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LEGISLATIVE ACTION

Senate

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House

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Senator Hays moved the following:

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

3  
4           Delete lines 442 - 469

5 and insert:

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

8           627.42393 Continuity of care for medically stable  
9 patients.-

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

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



861542

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

15 (b) "Rare disease" has the same meaning as in 42 U.S.C. s.  
16 287a-1(c).

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

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

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

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

33 2. The manufacturer of the drug has notified the United  
34 States Food and Drug Administration of any manufacturing  
35 discontinuance or potential discontinuance as required by s.  
36 506C of the Federal Food Drug and Cosmetic Act, 21 U.S.C. s.  
37 356c.

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



861542

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

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

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

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

50 (4) This section does not apply to a grandfathered health  
51 plan as defined in s. 627.402, or to benefits set forth in s.  
52 627.6561(5)(b)-(e).

53 Section 9. Effective January 1, 2018, paragraph (e) of  
54 subsection (5) of section 627.6699, Florida Statutes, is amended  
55 to read:

56 627.6699 Employee Health Care Access Act.—

57 (5) AVAILABILITY OF COVERAGE.—

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

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

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



861542

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

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

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

97         5. If a small employer carrier offers coverage to a small  
98 employer, it must offer coverage to all the small employer's



861542

99 eligible employees and their dependents. A small employer  
100 carrier may not offer coverage limited to certain persons in a  
101 group or to part of a group, except with respect to late  
102 enrollees.

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

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

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

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

118 641.31 Health maintenance contracts.—

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



861542

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

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

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

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

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

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

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

156 a. The United States Food and Drug Administration has



861542

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

160 b. The manufacturer of the drug has notified the United  
161 States Food and Drug Administration of any manufacturing  
162 discontinuance or potential discontinuance as required by s.  
163 506C of the Federal Food Drug and Cosmetic Act, 21 U.S.C. s.  
164 356c.

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

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

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

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

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

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

182 2. "Rare disease" has the same meaning as in 42 U.S.C. s.  
183 287a-1(c).

184 (d) This section does not apply to a grandfathered health  
185 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.



861542

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641.394, F.S.; requiring a