A bill to be entitled

An act relating to prescription drug formulary consumer protection; creating s. 627.42393, F.S.; requiring insurers issuing individual or group health insurance policies to provide certain notices to current and prospective insureds, and the insureds' treating physicians, within a certain timeframe before the effective date of any change to a prescription drug formulary during a policy year; requiring such insurers to maintain a record of formulary changes and submit a certain annual report to the Office of Insurance Regulation; specifying requirements for the annual report; requiring the office to annually compile data in such reports and prepare an annual report summarizing such data; requiring the office to annually post the report on its website and submit the report to the Governor and Legislature by a certain date; amending s. 627.6699, F.S.; requiring small employer carriers to comply with certain requirements for any change to a prescription drug formulary under the health benefit plan; amending s. 641.31, F.S.; requiring health maintenance organizations to provide certain notices to current and prospective subscribers, and the subscribers' treating physicians, within a certain timeframe before the effective date of any change to a prescription drug formulary during a contract year; requiring such health maintenance organizations to maintain a record of formulary changes and submit a certain annual report to the

office; specifying requirements for the annual report; requiring the office to annually compile data in such reports and prepare an annual report summarizing such data; requiring the office to annually post the report on its website and submit the report to the Governor and Legislature; providing a declaration of important state interest; 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 Health insurance policies; changes to prescription drug formularies; requirements.—

(1) At least 60 days before the effective date of any change to a prescription drug formulary during a policy year, an insurer issuing individual or group health insurance policies in this state shall provide general notification of the change in the formulary to current and prospective insureds in a readily accessible format on the insurer's website and notify, electronically or by first-class mail, any insured currently receiving coverage for a prescription drug for which the formulary change modifies coverage and the insured's treating physician, including information on the specific drugs involved.

(2) A health insurer shall maintain a record of any change in its formulary during a calendar year. By March 1 annually, a health insurer shall submit a report to the office delineating such changes made in the previous calendar year. The annual report must include, at a minimum:

(a) A list of all drugs that were removed from a formulary and the reasons for the removal;

(b) A list of all drugs that were moved to a tier that resulted in additional out-of-pocket costs to insureds;

(c) The number of insureds notified by the insurer of a change in formulary; and

(d) The increased cost, by dollar amount, incurred by insureds because of such change in the formulary.

(3) By May 1 annually, the office shall:

(a) Compile the data in such annual reports submitted by health insurers and prepare a report summarizing the data submitted;

(b) Make the report publicly accessible on its website; and

(c) Submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

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 shall comply with s. 627.42393 for any change to a prescription drug formulary.

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

641.31 Health maintenance contracts.—

(36) Except as provided in paragraph (a), 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) At least 60 days before the effective date of any change to a prescription drug formulary during a contract year, the health maintenance organization shall provide general notification of the change in the formulary to current and prospective subscribers in a readily accessible format on the health maintenance organization's website and notify, electronically or by first-class mail, any subscriber currently receiving coverage for a prescription drug for which the formulary change modifies coverage and the subscriber's treating physician, including information on the specific drugs involved.

(b) A health maintenance organization shall maintain a record of any change in its formulary during a calendar year. By March 1 annually, a health maintenance organization shall submit a report to the office delineating such changes made in the previous calendar year. The annual report must include, at a minimum:

1. A list of all drugs that were removed from a formulary and the reasons for the removal;

2. A list of all drugs that were moved to a tier that resulted in additional out-of-pocket costs to subscribers;

3. The number of subscribers notified by the health maintenance organization of a change in formulary; and

4. The increased cost, by dollar amount, incurred by subscribers because of such change in the formulary.

(c) By May 1 annually, the office shall:

1. Compile the data in such annual reports submitted by health maintenance organizations and prepare a report summarizing the data submitted;

2. Make the report publicly accessible on its website; and

3. Submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

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

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