Tab 1	**SB 182** by **Mayfield**; (Similar to H 0095) Consumer Protection from Nonmedical Changes to Prescription Drug Formularies					
753734	A	S	RCS	BI, Mayfield	Delete L.113 - 114:	02/07 11:09 AM

Tab 2	**SB 240** by **Lee**; (Similar to H 0161) Direct Primary Care					
935534	A	S	RCS	BI, Lee	btw L.80 - 81:	02/07 11:09 AM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Flores, Chair
Senator Steube, Vice Chair

MEETING DATE: Tuesday, February 7, 2017
TIME: 10:00 a.m.—12:00 noon
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Steube, Vice Chair; Senators Bracy, Braynon, Farmer, Gainer, Garcia, Mayfield, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 182** Mayfield (Similar H 95)	Consumer Protection from Nonmedical Changes to Prescription Drug Formularies; Limiting changes to a health insurance policy prescription drug formulary during a policy year; requiring small employer carriers to provide continuity of care for certain patients with respect to prescription drug coverage, etc. BI 02/07/2017 Fav/CS HP RC	Fav/CS Yeas 6 Nays 1
2	**SB 240** Lee (Similar H 161)	Direct Primary Care; Specifying that a direct primary care agreement does not constitute insurance and is not subject to ch. 636, F.S., relating to prepaid limited health service organizations and discount medical plan organizations, or any other chapter of the Florida Insurance Code; providing that certain certificates of authority and licenses are not required to market, sell, or offer to sell a direct primary care agreement, etc. BI 02/07/2017 Fav/CS HP AHS AP	Fav/CS Yeas 8 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 182
INTRODUCER:	Banking and Insurance Committee and Senator Mayfield
SUBJECT:	Consumer Protection from Nonmedical Changes to Prescription Drug Formularies
DATE:	February 7, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			HP	
3.			RC	
4.				
5.				
6.				

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 182 amends the Insurance Code to provide additional consumer protections by prohibiting a health insurer or a health maintenance organization (HMO) from removing a covered prescription drug from its formulary except during open enrollment with some limited exceptions. The bill also prohibits an insurer or HMO from reclassifying a drug to a more restrictive tier, increasing the out-of-pocket costs (e.g., copayment, coinsurance, or deductible) of an insured, or reclassifying a drug to higher-cost sharing tier during the policy year. Under current law, only HMOs offering group contracts are prohibited from increasing the copayment for any benefit or removing, amending or limiting any of the contract benefits except at renewal time with some exceptions.

Often, insureds with chronic, disabling conditions select a health insurance policy or contract based on the availability of certain drugs on the formulary at a preferred cost. Typically, health insurers and pharmacy benefit managers may change their prescription drug formularies during the year in response to the availability of new drugs or changes in prices by drug manufacturers. As a result, certain prescription drugs may become more costly or unavailable, thereby restricting the insureds access to these drugs during a plan year. The insured is unable to switch to a different health insurance plan until the next open enrollment.

The Division of State Group Insurance (DSGI) of the Department of Management Services indicates that the bill will have an indeterminate, negative fiscal impact. The pharmacy benefit manager of the DSGI estimates the annual loss of rebates from drug manufacturers to the state is $9.2 million and the annual additional costs of drugs to the DSGI is $50,000.

The bill has no fiscal impact on the Florida Medicaid program, as it does not amend ch. 409, F.S., which governs the Florida Medicaid program, nor does it require Medicaid to amend existing policies or procedures.

II. Present Situation:

Access to affordable health care can be a significant issue for anyone with an illness, but it is particularly critical for individuals who have conditions with the potential to cause death, disability, or serious discomfort unless treated with the most appropriate medical care. In recent years, many innovative treatments for diseases that affect large populations, such as cancer, hepatitis C, diabetes, and multiple sclerosis have been approved. Some of the benefits of these innovative drugs include fewer side effects, convenience (oral solids instead of injectables), and greater efficacy.[1] However, the financial burden from out-of-pocket drug costs can lead patients with chronic illnesses to forgo prescribed drugs, ultimately affecting their health.

Prescription Drug Cost Containment

In 2014, spending on retail prescription drugs in the United States was approximately $298 billion.[2] In 2015, total retail prescription drug spending increased by 9 percent, reaching $325 billion. The significant growth in 2015 was attributed to certain cost drivers, such as, spending on new drugs, price growth for existing brand-name drugs, increased spending on generics, and a decrease in the number of expensive drugs whose patents have expired.[3]

Due to increasing health care expenditures, public and private employers and insurers continue to look for cost containment methods, including the reduction of prescription drug costs. Many employer-sponsored health plans and insurers contract with pharmacy benefit managers (PBMs). The PBMs negotiate drug prices with pharmacies and drug manufacturers on behalf of health plans and, in addition to other administrative, clinical, and cost containment services, process drug claims for the health plans. The PBM generally manages the list of preferred drug products (formulary) for each of its plan sponsors. Insurers and self-insured employers provide insureds with financial incentives, such as lower copayments, to use formulary drugs.

Non-medical switching or substitution of prescription drugs occurs when there may be multiple options available within a treatment class and a less expensive or patient-preferred medicine is substituted, often for cost containment reasons. Non-medical switching may be as simple as the substitution of a brand name drug for its generic equivalent. Generic drugs are copies of brand-name drugs and are the same in dosage form, safety, strength, route of administration,

[1] *See* HEALTH AFFAIRS 35, No. 9 (2016): 1595-1603.
[2] *See* HEALTH AFFAIRS 36, No. 1 (2017):166-176.
[3] *Id.*

performance characteristics, and intended use.[4] A generic drug must pass the same safety standards as a brand-name drug. The second method of switching or substitution involves dispensing drugs that are therapeutically equivalent to but chemically different from the originally prescribed drug.[5]

Research notes that the biologic therapy medications of some patients are being switched for nonclinical reasons, despite the lack of data to support this practice and an abundance of data demonstrating clinically meaningful differences among biologics.[6] For example, one study reviewing the reason for adjusting anti-tumor necrosis (TNF) agents involving patients primarily with rheumatoid arthritis, psoriasis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, or ulcerative colitis found that non-medical switching of anti-TNF agents was associated with an increase in side effects and lack of efficacy that also led to an increase in health care utilization.[7]

Federal Patient Protection and Affordable Care Act

Health Insurance Reforms

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[8] The PPACA requires health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA also mandates required essential health benefits,[9] cost-sharing limits, rating and underwriting standards, and appeals of adverse benefit determinations. The PPACA requires issuers (insurers and HMOs) of qualified health plans (QHPs) to provide 10 categories of essential health benefits (EHB), which includes prescription drugs.[10] The federal deadline for insurers and HMOs to submit 2018 rates and forms to the Centers for Medicare and Medicare and the Office of Insurance Regulation is May 13, 2017.[11] [12]

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[4] Federal Food and Drug Administration, *Understanding Generic Drugs available at* http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandinggenericdrugs/default.htm (last visited Feb. 2, 2017).

[5] Rachel Chu, et al, *Patient Safety and Comfort - The Challenges of Switching Medicines* (2010) *available at* http://www.patients-rights.org/uploadimages/Patient_Safety_and_Comfort_The_Challenges_of_Switching.pdf (last viewed Feb. 2, 2017).

[6] *See* http://www.medscape.com/viewarticle/768031_5 (last viewed Feb. 2, 2017).

[7] D.T. Rubin, et al, *Analysis of outcomes after non-medical switching of anti-tumor necrosis factor agents,* European Crohn's and Colitis Organisation (2015) *available at* https://www.ecco-ibd.eu/index.php/publications/congress-abstract-s/abstracts-2015/item/p354-analysis-of-outcomes-after-non-medical-switching-of-anti-tumor-necrosis-factor-agents.html?category_id=430 (last viewed Feb. 4, 2017).

[8] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010.

[9] 42 U.S.C. s.18022.

[10] See https://www.cms.gov/cciio/resources/data-resources/ehb.html (last visited Feb. 2, 2017) for Florida's benchmark plan.

[11] Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS), *2018 Letter to Issuers in the Federally-facilitated Marketplaces* (Dec. 16, 2016), p. 7, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf. (last viewed Feb.2, 2017).

[12] President Trump, Executive Order 13765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal* (Jan. 20, 2017). President Trump issued an executive order indicating that it is the intent of his administration to seek the prompt repeal of PPACA.

Prescription Drug Coverage

For purposes of complying with PPACA's EHBs for prescription drugs, issuers must include in their formulary drug list the greater of one drug for each U.S. Pharmacopeia (USP) category and class; or the same number of drugs in each USP category and class as the state's EHB benchmark plan. Issuers must have a Pharmacy and Therapeutics Committee design formularies using scientific evidence that will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines. Plans providing EHBs must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not included on the plan's formulary drug list. Such procedures must include a process to request an expedited review.[13]

An issuer does not provide EHBs if its benefit design discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.[14] Issuers of QHPs may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[15]

Changes in Medicare Part D Formularies

Medicare Part D[16] plans may alter their formularies from year to year, and in limited circumstances, to make changes to their formularies within a plan year.[17] Plans may not change therapeutic categories and classes of drugs within a plan year, except to account for new therapeutic uses or to add newly approved Part D drugs. If Part D plans remove drugs from their formularies during a plan year (or change cost-sharing or access requirements), they must provide timely notice to the Centers for Medicare and Medicaid Services (CMS), affected enrollees, physicians, pharmacies, and pharmacists.

Formulary changes are allowed in limited circumstances. Plans may immediately remove drugs from their formularies that are deemed unsafe by the FDA or are pulled from the market by their manufacturers. Plans may make formulary maintenance changes after March 1, such as replacing a brand-name drug with a new generic drug or modifying formularies because of new information on safety or effectiveness. These changes require CMS approval and 60 days' notice to appropriate parties.

The CMS will generally give positive consideration to formulary maintenance changes such as expanding formularies by adding drugs, moving a drug to a lower tier (thereby reducing copayments or coinsurance), or eliminating utilization management requirements. Plans may

[13] 45 C.F.R. s. 156.122.
[14] 45 C.F.R. s. 156.125.
[15] 45 C.F.R. s. 156.225.
[16] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) established a voluntary, outpatient prescription drug benefit under Medicare Part D, effective January 1, 2006. Medicare Part D provides coverage through private prescription drug plans (PDPs) that offer only drug coverage, or through Medicare Advantage (MA) prescription drug plans (MA-PDs) that offer coverage as part of broader, managed care plans.
[17] Centers for Medicare and Medicaid, *Medicare Prescription Drug Benefit Manual*, Chapter 6, (Jan. 15, 2016) available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf. (last viewed Feb. 2, 2017).

only remove drugs from a formulary, move covered drugs to a less-preferred tier status, or add utilization management requirements in accordance with approved procedures and after 60 days' notice to appropriate parties. Plans may make such changes only if enrollees currently taking the affected drugs are exempt from the formulary change for the remainder of the plan year.

Regulation of Insurers and Health Maintenance Organizations in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[18] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[19]

Currently, under the Insurance Code, an HMO may increase the copayment for any benefit, or delete, amend, or limit any of the benefits under a group contract only upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The HMO may amend the contract with the contract holder, with such amendment to be effective immediately at the time of coverage renewal. The written notice to the contract holder must specifically identify any deletions, amendments, or limitations to any of the benefits provided in the group contract during the current contract period, which will be included in the group contract upon renewal. This provision does not apply to any increases in benefits. The notice requirements do not apply if benefits are amended, deleted, or limited, pursuant to a request of the contract holder.[20]

Florida' State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the DGSI, administers the state group health insurance program under a cafeteria plan consistent with section 125, Internal Revenue Code. To administer the state group health insurance program, the DMS contracts with third party administrators for self-insured health plans, insured HMOs, and a pharmacy benefit manager (PBM) for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

The state employees' self-insured prescription drug program has three cost-share categories for members: generic drugs, preferred brand name drugs (those brand name drugs on the preferred drug list), and non-preferred brand name drugs (those brand name drugs not on the preferred drug list). Contractually the PBM for the state employees' self-insured prescription drug program updates the preferred drug list quarterly as brand drugs enter the market and as the PBM negotiates pricing, including rebates with manufacturers.

Generic drugs are the least expensive and have the lowest member cost share, preferred brand name drugs have the middle cost share, and non-preferred brand name drugs are the most expensive and have the highest member cost share. Generally, prescriptions written for a brand name drug, preferred or non-preferred, will be substituted with a generic drug when available. If the prescribing provider states on the prescription that the brand name drug is "medically

[18] Section 20.121(3), F.S.
[19] Section 641.21(1), F.S.
[20] Section 641.31(36), F.S.

necessary" over the generic equivalent, the member will pay only the brand name (preferred or non-preferred) cost share. If the member requests the brand name drug over the generic equivalent then the member will pay the brand name, (preferred or non-preferred) cost share plus the difference between the cost of the generic drug and the brand name drug.

The program covers all federal legend drugs (open formulary) for covered medical conditions, and employs very limited utilization review and clinical review for traditional or specialty prescription drugs. Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions such as cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling (e.g., refrigeration during shipping) and administration (such as injection or infusion).

The federal out-of-pocket limit applies to members of the state group self-insured health plans and insured HMOs, all of which include prescription drug coverage. Copayments (and coinsurance for high deductible plans) for each drug tier are the same for all members, as follows:

Drug Tier	Retail – Up to 30-Day Supply	Retail and Mail – Up to 90-Day Supply and Specialty Medications
Generic	$7	$14
Preferred Brand	$30	$60
Non-Preferred Brand	$50	$100

The program typically makes benefits changes on a plan year basis, which is January 1 through December 31.[21]

Health Insurance Mandate Report

Section 624.215, F.S., requires that a report assessing the social and financial impact of any proposal for legislation that mandates health benefit coverage or mandates offering requirements must be submitted to Agency for Health Care Administration and the legislative committee having jurisdictions.

According to a report provided by advocates of the bill, the bill will not increase coverage of drug benefits or the total cost of health care. [22] The bill creates transparency for consumers to know that the coverage benefit they sign up for is the coverage benefit they will receive for the plan year. The bill addresses the practice of some insurers and HMOs marketing certain pharmacy benefits to consumers at open enrollment, only to change the benefits during the plan year when insureds are generally unable to change plans. According to the report, there is no indication that the bill will have an impact on the cost of coverage. Advocates cite studies that document that some nonclinical drug substitutions may increase overall health care costs and result in adverse outcomes.

[21]Department of Management Services, *2017 Agency Legislative Bill Analysis of SB 182* (Jan. 19, 2017) (on file with Senate Committee on Banking and Insurance Committee).
[22] *Non-Medical Switching, Health Insurance Mandate Report* (Jan. 2017) (on file with Senate Committee on Banking and Insurance Committee).

Regulation of Prescription Drug Formularies Changes in Other States

Staff conducted a limited survey of some states that had enacted legislation addressing formulary benefit changes or cost-sharing limits. In Louisiana, the formulary change must occur at the time of coverage renewal and prior notice is required to each affected covered employer and enrollee, or individual.[23] California prohibits changes in cost sharing designs during the plan or policy year, except when such change is required by state or federal law.[24] Nevada generally prohibits a health insurer that offers individual coverage from removing prescription drugs from a formulary or moving a drug to a higher cost-sharing tier during the plan year with some exceptions.[25] New Mexico generally limits when health insurance policies may change prescription drug coverage, with exceptions, and requires prior notification of all affected enrollees.[26] Virginia requires insurers to establish a process for insureds to obtain continued access to drugs that they have been receiving for at least six months prior to a formulary change at a cost-sharing level that is no higher than the level imposed on formulary drugs.[27] Texas prohibits insurers and HMOs from making mid-year formulary benefit and cost-sharing changes.[28]

III. Effect of Proposed Changes:

Section 1 creates s. 627.42393, F.S., and **Sections 2 and 3** amend s. 627.6699, F.S., and s. 641.31, F.S., respectively.

SB 182 amends the Insurance Code to provide additional consumer protections by prohibiting a health insurer or health maintenance organization (HMO) from removing a covered drug from its formulary during the policy year except during open enrollment with some limited exceptions. These provisions would apply to individual and group policies and contracts. An insurer or health maintenance organization (HMO) may remove a prescription drug from its list of covered drugs during the policy year if:

- The United States Food and Drug Administration has issued a statement about the drug which calls into question the clinical safety of the drug; or
- The manufacturer of the drug has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by s. 506C 32 of the of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. s. 356c.

SB 182 also prohibits an insurer or HMO from reclassifying a drug to a more restrictive drug tier; increasing the amount that an insured must pay out-of-pocket for a copayment, coinsurance, or deductible for prescription drugs, or reclassifying a drug to a higher cost-sharing tier during the policy year.

SB 182 also:

- Does not prohibit the addition of prescription drugs to the list of drugs covered under the policy during the policy year.

[23] La. Admin. Code title 37, pt. XIII, ss. 14111, 14115, and 14117.
[24] Chapter 192, Statutes of 2016. Approved by the Governor August 25, 2016.
[25] Nevada Division of Insurance, *Adopted Regulation R074*-14 (uncodified).
[26] N.M. Stat. ss. 59A-22-49.4, 59A-23-7.13, 59A-46-50.4, and 59A-47-45.4.
[27] *See* Va. Code Ann. s. 38.2-3407.9.01.
[28] Tex. Ins. Code ss. 1369.0541 and 1501.108.

- Does not alter or amend s. 465.025, F.S., which provides conditions under which a pharmacist may substitute a generically equivalent drug product for a brand name drug product.
- Does not alter or amend s. 465.0252, F.S., which provides conditions under which a pharmacist may dispense a substitute biological product for the prescribed biological product.

The provisions of the bill do not apply to grandfathered health plans, as defined in s. 627.402, F.S., or to benefits set forth in s. 627.6513(1)-(14), F.S.

Section 4 provides the bill is effective January 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply if the bill requires local governments to spend funds. If those provisions do apply, in order for the law to be binding upon the cities and counties, the Legislature must find that the law fulfills an important state interest, and one of the following relevant exceptions must apply:

- The expenditure is required to comply with a law that applies to all persons similarly situated; or
- The law must be approved by two-thirds of the membership of each house of the Legislature.

Since this bill requires all public sector health plans to limit drug changes in the formulary and insureds' cost sharing, it appears the bill applies to all persons similarly situated (state, counties, and municipalities).

The bill does not provide a finding that the bill fulfills an important state interest.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

By limiting changes to the prescription drug formulary, the bill would allow insureds to receive their brand drugs at a preferred cost for the policy year. Currently, the Insurance Code only prohibits HMO group contracts from increasing a member's copayment for any benefit or reducing a benefit during a plan year with some exceptions.

The prohibition on mid-policy year changes to drug formularies may increase the claim costs for health insurers and HMOs providing prescription drug benefits. Any increased costs would likely be passed along to insureds. The provisions of the bill would not apply to ERISA (Employee Retirement Income Security Act of 1974)[29] self-insured plans, which represent approximately 50 percent of the insureds in Florida. ERISA preempts the regulation of such plans by state regulation.

C. Government Sector Impact:

Division of State Group Insurance

The bill provides limitations on changes in formularies by allowing insureds to continue to obtain specified brand drugs at a "preferred" cost share throughout a calendar year; as a result, SB 182 prohibits the State Employees' Prescription Drug Plan from obtaining lower costs, even when the PBM negotiates better pricing and rebates for equally clinically effective brand and generic drugs. The PBM states for the three quarterly formulary updates in 2016, approximately 1,100 of 139,000 drug plan users were impacted.

The DSGI indicates that the bill will have indeterminate and substantial negative fiscal impact.[30] The severity of the impact would be contingent on the number of brand drugs that are required to remain on the preferred drug list when other, less expensive, interchangeable and clinically appropriate brand and generic drugs are available. The DSGI notes, that not only would the cost of the medication be higher for the prescription drug program, but also the rebates from manufacturers to the program would be reduced significantly. The PBM provided the following estimates regarding the recurring impact on the DSGI:

- An additional cost of drugs to the State of Florida of $50,000.
- Loss of manufacturers' rebates to the State of Florida of $9.2 million.

Florida Medicaid Program

According to the Agency for Healthcare Administration, the bill has no fiscal impact on the Florida Medicaid program since it does not amend ch. 409, F.S., governing Florida Medicaid, nor does it require Medicaid to amend existing policies or procedures.[31]

[29] 29 U.S.C. 1001 et seq. (1974).
[30] Department of Management Services, *2017 Agency Legislative Bill Analysis of SB 182* (Jan. 19, 2017) (on file with Senate Committee on Banking and Insurance Committee).
[31] Email from Tony Guzzo, Agency for Healthcare Administration (Feb. 1, 2017) (on file with Senate Committee on Banking and Insurance).

VI. Technical Deficiencies:

For group HMO contracts, the requirements of Section 3 of the bill, which creates subsection (46) of s. 641.31, F.S., may duplicate or create ambiguity with some of the provisions of existing s. 641.31(36), F.S. For example, s. 641.31(36), F.S. allows an HMO to increase the copayment for any benefit, or delete, amend, or limit any of the benefits under a group contract only upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. SB182 allows changes in the formulary and out-of-pocket costs to occur during open enrollment. The PPACA open enrollment occurs November 1, 2017 through January 31, 2017. However, the PPACA plan year is typically January 1 through December 31.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 641.31 and 627.6699.

This bill creates section 627.42392 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on February 7, 2017:
The CS corrects a scrivener's error.

B. Amendments:

None.

753734

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/07/2017	.	
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The Committee on Banking and Insurance (Mayfield) recommended the following:

Senate Amendment (with title amendment)

Delete lines 113 - 114

and insert:

8. A small employer carrier must limit changes to prescription drug formularies as required by s. 627.42393.

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

And the title is amended as follows:

Delete lines 8 - 9

753734

and insert:

carriers to limit changes to prescription drug formularies under certain circumstances;

By Senator Mayfield

17-00357-17 2017182__

A bill to be entitled

An act relating to consumer protection from nonmedical changes to prescription drug formularies; creating s. 627.42393, F.S.; limiting changes to a health insurance policy prescription drug formulary during a policy year; providing applicability and construction; amending s. 627.6699, F.S.; requiring small employer carriers to provide continuity of care for certain patients with respect to prescription drug coverage; amending s. 641.31, F.S.; limiting changes to a health maintenance contract prescription drug formulary during a contract year; providing applicability and construction; providing an effective date.

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

Section 1. Section 627.42393, Florida Statutes, is created to read:

627.42393 Insurance policies; limiting changes to prescription drug formularies.—

(1) Other than during an open enrollment period, an individual or group insurance policy that is delivered, issued for delivery, renewed, amended, or continued in this state and that provides medical, major medical, or similar comprehensive coverage may not:

(a) Remove a covered prescription drug from its list of covered drugs during the policy year unless the United States Food and Drug Administration has issued a statement about the drug which calls into question the clinical safety of the drug, or the manufacturer of the drug has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by s. 506C

17-00357-17 2017182__

of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. s. 356c.

(b) Reclassify a drug to a more restrictive drug tier or increase the amount that an insured must pay for a copayment, coinsurance, or deductible for prescription drug benefits, or reclassify a drug to a higher cost-sharing tier during the policy year.

(2) This section does not prohibit the addition of prescription drugs to the list of drugs covered under the policy during the policy year.

(3) This section does not apply to a grandfathered health plan as defined in s. 627.402 or to benefits set forth in s. 627.6513(1)-(14).

(4) This section does not alter or amend s. 465.025, which provides conditions under which a pharmacist may substitute a generically equivalent drug product for a brand name drug product.

(5) This section does not alter or amend s. 465.0252, which provides conditions under which a pharmacist may dispense a substitute biological product for the prescribed biological product.

Section 2. Paragraph (e) of subsection (5) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

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

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage

continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

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

4. A small employer carrier shall not increase any requirement for minimum employee participation or any

requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

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

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

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

Section 3. Subsection (44) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(44)(a) Other than during an open enrollment period, a health maintenance contract that is delivered, issued for

delivery, renewed, amended, or continued in this state and that provides medical, major medical, or similar comprehensive coverage may not:

1. Remove a covered prescription drug from its list of covered drugs during the contract year unless the United States Food and Drug Administration has issued a statement about the drug which calls into question the clinical safety of the drug, or the manufacturer of the drug has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by s. 506C of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. s. 356c.

2. Reclassify a drug to a more restrictive drug tier or increase the amount that an insured must pay for a copayment, coinsurance, or deductible for prescription drug benefits, or reclassify a drug to a higher cost-sharing tier during the contract year.

(b) This subsection does not prohibit the addition of prescription drugs to the list of drugs covered during the contract year.

(c) This subsection does not apply to a grandfathered health plan as defined in s. 627.402 or to benefits set forth in s. 627.6513(1)-(14).

(d) This subsection does not alter or amend s. 465.025, which provides conditions under which a pharmacist may substitute a generically equivalent drug product for a brand name drug product.

(e) This subsection does not alter or amend s. 465.0252, which provides conditions under which a pharmacist may dispense a substitute biological product for the prescribed biological

product.

Section 4. This act shall take effect January 1, 2018.

THE FLORIDA SENATE

APPEARANCE RECORD

February 7, 2017 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 182

Meeting Date *Bill Number (if applicable)*

Topic Bait and Switch Bill *Amendment Barcode (if applicable)*

Name Kayla Abramowitz

Job Title Chief Kid Officer

Address 579 Anchorage Dr. Phone 561 389 4648
Street

North Palm Beach FL 33408 Email Kayla@kaylacares4kids.org
City *State* *Zip*

Speaking: ✓ For Against Information Waive Speaking: ✓ In Support Against
(The Chair will read this information into the record.)

Representing Arthritis Foundation

Appearing at request of Chair: Yes ✓ No Lobbyist registered with Legislature: Yes (No)

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/2017
Meeting Date

SB 182
Bill Number (if applicable)

Topic Consumer Protection from Nonmedical Switching

Amendment Barcode (if applicable)

Name Doug Bell

Job Title lobbyist

Address 101 N. Monroe St.
Street

Phone 850.681.4270

Tallahassee fl 32312
City *State* *Zip*

Email Douglas.bell@bipc.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Epilepsy Association of Central Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/17
Meeting Date

SB 182
Bill Number (if applicable)

Topic FAIRY

Amendment Barcode (if applicable)

Name JERI FRANCOEUR

Job Title ADVOCACY CHAIR, FLORIDA BREAST CANCER FOUNDATION

Address 1 SHARON TERR
Street

Phone 386-295-1554

ORMOND BEACH, FL 32174
City *State* *Zip*

Email jfrancoeur@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA BREAST CANCER FOUNDATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2-7-17
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

SB 182
Bill Number (if applicable)

Topic Consumer Protection

Amendment Barcode (if applicable)

Name Michael Ruppal

Job Title Executive Director

Address 17 Davis Blvd, Suite 403
Street

Phone 813-505-1941

Tampa FL 33606
City *State* *Zip*

Email m

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing The AIDS Institute

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/2017
Meeting Date

182
Bill Number (if applicable)

Topic SB 182

Amendment Barcode (if applicable)

Name Margaret Mitchell

Job Title Legislative Aide II

Address 1335 22nd ave SW
Street

Phone 3144359335

Vero Beach FL 32962
City *State* *Zip*

Email maggumz@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-7-2017
Meeting Date

SB 182
Bill Number (if applicable)

Topic CONSUMER PROTECTION FROM NON MEDICAL CHANGES TO PRESCRIPTIONS

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DR
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-7-17
Meeting Date

SB 182
Bill Number (if applicable)

Topic SB 182 - Drug formularies

Amendment Barcode (if applicable)

Name DAVID MCKAY MD

Job Title Board mbr - Florida AANS - Neurosurgeon

Address 1955 1st Ave N #101
Street

St Pete FL 33713
City *State* *Zip*

Phone 727-822-3580

Email DMCKAYPC NEURO.NET

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida AANS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/17
Meeting Date

182
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nland

Job Title _____

Address 1000 Riverside Ave
Street
Jacksonville
City *State* *Zip*

Phone 904-233-3051

Email nlandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians / Fl. Society Gastroenterology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2-7-17 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 182

Meeting Date *Bill Number (if applicable)*

Topic Non med switching *Amendment Barcode (if applicable)*

Name Matt Jordan

Job Title GRD

Address 1422 Dellwood Dr Phone 850-519-2801

Street

Tallahassee FL 32303 Email matt.jordan@cancer.org

City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information Waive Speaking: ☐ In Support ☐ Against

(The Chair will read this information into the record.)

Representing American Cancer Society Cancer Action Network

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

182

Meeting Date | *Bill Number (if applicable)*

Topic Pharma

Amendment Barcode (if applicable)

Name MIKE HARRELL

Job Title

Address *Street* Phone

City *State* *Zip* Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AFL Chapt of Cardiology

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/17
Meeting Date

SB 182
Bill Number (if applicable)

Topic CONSUMER Protection

Amendment Barcode (if applicable)

Name KEVIN SWEENY

Job Title

Address
Street

Phone

City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA JUSTICE ASSOC.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/16
Meeting Date

182
Bill Number (if applicable)

Topic Nonmedical Changes

Amendment Barcode (if applicable)

Name Mary Thomas

Job Title Assistant Gen Counsel

Address 1430 Piedmont Dr E
Street

TLH FL 32308
City *State* *Zip*

Phone 850 2246496

Email MThomas@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Fla. Med. Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/2017
Meeting Date

SB 182
Bill Number (if applicable)

Topic SB 182

Amendment Barcode (if applicable)

Name Jim DeBeauvoir (DeBogran)

Job Title

Address 1778 Vineyard Way
Street

Phone 850-508-8908

Tallahassee FL 32317
City *State* *Zip*

Email jim_debeauvoir@comcast.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Arc of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/17
Meeting Date

SB 182
Bill Number (if applicable)

Topic Consumer Protection From Nonmedical Formulary changes

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title President + C.E.O

Address 200 W. College Ave
Street

Phone 850-386-2904

Tallahassee FL 32301
City *State* *Zip*

Email Audrey@FAHP.net

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2-7-17
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

SB182
Bill Number (if applicable)

Topic Nonmedical Changes - Rx Formularies

Amendment Barcode (if applicable)

Name Joy Ryan

Job Title

Address 325 W. College Ave
Street
Tallahassee, FL 32301
City *State* *Zip*

Phone 425-4000

Email joyryan0010@comcast.net

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing America's Health Insurance Plans

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/17
Meeting Date

182
Bill Number (if applicable)

Topic Drug Formulary - switching

Amendment Barcode (if applicable)

Name Alisa LaPolt (uh LEE sA)

Job Title Executive Director

Address PO Box 961
Street

Tallahassee FL
City *State* *Zip*

Phone 671-4445

Email alisa@namiflorida.org

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing NAMI Florida - National Alliance on Mental Illness

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-7-17
Meeting Date

182
Bill Number (if applicable)

Topic Consumer Protection for Non Medical Charges

Amendment Barcode (if applicable)

Name Fely Curva

Job Title Senior Partner, Curva & Associates LLC

Address 1212 Piedmont Dr.
Street

Phone (850) 508-2256

Tallahassee FL 32312
City *State* *Zip*

Email fely.curva@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

WAIVE IN SUPPORT

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Budd Bell Clearinghouse on Human Services

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/17
Meeting Date

SB 182
Bill Number (if applicable)

Topic Consumer Protection for nonmedical *Amendment Barcode (if applicable)*

Name Melanie Brown

Job Title Government Affairs

Address PO Box 10805 *Street*

Phone 8502241900

Tall *City* FL *State* 32302 *Zip*

Email melanie@teamjb.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Dermatology Society

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/2017
Meeting Date

SB 182
Bill Number (if applicable)

Topic Consumer Protection from Nonmedical Switching

Amendment Barcode (if applicable)

Name Doug Bell

Job Title lobbyist

Address 101 N. Monroe St.
Street

Phone 850.681.4270

Tallahassee fl 32312
City *State* *Zip*

Email Douglas.bell@bipc.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American Academy of Pediatrics

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/7/17
Meeting Date

SB 182
Bill Number (if applicable)

Topic Nonmedical Changes to Prescription Drug Formularies
Amendment Barcode (if applicable)

Name Brewster Bevis

Job Title Senior Vice President

Address 516 n. Adams St
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 224-7173

Email bbevis@aif.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

February 7, 2017
Meeting Date

SB182
Bill Number (if applicable)

Topic Consumer Protection from Nonmedical Changes to Rx Formularies

Amendment Barcode (if applicable)

Name Michael Jackson

Job Title Executive Vice President and CEO

Address 610 North Adams Street
Street

Phone (850) 222-2400

Tallahassee — *City* | Florida — *State* | 32301 — *Zip*

Email mjackson@pharmview.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Pharmacy Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

February 7, 2017
Meeting Date

SB 182
Bill Number (if applicable)

Topic Consumer Protection from N.M. Changes + Prescription Drug Formularies.

Amendment Barcode (if applicable)

Name Dorene Barker

Job Title Associate State Director

Address 200 West College, Suite 304
Street

Tall Fl 32301
City *State* *Zip*

Phone 850-228-6387

Email dobarker@aarp.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 240
INTRODUCER:	Banking and Insurance Committee and Senator Lee
SUBJECT:	Direct Primary Care
DATE:	February 7, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			HP	
3.			AHS	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 240 amends the Florida Insurance Code (code) to provide that a direct primary care agreement is not insurance and is not subject to regulation under the code. Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. Through a contractual agreement, a patient pays a monthly fee, usually between $50 and $100 per individual, to the primary care provider for defined primary care services. As of June 2016, 16 states have adopted DPC laws that define DPC as a medical service outside the scope of state insurance regulation. The bill defines terms and specifies certain provisions, including consumer disclosures, which must be included in a direct primary care agreement.

II. Present Situation:

Direct Primary Care

Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the provider-patient relationship. Through a contractual agreement, a patient generally pays a monthly retainer fee, on average $77 per individual,[1] to the primary care

[1] A study of 141 DPC practices found the average monthly retainer fee to be $77.38. Of the 141 practices identified, 116 (82 percent) have cost information available online. When these 116 practices were analyzed, the average monthly cost to the patient was $93.26 (median monthly cost, $75.00; range, $26.67 to $562.50 per month). Of the 116 DPCs noted, 36 charged a

provider for defined primary care services, such as office visits, preventative care, annual physical examination, and routine laboratory tests.

After paying the monthly fee, a patient can access all services under the agreement at no extra charge contingent upon the agreement. Typically, DPC practices provide routine preventative services, screenings, or tests, like lab tests, mammograms, Pap screenings, and vaccinations. A primary care provider DPC model can be designed to address most health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

Some of the potential benefits of the DPC model for providers include reducing patient volume, minimizing administrative and staffing expenses; increasing time with patients; and increasing revenues. In the DPC practice model, the primary care provider eliminates administrative costs associated with filing and resolving insurance claims. Direct primary care practices claim to reduce expenses by more than 40 percent by eliminating administrative staff resources associated with third-party costs.[2]

In 2014, the American Academy of Private Physicians estimated that approximately 5,500 physicians operate under some type of direct financial relationship with their patients, outside of standard insurance coverage. According to the AAPP, that number has increased around 25 percent per year since 2010.[3] The Direct Primary Care Coalition has adopted model state legislation for DPC agreements.[4] As of June 2016, 16 states have adopted DPC legislation, which defines DPC as a medical service outside the scope of state insurance regulation. [5]

Federal Health Care Reform and Direct Primary Care

The federal Patient Protection and Affordable Care Act (PPACA)[6] requires health insurers to make guaranteed issue coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA also mandates that insurers that offer qualified health plans (QHPs) provide 10 categories of essential health benefits,[7] which includes preventative[8] care and other benefits.

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one-time enrollment fee and the average enrollment fee was $78. Twenty-eight of 116 DPCs charged a fee for office visits in addition to the retainer fee, and the average visit fee was $16. *See* Phillip M. Eskew and Kathleen Klink, *Direct Primary Care: Practice Distribution and Cost Across the Nation,* Journal of the Amer. Bd. of Family Med. (Nov.-Dec. 2015) Vol. 28, No. 6, p. 797, *available at:* http://www.jabfm.org/content/28/6/793.full.pdf (last viewed Jan. 28, 2017).

[2] Lisa Zamosky, Direct-Pay Medical Practices Could Diminish Payer Headaches, MEDICAL ECONOMICS, (April 24, 2014), http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/concierge-service/direct-pay-medical-practices-could-diminish-payer-h. (last viewed January 28, 2017).

[3] David Twiddy, *Practice Transformation: Taking the Direct Primary Care Route,* Family Practice Management, No. 3, (May-June 2014), *available at:* http://www.aafp.org/fpm/2014/0500/p10.html (last viewed Jan. 29, 2017).

[4] Direct Primary Care Coalition Model State Legislation available at: http://www.dpcare.org/dpcc-model-legislation. (last viewed January 28, 2017).

[5] See http://www.dpcare.org/ (last viewed January 26, 2017).

[6] Pub. Law No. 111-148 (Mar. 23, 2010) amended by Pub. Law. No. 111-152 (Mar. 30, 2010).

[7] 42 U.S.C. s.18022.

[8] Available at: https://www.hhs.gov/healthcare/about-the-law/preventive-care/index.html#. (last viewed Feb. 5, 2017). Many of these preventive services must be covered without any cost sharing by the patient.

The PPACA addresses the DPC practice model as part of health care reform. A QHP may provide coverage through a DPC medical home plan that meets criteria[9] established by the federal Department of Health and Human Services, provided the QHP meets all other applicable requirements.[10] Insureds who are enrolled in a DPC medical home plan are compliant with the individual mandate if they have coverage for other services, such as a wraparound catastrophic health policy[11] or high deductible, health insurance plans[12] to provide coverage for severe injuries or chronic conditions. In Colorado and Washington, qualified health plans offer DPC medical home coverage on the state-based health insurance exchanges.[13]

State Regulation of Insurance

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities. These specified entities must meet certain. Agency for Health Care Administration (agency) regulations regarding the quality of care provided by HMOs and prepaid health clinics under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, a HMO and a prepaid health clinic must receive a Health Care Provider Certificate[14] from the agency pursuant to part III of ch. 641, F.S.[15]

Currently, Florida law does not address direct primary care agreements. However, a medical provider offering direct primary care agreements may be considered to be operating a prepaid health clinic if the medical provider is offering to provide services in exchange for a prepaid fixed fee.[16]

Prepaid Health Clinics

Prepaid health clinics[17] are required to obtain a certificate of authority from the OIR pursuant to part II of Chapter 641, F.S. The entity must meet minimum surplus requirements[18] and comply with solvency protections for the benefit of subscribers by securing insurance or filing a surety bond with the OIR.[19] Part II also provides that the procedures for offering basic services and

[9] The HHS has not adopted criteria to date.
[10] *See* 42 U.S.C. ss. 18021(a)(3) and 18022.
[11] Catastrophic plans are a form of high deductible plans, which meet the minimum essential coverage requirements. See 42 U.S.C 18021 for eligibility and coverage requirements.
[12] A high deductible health plan (HDHP) has a higher deductible than typical plans and a maximum limit on amount of the annual deductible and out-of-pocket medical expenses that an insured must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, excluding premiums.
[13] See http://www.akleg.gov/basis/get_documents.asp?session=29&docid=7936 (last visited Feb. 5, 2017).
[14] Section 641.49, F.S.
[15] Section 641.48, F.S., provides that the purpose of part III of ch. 641, F.S., is to ensure that HMOs and prepaid health clinics deliver high-quality care to their subscribers.
[16] Part II of ch. 641, F.S.
[17] Section 641.402, F.S., defines the term, "prepaid health clinic," to mean any organization authorized under part II that provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. However, no clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall be a prepaid health clinic.
[18] Section 641.406, F.S. Each prepaid health clinic must maintain minimum surplus in the amount $150,000 or 10 percent of total liabilities, whichever is greater.
[19] Section 641.409, F.S.

offering and terminating contracts to subscribers may not unfairly discriminate based on age, health, or economic status.[20]

Prepaid Limited Health Service Organizations

Prepaid limited health service organizations provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment authorized under ch. 636, F.S. Limited health services include ambulance, dental, vision, mental health, substance abuse, chiropractic, podiatric, and pharmaceutical. Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

III. Effect of Proposed Changes:

Section 1 creates s. 624.27, F.S. The bill provides that a direct primary care agreement is not insurance and entering into such an agreement is not the business of insurance. The bill exempts both the agreement and the activity of entering into a direct primary care agreement from the Florida Insurance Code (code). The bill also exempts a primary care provider, or his or her agent, from obtaining a certificate of authority or license under the code to market, sell, or offer to sell a direct primary care agreement. The bill creates the following definitions:

- "Direct primary care agreement" is a contract between a primary care provider and a patient, the patient's legal representative, or an employer which must satisfy certain requirements within the bill and does not indemnify for services provided by a third party.
- "Primary care provider" is a licensed health care practitioner under ch. 458 (medical doctor or physician assistant), ch. 459 (osteopathic doctor or physician assistant), ch. 460 (chiropractic physician), or ch. 464, F.S., (nurses and advanced registered nurse practitioners), or a primary care group practice that provides medical services which are commonly provided without referral from another health care provider.
- "Primary care service" is the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

The bill specifies the following minimum requirements and disclosures for direct primary care agreements:

- Be in writing and signed by the provider or their agent and the patient, their legal representative or their employer;
- Allow a party to terminate the agreement with 30 days' advance written notice and provide for the immediate termination of the agreement if the physician-patient relationship is violated or a party breaches the terms of the agreement;
- Describe the scope of primary care services covered by the monthly fee.
- Specify the monthly fee and any fees for primary care services not covered by the monthly fee.
- Specify the duration of the agreement and any automatic renewal provisions.
- Offer a refund of monthly fees paid in advance if the provider ceases to offer primary care services for any reason.

[20] Section 641.406, F.S.

- Contain the following statements in contrasting color and 12-point or larger type, on the same page as the applicant's signature:
  - "This agreement is not insurance, and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by this agreement."
  - "This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provisions of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148."
  - "This agreement is not workers' compensation insurance and may not replace the employer's obligations under ch. 440, F.S."

Section 2 provides the bill is effective July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill removes regulatory uncertainty for health care providers by stating that the direct primary care agreement is not insurance, and as a result, the OIR does not regulate the agreements. This statutory change eliminates a long-standing concern with part II of ch. 641, F.S., which requires licensure and regulation of prepaid health clinics. Currently, that section of the code is unclear about the treatment of these types of arrangements with providers. To date, the OIR has not licensed any direct primary care providers under part II to provide such services.[21]

Additional primary care providers may elect to pursue a direct primary care model and establish direct primary care practices, which may increase patients' access to affordable primary care services.

[21] Office of Insurance Regulation, *Senate Bill Analysis 240* (Jan. 17, 2017) (on file with the Senate Committee on Banking and Insurance).

Many individuals have high deductible policies and must meet a significant out of pocket cost to access many types of medical care. The DPC agreements may provide a less expensive option for accessing certain services. For many patients, the greater use of direct primary care agreements may decrease reliance on emergency rooms as a source of routine care.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not include a provision relating to non-discrimination based on health status. The model bill provides the following:

> Direct primary care practices may not decline to accept new direct primary care patients or discontinue care to existing patients solely because of the patient's health status. A direct practice may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of primary care services the patient requires.[22]

VIII. Statutes Affected:

This bill substantially amends section 624.27 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on February 7, 2017:
The CS provides an additional mandatory disclosure to the direct primary care agreement that states that the agreement is not workers' compensation insurance and may not replace the employer's obligation under ch. 440, F.S.

B. Amendments:

None.

[22] *See* http://www.dpcare.org/dpcc-model-legislation (last viewed Feb. 1, 2017.

935534

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/07/2017	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment

Between lines 80 and 81
insert:
3. This agreement is not workers' compensation insurance and may not replace the employer's obligations under chapter 440, Florida Statutes.

By Senator Lee

20-00301-17 2017240__

A bill to be entitled

An act relating to direct primary care; creating s. 624.27, F.S.; defining terms; specifying that a direct primary care agreement does not constitute insurance and is not subject to ch. 636, F.S., relating to prepaid limited health service organizations and discount medical plan organizations, or any other chapter of the Florida Insurance Code; specifying that entering into a direct primary care agreement does not constitute the business of insurance and is not subject to ch. 636, F.S., or any other chapter of the code; providing that certain certificates of authority and licenses are not required to market, sell, or offer to sell a direct primary care agreement; specifying requirements for direct primary care agreements; providing an effective date.

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

Section 1. Section 624.27, Florida Statutes, is created to read:

624.27 Application of code as to direct primary care agreements.—

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

(a) "Direct primary care agreement" means a contract between a primary care provider and a patient, the patient's legal representative, or an employer which meets the requirements specified under subsection (4) and does not indemnify for services provided by a third party.

(b) "Primary care provider" means a health care practitioner licensed under chapter 458, chapter 459, chapter 460, or chapter 464, or a primary care group practice that

20-00301-17 2017240__

provides medical services to patients which are commonly provided without referral from another health care provider.

(c) "Primary care service" means the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

(2) A direct primary care agreement does not constitute insurance and is not subject to chapter 636 or any other chapter of the Florida Insurance Code. The act of entering into a direct primary care agreement does not constitute the business of insurance and is not subject to chapter 636 or any other chapter of the Florida Insurance Code.

(3) A primary care provider or an agent of a primary care provider is not required to obtain a certificate of authority or license under chapter 636 or any other chapter of the Florida Insurance Code to market, sell, or offer to sell a direct primary care agreement.

(4) For purposes of this section, a direct primary care agreement must:

(a) Be in writing.

(b) Be signed by the primary care provider or an agent of the primary care provider and the patient, the patient's legal representative, or an employer.

(c) Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.

(d) Describe the scope of primary care services that are

covered by the monthly fee.

(e) Specify the monthly fee and any fees for primary care services not covered by the monthly fee.

(f) Specify the duration of the agreement and any automatic renewal provisions.

(g) Offer a refund to the patient of monthly fees paid in advance if the primary care provider ceases to offer primary care services for any reason.

(h) Contain, in contrasting color and in not less than 12-point type, the following statements on the same page as the applicant's signature:

1. This agreement is not health insurance, and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by this agreement.

2. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

Section 2. This act shall take effect July 1, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

1-7-17 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 240

Meeting Date *Bill Number (if applicable)*

Topic Direct Primary Care *Amendment Barcode (if applicable)*

Name Jay Millson

Job Title EVP

Address 6720 Atlantic Blvd Phone 904-400-6189

Street

JAX FL 32211 Email

City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information Waive Speaking: ☐ In Support ☐ Against

(The Chair will read this information into the record.)

Representing FL Academy of Family Physicians

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/1/17
Meeting Date

240
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Niland

Job Title _____

Address 1000 Riverside Ave
Street
Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nilandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-17-17
Meeting Date

SB 240
Bill Number (if applicable)

Topic SB 240 - Direct Primary Care

Amendment Barcode (if applicable)

Name David McKalip, M.D.

Job Title President - Neurosurgeon

Address 1955 1st Ave N #101
Street
St. Pete FL 33713
City *State* *Zip*

Phone 727-822-3500

Email MckalipE@NEUROS.NET

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida AAPS (Assoc. of American Phys. Surgeons)

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-7-17
Meeting Date

240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Andrew Hosek

Job Title Policy Analyst

Address _____ Phone _____
Street

_____ Email ahosek@afphq.org
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Americans for Prosperity - Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-7-2017
Meeting Date

SB 240
Bill Number (if applicable)

Topic DIRECT PRIMARY CARE

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DR
Street

Phone 878-7364

TALLAHASSEE, FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-7-17
Meeting Date

240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Tim Nungesser

Job Title Legislative Director

Address 110 E. Jefferson St.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-445-5367

Email tim.nungesser@nfib.org

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing National Federation of Independent Business

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/7/17 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 240

Meeting Date *Bill Number (if applicable)*

Topic Direct Primary Care *Amendment Barcode (if applicable)*

Name Paul Lambert

Job Title

Address 263 Rosehill Dr. N. Phone 850 597-2696

Street

Tallahassee FL 32312 Email plambert@paullambertlaw.com

City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information Waive Speaking: [X] In Support [ ] Against

(The Chair will read this information into the record.)

Representing Florida Chiropractic Association

Appearing at request of Chair: [ ] Yes [ ] No Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/16
Meeting Date

240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Mary Thomas

Job Title Assistant Gen. Counsel

Address 1430 Piedmont Dr E
Street

TLH FL 32308
City *State* *Zip*

Phone 850 224 4996

Email MThomas@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Medical Assoc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/7/17
Meeting Date

SB 240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Adrian Moore

Job Title Vice President / Reason

Address 1132 Crescent ST
Street

Sarasota FL 34232
City *State* *Zip*

Phone 661 477 3107

Email adrian.moore@reason.org

Speaking: ☒ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Reason Foundation

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Rules, *Vice Chair*
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Banking and Insurance
Education
Judiciary
Regulated Industries

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR PERRY E. THURSTON, JR.
Democratic Caucus Rules Chair
33rd District

February 2nd, 2017

The Honorable Anitere Flores
Florida Senate
404 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

I respectfully request an excused absence from Banking and Insurance Committee meeting that is scheduled Tuesday, February 7th, 2017. Thank you for your consideration in this matter.

Respectfully,

Perry E. Thurston, Jr.
District 33

REPLY TO:
❒ 2151 NW 6th Street, Fort Lauderdale, Florida 33311 (954) 321-2705 FAX: (954) 321-2707
❒ 208 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5033

Senate's Website: *www.flsenate.gov*

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

CourtSmart Tag Report

Room: EL 110 **Case No.:** **Type:**
Caption: Senate Banking and Insurance Meeting called to order **Judge:**

Started: 2/7/2017 10:05:07 AM
Ends: 2/7/2017 10:50:01 AM Length: 00:44:55

10:05:26 AM roll call quorum present
10:05:35 AM tab 2 SB 240 on Direct Primary Care
10:05:46 AM Senator Lee presents
10:07:10 AM Senator Lee presents bill SB 240
10:08:10 AM Senator Flores announces Amendment 1 barcode 935534
10:08:27 AM Senator Lee explains Amendment 1
10:09:19 AM Senator Lee explains
10:09:20 AM S Flores states amendment is adopted
10:09:45 AM S Flores - any questions on the bill
10:09:46 AM Appearance Cards - first Jay Millson of Florida Academy of Family Physicians - waives in support
10:10:07 AM Chirs Nuland of Florida Chaprer, America College of Physicians waive in support
10:10:08 AM Dr. David Mckali Neurosurgeon of Florida Association of Physicians and Surgeons of St. Pete Fl
10:11:52 AM Dr.Mckali speaks in support
10:11:58 AM Andrew Hosck Policy Analyst of Americans for Prosperity - Florida waives in support
10:12:02 AM Stephen Winn Executive Director of florida Osteopathic Medical Association waive in support
10:12:46 AM Tim Nungesser of National Fereration of Independent Business
10:12:54 AM Paul Lambert of Florida Chiropractic Association waive in support
10:13:16 AM Mary Thomas - Assistant General Counsel of Florida Medical Association waive in support
10:13:16 AM Adrian Moore - Vice President of Reuson Founation speaks
10:14:12 AM Senator Flores
10:14:33 AM Back on bill as amended
10:14:33 AM
10:14:40 AM Any questions - non from members
10:14:46 AM Senator Lee recognized to close.
10:15:16 AM Call roll for vote
10:15:36 AM bill Reported favorable
10:15:42 AM Sentaor Flores - go to Tab 1 Senator Mayfield recognized to explain bill SB 182
10:17:57 AM Senator Mayfield on SB 182
10:17:57 AM S Flores - one amendment 753734
10:18:12 AM S Mayfield explains amendment
10:18:26 AM S Flores without objection show the amendment adopted
10:18:30 AM Questions for members
10:18:42 AM Sen Braynon with question on the bill
10:19:08 AM Sen Mayfield responds
10:19:21 AM Sen Garcia with question
10:20:03 AM Sen Mayfield responds
10:20:20 AM S Flores -any other questions? none - Appearance cards
10:20:33 AM Jeri Francoeur Advocacy chair, Florida Breast Cancer Foundation - Ormond Beach Fl waive in support
10:20:40 AM Michael Ruppal The aids institute
10:22:31 AM Margaret Mitchell Legislative Aide II Vero Beach
10:24:22 AM Senator Flores with Question
10:24:29 AM Mitchell responds
10:25:24 AM David McKalip a neurosurgeon of Florida AAPS in support , then Chris Nuland of Florida Chapter , American College of Physicians - Jacksonville
10:25:36 AM Kayla Abramowitz Chief Kid Officer of Arthritis Foundation of North Palm Beach Florida
10:26:47 AM S Flores
10:27:03 AM Matt Jordan GRD of American Cancer Society Cancer Action Network in support
10:27:07 AM Mike Harrell of Florida Chapter of Emediology waive in support
10:27:16 AM Kevin Sweeney of Florida Justice Association in support
10:27:18 AM Mary Thomas Assistant General Counsel of Florida Medical Association
10:27:21 AM Jim DeBequerine (DeBogran) of Arc Of Florida waive in support
10:27:24 AM

10:27:27 AM
10:27:28 AM Sen Flores
10:27:52 AM Audrey Brown President & CEO Forida Association of Health Plans- Tallahassee Fl
10:31:38 AM
10:31:39 AM s flores
10:31:44 AM S Farmer with question
10:32:24 AM Brown with Response
10:32:38 AM S Farmer with question
10:33:41 AM S Farmer with question
10:33:43 AM Brown with response
10:33:47 AM S flores
10:33:49 AM Joy Ryan speaking
10:34:03 AM on behalf ofAmericas Health Insurance Plans
10:37:09 AM Alisa LaPolt , Executive Director of National Alliance on mental Ilness - Tallahassee Fl
10:40:04 AM Fely Curva, Senior Partner of Curve & Associates LLC representing Budd Bell Clearinghouse on Human Services waive in support
10:40:15 AM Melanie Brown Government Affairs of Fl Dermatology Society - waive in support
10:40:18 AM Doug Bell waive in support for both Floirda Cahpter, American Academy of Pediatrics and the Epilepsy Association of Central Florida- Tallahassee Fl
10:40:30 AM Brewster Bevis Associated Industries of Florida, Tallahassee Fl- opposed
10:41:59 AM Michael Jackson Executive Vice President of Florida Pharmacy Association of Tallahassee Fl - waive in support
10:42:07 AM Dorene Barker, Associate State Director of AARP in Tallahassee Florida waive in support
10:42:26 AM Chris Nuland, Florida Chapter American College of Physicans and Stephen R. Winn Executive Director of Florida Osteoporosis Medical Association - waived in support
10:42:31 AM Senator Flores - any questions?
10:42:34 AM S flores - any debate?
10:42:46 AM S Garcia with debate
10:44:36 AM S FLores -
10:44:45 AM Senator Farmer with debate
10:45:23 AM Senator Farmer with support
10:45:42 AM S flores with comments
10:47:14 AM Senator Mayfield on the bill
10:49:14 AM S Mayfield closes
10:49:24 AM roll call for vote - bill found favorable
10:49:33 AM Senator Farmer moves meeting adjourned