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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/19/2017	.	
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The Committee on Rules (Lee) recommended the following:

Senate Amendment (with title amendment)

Delete lines 20 - 165
and insert:
Section 1. Effective January 1, 2018, section 627.42393, Florida Statutes, is created to read:
627.42393 Insurance policies; limiting changes to prescription drug formularies.—
(1) Other than at the time of coverage renewal, an individual or group insurance policy that is delivered, issued for delivery, renewed, amended, or continued in this state and

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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 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. 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 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

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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 limit changes to prescription drug formularies as required by s. 627.42393.

Section 3. Effective January 1, 2018, subsection (36) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(36) A health maintenance organization may increase the copayment for any benefit, or delete, amend, or limit any of the benefits to which a subscriber is entitled under the group contract only, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The health maintenance organization 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 ~~shall~~ 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 subsection does not apply to any increases in benefits. The 45-day notice requirement does ~~shall~~ not apply if benefits are amended, deleted, or limited at the request of the contract holder.

(a) Other than at the time of coverage renewal, a health maintenance organization 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

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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:

1. Prohibit the addition of prescription drugs to the list of drugs covered during the contract year.

2. Apply to a grandfathered health plan as defined in s. 627.402 or to benefits set forth in s. 627.6513(1)-(14).

3. 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.

4. 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. The Legislature finds that the creation of section 627.42393, Florida Statutes, and the amendments made by this act to sections 627.6699 and 641.31, Florida Statutes, fulfill an important state interest.

Section 5. Subsection (4) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(4) The agency shall:


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(a) Develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage.

(b) Contingent upon federal approval, ~~the agency shall also~~ enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Florida Health Choices Program, or any health exchange, to opt out.

(c) Provide ~~The amount of~~ financial assistance ~~provided~~ for each recipient in an amount ~~may~~ not to exceed the amount of the Medicaid premium which ~~that~~ would have been paid to a managed care plan for that recipient opting to receive services under this subsection.

(d) ~~The agency shall~~ Seek federal approval to require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

(e) By January 1, 2018, resubmit an appropriate federal waiver or waiver amendment to the Centers for Medicare and Medicaid Services, the United States Department of Health and Human Services, or any other designated federal entity to incorporate the election by a recipient for a direct primary

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care agreement, as defined in s. 456.0625, within the Statewide Medicaid Managed Care program.

Section 6. Section 456.0625, Florida Statutes, is created to read:

456.0625 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 (3) and which 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 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 primary care provider or an agent of the primary care provider may enter into a direct primary care agreement for providing primary care services. Section 624.27 applies to a direct primary care agreement.

(3) 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.

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(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.

3. This agreement is not workers' compensation insurance and may not replace the employer's obligations under chapter 440, Florida Statutes.

Section 7. Section 624.27, Florida Statutes, is created to

read:

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

(1) A direct primary care agreement, as defined in s. 456.0625, does not constitute insurance and is not subject to any 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 any chapter of the Florida Insurance Code.

(2) A primary care provider or an agent of a primary care provider is not required to obtain a certificate of authority or license under any chapter of the Florida Insurance Code to market, sell, or offer to sell a direct primary care agreement pursuant to s. 456.0625.

Section 8. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2017.

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

And the title is amended as follows:

Delete lines 2 - 16

and insert:

An act relating to health care; creating s. 627.42393, F.S.; limiting, under specified circumstances, changes to a health insurance policy prescription drug formulary during a policy year; providing construction and applicability; amending s. 627.6699, F.S.; requiring small employer carriers to limit changes to prescription drug formularies under certain circumstances; amending s. 641.31, F.S.; limiting,


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under specified circumstances, changes to a health maintenance contract prescription drug formulary during a contract year; providing construction and applicability; providing a declaration of important state interest; amending s. 409.977, F.S.; requiring the Agency for Health Care Administration to provide specified financial assistance to certain Medicaid recipients; requiring the agency to resubmit, by a specified date, certain federal waivers or waiver amendments to specified federal entities to incorporate recipient elections of certain direct primary care agreements; creating s. 456.0625, F.S.; defining terms; authorizing primary care providers or their agents to enter into direct primary care agreements for providing primary care services; providing applicability; specifying requirements for direct primary care agreements; creating s. 624.27, F.S.; providing construction and applicability of the Florida Insurance Code as to direct primary care agreements; providing an exception for primary care providers or their agents from certain requirements under the code under certain circumstances; providing effective dates.