

1 A bill to be entitled
2 An act relating to prescription drug coverage;
3 creating s. 627.42394, F.S.; requiring individual and
4 group health insurers to provide notice of
5 prescription drug formulary changes to current and
6 prospective insureds and the insureds' treating
7 physicians; specifying the timeframe and manner in
8 which such notice must be provided; specifying
9 requirements for a notice of medical necessity
10 submitted by the treating physician; authorizing
11 insurers to provide certain means for submitting the
12 notice of medical necessity; requiring the Financial
13 Services Commission to adopt a certain form by rule by
14 a specified date; specifying a coverage requirement
15 and restrictions on coverage modification by insurers
16 receiving such notice; providing construction and
17 applicability; requiring insurers to maintain a record
18 of formulary changes; requiring insurers to annually
19 submit a specified report to the Office of Insurance
20 Regulation; requiring the office to annually compile
21 certain data, prepare a report and make the report
22 publicly accessible on its website, and submit the
23 report to the Governor and the Legislature; creating
24 s. 627.6404, F.S.; requiring insurers to apply certain
25 reductions in out-of-pocket expenses for prescription

26 | drugs toward an insured's cost-sharing obligation;
27 | creating s. 627.64742, F.S.; defining the term
28 | "pharmacy benefit manager"; requiring pharmacy benefit
29 | managers to annually file with the office a specified
30 | report relating to payments collected from
31 | pharmaceutical manufacturers; requiring the office to
32 | publish such reports on its website within a certain
33 | timeframe; authorizing the commission to adopt rules;
34 | amending s. 627.6699, F.S.; requiring small employer
35 | carriers to comply with certain requirements for
36 | prescription drug formulary changes; amending s.
37 | 641.31, F.S.; requiring health maintenance
38 | organizations to provide notice of prescription drug
39 | formulary changes to current and prospective
40 | subscribers and the subscribers' treating physicians;
41 | specifying the timeframe and manner in which such
42 | notice must be provided; specifying requirements for a
43 | notice of medical necessity submitted by the treating
44 | physician; authorizing health maintenance
45 | organizations to provide certain means for submitting
46 | the notice of medical necessity; requiring the
47 | commission to adopt a certain form by rule by a
48 | specified date; specifying a coverage requirement and
49 | restrictions on coverage modification by health
50 | maintenance organizations receiving such notice;

51 providing construction and applicability; requiring
52 health maintenance organizations to maintain a record
53 of formulary changes; requiring health maintenance
54 organizations to annually submit a specified report to
55 the office; requiring the office to annually compile
56 certain data, prepare a report and make the report
57 publicly accessible on its website, and submit the
58 report to the Governor and the Legislature; creating
59 s. 641.3157, F.S.; requiring health maintenance
60 organizations to apply certain reductions in out-of-
61 pocket expenses for prescription drugs toward a
62 subscriber's cost-sharing obligation; providing
63 applicability; providing a declaration of important
64 state interest; providing an effective date.

65
66 Be It Enacted by the Legislature of the State of Florida:

67
68 Section 1. Section 627.42394, Florida Statutes, is created
69 to read:

70 627.42394 Health insurance policies; changes to
71 prescription drug formularies; requirements.-

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

76 (a) Provide notification of the change in the formulary to
77 current and prospective insureds in a readily accessible format
78 on the insurer's website; and

79 (b) Notify, electronically and by first-class mail, any
80 insured currently receiving coverage for a prescription drug for
81 which the formulary change modifies coverage and the insured's
82 treating physician, including information on the specific drugs
83 involved and a statement that the submission of a notice of
84 medical necessity by the insured's treating physician to the
85 insurer at least 30 days before the effective date of the
86 formulary change will result in continuation of coverage at the
87 existing level.

88 (2) The notice provided by the treating physician to the
89 insurer must include a completed one-page form in which the
90 treating physician certifies to the insurer that the
91 prescription drug for the insured is medically necessary as
92 defined under s. 627.732(2). The treating physician shall submit
93 the notice electronically or by first-class mail. The insurer
94 may provide the treating physician with access to an electronic
95 portal through which the treating physician may electronically
96 submit the notice. By January 1, 2021, the commission shall
97 adopt by rule a form for the notice.

98 (3) If the treating physician certifies to the insurer in
99 accordance with subsection (2) that the prescription drug is
100 medically necessary for the insured, the insurer:

101 (a) Must authorize coverage for the prescribed drug until
102 the end of the policy year, based solely on the treating
103 physician's certification that the drug is medically necessary;
104 and

105 (b) May not modify the coverage related to the covered
106 drug during the policy year by:

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

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

110 3. Denying an insured coverage of the drug for which the
111 insured has been previously approved for coverage by the
112 insurer; or

113 4. Limiting or reducing coverage of the drug in any other
114 way, including subjecting it to a new prior authorization or
115 step therapy requirement.

116 (4) Subsections (1), (2), and (3) do not:

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

119 (b) Apply to a grandfathered health plan as defined in s.
120 627.402 or to benefits specified in s. 627.6513(1)-(14).

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

124 (d) Alter or amend s. 465.0252, which provides conditions
125 under which a pharmacist may dispense a substitute biological

126 | product for the prescribed biological product.

127 | (e) Apply to a Medicaid managed care plan under part IV of
 128 | chapter 409.

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

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

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

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

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

142 | (6) By May 1 annually, the office shall:

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

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

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

150 | Section 2. Section 627.6404, Florida Statutes, is created

151 to read:

152 627.6404 Application of reductions to insured cost-sharing
153 obligations.-An insurer shall apply any third-party payment,
154 financial assistance, discount, patient voucher, or other
155 reduction in out-of-pocket expenses made by or on behalf of an
156 insured for prescription drugs toward the insured's deductible,
157 copay, cost-sharing responsibility, or out-of-pocket maximum
158 associated with the insured's policy.

159 Section 3. Section 627.64742, Florida Statutes, is created
160 to read:

161 627.64742 Pharmacy benefit manager annual reporting.-

162 (1) As used in this section, the term "pharmacy benefit
163 manager" has the same meaning as provided in s. 627.64741(1). By
164 March 1, 2021, and every March 1 thereafter, each pharmacy
165 benefit manager shall file a report with the office. The report
166 must contain the following information for the immediately
167 preceding calendar year:

168 (a) The aggregated dollar amount of rebates, fees, price
169 protection payments, and other payments collected from
170 pharmaceutical manufacturers;

171 (b) The aggregated dollar amount of rebates, fees, price
172 protection payments, and other payments collected from
173 pharmaceutical manufacturers which was passed to health insurers
174 or health maintenance organizations authorized under chapter
175 624; and

176 (c) The aggregated dollar amount of rebates, fees, price
177 protection payments, and other payments collected from
178 pharmaceutical manufacturers which was passed to insureds at the
179 point of sale.

180 (2) The office shall publish on its website the reports
181 received under subsection (1) within 60 days after receipt.

182 (3) The commission may adopt rules to administer this
183 section.

184 Section 4. Paragraph (e) of subsection (5) of section
185 627.6699, Florida Statutes, is amended to read:

186 627.6699 Employee Health Care Access Act.—

187 (5) AVAILABILITY OF COVERAGE.—

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

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

195 2. Any requirement used by a small employer carrier in
196 determining whether to provide coverage to a small employer
197 group, including requirements for minimum participation of
198 eligible employees and minimum employer contributions, must be
199 applied uniformly among all small employer groups having the
200 same number of eligible employees applying for coverage or

201 receiving coverage from the small employer carrier, except that
202 a small employer carrier that participates in, administers, or
203 issues health benefits pursuant to s. 381.0406 which do not
204 include a preexisting condition exclusion may require as a
205 condition of offering such benefits that the employer has had no
206 health insurance coverage for its employees for a period of at
207 least 6 months. A small employer carrier may vary application of
208 minimum participation requirements and minimum employer
209 contribution requirements only by the size of the small employer
210 group.

211 3. In applying minimum participation requirements with
212 respect to a small employer, a small employer carrier shall not
213 consider as an eligible employee employees or dependents who
214 have qualifying existing coverage in an employer-based group
215 insurance plan or an ERISA qualified self-insurance plan in
216 determining whether the applicable percentage of participation
217 is met. However, a small employer carrier may count eligible
218 employees and dependents who have coverage under another health
219 plan that is sponsored by that employer.

220 4. A small employer carrier shall not increase any
221 requirement for minimum employee participation or any
222 requirement for minimum employer contribution applicable to a
223 small employer at any time after the small employer has been
224 accepted for coverage, unless the employer size has changed, in
225 which case the small employer carrier may apply the requirements

226 that are applicable to the new group size.

227 5. If a small employer carrier offers coverage to a small
228 employer, it must offer coverage to all the small employer's
229 eligible employees and their dependents. A small employer
230 carrier may not offer coverage limited to certain persons in a
231 group or to part of a group, except with respect to late
232 enrollees.

233 6. A small employer carrier may not modify any health
234 benefit plan issued to a small employer with respect to a small
235 employer or any eligible employee or dependent through riders,
236 endorsements, or otherwise to restrict or exclude coverage for
237 certain diseases or medical conditions otherwise covered by the
238 health benefit plan.

239 7. An initial enrollment period of at least 30 days must
240 be provided. An annual 30-day open enrollment period must be
241 offered to each small employer's eligible employees and their
242 dependents. A small employer carrier must provide special
243 enrollment periods as required by s. 627.65615.

244 8. A small employer carrier shall comply with s. 627.42394
245 for any change to a prescription drug formulary.

246 Section 5. Subsection (36) of section 641.31, Florida
247 Statutes, is amended to read:

248 641.31 Health maintenance contracts.—

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

251 any benefit, or delete, amend, or limit any of the benefits to
252 which a subscriber is entitled under the group contract only,
253 upon written notice to the contract holder at least 45 days in
254 advance of the time of coverage renewal. The health maintenance
255 organization may amend the contract with the contract holder,
256 with such amendment to be effective immediately at the time of
257 coverage renewal. The written notice to the contract holder must
258 ~~shall~~ specifically identify any deletions, amendments, or
259 limitations to any of the benefits provided in the group
260 contract during the current contract period which will be
261 included in the group contract upon renewal. This subsection
262 does not apply to any increases in benefits. The 45-day notice
263 requirement does ~~shall~~ not apply if benefits are amended,
264 deleted, or limited at the request of the contract holder.

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

268 1. Provide notification of the change in the formulary to
269 current and prospective subscribers in a readily accessible
270 format on the health maintenance organization's website; and

271 2. Notify, electronically and by first-class mail, any
272 subscriber currently receiving coverage for a prescription drug
273 for which the formulary change modifies coverage and the
274 subscriber's treating physician, including information on the
275 specific drugs involved and a statement that the submission of a

276 notice of medical necessity by the subscriber's treating
277 physician to the health maintenance organization at least 30
278 days before the effective date of the formulary change will
279 result in continuation of coverage at the existing level.

280 (b) The notice provided by the treating physician to the
281 health maintenance organization must include a completed one-
282 page form in which the treating physician certifies to the
283 health maintenance organization that the prescription drug for
284 the subscriber is medically necessary as defined under s.
285 627.732(2). The treating physician shall submit the notice
286 electronically or by first-class mail. The health maintenance
287 organization may provide the treating physician with access to
288 an electronic portal through which the treating physician may
289 electronically submit the notice. By January 1, 2021, the
290 commission shall adopt by rule a form for the notice.

291 (c) If the treating physician certifies to the health
292 maintenance organization in accordance with paragraph (b) that
293 the prescription drug is medically necessary for the subscriber,
294 the health maintenance organization:

295 1. Must authorize coverage for the prescribed drug until
296 the end of the contract year, based solely on the treating
297 physician's certification that the drug is medically necessary;
298 and

299 2. May not modify the coverage related to the covered drug
300 during the contract year by:

- 301 a. Increasing the out-of-pocket costs for the covered
302 drug;
- 303 b. Moving the covered drug to a more restrictive tier;
- 304 c. Denying a subscriber coverage of the drug for which the
305 subscriber has been previously approved for coverage by the
306 health maintenance organization; or
- 307 d. Limiting or reducing coverage of the drug in any other
308 way, including subjecting it to a new prior authorization or
309 step therapy requirement.
- 310 (d) Paragraphs (a), (b), and (c) do not:
- 311 1. Prohibit the addition of prescription drugs to the list
312 of drugs covered under the contract during the contract year.
- 313 2. Apply to a grandfathered health plan as defined in s.
314 627.402 or to benefits specified in s. 627.6513(1)-(14).
- 315 3. Alter or amend s. 465.025, which provides conditions
316 under which a pharmacist may substitute a generically equivalent
317 drug product for a brand name drug product.
- 318 4. Alter or amend s. 465.0252, which provides conditions
319 under which a pharmacist may dispense a substitute biological
320 product for the prescribed biological product.
- 321 5. Apply to a Medicaid managed care plan under part IV of
322 chapter 409.
- 323 (e) A health maintenance organization shall maintain a
324 record of any change in its formulary during a calendar year. By
325 March 1 annually, a health maintenance organization shall submit

326 to the office a report delineating such changes made in the
327 previous calendar year. The annual report must include, at a
328 minimum:

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

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

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

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

337 (f) By May 1 annually, the office shall:

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

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

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

344 Section 6. Section 641.3157, Florida Statutes, is created
345 to read:

346 641.3157 Application of reductions to subscriber cost-
347 sharing obligations.—A health maintenance organization shall
348 apply any third-party payment, financial assistance, discount,
349 patient voucher, or other reduction in out-of-pocket expenses
350 made by or on behalf of a subscriber for prescription drugs

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351 toward a subscriber's deductible, copay, cost-sharing
352 responsibility, or out-of-pocket maximum associated with the
353 subscriber's health maintenance contract.

354 Section 7. This act applies to health insurance policies,
355 health benefit plans, and health maintenance contracts entered
356 into or renewed on or after January 1, 2021.

357 Section 8. The Legislature finds that this act fulfills an
358 important state interest.

359 Section 9. This act shall take effect July 1, 2020.