

By Senator Rodriguez

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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; amending
24 s. 627.6699, F.S.; requiring small employer carriers
25 to comply with certain requirements for prescription
26 drug formulary changes; amending s. 641.31, F.S.;
27 providing an exception; requiring health maintenance
28 organizations to provide notice of prescription drug
29 formulary changes to current and prospective

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30 subscribers and the subscribers' treating physicians;
31 specifying the timeframe and manner in which such
32 notice must be provided; specifying requirements for a
33 notice of medical necessity submitted by the treating
34 physician; authorizing health maintenance
35 organizations to provide certain means for submitting
36 the notice of medical necessity; requiring the
37 commission to adopt a certain form by rule by a
38 specified date; specifying a coverage requirement and
39 restrictions on coverage modification by health
40 maintenance organizations receiving such notice;
41 providing construction and applicability; requiring
42 health maintenance organizations to maintain a record
43 of formulary changes; requiring health maintenance
44 organizations to annually submit a specified report to
45 the office; requiring the office to annually compile
46 certain data, prepare a report and make the report
47 publicly accessible on its website, and submit the
48 report to the Governor and the Legislature; providing
49 applicability; providing a declaration of important
50 state interest; providing an effective date.

51
52 Be It Enacted by the Legislature of the State of Florida:

53
54 Section 1. Section 627.42394, Florida Statutes, is created
55 to read:

56 627.42394 Health insurance policies; changes to
57 prescription drug formularies; requirements.-

58 (1) At least 60 days before the effective date of any

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59 change to a prescription drug formulary during a policy year, an
60 insurer issuing individual or group health insurance policies in
61 this state shall notify:

62 (a) Current and prospective insureds of the change in the
63 formulary in a readily accessible format on the insurer's
64 website; and

65 (b) Electronically and by first-class mail, any insured
66 currently receiving coverage for a prescription drug for which
67 the formulary change modifies coverage and the insured's
68 treating physician. Such notification must include information
69 on the specific drugs involved and a statement that the
70 submission of a notice of medical necessity by the insured's
71 treating physician to the insurer at least 30 days before the
72 effective date of the formulary change will result in
73 continuation of coverage at the existing level.

74 (2) The notice provided by the treating physician to the
75 insurer must include a completed one-page form in which the
76 treating physician certifies to the insurer that the
77 prescription drug for the insured is medically necessary as
78 defined under s. 627.732(2). The treating physician shall submit
79 the notice electronically or by first-class mail. The insurer
80 may provide the treating physician with access to an electronic
81 portal through which the treating physician may electronically
82 submit the notice. By January 1, 2022, the commission shall
83 adopt by rule a form for the notice.

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

87 (a) Must authorize coverage for the prescribed drug until

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88 the end of the policy year, based solely on the treating
89 physician's certification that the drug is medically necessary;
90 and

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

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

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

95 3. Denying an insured coverage of the drug for which the
96 insured has been previously approved for coverage by the
97 insurer; or

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

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

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

104 (b) Apply to a grandfathered health plan as defined in s.
105 627.402 or to benefits specified in s. 627.6513(1)-(14).

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

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

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

114 (5) A health insurer shall maintain a record of any change
115 in its formulary during a calendar year. By March 1 annually, a
116 health insurer shall submit to the office a report delineating

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117 such changes made in the previous calendar year. The annual
118 report must include, at a minimum:

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

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

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

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

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

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

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

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

134 Section 2. Paragraph (e) of subsection (5) of section
135 627.6699, Florida Statutes, is amended to read:

136 627.6699 Employee Health Care Access Act.—

137 (5) AVAILABILITY OF COVERAGE.—

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

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

145 2. Any requirement used by a small employer carrier in

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

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

170 4. A small employer carrier shall not increase any
171 requirement for minimum employee participation or any
172 requirement for minimum employer contribution applicable to a
173 small employer at any time after the small employer has been
174 accepted for coverage, unless the employer size has changed, in

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175 which case the small employer carrier may apply the requirements
176 that are applicable to the new group size.

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

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

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

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

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

198 641.31 Health maintenance contracts.—

199 (36) Except as provided in paragraphs (a), (b), and (c), a
200 health maintenance organization may increase the copayment for
201 any benefit, or delete, amend, or limit any of the benefits to
202 which a subscriber is entitled under the group contract only,
203 upon written notice to the contract holder at least 45 days in

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

215 (a) At least 60 days before the effective date of any
216 change to a prescription drug formulary during a contract year,
217 a health maintenance organization shall notify:

218 1. Current and prospective subscribers of the change in the
219 formulary in a readily accessible format on the health
220 maintenance organization's website; and

221 2. Electronically and by first-class mail, any subscriber
222 currently receiving coverage for a prescription drug for which
223 the formulary change modifies coverage and the subscriber's
224 treating physician. Such notification must include information
225 on the specific drugs involved and a statement that the
226 submission of a notice of medical necessity by the subscriber's
227 treating physician to the health maintenance organization at
228 least 30 days before the effective date of the formulary change
229 will result in continuation of coverage at the existing level.

230 (b) The notice provided by the treating physician to the
231 health maintenance organization must include a completed one-
232 page form in which the treating physician certifies to the

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233 health maintenance organization that the prescription drug for
234 the subscriber is medically necessary as defined under s.
235 627.732(2). The treating physician shall submit the notice
236 electronically or by first-class mail. The health maintenance
237 organization may provide the treating physician with access to
238 an electronic portal through which the treating physician may
239 electronically submit the notice. By January 1, 2022, the
240 commission shall adopt by rule a form for the notice.

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

245 1. Must authorize coverage for the prescribed drug until
246 the end of the contract year, based solely on the treating
247 physician's certification that the drug is medically necessary;
248 and

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

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

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

253 c. Denying a subscriber coverage of the drug for which the

254 subscriber has been previously approved for coverage by the
255 health maintenance organization; or

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

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

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

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262 2. Apply to a grandfathered health plan as defined in s.
263 627.402 or to benefits specified in s. 627.6513(1)-(14).

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

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

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

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

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

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

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

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

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

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

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

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

293 Section 4. This act applies to health insurance policies,
294 health benefit plans, and health maintenance contracts entered
295 into or renewed on or after January 1, 2022.

296 Section 5. The Legislature finds that this act fulfills an
297 important state interest.

298 Section 6. This act shall take effect January 1, 2022.