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LEGISLATIVE ACTION

Senate

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House

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Floor: NC/2R

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03/09/2016 05:01 PM

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Senator Hays moved the following:

Senate Amendment (with title amendment)

Between lines 960 and 961

insert:

Section 20. Effective January 1, 2018, section 627.42393,
Florida Statutes, is created to read:

627.42393 Continuity of care for medically stable
patients.-

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

(a) "Complex or chronic medical condition" means a
physical, behavioral, or developmental condition that does not



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12 have a known cure or that can be severely debilitating or fatal
13 if left untreated or undertreated.

14 (b) "Rare disease" has the same meaning as in 42 U.S.C. s.
15 287a-1(c).

16 (2) A pharmacy benefits manager or an individual or a group
17 insurance policy that is delivered, issued for delivery,
18 renewed, amended, or continued in this state and that provides
19 medical, major medical, or similar comprehensive coverage must
20 continue to cover a drug for an insured with a complex or
21 chronic medical condition or a rare disease if:

22 (a) The drug was previously covered by the insurer for a
23 medical condition or disease of the insured; and

24 (b) The prescribing provider continues to prescribe the
25 drug for the medical condition or disease, the drug is
26 appropriately prescribed, and neither of the following has
27 occurred:

28 1. The United States Food and Drug Administration has
29 issued a notice, a guidance, a warning, an announcement, or any
30 other statement about the drug which calls into question the
31 clinical safety of the drug; or

32 2. The manufacturer of the drug has notified the United
33 States Food and Drug Administration of any manufacturing
34 discontinuance or potential discontinuance as required by s.
35 506C of the Federal Food Drug and Cosmetic Act, 21 U.S.C. s.
36 356c.

37 (3) With respect to a drug for an insured with a complex or
38 chronic medical condition or a rare disease which meets the
39 conditions of paragraphs (2)(a) and (b), except during open
40 enrollment periods, a pharmacy benefits manager or an individual



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41 or a group insurance policy may not:

42 (a) Set forth, by contract, limitations on maximum coverage
43 of prescription drug benefits;

44 (b) Subject the insured to increased out-of-pocket costs;
45 or

46 (c) Move a drug for an insured to a more restrictive tier,
47 if an individual or a group insurance policy or a pharmacy
48 benefits manager uses a formulary with tiers.

49 (4) This section does not apply to a grandfathered health
50 plan as defined in s. 627.402, or to benefits set forth in s.
51 627.6561(5)(b)-(e).

52 Section 21. Effective January 1, 2018, paragraph (e) of
53 subsection (5) of section 627.6699, Florida Statutes, is amended
54 to read:

55 627.6699 Employee Health Care Access Act.—

56 (5) AVAILABILITY OF COVERAGE.—

57 (e) All health benefit plans issued under this section must
58 comply with the following conditions:

59 1. For employers who have fewer than two employees, a late
60 enrollee may be excluded from coverage for no longer than 24
61 months if he or she was not covered by creditable coverage
62 continually to a date not more than 63 days before the effective
63 date of his or her new coverage.

64 2. Any requirement used by a small employer carrier in
65 determining whether to provide coverage to a small employer
66 group, including requirements for minimum participation of
67 eligible employees and minimum employer contributions, must be
68 applied uniformly among all small employer groups having the
69 same number of eligible employees applying for coverage or



70 receiving coverage from the small employer carrier, except that
71 a small employer carrier that participates in, administers, or
72 issues health benefits pursuant to s. 381.0406 which do not
73 include a preexisting condition exclusion may require as a
74 condition of offering such benefits that the employer has had no
75 health insurance coverage for its employees for a period of at
76 least 6 months. A small employer carrier may vary application of
77 minimum participation requirements and minimum employer
78 contribution requirements only by the size of the small employer
79 group.

80 3. In applying minimum participation requirements with
81 respect to a small employer, a small employer carrier shall not
82 consider as an eligible employee employees or dependents who
83 have qualifying existing coverage in an employer-based group
84 insurance plan or an ERISA qualified self-insurance plan in
85 determining whether the applicable percentage of participation
86 is met. However, a small employer carrier may count eligible
87 employees and dependents who have coverage under another health
88 plan that is sponsored by that employer.

89 4. A small employer carrier shall not increase any
90 requirement for minimum employee participation or any
91 requirement for minimum employer contribution applicable to a
92 small employer at any time after the small employer has been
93 accepted for coverage, unless the employer size has changed, in
94 which case the small employer carrier may apply the requirements
95 that are applicable to the new group size.

96 5. If a small employer carrier offers coverage to a small
97 employer, it must offer coverage to all the small employer's
98 eligible employees and their dependents. A small employer



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99 carrier may not offer coverage limited to certain persons in a
100 group or to part of a group, except with respect to late
101 enrollees.

102 6. A small employer carrier may not modify any health
103 benefit plan issued to a small employer with respect to a small
104 employer or any eligible employee or dependent through riders,
105 endorsements, or otherwise to restrict or exclude coverage for
106 certain diseases or medical conditions otherwise covered by the
107 health benefit plan.

108 7. An initial enrollment period of at least 30 days must be
109 provided. An annual 30-day open enrollment period must be
110 offered to each small employer's eligible employees and their
111 dependents. A small employer carrier must provide special
112 enrollment periods as required by s. 627.65615.

113 8. A small employer carrier must provide continuity of care
114 for medically stable patients as required by s. 627.42393.

115 Section 22. Effective January 1, 2018, subsections (44) and
116 (45) are added to section 641.31, Florida Statutes, to read:

117 641.31 Health maintenance contracts.—

118 (44) A health maintenance organization may not require a
119 health care provider, by contract with another health care
120 provider, a patient, or another individual or entity, to use a
121 clinical decision support system or a laboratory benefits
122 management program before the provider may order clinical
123 laboratory services or in an attempt to direct or limit the
124 provider's medical decisionmaking relating to the use of such
125 services. This subsection may not be construed to prohibit any
126 prior authorization requirements that the health maintenance
127 organization may have regarding the provision of clinical



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128 laboratory services. As used in this subsection, the term:

129 (a) "Clinical decision support system" means software
130 designed to direct or assist clinical decisionmaking by matching
131 the characteristics of an individual patient to a computerized
132 clinical knowledge base and providing patient-specific
133 assessments or recommendations based on the match.

134 (b) "Clinical laboratory services" means the examination of
135 fluids or other materials taken from the human body, which
136 examination is ordered by a health care provider for use in the
137 diagnosis, prevention, or treatment of a disease or in the
138 identification or assessment of a medical or physical condition.

139 (c) "Laboratory benefits management program" means a health
140 maintenance organization protocol that dictates or limits health
141 care provider decisionmaking relating to the use of clinical
142 laboratory services.

143 (45) (a) A pharmacy benefits manager or a health maintenance
144 contract that is delivered, issued for delivery, renewed,
145 amended, or continued in this state and that provides medical,
146 major medical, or similar comprehensive coverage must continue
147 to cover a drug for a subscriber with a complex or chronic
148 medical condition or a rare disease if:

149 1. The drug was previously covered by the health
150 maintenance organization for a medical condition or disease of
151 the subscriber; and

152 2. The prescribing provider continues to prescribe the drug
153 for the medical condition or disease, the drug is appropriately
154 prescribed, and neither of the following has occurred:

155 a. The United States Food and Drug Administration has
156 issued a notice, a guidance, a warning, an announcement, or any



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157 other statement about the drug which calls into question the
158 clinical safety of the drug; or

159 b. The manufacturer of the drug has notified the United
160 States Food and Drug Administration of any manufacturing
161 discontinuance or potential discontinuance as required by s.
162 506C of the Federal Food Drug and Cosmetic Act, 21 U.S.C. s.
163 356c.

164 (b) With respect to a drug for a subscriber with a complex
165 or chronic medical condition or a rare disease which meets the
166 conditions of subparagraphs (c)1. and (c)2., except during open
167 enrollment periods, a pharmacy benefits manager or a health
168 maintenance contract may not:

169 1. Set forth, by contract, limitations on maximum coverage
170 of prescription drug benefits;

171 2. Subject the subscriber to increased out-of-pocket costs;
172 or

173 3. Move a drug for a subscriber to a more restrictive tier,
174 if a health maintenance contract or a pharmacy benefits manager
175 uses a formulary with tiers.

176 (c) As used in this subsection, the term:

177 1. "Complex or chronic medical condition" means a physical,
178 behavioral, or developmental condition that does not have a
179 known cure or that can be severely debilitating or fatal if left
180 untreated or undertreated.

181 2. "Rare disease" has the same meaning as 42 U.S.C. s.
182 287a-1(c).

183 (d) This section does not apply to a grandfathered health
184 plan as defined in s. 627.402.

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186 ===== T I T L E A M E N D M E N T =====

187 And the title is amended as follows:

188 Between lines 71 and 72

189 insert:

190 creating s. 627.42393, F.S.; defining terms; requiring
191 a pharmacy benefits manager or a specified individual
192 or group insurance policy to continue to cover a drug
193 for specified insureds under certain circumstances;
194 prohibiting certain actions by a pharmacy benefits
195 manager or an individual or a group policy with
196 respect to a drug for a certain insured except under
197 certain circumstances; providing applicability;
198 amending s. 627.6699, F.S.; expanding a list of
199 conditions that certain health benefit plans must
200 comply with; amending s. 641.31, F.S.; prohibiting a
201 health maintenance organization from requiring that a
202 health care provider use a clinical decision support
203 system or a laboratory benefits management program in
204 certain circumstances; providing for construction;
205 defining terms; requiring a pharmacy benefits manager
206 or a specified health maintenance contract to continue
207 to cover a drug for specified subscribers under
208 certain circumstances; prohibiting certain actions by
209 a pharmacy benefits manager or a health maintenance
210 contract with respect to a drug for a certain
211 subscriber except under certain circumstances;
212 defining terms; providing applicability;