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LEGISLATIVE ACTION

| Senate | . | House |
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| Floor: 1c/OO/2R | . | |
| 03/08/2016 05:32 PM | . | |
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Senator Hays moved the following:

**Senate Amendment to Amendment (725590) (with title amendment)**

Delete lines 442 - 469

and insert:

Section 8. Effective January 1, 2018, section 627.42393, Florida Statutes, is created to read:

627.42393 Continuity of care for medically stable patients.—

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

(a) "Complex or chronic medical condition" means a

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physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

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

(2) A pharmacy benefits manager or an individual or a 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 must continue to cover a drug for an insured with a complex or chronic medical condition or a rare disease if:

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

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

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

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

(3) With respect to a drug for an insured with a complex or chronic medical condition or a rare disease which meets the conditions of paragraphs (2)(a) and (b), except during open

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enrollment periods, a pharmacy benefits manager or an individual or a group insurance policy may not:

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

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

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

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

Section 9. Effective January 1, 2018, 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


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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


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

641.31 Health maintenance contracts.—

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


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organization may have regarding the provision of clinical laboratory services. As used in this subsection, the term:

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

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

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

(45)(a) A pharmacy benefits manager or 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 must continue to cover a drug for a subscriber with a complex or chronic medical condition or a rare disease if:

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

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

a. The United States Food and Drug Administration has

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issued a notice, a guidance, a warning, an announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

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

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

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

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

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

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

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

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

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


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========== T I T L E  A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 798 - 804
and insert:
defining the term "fail-first protocol"; creating s. 627.42393, F.S.; defining terms; requiring a pharmacy benefits manager or a specified individual or group insurance policy to continue to cover a drug for specified insureds under certain circumstances; prohibiting certain actions by a pharmacy benefits manager or an individual or a group policy with respect to a drug for a certain insured except under certain circumstances; providing applicability; amending s. 627.6699, F.S.; expanding a list of conditions that certain health benefit plans must comply with; amending s. 641.31, F.S.; prohibiting a health maintenance organization from requiring that a health care provider use a clinical decision support system or a laboratory benefits management program in certain circumstances; providing for construction; defining terms; requiring a pharmacy benefits manager or a specified health maintenance contract to continue to cover a drug for specified subscribers under certain circumstances; prohibiting certain actions by a pharmacy benefits manager or a health maintenance contract with respect to a drug for a certain subscriber except under certain circumstances; defining terms; providing applicability; creating s.

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641.394, F.S.; requiring a