

By Senator Mayfield

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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

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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

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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.

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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 drug
106 during the policy year by:

107 1. Increasing the out-of-pocket costs for the covered drug;
108 2. Moving the covered drug to a more restrictive tier;
109 3. Denying an insured coverage of the drug for which the
110 insured has been previously approved for coverage by the
111 insurer; or

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

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

116 (a) Prohibit the addition of prescription drugs to the list

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117 of drugs covered under the policy during the policy year.

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

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

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

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

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

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

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

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

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

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

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

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

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

148 Section 2. Section 627.6404, Florida Statutes, is created
149 to read:

150 627.6404 Application of reductions to insured cost-sharing
151 obligations.—An insurer shall apply any third-party payment,
152 financial assistance, discount, patient voucher, or other
153 reduction in out-of-pocket expenses made by or on behalf of an
154 insured for prescription drugs toward the insured's deductible,
155 copay, cost-sharing responsibility, or out-of-pocket maximum
156 associated with the insured's policy.

157 Section 3. Section 627.64742, Florida Statutes, is created
158 to read:

159 627.64742 Pharmacy benefit manager annual reporting.—

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

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

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

174 (c) The aggregated dollar amount of rebates, fees, price

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175 protection payments, and other payments collected from
176 pharmaceutical manufacturers which was passed to insureds at the
177 point of sale.

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

180 (3) The commission may adopt rules to administer this
181 section.

182 Section 4. Paragraph (e) of subsection (5) of section
183 627.6699, Florida Statutes, is amended to read:

184 627.6699 Employee Health Care Access Act.—

185 (5) AVAILABILITY OF COVERAGE.—

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

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

193 2. Any requirement used by a small employer carrier in
194 determining whether to provide coverage to a small employer
195 group, including requirements for minimum participation of
196 eligible employees and minimum employer contributions, must be
197 applied uniformly among all small employer groups having the
198 same number of eligible employees applying for coverage or
199 receiving coverage from the small employer carrier, except that
200 a small employer carrier that participates in, administers, or
201 issues health benefits pursuant to s. 381.0406 which do not
202 include a preexisting condition exclusion may require as a
203 condition of offering such benefits that the employer has had no

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204 health insurance coverage for its employees for a period of at
205 least 6 months. A small employer carrier may vary application of
206 minimum participation requirements and minimum employer
207 contribution requirements only by the size of the small employer
208 group.

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

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

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

231 6. A small employer carrier may not modify any health
232 benefit plan issued to a small employer with respect to a small

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233 employer or any eligible employee or dependent through riders,
 234 endorsements, or otherwise to restrict or exclude coverage for
 235 certain diseases or medical conditions otherwise covered by the
 236 health benefit plan.

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

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

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

246 641.31 Health maintenance contracts.—

247 (36) Except as provided in paragraphs (a), (b), and (c), a
 248 health maintenance organization may increase the copayment for
 249 any benefit, or delete, amend, or limit any of the benefits to
 250 which a subscriber is entitled under the group contract only,
 251 upon written notice to the contract holder at least 45 days in
 252 advance of the time of coverage renewal. The health maintenance
 253 organization may amend the contract with the contract holder,
 254 with such amendment to be effective immediately at the time of
 255 coverage renewal. The written notice to the contract holder must
 256 ~~shall~~ specifically identify any deletions, amendments, or
 257 limitations to any of the benefits provided in the group
 258 contract during the current contract period which will be
 259 included in the group contract upon renewal. This subsection
 260 does not apply to any increases in benefits. The 45-day notice
 261 requirement does ~~shall~~ not apply if benefits are amended,

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262 deleted, or limited at the request of the contract holder.

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

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

269 2. Notify, electronically and by first-class mail, any
270 subscriber currently receiving coverage for a prescription drug
271 for which the formulary change modifies coverage and the
272 subscriber's treating physician, including information on the
273 specific drugs involved and a statement that the submission of a
274 notice of medical necessity by the subscriber's treating
275 physician to the health maintenance organization at least 30
276 days before the effective date of the formulary change will
277 result in continuation of coverage at the existing level.

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

289 (c) If the treating physician certifies to the health
290 maintenance organization in accordance with paragraph (b) that

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291 the prescription drug is medically necessary for the subscriber,
292 the health maintenance organization:

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

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

299 a. Increasing the out-of-pocket costs for the covered drug;

300 b. Moving the covered drug to a more restrictive tier;

301 c. Denying a subscriber coverage of the drug for which the
302 subscriber has been previously approved for coverage by the
303 health maintenance organization; or

304 d. Limiting or reducing coverage of the drug in any other
305 way, including subjecting it to a new prior authorization or
306 step therapy requirement.

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

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

310 2. Apply to a grandfathered health plan as defined in s.
311 627.402 or to benefits specified in s. 627.6513(1)-(14).

312 3. Alter or amend s. 465.025, which provides conditions
313 under which a pharmacist may substitute a generically equivalent
314 drug product for a brand name drug product.

315 4. Alter or amend s. 465.0252, which provides conditions
316 under which a pharmacist may dispense a substitute biological
317 product for the prescribed biological product.

318 5. Apply to a Medicaid managed care plan under part IV of
319 chapter 409.

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

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

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

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

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

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

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

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

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

341 Section 6. Section 641.3157, Florida Statutes, is created
342 to read:

343 641.3157 Application of reductions to subscriber cost-
344 sharing obligations.—A health maintenance organization shall
345 apply any third-party payment, financial assistance, discount,
346 patient voucher, or other reduction in out-of-pocket expenses
347 made by or on behalf of a subscriber for prescription drugs
348 toward a subscriber's deductible, copay, cost-sharing

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349 responsibility, or out-of-pocket maximum associated with the
350 subscriber's health maintenance contract.

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

354 Section 8. The Legislature finds that this act fulfills an
355 important state interest.

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