

By the Committees on Rules; Health Policy; and Banking and Insurance; and Senators Mayfield and Harrell

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1 A bill to be entitled
2 An act relating to prescription drug formulary
3 consumer protection; creating s. 627.42393, F.S.;
4 requiring insurers issuing individual or group health
5 insurance policies to provide certain notices to
6 current and prospective insureds within a certain
7 timeframe before the effective date of any change to a
8 prescription drug formulary during a policy year;
9 specifying requirements for a notice of medical
10 necessity that an insured's treating physician may
11 submit to the insurer within a certain timeframe;
12 specifying means by which the notice is to be
13 submitted; requiring the Financial Services Commission
14 to adopt a certain rule; specifying a requirement and
15 prohibited acts relating to certain coverage changes
16 by an insurer if the treating physician provides
17 certain certification; providing construction and
18 applicability; providing an exception for certain
19 increases in prescription drug prices by the drug
20 manufacturer; specifying notification requirements for
21 insurers under such circumstances; requiring insurers
22 to maintain a record of formulary changes and submit
23 an annual report to the Office of Insurance Regulation
24 delineating such changes within a certain timeframe;
25 requiring the commission to adopt a certain form by
26 rule; amending s. 627.6699, F.S.; requiring small
27 employer carriers to comply with certain requirements
28 for any change to a prescription drug formulary under
29 the health benefit plan; amending s. 641.31, F.S.;

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30 requiring health maintenance organizations to provide
31 certain notices to current and prospective subscribers
32 within a certain timeframe before the effective date
33 of any change to a prescription drug formulary during
34 a contract year; specifying requirements for a notice
35 of medical necessity that a subscriber's treating
36 physician may submit to the health maintenance
37 organization within a certain timeframe; specifying
38 means by which the notice is to be submitted;
39 requiring the commission to adopt a certain rule;
40 specifying a requirement and prohibited acts relating
41 to certain coverage changes by a health maintenance
42 organization if the treating physician provides
43 certain certification; providing construction and
44 applicability; providing an exception for certain
45 increases in prescription drug prices by the drug
46 manufacturer; specifying notification requirements for
47 health maintenance organizations under such
48 circumstances; requiring health maintenance
49 organizations to maintain a record of formulary
50 changes and submit an annual report to the office
51 delineating such changes within a certain timeframe;
52 requiring the commission to adopt a certain form by
53 rule; providing a declaration of important state
54 interest; providing an effective date.

55
56 Be It Enacted by the Legislature of the State of Florida:

57
58 Section 1. Section 627.42393, Florida Statutes, is created

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59 to read:

60 627.42393 Health insurance policies; changes to
61 prescription drug formularies; requirements.-

62 (1) At least 60 days before the effective date of any
63 change to a prescription drug formulary during a policy year, an
64 insurer issuing individual or group health insurance policies in
65 this state shall:

66 (a) Provide general notification of the change in the
67 formulary to current and prospective insureds in a readily
68 accessible format on the insurer's website; and

69 (b) Notify, electronically or by first-class mail, any
70 insured currently receiving coverage for a prescription drug for
71 which the formulary change modifies coverage and the insured's
72 treating physician, including information on the specific drugs
73 involved and a statement that the submission of a notice of
74 medical necessity by the insured's treating physician to the
75 insurer at least 30 days before the effective date of the
76 formulary change will result in continuation of coverage at the
77 existing level.

78 (2) The notice provided by the treating physician to the
79 insurer must include a completed one-page form in which the
80 treating physician certifies to the insurer that coverage of the
81 prescription drug for the insured is medically necessary. The
82 treating physician shall submit the notice electronically or by
83 first-class mail. The insurer may provide the treating physician
84 with access to an electronic portal through which the treating
85 physician may electronically file the notice. The commission
86 shall prescribe a form by rule for the notice.

87 (3) If the treating physician certifies to the insurer, in

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88 accordance with subsection (2), that the prescription drug is
89 medically necessary for the insured, the insurer:

90 (a) Must authorize coverage for the prescribed drug based
91 solely on the treating physician's certification that coverage
92 is medically necessary; and

93 (b) May not modify the coverage related to the covered drug
94 by:

95 1. Increasing the out-of-pocket costs for the covered drug;

96 2. Moving the covered drug to a more restrictive tier; or

97 3. Denying an insured coverage of the drug for which the

98 insured has been previously approved for coverage by the

99 insurer.

100 (4) This section does not:

101 (a) Prohibit the addition of prescription drugs to the list
102 of drugs covered under the policy during the policy year.

103 (b) Apply to a grandfathered health plan as defined in s.
104 627.402, to benefits specified in s. 627.6513(1)-(14), or to any
105 policy issued or delivered between March 23, 2010, and December
106 31, 2013, inclusive.

107 (c) Alter or amend s. 465.025, which provides conditions
108 under which a pharmacist may substitute a generically equivalent
109 drug product for a brand name drug product.

110 (d) Alter or amend s. 465.0252, which provides conditions
111 under which a pharmacist may dispense a substitute biological
112 product for the prescribed biological product.

113 (e) Apply to a Medicaid managed care plan under part IV of
114 chapter 409.

115 (5) (a) This section does not apply if a drug manufacturer
116 increases the list price of a prescription drug on the health

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117 insurer's formulary to the health insurer or the pharmacy
118 benefit manager after November 1 of the year before the health
119 insurer's earliest required rate submission date to applicable
120 state and federal rate review authorities for the succeeding
121 calendar or policy year.

122 (b) However, at least 60 days before the effective date of
123 a formulary change as a result of circumstances described in
124 paragraph (a), the health insurer shall provide general
125 notification of the formulary change to current and prospective
126 insureds in a readily accessible format on the insurer's
127 website; and notify, electronically or by first-class mail, any
128 insured currently receiving coverage for a prescription drug for
129 which the formulary change modifies coverage and the insured's
130 treating physician, including information on the specific drugs
131 involved.

132 (6) A health insurer shall maintain a record of any change
133 in its formulary during the calendar or plan year and, within 45
134 days after the end of the plan year, submit an annual report to
135 the office delineating such changes. The commission shall
136 prescribe a form by rule for such reports.

137 Section 2. Paragraph (e) of subsection (5) of section
138 627.6699, Florida Statutes, is amended to read:

139 627.6699 Employee Health Care Access Act.—

140 (5) AVAILABILITY OF COVERAGE.—

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

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

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

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

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

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

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

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

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

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

197 8. A small employer carrier shall comply with s. 627.42393
198 for any change to a prescription drug formulary.

199 Section 3. Subsection (36) of section 641.31, Florida
200 Statutes, is amended to read:

201 641.31 Health maintenance contracts.—

202 (36) Except as provided in paragraphs (a), (b), and (c), a
203 health maintenance organization may increase the copayment for

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204 any benefit, or delete, amend, or limit any of the benefits to
205 which a subscriber is entitled under the group contract only,
206 upon written notice to the contract holder at least 45 days in
207 advance of the time of coverage renewal. The health maintenance
208 organization may amend the contract with the contract holder,
209 with such amendment to be effective immediately at the time of
210 coverage renewal. The written notice to the contract holder must
211 ~~shall~~ specifically identify any deletions, amendments, or
212 limitations to any of the benefits provided in the group
213 contract during the current contract period which will be
214 included in the group contract upon renewal. This subsection
215 does not apply to any increases in benefits. The 45-day notice
216 requirement does ~~shall~~ not apply if benefits are amended,
217 deleted, or limited at the request of the contract holder.

218 (a) At least 60 days before the effective date of any
219 change to a prescription drug formulary during a contract year,
220 the health maintenance organization shall:

221 1. Provide general notification of the change in the
222 formulary to current and prospective subscribers in a readily
223 accessible format on the health maintenance organization's
224 website; and

225 2. Notify, electronically or by first-class mail, any
226 subscriber currently receiving coverage for a prescription drug
227 for which the formulary change modifies coverage and the
228 subscriber's treating physician, including information on the
229 specific drugs involved and a statement that the submission of a
230 notice of medical necessity by the subscriber's treating
231 physician to the health maintenance organization at least 30
232 days before the effective date of the formulary change will

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233 result in continuation of coverage at the existing level.

234 (b) The notice provided by the treating physician to the
235 insurer must include a completed one-page form in which the
236 treating physician certifies to the health maintenance
237 organization that coverage of the prescription drug for the
238 subscriber is medically necessary. The treating physician shall
239 submit the notice electronically or by first-class mail. The
240 health maintenance organization may provide the treating
241 physician with access to an electronic portal through which the
242 treating physician may electronically file the notice. The
243 commission shall prescribe a form by rule for the notice.

244 (c) If the treating physician certifies to the health
245 maintenance organization, in accordance with paragraph (b), that
246 the prescription drug is medically necessary for the subscriber,
247 the health maintenance organization:

248 1. Must authorize coverage for the prescribed drug based
249 solely on the treating physician's certification that coverage
250 is medically necessary; and

251 2. May not modify the coverage related to the covered drug
252 by:

253 a. Increasing the out-of-pocket costs for the covered drug;
254 b. Moving the covered drug to a more restrictive tier; or
255 c. Denying a subscriber coverage of the drug for which the
256 subscriber has been previously approved for coverage by the
257 health maintenance organization.

258 (d) Paragraphs (a), (b), and (c) do not:

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

261 2. Apply to a grandfathered health plan as defined in s.

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262 627.402 or to benefits specified in s. 627.6513(1)-(14).

263 3. Alter or amend s. 465.025, which provides conditions
264 under which a pharmacist may substitute a generically equivalent
265 drug product for a brand name drug product.

266 4. Alter or amend s. 465.0252, which provides conditions
267 under which a pharmacist may dispense a substitute biological
268 product for the prescribed biological product.

269 5. Apply to a Medicaid managed care plan under part IV of
270 chapter 409.

271 (e)1. Paragraphs (a), (b), and (c) do not apply if a drug
272 manufacturer increases the list price of a prescription drug on
273 the health maintenance organization's formulary to the health
274 maintenance organization or the pharmacy benefit manager after
275 November 1 of the year before the health maintenance
276 organization's earliest required rate submission date to
277 applicable state and federal rate review authorities for the
278 succeeding calendar or policy year.

279 2. However, at least 60 days before the effective date of a
280 formulary change as a result of circumstances described in
281 subparagraph 1., the health maintenance organization shall
282 provide general notification of the formulary change to current
283 and prospective subscribers in a readily accessible format on
284 the health maintenance organization's website; and notify,
285 electronically or by first-class mail, any subscriber currently
286 receiving coverage for a prescription drug for which the
287 formulary change modifies coverage and the subscriber's treating
288 physician, including information on the specific drugs involved.

289 (f) A health maintenance organization shall maintain a
290 record of any change in its formulary during the calendar or

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291 plan year and, within 45 days after the end of the plan year,
292 submit an annual report to the office delineating such changes.
293 The commission shall prescribe a form by rule for such reports.

294 Section 4. The Legislature finds that this act fulfills an
295 important state interest.

296 Section 5. This act shall take effect January 1, 2020.