the average wholesale price (AWP) of the drug plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount.[13] The term AWP is not defined in the workers' compensation statute (ch. 440, F.S.) and does not have a universally-accepted definition,[14] but may be considered comparable to a wholesaler's suggested price.

Drug repackagers purchase pharmaceuticals in bulk from the manufacturer and relabel and repackage the drugs into individual prescription sizes. Although drug repackagers do not alter the drugs, they sell them in different quantities. Repackagers typically assign an AWP for a repackaged drug that differs from the AWP suggested by the original manufacturer of the drug. Current law does not provide a cap on reimbursements for repackaged or relabeled prescription drugs.[15]

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[6] *See* s. 465.0276(2)(c), F.S.
[7] *See* s. 440.13(2) (a), F.S.
[8] *See* s. 440.12(1), F.S.
[9] *See* s. 440.13(2)(a), F.S. Whether an employer is required to have workers' compensation insurance depends upon the employer's industry (construction, non-construction, or agricultural) and the number of employees.
[10] Section 440.13(3)(a), F.S.; s. 440.13(1)(d), F.S.; Rule 69L-29.002, F.A.C.
[11] NCCI presentation to Three-Member Panel, November 16, 2011 (copy on file with Government Efficiency Task Force staff).
[12] Based on a study by HealthCare Solutions. *Id*.
[13] *See* s. 440.13(12)(c), F.S.
[14] *See*, for example, Workers' Compensation Research Institute, *Prescription Benchmarks for Florida*, 2nd Edition, July 2011 (copy on file with Government Efficiency Task Force staff) compared with Frank Neuhauser et al., *Impact of Physician-Dispensing of Repackaged Drugs on California Workers' Compensation, Employers Cost, and Workers' Access to Quality Care*, California Commission on Health and Safety and Workers' Compensation, 2006, http://www.dir.ca.gov/CHSWC/Reports/Physician-Dispensend-Pharmaceuticals.pdf (last accessed 05/14/2012).
[15] The Division of Workers' Compensation previously stated that it is unaware of any specific provisions of the workers' compensation law that addresses whether employers/carriers may appropriately deny authorization or reimbursement for prescription

B. Repackaged Drug Costs to the Workers' Compensation Industry

Recent increases in physician dispensing and reimbursement costs for repackaged drugs have had a substantial impact on pharmaceutical costs in the workers' compensation system. Studies have shown that Florida's costs are among the highest when compared to other states and rising.

In July 2011, the Workers' Compensation Research Institute (WCRI) published "Prescription Benchmarks for Florida, 2nd Edition,"[16] a study that compares the cost, price, and use of pharmaceuticals in workers' compensation in Florida with 16 other states.[17] Among the study's findings on Florida:

- For 2007/2008, the average payment per workers' compensation claim for prescription drugs was $536, the second highest cost of the 17 states studied, and 45% higher than the median of the states studied.[18]
- Between 2005/2006 and 2007/2008, the average cost per claim for prescription drugs in Florida increased by 14%, but remained relatively stable in the other study states.[19]
- Higher and growing costs of prescription drugs in Florida were largely due to more frequent and higher-priced physician dispensing.[20]
- Over a four-year period (from 2004/2005 and 2007/2008), the percentage of payments for physician-dispensed prescriptions increased from 17% to 46% of all prescription payments.[21]
- Prices per pill paid to pharmacies were similar to the median of the 17 states studied.[22]

The National Council on Compensation Insurance (NCCI), Florida's designated licensed rating and statistical organization for workers' compensation,[23] has found the following data related to drug repackaging costs:[24]

- Markup on Florida repackaged drugs may be as high as 679 percent above the same drug in a non-repackaged format.[25]
- Physician dispensed drugs have grown from 9 percent of drug costs in 2003 to 50 percent of drug costs in 2009.[26]
- Florida has the highest rate of physician-dispensed drugs of the 46 states studied.[27]

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medication dispensed by a physician instead of a pharmacist. Department of Financial Services, Informational Bulletin DFS-02-2009, August 12, 2009, p. 1, http://www.myfloridacfo.com/wc/pdf/DFS-02-2009.pdf (last accessed 05/14/2012).

[16] Workers' Compensation Research Institute, *Prescription Benchmarks for Florida*, 2nd Edition, July 2011 (copy on file with Government Efficiency Task Force staff).

[17] *Id*. The 17 states in the WCRI study are California, Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin. Physician dispensing is not generally allowed in three of the states in its study - Massachusetts, New York, and Texas.

[18] *Id.* at p. 14.

[19] *Id*.

[20] *Id*.

[21] *Id.* at p. 15.

[22] *Id.* at p. 18.

[23] Among its responsibilities, NCCI collects data from workers' compensation insurers in Florida and makes rate filings on the insurers' behalf. NCCI manages the nation's largest database of workers' compensation insurance information. NCCI is licensed by the Office of Insurance Regulation.

[24] NCCI presentation to Government Efficiency Task Force Subcommittee on Health and Human Services, April 26, 2012, http://www.floridaefficiency.com/UserContent/docs/File/20120426HHSMeetingPacket.pdf (last accessed 05/14/2012). Video available at http://thefloridachannel.org/watch/video/14955 (last accessed 05/14/2012). *See also* NCCI presentation to the Three Member Panel, November 16, 2011 (copy on file with Government Efficiency Task Force staff) and NCCI presentation to the Senate Committee on Budget Senate Committee on Budget, November 16, 2011, http://streams.leg.state.fl.us/archive/HIGH/S_BC_2011_11_16_2011_9098.asx (last accessed 05/14/2012).

[25] *Id.* at p. 6.

[26] *Id.*

[27] *Id*.

- The 15 most frequently dispensed drugs are 45% to 679% more expensive when a repackaged drug, rather than the identical non-repackaged drug,[28] is dispensed (see chart below).[29]
- Physician-dispensed drugs account for 50% of all prescription drug dollars. This is the highest percentage of the 46 states studied by NCCI.[30]

Florida Repackaged and Non-repackaged Drugs Dispensed by Physicians, Pharmacies, and Others for Service Year 2009[31]

	Average Unit Price		
	Repackaged Drugs	**Non-repackaged Drugs**	**Difference in %**
	(1)	(2)	(3) = (1)/(2) - 1
Carisoporodol	4.21	0.54	679.6%
Meloxicam	5.70	3.04	87.5%
Ranitidine HCL	3.77	1.32	185.6%
Tramadol HCL	1.63	0.78	109.0%
Lidoderm®	13.69	7.32	87.0%
Naproxen	2.10	1.09	92.7%
Omeprazole	7.53	3.85	95.6%
Hydrocodone-Acetaminophen	1.28	0.39	228.2%
Etodolac	2.81	1.40	100.7%
Skelaxin®	5.41	3.72	45.4%
Oxycodone-Acetaminophen	3.43	0.49	600.0%
Cyclobenzaprine HCL	1.95	1.05	85.7%
Cephalexin	3.01	0.66	356.1%
Zolpidem Tartrate	6.81	3.72	83.1%
Ibuprofen	0.65	0.33	97.0%

Department of Financial Services

The Division of Workers' Compensation has found that pharmacy payments decreased from $136.2 million in 2007 to $122.3 million in 2010. Over the same time period, practitioner payments rose from $35.9 million to

[28]NCCI's cost analysis compared brand name drugs to brand name drugs and generic drugs to generic drugs. Accordingly, the calculations did not involve a comparison of brand name drugs with generic drugs, which would have inflated the price increases that were reported for repackaged drugs.
[29] The 15 drugs are Carisoprodol, Meloxicam, Ranitidine HCL, Tramadol HCL, Lidoderm®, Naproxen, Omeprazole, Hydrocodone-Acetaminophen, Etodolac, Skelaxin®, Oxycodone-Acetaminophen, Cyclobenzaprine HCL, Cephalexin, Zolpidem Tartrate, and Ibuprofen. *Id*. at p. 15.
[30] *Id.* at p. 13.
[31] *Id.* at p. 15.

$63.2 million.[32] The average amount paid per prescription increased by 13.1% over four years, compared to a 62.1% increase for practitioners over the same time period.[33] During 2010, the average amount paid per practitioner-dispensed prescription was 11.7% higher than pharmacy-dispensed items.[34]

The Division of Risk Management (division) within DFS administers the State of Florida's self-insurance program for property and casualty risk, which includes workers' compensation coverage.[35] The program covers executive, legislative, and judicial branches of Florida government and state universities and is funded by yearly assessments to participating state agencies. In 2011, the division identified medical costs, including pharmacy, as a claims cost driver.[36] The department has stated that the division's pharmacy costs increased from $12,000 in 2008 to $1.2 million in 2010.[37]

Change and Efficiency

The Subcommittee recommends adjusting workers' compensation pharmaceutical reimbursement to the original manufacturer's AWP plus a $4.18 dispensing fee. This will provide the same rate of reimbursement for repackaged drugs as for non-repackaged drugs, creating parity in reimbursement throughout the workers' compensation system. HB 511, filed during the 2012 regular Legislative session, should serve as a model for these reforms.[38] This bill specified that reimbursement for repackaged or relabeled drugs would be calculated by multiplying the number of units of the drug dispensed by the per-unit AWP set by the original manufacturer of the drug, which may not be the manufacturer of the repackaged or relabeled drug, plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount. HB 511 contained language expressly prohibiting the price of a repackaged drug from exceeding the amount that would otherwise be payable had the drug not been repackaged.

Limiting workers' compensation drug reimbursement to original manufacturer's AWP plus a $4.18 dispensing fee will significantly reduce costs for Florida's workers' compensation system. Within state government, DFS has estimated that providing the same rate of reimbursement for repackaged, relabeled, and non-repackaged drugs dispensed to injured state employees will reduce costs incurred by the Division of Risk Management by $1 million annually, from a total cost of approximately $1.2 million.[39]

NCCI has estimated that elimination of the higher reimbursements available for repackaged drugs, as compared to non-repackaged drugs, would decrease system costs by 2.5%, or $62 million annually.[40] In a

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[32] Division of Workers' Compensation, *2011 Annual Report*, September 2011, p. 40 http://www.myfloridacfo.com/wc/pdf/DWC-Annual-Report-2011.pdf (last accessed 04/23/2012).
[33] *Id.*
[34] *Id.*
[35] Chapter 284, F.S.
[36] Department of Financial Services presentation to the House Subcommittee on General Government Appropriations, February 8, 2011 (copy on file with Government Efficiency Task Force staff). This is supported by the Three-Member Panel, which reports on methods for improving the workers' compensation medical deliver system. *Three-Member Panel Biennial Report*, 2011, p. 7, http://www.myfloridacfo.com/wc/pdf/3MP_Report_2011.pdf (last accessed 05/14/2012).
[37] Based on a study by HealthCare Solutions. Department of Financial Services presentation to the Senate Committee on Budget, November 16, 2011, http://streams.leg.state.fl.us/archive/HIGH/S_BC_2011_11_16_2011_9098.asx (last accessed 05/14/2012).
[38] See CS/HB 511, as amended by the Health and Human Services Committee, http://www.flsenate.gov/Session/Bill/2012/0511/BillText/c1/PDF (last accessed 05/16/2012).
[39] Fiscal Analysis of SB 668 by the Department of Financial Services, November 2011 (copy on file Government Efficiency Task Force staff).
[40] Estimate is based on 2009 data. The total prescription count for Division of Workers' Compensation data used in development of this figure is nearly 1.5 million. NCCI, *Analysis of Florida SB 1068*, March 7, 2011, p. 1 (copy on file with Government Efficiency Task Force staff). NCCI reviewed more recent data and concluded that the impact will not exceed 2.5%, or $62 million. NCCI, *Update Regarding NCCI Pricing of Florida Drug Repackaging Bills*, January 30, 2012, p. 1 (copy on file with Government Efficiency Task Force staff). *See also* testimony by NCCI at the 2012 workers' compensation rate hearing, held October 11, 2011 http://www.floir.com/siteVideos/NCCI2011.aspx (last accessed 05/14/2012); OIR commitment to seek 2.5% premium rate reduction following passage of reforms in HB 511, Letter from Commissioner Kevin M. McCarty, Office of Insurance Regulation, to The Honorable Rene Garcia, Chair, Senate Committee on Health Regulation, January 25, 2012 (copy on file with Government Efficiency

letter to Senator Rene Garcia, Office of Insurance Regulation Commissioner Kevin McCarty confirmed the effectiveness of HB 511 in addressing repackaged drug reimbursement as a critical cost driver in the workers' compensation system. Commissioner McCarty committed to issuing a 2.5% rate reduction following passage of the reforms.[41] Implementation of this recommendation on drug reimbursement would save Florida employers at least **$62 million** annually and promote a business friendly climate in the state.

The Subcommittee recommends retaining physician dispensing within the workers' compensation system. Physician dispensing can provide certain benefits, including increased patient access to care and more convenient and timely patient access to medication. Physician dispensing should continue to be offered to patients seeking care under the workers' compensation system. If a physician is a dispensing practitioner and is authorized by an employer or carrier to treat an injured worker, the physician should be permitted to dispense and fill prescriptions pursuant to ch. 440, F.S. Authorization from an employer or carrier should not be refused solely because the physician is a dispensing practitioner. A similar provision was included in HB 511, as amended.[42]

Recent reforms in California demonstrate that limiting reimbursements for repackaged drugs will not diminish the ability of physicians to dispense to their patients. When California enacted a reform to eliminate higher reimbursements for repackaged or relabeled drugs and provide for the same rate of reimbursement as for non-repackaged drugs, physician dispensing remained fairly stable. Pre-reform (2003-2006), physician dispensing in California ranged from 38% to 53%; after the 2007 reform, physician dispensing has ranged from 46% to 50%. While prescription dispensing of repackaged drugs by California physicians has decreased since the reform (from over 49% of overall prescription dollars in 2006 to less than 5% of prescription drug dollars in 2009), physician dispensing of non-repackaged drugs increased (from less than 5% in 2006 to approximately 43% in 2009).[43]

In 2010, the California Workers' Compensation Institute has suggested that increases in prescription drug costs following the implementation of reimbursement reforms resulted from changes in the mix of workers' compensation medications, including greater reliance on more expensive drugs and the emergence of compound drugs, co-packs, and medical foods; increases in the average number of prescriptions per claim; increases in the AWP used to calculate reimbursement; and pharmacy benefit manager contract rates and payments that exceed the pharmacy fee schedule allowances.[44]

Recommendations:

- The Subcommittee recommends adjusting workers' compensation pharmaceutical reimbursement to the original manufacturer's average wholesale price (AWP) plus a $4.18 dispensing fee.
- The Subcommittee recommends retaining physician dispensing within the workers' compensation system.

Task Force staff). Estimates are not adjusted to account for elimination of physician dispensing of Schedule II and III substances, effective July 1, 2011, pursuant to Ch. 2011-141, L.O.F. NCCI has estimated that, prior to implementation of Ch. 2011-131, L.O.F., Schedule II and II substances accounted for 4.4% of workers' compensation drug prescriptions, or 5.4% of workers' compensation drug costs. NCCI presentation to Three-Member Panel, November 16, 2011 (copy on file with Government Efficiency Task Force staff).

[41] Letter from Commissioner Kevin M. McCarty, Office of Insurance Regulation, to The Honorable Rene Garcia, Chair, Senate Committee on Health Regulation, January 25, 2012 (copy on file with Government Efficiency Task Force staff).

[42] See CS/HB 511, as amended by the Health and Human Services Committee, http://www.flsenate.gov/Session/Bill/2012/0511/BillText/c1/PDF (last accessed 05/16/2012).

[43] NCCI presentation to Government Efficiency Task Force Subcommittee on Health and Human Services, April 26, 2012, p. 10, http://www.floridaefficiency.com/UserContent/docs/File/20120426HHSMeetingPacket.pdf (last accessed 05/14/2012). Video available at http://thefloridachannel.org/watch/video/14955 (last accessed 05/14/2012).

[44] California Workers' Compensation Institute, *The Percentage of California Workers' Compensation Prescriptions Falling Outside the Medi-Cal Fee Schedule Database*, 2010, p. 4, http://www.cwci.org/research.html (last accessed 05/16/2012).

Florida Government Efficiency Task Force

Subcommittee on Health and Human Services ***Recommendation Analysis***

Subject Matter: Criminal Justice

Subcommittee Members: Bob Rohrlack (Chair), Frank Attkisson, Larry Cretul, Julie Fess, and Bob Stork

RECOMMENDATION SUMMARY

The Subcommittee on Health and Human Services met on May 11 and makes the following recommendations to the Government Efficiency Task Force:

- Provide the Department of Corrections (department) with flexibility to develop and implement cost savings initiatives, in conjunction with counties. The department should have the flexibility to implement new models of inmate transfer, assignment, or supervision if determined to effectively carry out inmate sentences, following existing statutory requirements, while achieving cost savings. Counties should be able to submit cost savings proposals to the department and appeal decisions to the Governor and Cabinet.
- Provide incentives for counties to participate in initiatives that will achieve efficiencies and cost savings for the state. Incentives should be created for arrangements that promote flexibility and produce mutually-beneficial arrangements for the state and counties. Incentives may include, but are not limited to, diversion of inmates from state to local facilities and increased utilization of community supervision, including electronic monitoring.
- Investigate implementation of a web-based risk and needs assessment tool for use at time of sentencing. Estimated costs for sentencing options should be included in the tool to allow judges to weigh projected results with estimated costs of sentences. The tool should be made available to judges at the time of sentencing and to the public through a web portal.
- Perform a study to determine the potential cost savings resulting from a risk and needs assessment tool.
- Stakeholders develop recommendations to the Legislature for increasing flexibility in sentencing guidelines. Judges should be provided with the flexibility to consider the many purposes of sentencing, including punishment, rehabilitation, deterrence, restitution, recidivism reduction, and protection of public safety, as well as cost.

FULL RECOMMENDATION(S) ANALYSIS

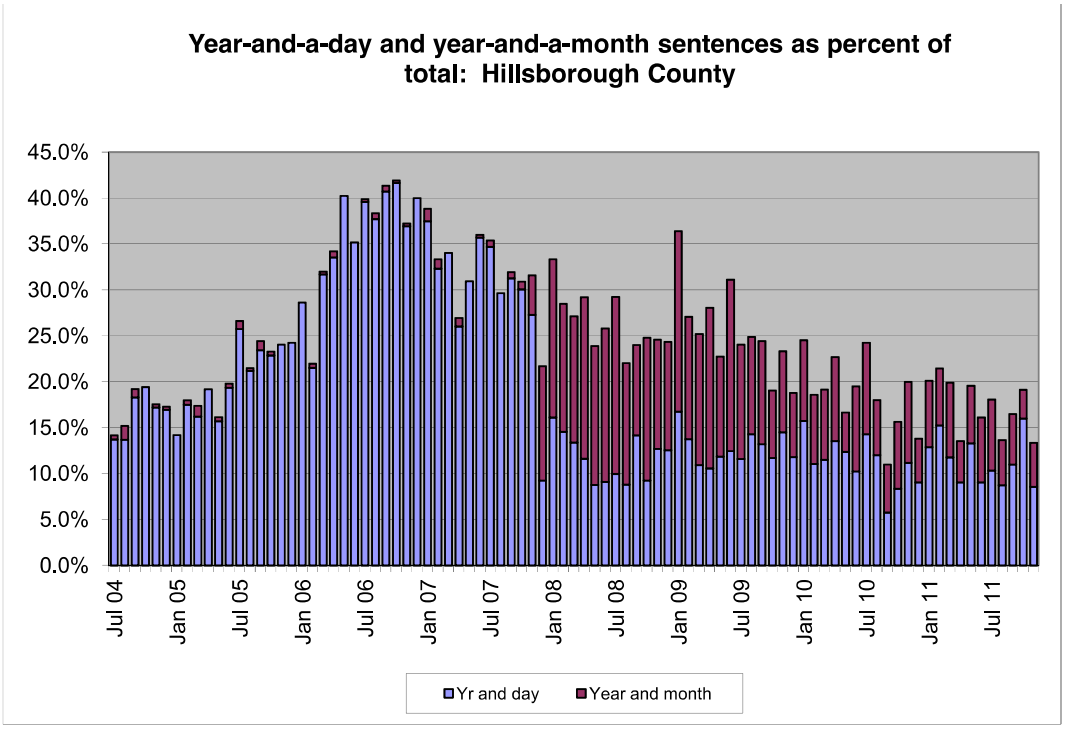
I. BACKGROUND

A. State and Local Incarceration

State and Local Incarceration in Florida

In Florida, defendants whose sentences include incarceration for one year or less are incarcerated in local prisons. The county in which the individual is incarcerated pays the costs of incarceration in local facilities. If a defendant is sentenced to incarceration for a year and a day or longer, the individual is placed in a state facility and the state pays the costs of incarceration.[1]

Year-and-a-day commitments rose to a peak of 17.7% of all new sentences in FY 2006-2007.[2] Attempts to reduce year-and-a-day commitments resulted in a decrease to 8.4% of all new sentences in FY 2010-2011.[3] It has been suggested that this reduction reflects a shift to year-and-a-month sentences, rather than shorter sentences resulting in local incarceration, as demonstrated in the graph below comparing year-and-a-day and year-and-a-month sentences in Hillsborough County.[4]



At the time of sentencing, many offenders have already served a portion of their sentence in jail, pending disposition of the case. If the prisoner is then sentenced for a term of incarceration longer than a year, he or she is transferred to a state facility. Each prisoner transferred to a state facility is first transported to a reception center.[5]

For FY 2010-2011, the department reported an average per diem of $53.35 for all facilities, $42.36 for adult male custody facilities, $63.12 for male youthful offender custody facilities, and $69.74 for adult and youthful

[1] *See* s. 944.17(3), F.S.
[2] "Criminal Justice Trends," Criminal Justice Estimating Conference, December 14, 2011, p. 35, http://edr.state.fl.us/content/conferences/criminaljustice/trends.pdf (last accessed 05/02/2012).
[3] *Id.*
[4] *Id.* at p. 37.
[5] *See* s. 944.17(3), F.S.

female custody facilities.[6] Reception centers average a higher per diem of $96.90.[7] Because of the higher cost of reception centers, the overall cost of a sentence just over a year in length, which requires transferring the prisoner to a state facility, may be more per inmate than a sentence just under a year, which is served in a local facility only.

Incentives for Local Incarceration

California, Colorado, Illinois, Kansas, and Texas provide incentives to localities for successfully supervising offenders in the community instead of sending them to state prison.[8] Under these arrangements, local correctional agencies receive state funding and other assistance to implement community-based programming with the goal of reducing recidivism and supervision violations that result in probation revocations.[9]

In Illinois, the Crime Reduction Act[10] established the Adult Redeploy Illinois program, which provides financial incentives to local jurisdictions for designing and utilizing community-based programs to treat offenders instead of sending them to state facilities. Texas utilizes a grant program for counties to implement a system of progressive community-based sanctions.[11] California provides funding to counties for implementing community-based sanctions for probation and parole violations in lieu of prison.[12] In the first year of implementation of a law providing funding to counties for implementing community-based sanctions, Arizona experienced a 14.5 percent decrease in probation revocations to prison.[13]

A potential issue with incentive programs is that data reported by localities may not accurately reflect true diversion from state facilities. In order to receive incentive funds, localities may improperly report diversions of individuals who would have been sentenced to local jails or community-based alternatives without the incentives in place. Other concerns about increasing community-based sanctions include potential for absconding.

B. Electronic Monitoring

Electronic monitoring (EM) by location tracking devices can be used as an aid in supervising pre-trial releasees and sentenced offenders who are not incarcerated. In Florida, electronic monitoring is primarily used by DOC to provide an extra measure of security for high-risk offenders under some form of community supervision, particularly sex offenders. In recent years there have been proposals to reduce corrections costs by replacing all or part of a term of incarceration of low-risk offenders with less expensive community supervision, including EM. In addition to reducing costs, it has been suggested that use of EM may support successful reentry into the community by providing for a period of supervision before release from custody.

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[6] Department of Corrections, "2010-2011 Annual Report," 2011, p. 7, http://www.dc.state.fl.us/pub/annual/1011/pdfs/AR1011-Final.pdf (last accessed 05/02/2012).
[7] *Id.*
[8] National Conference of State Legislatures (NCSL), "Innovations in Community Corrections," 2010, p. 2 http://www.ncsl.org/documents/cj/pew/innovations.pdf (last accessed 05/02/2012).
[9] *Id.*
[10] *See* 730 ILL. COMP. Stat. 190 (2012).
[11] *See* TEX. CODE ANN. §509.0017 (2011).
[12] *See* CAL. PENAL CODE §1228-1233.8 (2012).
[13] *See* ARIZ. REV. STAT. ANN. §12-270 (2011) (repealed 2011). The law was first implemented during FY 2009-2010. Due to state budget shortfalls, the Arizona Legislature suspended reinvestment of savings in communities for FY 2010-2011. National Conference of State Legislatures (NCSL), "Innovations in Community Corrections," 2010, p. 2, http://www.ncsl.org/documents/cj/pew/innovations.pdf (last accessed 05/02/2012).

Requirements for Electronic Monitoring in Florida

Chapter 948, F.S., permits a sentencing court to order EM for offenders placed on probation or community control.[14] The Florida Parole Commission may also use EM as a condition of post-release supervision.[15] In some cases, the court is required to order EM due to the offender's current or past offenses.[16] The most stringent requirement is found in s. 948.012, F.S., which requires a minimum 25-year prison sentence followed by lifetime supervision with electronic monitoring for any adult offender who commits lewd or lascivious molestation against a child under 12 years of age.[17] EM is a required condition for offenders placed on sex offender probation for certain sex offenses, but can only be ordered "when deemed necessary by the community control or probation officer and his or her supervisor, and ordered by the court at the recommendation of the Department of Corrections."[18]

Apart from the statutory authority given to the courts, DOC has discretion pursuant to s. 948.11(1), F.S., to place a community controlee on EM. The department does not exercise this discretion based on case law that an offender's failure to submit to EM ordered by the department cannot be a basis for revocation of community control.[19]

As of February 29, 2012, the department was actively supervising 114,761 offenders on some form of supervision in the community.[20] Of those offenders, 2,984 were being electronically monitored, with the majority (2,981) monitored by global positioning system (GPS) and the remaining 3 by radio frequency (RF) systems.[21] Of the monitored offenders, 1,934 were sex offenders or sexual predators.[22]

Electronic Monitoring Systems and Costs

EM systems mainly consist of two types: radio frequency (RF) monitoring or global positioning system (GPS) monitoring. Early EM systems used RF technology to alert or record an instance when the offender left a restricted area. These systems were typically used to monitor individuals under house arrest and do not provide information about the offender's location when the offender moves outside the range of the receiver.

[14] Section 948.101(1)(d), F.S., specifically provides that a court may order electronic monitoring as a condition of community control for any offender. Section 948.03(2), F.S. authorizes a sentencing court to order special conditions of probation not specifically set forth in statute.

[15] The Parole Commission's discretionary authority is authorized by s. 947.18, F.S., (parole), s. 947.1405, F.S., (conditional release), and s. 947.149, F.S., (conditional medical release).

[16] For example, *see* ss. 775.082(3), 947.1405, 948.012, and 948.30(3), F.S.

[17] *See* s. 800.04(5)(b), F.S.

[18] Section 948.30(2)(e), F.S. The Jessica Lunsford Act, Ch. 2005-28, L.O.F., made significant changes to Florida's electronic monitoring program. Among the provisions of the Act were requirements for electronic monitoring of certain sex offenders. Before passage of the Jessica Lunsford Act, the only statute mandating the sentencing court to require electronic monitoring was found in s. 948.101(1)(b), F.S., and applied only to offenders placed on criminal quarantine community control for criminal transmission of HIV. No offenders were ever placed on this form of community supervision and it was removed from the statutes in 2010.

[19] See *Carson v. State*, 531 So. 2d 1069 (Fla. 4th DCA 1988) and *Anthony v. State*, 854 So. 2d 744 (Fla. 2d DCA 2003).

[20] Another 30,768 offenders were in active-suspense supervision status, meaning that the offender was unavailable for direct supervision for reasons such as incarceration or hospitalization, but was still being monitored by a probation officer. Additionally, the department was monitoring 6,520 offenders whose supervision had been transferred out of state, and 29,342 offenders had absconded from supervision. Florida's Community Supervision population Monthly Status Report, February 2012, Department of Corrections, p. 3, http://www.dc.state.fl.us/pub/spop/2012/02/0212.pdf (last accessed 05/02/2012).

[21] *Id.* at p. 2.

[22] Florida's Community Supervision population Monthly Status Report, February 2012, Department of Corrections, p. 2, http://www.dc.state.fl.us/pub/spop/2012/02/0212.pdf (last accessed 05/02/2012).

In 2011, Florida's RF monitoring cost was $1.97 per day per monitored offender, making RF the least expensive form of electronic monitoring. RF system limitations and laws requiring use of monitoring with location tracking technology for sex offenders have led to reduced use by the department.[23]

GPS technology allows tracking of an offender's location even when he or she moves away from a fixed location using satellite positioning. Active GPS monitoring provides real-time reporting of an offender's location by incorporating a cell phone into the equipment in order to transmit location coordinates to a monitoring station. The monitoring station alerts the probation officer when the offender either leaves an area to which he or she is restricted or enters an area from which he or she is barred. An active GPS monitoring system includes a Mobile Tracking Device (MTD) that receives, stores, and transmits the location data as well as displays messages and instructions from the monitoring station or probation officer. In 2011, Florida's GPS monitoring cost was approximately $8.94 per day per monitored offender.

Section 948.09, F.S., requires the monitored offender to pay the full cost of the electronic monitoring services. The department has authority to exempt the offender from all or part of the payment under certain circumstances, such as inability to find a job.[24] Willful failure to pay non-exempted monitoring costs is grounds for the court to find a violation of the conditions of supervision. Few offenders have the financial resources to pay this amount on top of restitution, court costs, supervision fees, and other fees that have priority for payment.

Impact of Electronic Monitoring on Supervision

In 2010, researchers from the Florida State University College of Criminology and Criminal Justice submitted a report to the United States Department of Justice that addressed whether EM is "an effective and cost efficient correctional strategy that increases the level of monitoring and supervision of high-risk offenders while maintaining public safety."[25] The study found that:

- Overall, EM reduces the likelihood that an offender will not successfully complete community supervision by approximately 31% relative to the supervision failure rate of offenders who are not subject to it.[26]
- EM significantly reduces the failure rate for all types of offenders, but has less of an impact on violent offenders than on offenders who committed sex, drug, property, or other types of crimes.[27]
- Offenders who were monitored by use of active GPS monitoring had a 6% improvement rate in the reduction of supervision failures relative to offenders who were on RF monitoring.[28]

The study also noted drawbacks of EM, including:

- Offenders believe EM has negative consequences on their relationships with their spouses, significant others, and children, and a large proportion felt shame and were stigmatized by others disproportionate to their actions as a result of being on EM.[29]

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[23] The Jessica Lunsford Act requires the department to use "a system that actively monitors and identifies the offender's location and timely reports or records the offender's presence near or within a crime scene or in a prohibited area or the offender's departure from specified geographic limitations" for any court-ordered EM of a probationer, community controlee, or conditional release who has a conviction for a violent or sexual offense. *See* s. 948.11(6), F.S.

[24] Section 948.09(2) and (3), F.S.

[25] Bales, Bill, et al, *A Quantitative and Qualitative Assessment of Electronic Monitoring*, The Florida State University College of Criminology and Criminal Justice, Center for Criminology and Public Policy Research, January 2010, p. 5, https://www.ncjrs.gov/pdffiles1/nij/grants/230530.pdf (last accessed 05/02/2012).

[26] *Id.* at p. 64.

[27] *Id.*

[28] *Id.*

[29] *Id* at p. xi.

- Offenders and officers were nearly unanimous in stating that EM is a detriment to ability to obtain and maintain employment.[30]

A previous study conducted by researchers at Florida State University found significant reductions in absconding and in revocations for technical violations or new offenses among electronically monitored offenders as compared to those who were not electronically-monitored. The study also found that electronic monitoring was effective across a range of violent, property, and drug offenders.[31]

The National Conference of State Legislatures Sentencing and Corrections Work Group provided that the value of intermediate sanctions, including EM, "depends upon policies that target resources effectively and focus the highest-level supervision on the highest-risk offenders. Creating more intensive supervision for lower-risk offenders usually does not help meet corrections goals, affect cost control, or reduce reoffending."[32] When used in lieu of incarceration, the Work Group noted that EM can benefit offenders by allowing them to continue working, attend treatment, support their families, and remain in their residences.[33]

The Office of Program Policy Analysis and Government Accountability (OPPAGA) found that in addition to offender costs for EM, logistical problems may occur in monitoring homeless persons lacking a permanent residence and ability to recharge the unit for eight hours each day. Additionally, in rural areas offenders may be unable to acquire cellular signal for GPS monitoring, and offenders may not meet land-line telephone requirements for RF monitoring.[34]

In a 2010 report, OPPAGA found that increased use of intermediate sanctions, including community supervision with electronic monitoring, could reduce prison costs, but also has both positive and negative considerations.[35] OPPAGA determined that although the majority of persons on EM were sex offenders (70%), non-violent offenders with a Criminal Punishment Code score sheet total in the 45-60 point range are another population that may be effectively sanctioned with EM.[36] EM could be used as a sentencing alternative for persons driving with suspended licenses.[37] OPPAGA estimated potential savings of $1.2 million in the first year for every 100 offenders diverted from prison to EM supervision.[38]

Change and Efficiency

The Subcommittee recommends providing the Department of Corrections with flexibility to develop and implement cost savings initiatives, in conjunction with counties. The department should have the flexibility to implement new models of inmate transfer, assignment, or supervision if determined to effectively carry out inmate sentences, following existing statutory requirements, while achieving cost savings. Counties

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[30] *Id.*

[31] Padgett, Kathy G., William D. Bales and Thomas G. Blomberg, "Under Surveillance: An Empirical Test of the Effectiveness and Consequences of Electronic Monitoring," *Criminology & Public Policy* 5/1, February 2006, http://ccoso.org/undersurveillance.pdf (last accessed 05/08/2012).

[32] NCSL Sentencing and Corrections Work Group, "Principles of Effective State Sentencing and Corrections Policy," August 2011, p. 11, http://www.ncsl.org/documents/cj/pew/WGprinciplesreport.pdf (last accessed 05/02/2012).

[33] *Id*. at p. 12.

[34] OPPAGA, Report 10-27, "Intermediate Sanctions for Non-Violent Offenders Could Produce Savings," March 2010, p. 5 http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1027rpt.pdf (last accessed 05/02/2012).

[35] *Id*. at p. 2.

[36] Section 921.0024, F.S., provides a score sheet for determining the lowest permissible prison sentence under the Criminal Punishment Code. The lowest permissible sentence for an offender with 45 or 60 points is 12 or 24 months, respectively. *Id* at p. 4.

[37] This sanction already exists within the state corrections system but is not commonly used by judges at sentencing. OPPAGA, Report No. 08-12, "Several Alternatives Could Be Used to Reduce Increasing Imprisonment of Persons Driving with Suspended Licenses," March 2008, http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0812rpt.pdf (last accessed 05/02/2012).

[38] This assumes that 75% of diversions will result in successful outcomes. Savings estimate includes expanding the number of probation officers employed by DOC to serve additional offenders. OPPAGA Report No. 10-27, "Intermediate Sanctions for Non-Violent Offenders Could Produce Savings," March 2010, p. 3-5, http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1027rpt.pdf (last accessed 05/02/2012).

should be able to submit cost savings proposals to the department and appeal decisions to the Governor and Cabinet.

The Subcommittee recommends providing incentives for counties to participate in initiatives that will achieve efficiencies and cost savings for the state. Incentives should be created for arrangements that promote flexibility and produce mutually-beneficial arrangements for the state and counties. Incentives may include, but are not limited to, diversion of inmates from state to local facilities and increased utilization of community supervision, including electronic monitoring.

Recommendations:

- The Subcommittee recommends providing the Department of Corrections with flexibility to develop and implement cost savings initiatives, in conjunction with counties.
- The Subcommittee recommends providing incentives for counties to participate in initiatives that will achieve efficiencies and cost savings for the state.

C. Risk and Needs Assessment Instruments

Florida's Sentencing Policies

Florida's sentencing policies use items such as nature of the primary offense and any additional offenses, prior criminal history, and injury to the victim to calculate a recommended sentence for the offender. This type of determinant sentencing is put forth in the Criminal Punishment Code.[39] Section 921.002(1)(b), F.S., provides, "The primary purpose of sentencing is to punish the offender. Rehabilitation is a desired goal of the criminal justice system but is subordinate to the goal of punishment."[40] To this end, the Criminal Punishment Code provides that sentences should be commensurate with the severity and circumstances of the primary offense, increase with the length and nature of the offender's prior record, and prioritize incarceration toward offenders of serious offenses and those with long prior records.[41]

A sentencing scoresheet must be completed for each felony defendant prior to sentencing.[42] The offender's score determines the lowest permissible sentence, with upward discretion to the statutory maximum sentence. Florida's sentencing guidelines scoring system has been shown to serve as a valid indicator of offender seriousness.[43] The weighted score produced by this system takes into account an offender's primary offense and all additional offenses, his or her prior record and the seriousness of prior offenses, and other circumstances of the criminal event (victim injury, weapon use, supervision violation, etc.). A study by Padgett, Bales, and Blomberg stated that "In the absence of risk scores derived from psychological or other such inventories, this indicator of offender seriousness is the best available quantitative measure of the risk an offender poses to public safety."[44]

[39] *See* s. 921.002, F.S.
[40] Section 921.002(1)(b), F.S.
[41] Section 921.002(1), F.S.
[42] Section 921.0024(7), F.S. The Florida Criminal Punishment Code worksheet is provided in s. 921.0024(1), F.S.
[43] Burton, Susan E., et al., "Applying a Crime Seriousness Scale to Measure Changes in the Severity of Offenses by Individuals Arrested in Florida," *Justice Research and Policy* 6/1, 2004.
[44] Padgett, Kathy G., William D. Bales and Thomas G. Blomberg, "Under Surveillance: An Empirical Test of the Effectiveness and Consequences of Electronic Monitoring," *Criminology & Public Policy* 5/1, February 2006, p. 68, http://ccoso.org/undersurveillance.pdf (last accessed 05/08/2012).

Sentencing Tools

Actuarial risk and needs assessment tools use data about past cases to identify the indicators most closely associated with the likelihood of future criminality. After validation through testing on a known correctional population, this data is applied to individual offenders to produce recommendations based on offender characteristics, criminal history, and severity of current offense.

Once used largely by probation and parole departments to help determine the best supervision and treatment strategies for offenders, use of risk and needs assessment tools is expanding to inform decisions at other points in the criminal justice process. At sentencing, risk and needs assessments are intended to assist judges by providing information on risk management and reduction. Costs of different sentencing options may also be included in results. Judges consider this information in balancing the many purposes of sentencing, including punishment, rehabilitation, deterrence, restitution, recidivism, and public safety.

Application of Risk and Needs Assessment Instruments

According to the National Center for State Courts' National Working Group on Using Risk and Needs Assessment Information at Sentencing, risk and needs assessment tools are effective in determining:

- Public safety and risk management;
- Amenability to probation, community supervision, and intermediate sanctions;
- Effective behavioral treatment options;
- Suspension of all or part of a sentence; and
- Effective conditions of probation and responses to violations.[45]

The Pew Center on the States has found that "whether a particular offender is an appropriate candidate for recidivism reduction cannot accurately be assessed relying solely on the type of offense committed and the offender's prior criminal history. Individual offender characteristics must also be taken into consideration."[46] Pew recommends providing sufficient flexibility to consider recidivism reduction options and that state sentencing rules should avoid mandates that prohibit judges from granting probation.[47]

Alabama, Oregon, California, Arizona, Idaho, South Carolina, Utah, Washington, and Wisconsin have implemented evidence-based sentencing or declared recidivism reduction a goal of sentencing in recent years. Studies have found that actuarial risk and needs assessment tools that use data on prior cases to identify the likelihood of future criminality can be as accurate as human judgment in predicting risk of recidivism, but recommend use of both a third-generation actuarial toll and professional judgment.[48]

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[45] Casey, Pamela M., Roger K. Warren, and Jennifer K. Elek, "Using Offender Risk and Needs Assessment Information at Sentencing," National Center for State Courts, 2011, http://www.ncsc.org/~/media/Files/PDF/Services%20and%20Experts/Areas%20of%20expertise/Sentencing%20Probation/RNA%20Guide%20Final.ashx (last accessed 05/02/2012).

[46] Pew Center on the States, "Arming the Courts with Research: 10 Evidence-Based Sentencing Initiatives to Control Crime and Reduce Cost," May 2009, p. 2, http://cdpsweb.state.co.us/cccjj/pdf/june%202009/pew%20arming%20the%20courts%20with%20research.pdf (last accessed 05/02/2012).

[47] *Id.* at p. 2.

[48] *See* Andrews, D.A. James Bonta, and J. Stephen Wormith, "The Recent Past and Near Future of Risk and/or Need Assessment," *Crime and Delinquency* 52, January 2006; Gendreau, Paul, Tracy Little and Claire Goggin, "A Meta-Analysis of the Predictors of Adult Offender Recidivism: What Works!" *Criminology* 34/4, 1996.

The first state supreme court decision to discuss the use of risk and needs information at sentencing was in Indiana in *Malenchik v. State*.[49] In the decision, the Indiana Supreme Court distinguishes use of risk and needs assessment for sentencing alternatives for risk and recidivism management from sentencing as a punishment for criminal behavior. The *Malenchik* decision provides that risk and needs "evaluations and their scores are not intended to serve as aggravating or mitigating circumstances nor to determine the gross length of sentence, but a trial court may employ such results in formulating the manner in which a sentence is to be served."[50]

Risk and Needs Assessments in Other States

A 2010 survey by the Vera Institute of Justice found that over 60 community supervision agencies in 41 states reported using an actuarial assessment tool.[51] Of the survey respondents, 82 percent assessed both risk and need, and the remaining 18 percent assessed only risk.[52]

As of 2010, the Level of Service Inventory-Revised (LSI-R) was the most commonly used assessment tool and was utilized by at least 16 states.[53] LSI-R is used to predict recidivism across a range of correctional settings and assists determining the necessary level of supervision, sentencing, program or institutional classification, and release from custody. The tool consists of a 54-item scale in the areas of prior criminal history, education, employment, financial situation, family relationships, use of leisure time, companions, alcohol or drug use, mental health, and criminal attitudes.[54]

Other assessment tools include: the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) and the Level of Service/Case Management Inventory (LS/CMI).[55] Several states use state-specific assessment tools, including Ohio, Arizona, Wisconsin, Virginia, and California.

Virginia implemented a risk assessment instrument created by a state Sentencing Commission in 2003.[56] Since that time, Virginia judges have used the tool to successfully divert 25% of Virginia's nonviolent offenders who would have otherwise been incarcerated to alternative sanctions programs.[57] Beginning in 2013, Kentucky will include risk and needs assessments in presentence reports, allowing judges to review a defendant's likelihood of future criminal behavior when considering sentencing options.[58]

Missouri's Sentencing Commission developed the Recommended Sentencing Application (RSA), a web-based sentencing tool that provides extensive information about sentencing options and the risks and costs

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[49] *Malenchik v. State* 928 N.E.2d 564 (Ind. 2010).
[50] *Id.* at 575.
[51] Reponses were received from 72 agencies across 41 different states. Agencies included probation, parole, and releasing authorities. Vera Institute of Justice Center on Sentencing and Corrections memo to Illinois Risk, Assets and Needs Assessment Task Force, May 27, 2010, p. 1, http://www2.illinois.gov/idoc/Documents/National_Information_Offender_Assessments_PartII_Memo.pdf (last accessed 05/02/2012).
[52] Nearly all responding probation agencies conduct their assessments in the pre-sentence phase. Releasing authorities were more likely to assess only risk. *Id.* at p. 1-2.
[53] *Id.* at p. 1.
[54] Watkins, Ian, "The Utility Level of Service Inventory – Revised (LSI-R) Assessments within NSW Correctional Environments," Corrective Services NSW Research Bulletin No. 29, January 2011, p. 2, http://143.119.253.176/__data/assets/pdf_file/0018/302526/utility-of-level-of-service-inventory-.pdf (last accessed 05/08/2012).
[55] Vera Institute of Justice Center on Sentencing and Corrections memo to Illinois Risk, Assets and Needs Assessment Task Force, May 27, 2010, p. 1, http://www2.illinois.gov/idoc/Documents/National_Information_Offender_Assessments_PartII_Memo.pdf (last accessed 05/02/2012).
[56] *See* Section 17.1-803(5,6), Code of Virginia.
[57] Target populations for diversion include property and drug offenders. Warren, Roger K. "Evidence-Based Sentencing: The Application of Principles of Evidence-Based Practice to State Sentencing Practice and Policy," *University of San Francisco Law Review* 43, 2009, p. 608.
[58] NCSL Sentencing and Corrections Work Group, "Principles of Effective State Sentencing and Corrections Policy," August 2011, p. 4, http://www.ncsl.org/documents/cj/pew/WGprinciplesreport.pdf (last accessed 05/02/2012).

associated with each alternative.[59] RSA calculates recommended sentences, risk assessments, and recidivism projections using gender, prior felony convictions, prior misdemeanors, prior incarcerations, revocations, time since last conviction/release, recidivist offense, education, employment, substance abuse, escapes, and age. Also included in results are the estimated costs of incarceration, supervision, and community-based alternatives, allowing the judge to weigh projected results with estimated costs of sentences.[60]

Change and Efficiency

The Subcommittee recommends investigating implementation of a web-based risk and needs assessment tool for use at time of sentencing. Using data on the indicators most closely associated with the likelihood of future criminality, risk and needs assessment tools can provide recommended options based on the individual offender's risk of recidivating and effectiveness of various sentencing options. The state should investigate implementing a risk and needs assessment tool to provide judges with additional information on sentencing to effectively manage and reduce risk. Estimated costs for sentencing options should be included in the tool to allow judges to weigh projected results with estimated costs of sentences. The tool should be made available to judges at the time of sentencing and to the public through a web portal.

The Subcommittee recommends performing a study to determine the potential cost savings resulting from implementing a risk and needs assessment tool. Allowing for judicial discretion at time of sentencing, an assessment tool may lead to savings if judges select appropriate sentencing options that have lower costs. A study should be performed to determine the estimated savings from implementation of an assessment tool that includes costs with recommended sentencing options.

Programs that address the individual needs of inmates and prepare them for successful re-entry into the community should be utilized when appropriate, based on assessments performed at time of sentencing and at time of intake. Educational, vocational, chemical dependency, faith, and character-based programs should be expanded as part of recidivism reduction and re-entry programs. The Subcommittee supports the recommendations on prison education programs in these areas.[61]

To effectively implement the recommendations, flexibility in sentencing must be provided to judges. Options presented by a risk and needs assessment tool and initiatives partnering the state and counties must be available for judges to utilize at their discretion.

The Subcommittee recommends that stakeholders develop recommendations to the Legislature for increasing flexibility in sentencing guidelines. Judges should be provided with the flexibility to consider the many purposes of sentencing, including punishment, rehabilitation, deterrence, restitution, recidivism reduction, and protection of public safety, as well as cost. Judges should be given flexibility to determine the balance of these elements and most effective method of sentencing for each individual offender. Mandatory sentencing requirements should be evaluated and modified, if necessary, when determined to ineffectively limit judicial discretion.

Recommendations:

- The Subcommittee recommends investigating implementation of a web-based risk and needs assessment tool for use at time of sentencing.

[59] The Missouri Sentencing Advisory Commission Model can be accessed at www.courts.mo.gov/rs/ (last accessed 05/02/12).
[60] *See* www.courts.mo.gov/rs/ (last accessed 05/02/12).
[61] The Government Efficiency Task Force Subcommittee on Education discussed the issue of prison education programs on April 9 and May 9. Meeting materials and video available at http://www.floridaefficiency.com/meetings.cfm (last accessed 05/16/2012).

- The Subcommittee recommends performing a study to determine the potential cost savings resulting from a risk and needs assessment tool.
- The Subcommittee recommends that stakeholders develop recommendations to the Legislature for increasing flexibility in sentencing guidelines.

Florida Government Efficiency Task Force

Subcommittee on Health and Human Services ***Background Brief***

Subject Matter: State Employee Health Insurance Procurement

Subcommittee Members: Bob Rohrlack (Chair), Frank Attkisson, Larry Cretul, Julie Fess, and Bob Stork

ISSUE SUMMARY

- The State Employee Health Insurance Program (program) is an optional benefit for all state employees. The program is governed by s. 110.123, F.S,. and administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS or department).

- The department's statutory responsibilities with regard to the program include: development of requests for proposals or invitations to negotiate for state employee health services; determination of health care benefits to be provided; and negotiation of contracts for health care and health care administrative services.

- Pursuant to s. 110.123(5), F.S., all determinations, including the determination of health care benefits, are subject to prior approval by the Legislature.

- DMS is required by statute to advertise for competitive proposals and award the contract based on consideration of benefits provided in relationship to cost.

- The state health insurance plans and benefits are provided annually in the General Appropriations Act (GAA). Provisions in the GAA include: plan options to be offered; benefits provided under each of the plans; state and employee contributions to premiums; premium payments for Medicare participants, COBRA participants, and early retirees; and copayments, coinsurance, and other requirements for the prescription drug program.

- Recent procurements of health maintenance organization (HMO) and pharmacy benefit manager (PBM) contracts were conducted through the Invitation to Negotiate (ITN) process, including requests for vendor proposals to increase efficiency and provide cost-effective services for the best overall value to the state.

FULL ISSUE(S) ANALYSIS

I. BACKGROUND

A. STATE EMPLOYEE HEALTH INSURANCE:

State Employee Health Insurance Program

The State Employee Health Insurance Program (program) is governed by the State Group Insurance Program Law provided in s. 110.123, F.S. The program is administered by the Division of State Group Insurance (DSGI or division) within the Department of Management Services (DMS or department).

The program is an optional benefit for all state employees, including state agencies, state universities, the court system and the Legislature. The program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

As implemented by the department, the program offers four types of health plans: a standard statewide Preferred Provider Organization (PPO) Plan, a Health Investor PPO Plan, a standard Health Maintenance Organization (HMO) Plan, and a Health Investor HMO Plan.

The State Employees' PPO plan is a self-insured health plan administered by Blue Cross Blue Shield of Florida and available to employees across the state.[1] Each HMO is a self-administered, pre-paid health plan that provides health services to people who live or work within the HMO's service area. Six HMOs provide coverage in various geographic regions.[2]

The program also offers two high-deductible health plans with health savings accounts (HSA). The Health Investor PPO Plan is the statewide, high deductible health plan administered by Blue Cross Blue Shield of Florida. The Health Investor HMO Plan is a high deductible health plan in which the state has contracted with multiple state and regional HMOs.

Department of Management Services, Division of State Group Insurance

The Division of State Group Insurance is established within DMS pursuant to s. 110.123(3)(a), F.S. Statutory authority for the program is provided to DMS, which administers the provisions through the division. The department's statutory responsibilities with regard to the program are provided in s. 110.123, F.S., and include:

- Development of requests for proposals or invitations to negotiate for state employee health services;
- Determination of health care benefits to be provided; and
- Negotiation of contracts for health care and health care administrative services.[3]

While the department is directed to determine the benefits and contributions for the state group insurance program, all determinations are subject to prior approval by the Legislature.[4]

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[1] The administrator is responsible for processing health claims, providing access to a Preferred Provider Care Network, and managing customer service, utilization review, and case management functions.
[2] State contracted HMO plan providers are Aetna, AvMed, Capital Health Plan, Coventry Health Care of Florida, Florida Health Care Plans, and United Health Care. Department of Management Services, *State of Florida Employee and Retiree Benefits Guide,* September 2011. http://www.myflorida.com/mybenefits/pdf/BenefitsGuide_2012.pdf (last visited 03/20/2012).
[3] Section 110.123(3)(c), F.S.
[4] Section 110.123(5), F.S.

DMS is responsible for contract management of all health insurance contracts and day-to-day management of the state employee health insurance program, including employee eligibility and enrollment, premium collection, and payment to health care providers.[5]

DMS is directed to contract with an insurance carrier or carriers, or a professional administrator for the insurance program. If the department chooses to self-insure any of the plans within the state group insurance program, the department may contract with an insurance company or professional administrator.[6] DMS is required to advertise for competitive proposals and award the contract based on consideration of benefits provided in relationship to cost.[7] The department must follow good purchasing practices and applicable provisions established in Chapter 287, F.S., relating to procurement.[8]

General Appropriations Act

The state health insurance plans and benefits are provided annually in the General Appropriations Act (GAA).[9] The GAA provides:

- Plan options to be offered by DGSI, including a standard plan, high deductible plan, health maintenance organization (HMO) standard plans, and HMO high deductible plans;
- Benefits provided under each of the plans;
- State and employee contributions to premiums;
- Premium payments for Medicare participants, COBRA participants, and early retirees; and
- Copayments, coinsurance, and other requirements for the prescription drug program.[10]

The GAA establishes benefits and contributions for the applicable fiscal year (July-June). The plan year is aligned with the calendar year, running from January to December.

The Legislature established the state self-insured plan effective May 1, 1978.[11] There has not been a major plan redesign since that time, and the plan has been reestablished annually in the GAA, with periodic incremental changes. In 1988, s. 110.123, F.S., was amended to require that HMO contracts be awarded based on competitive bids.[12] The minimum benefit package for HMO plans has since been reestablished annually in the GAA, with periodic incremental changes.

The Legislature last modified benefits effective for plan year 2011.[13] For 2011, the benefits provided in plan year 2010 were reestablished, with the exception that benefits be modified as necessary to conform to the provisions of the Florida Clinical Trial Compact, certain copayments for standard HMO plans and the standard PPO plan were modified, and mammograms were deemed preventative benefits under the standard PPO plan.[14]

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[5] Section 110.123(3)(c), F.S.
[6] In a self-insured plan, the employer assumes the financial risk for providing health care benefits to its employees. Self-insured employers pay for claims as they are incurred. In a fully-insured plan, the employer pays a fixed premium to an insurance carrier, who assumes the financial risk for providing health care benefits.
[7] Section 110.123(5)(c), F.S.
[8] Section 110.123(3)(d)1., F.S.
[9] Section 8, Ch. 2012-118, L.O.F.
[10] *Id.*
[11] Information from DSGI on file with Government Efficiency Task Force staff.
[12] *Id.*
[13] Section 8, Ch. 2010-152, L.O.F.
[14] *Id.*

Recent Procurements

DMS recently procured contracts for the HMO benefit plans and a pharmacy benefit manager (PBM).[15] The department elected to use the Invitation to Negotiate (ITN) process established in s. 287.057, F.S. The ITN for the HMO procurement requested information to be used in developing positions on several questions, including:

- How can the Department most efficiently provide HMO medical and pharmacy benefits to program participants?
- Is a multiple vendor platform in the best interest of the state?
- Are statewide service areas preferable, where each HMO is required to provide access to enrollees in every county for which they have an AHCA approved network? Can more limited service areas result in lower costs? Which approach is cost- effective? Does the cost-effective approach provide high-value to enrollees? Which approach provides the overall best value?
- Are overlapping HMO service areas in the best interest of the state? Can single award service areas result in lower costs? Are there areas where more than one HMO should be offered due to the number of state employees in the area or any unique geographical characteristics of the area? Which approach provides the overall best value?
- Can the state achieve greater value from more limited provider networks? Is the tradeoff of access worth the savings?
- Is it more cost-effective to carve-in or carve-out pharmacy benefits from the HMO medical provider?
- How can the Department ensure pricing remains competitive throughout the term of the contract?
- How can the Department best position the HMO contract(s) and the State Group Insurance Program to provide flexibility for future program changes (e.g., benefit design, moving to a defined contribution structure, transitioning to a consumer-driven model with HSAs and/or Health Reimbursement Accounts (HRAs), implementing employee and/or Participant wellness initiatives, establishing on- site clinics)?
- How can the Department best position the HMO and PBM contract(s) for the State of Florida to implement and benefit from cost-saving programs?
- What additional value propositions do vendors offer that are in the best interest of the state?[16]

[15] ITN No.: DMS 10/11-011, Health Maintenance Organization Employee Benefit Services, November 15, 2010, http://www.myflorida.com/apps/vbs/adoc/F4568_HMORFPWordWrap_Final.pdf (last accessed 05/14/2012); ITN No.: DMS 10/11-010, Pharmacy Benefits Plan Management Services, September 10, 2010, http://myflorida.com/apps/vbs/adoc/F475_PBMITNFINAL20100910.pdf (last accessed 05/14/2012).

[16] ITN NO.: DMS 10/11-011, Health Maintenance Organization Employee Benefit Services, November 15, 2010, p. 9-10, http://www.myflorida.com/apps/vbs/adoc/F4568_HMORFPWordWrap_Final.pdf (last accessed 05/14/2012).

Osceola County
Florida
"Honoring the past shaping the future."

Cost Savings Initiatives for Healthcare – Our Journey

May 17, 2012

Outline

- Review the restructure of Osceola's health plan; implementation of an HRA as the County's base plan and placing the costly HMO as a buy-up plan saving $ 4 million.
- Discuss the need to consider other healthcare solutions to reduce costs.
- Discuss the County's RFLOI for Health Solutions and proposals received
- Discuss selection of Satori and Chappel Family Practice and savings estimates.

Health Plan Claims Overview

- Cost Savings achieved with implemented health plan changes:
  - October 1, 2010 the County implemented the HRA plan saving $ 4 Million in renewal premium.
  - Claims since the implementation of the HRA have continued to decrease. Claims are 8% below the expected rate for 2012.
  - Cigna provided a mid-year re-rate in 2012 with a $481,000 reduction off our claims liability.

Health Plan Claims Overview

- 70% of our employees are enrolled in the HRA as this is the County's base plan.
- Since the implementation of the HRA, Per Employee Per Month cost have dropped from $ 666 in 2010 to $ 651 in 2011 and at this point in 2012 to $ 581.
- Wellness program re-initiated. In 2010 the wellness program was revitalized. In 2011 Cigna provided $100,000 in wellness dollars for County programs.

Why We Considered Other Solutions?

- Health Insurance costs continue to rise
- Average 13% medical inflationary trend for the past 4 years
- Even with the success of the HRA, further containment or reduction of medical trend can be achieved
- **OUR FOCUS:**
  - **Provide incentive based preventative medicine and wellness for a healthier workforce**
  - **Provide timely and efficient access to quality care**
  - **Long Term reduction in catastrophic claims**
  - **Reduction in medical and prescription plan costs**

RFLOI for Healthcare Solutions

- The intent of the RFLOI was to gather information from proposers who could provide cost effective healthcare solutions to assist Osceola in reducing healthcare costs, without degrading the current healthcare and wellness level within the organization.

RFLOI for Healthcare Solutions

- The request for information was intended to explore “out of the box thinking” for potential solutions.
- Included providers from within the local community, as well as other interested parties from a regional or national basis.

PROPOSAL SUMMARY

- 15 Proposals Received
- Categorized by type of model:

  (1) - Broker Services/Wellness Program

  (7) - Clinic/Disease Management/Wellness and Occupational Health

  (2) - Data Mining/Predictive Modeling

  (1) - Equipment Maintenance Program

  (1) – International Medical Travel Services

  (2) - Local HealthCare Network

  (1) - Wellness Program/On-site

Board Shortlisted Proposers

- 6 Proposers were selected to move forward in the process:
  - 4 Firms under the category of; Clinic/Disease Management/Wellness and Occupational Health
  - 1 Firm under the category of; International Medical Travel Services
  - 1 Firm under the category of Data Mining/Predictive Modeling

Employee Focus Group Selected to Review Shortlisted Firms

- At the request of the Osceola County Board of County Commissioners, a cross-section of employees was assembled to create the RFLOI Employee Steering Committee consisting of 18 County employees.
- The ultimate purpose was to find an integrated healthcare solution for Osceola County Government employees and their families that will provide quality healthcare and positively impact long-term costs. Employees on the committee were solely asked to recommend the program they determined will offer County employees access to the most comprehensive medical care option available; and most importantly a program that employees and their family members will find simple and easy to use.

Focus Group Recommendation

- The Recommendation RFLOI Report was derived from the following:
- Committee members attended (3) in-house workshops/ discussion sessions facilitated by Bouchard Insurance, the Osceola's broker.
- Committee members participated in (1) provider webinar presentation presented by - Satori World Medical
- Committee members participated in (4) actual provider facility site tours as follows:
  - Chappel Family Practice, Kissimmee, FL - February 17, 2012
  - Florida Hospital/CentraCare – On-Site Clinic at Darden Restaurant Corporate Offices Orlando, Fl – February 21, 2012
  - Walgreen's /Take Care Clinics – On-Site Clinic at Disney World/Epcot Orlando, Fl – February 28, 2012
  - John Littell, MD / Primary Physicians Group (*formerly Osceola Accountable Care*), Kissimmee, Fl - March 7, 2012

Provider Analysis / Recommendations

- **The RFLOI committee stratified the providers into 3 separate categories:**
- **Medical Travel Provider (Medical Tourism):**
  - Satori World Medical
- **On-Site Medical Clinic Providers (Employer-owned):**
  - Florida Hospital/CentraCare
  - Walgreens/TakeCare Clinics
- **Off-Site Medical Clinic Providers (Independent Physician owned) Providers:**
  - John Littell, MD - primary Care Partners (formerly Osceola Accountable Care)
  - Chappel Family Medical Practice

Provider Analysis / Recommendations

MEDICAL TRAVEL PROVIDER (MEDICAL TOURISM):

SATORI MEDICAL: Some of the items noted as part of the presentation and considered by the RFLOI Committee were:

- No start-up/implementation cost for the County
- Satori's Centers of Excellence are documented as "high-quality" international Centers of Excellence
- Potential for significant financial savings to the County based on estimated savings provided by Satori to the Committee
- Potential for significant savings in out-of-pocket costs for Osceola County employees and family members, while providing the high-quality care abroad

✓ **Recommendation:** Based on the above, the RFLOI Committee recommends to BOCC to include Satori World Medical in the County's Self-Insured Medical Program, effective with our annual medical renewal, October 1, 2012

Provider Analysis / Recommendations

CHAPPEL FAMILY PRACTICE:

Some of the items taken into consideration by the RFLOI Committee were:

- No start-up/implementation cost for the County, no administration costs, a turn-key off-site independent medical provider versus a "brick & mortar" on-site provider
- Proximity of Chappel Facility to bulk of County employees is extremely advantageous, space for future growth for a county-specific clinic
- Large network of specialists, "One-Stop" shopping, specialists swing offices at Chappel facility provides excellent access to care and convenience to OCG employees
- Provider focus is treatment, not only of acute, but long-term episodic conditions
- Availability of a Fitness Center that can be integrated into the OCG Wellness initiative & capacity to include an OCG exclusive pharmacy

✓ **Recommendation**: Based on the above, the RFLOI Committee recommends to the BOCC, that if the BOCC elects to move forward with an "Off-Site Clinic" approach, that Chappel Family Medical would be selected as the provider of choice

Provider Analysis / Recommendations

WALGREENS/TAKE CARE:

Some of the items noted as part of the presentation and considered by the RFLOI Committee were:

- Global medical provider with extensive practice knowledge, Non-Cookie-Cutter approach to health care with a menu of options
- Provider focus is on total healthcare solution treating not only acute, but long-term episodic conditions
- Start-up/implementation cost for the County, and long-term administration costs, versus a turn-key off-site independent medical provider
- Integrated pharmacy, is a significant component of a sound care delivery program

✓ **Recommendation**: Unanimously, based on the above, the RFLOI Committee recommends to the Board of County Commissioners, that if the BOCC elects to move forward with an "Employer On-Site" approach, that Walgreens' TakeCare Clinic is selected as the provider of choice for pharmacy services.

Committee Final Recommendations

- ✓ As part of it final actions as a formal group, the RFLOI Steering Committee's final recommendations to the BOCC is that the Board move forward with discussion and planning with the Chappel Family Medical practice.
- ✓ The Committee also recommends that the BOCC instruct the County's consultant, Bouchard Insurance, to work with the County to secure a pharmacy-only bid from Walgreens. The goal being to establish an actual pharmacy to be housed within the Chappel Medical building, to serve as an integral part on the County's Healthcare Program.
- ✓ The Committee also recommends that the BOCC instruct the County's consultant, Bouchard Insurance, to work with the County to for the implementation of the Medical Travel Services with Satori World Medical for October 1, 2012.

Summary – Long Term Solutions

- HRA Implementation added employee consumerism and has proven cost savings.
- Partnership with local Health Center (Chappel Family Practice) to provide medical treatment plans and lifestyle education with fitness plans to lower claim costs.
- Partnership will also provide incentive based preventative medicine and wellness for a healthier workforce.
- Implementation of County's own pharmacy integrated into the Health Center with Pharmacy Benefit Manager (PBM) Walgreens.

Summary - How Will Savings Be Achieved

- In partnership with our broker, Osceola will be working to create client specific network (CSN) for services at Chappel Family practice and a network of specialists for lower rates than Cigna negotiated rates.
- Utilizing Satori World Medical's reduced rates for medical travel services for certain surgeries.

Summary - How Will Savings Be Achieved

- These long term changes have and will continue to provided an effective method for Osceola to protect our fiscal future.

Questions?