${\bf By}$ Senator Rodriguez

	39-00762-22 20221100
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 within a certain
6	timeframe to current and prospective insureds and the
7	insureds' treating physicians; specifying requirements
8	for the content of such notice and the manner in which
9	it must be provided; specifying requirements for a
10	notice of medical necessity submitted by the treating
11	physician; authorizing insurers to provide certain
12	means for submitting the notice of medical necessity;
13	requiring the Financial Services Commission to adopt a
14	certain form by rule by a specified date; specifying a
15	coverage requirement and restrictions on coverage
16	modification by insurers receiving a notice of medical
17	necessity; providing construction and applicability;
18	requiring insurers to maintain a record of formulary
19	changes; requiring insurers to annually submit a
20	specified report to the Office of Insurance Regulation
21	by a specified date; requiring the office to annually
22	compile certain data and prepare a report, make the
23	report publicly accessible on its website, and submit
24	the report to the Governor and the Legislature by a
25	specified date; amending s. 627.6699, F.S.; requiring
26	small employer carriers to comply with certain
27	requirements for prescription drug formulary changes;
28	amending s. 641.31, F.S.; providing an exception to
29	requirements relating to changes in a health

Page 1 of 11

58

39-00762-22 20221100 30 maintenance organization's group contract; requiring 31 health maintenance organizations to provide notice of 32 prescription drug formulary changes within a certain timeframe to current and prospective subscribers and 33 34 the subscribers' treating physicians; specifying requirements for the content of such notice and the 35 36 manner in which it must be provided; specifying 37 requirements for a notice of medical necessity 38 submitted by the treating physician; authorizing 39 health maintenance organizations to provide certain 40 means for submitting the notice of medical necessity; 41 requiring the commission to adopt a certain form by 42 rule by a specified date; specifying a coverage requirement and restrictions on coverage modification 43 44 by health maintenance organizations receiving a notice of medical necessity; providing construction and 45 46 applicability; requiring health maintenance 47 organizations to maintain a record of formulary changes; requiring health maintenance organizations to 48 49 annually submit a specified report to the office by a 50 specified date; requiring the office to annually 51 compile certain data and prepare a report, make the 52 report publicly accessible on its website, and submit 53 the report to the Governor and the Legislature by a 54 specified date; providing applicability; providing a 55 declaration of important state interest; providing an 56 effective date. 57

Page 2 of 11

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

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	39-00762-22 20221100
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60	Section 1. Section 627.42394, Florida Statutes, is created
61	to read:
62	627.42394 Health insurance policies; changes to
63	prescription drug formularies; requirements.—
64	(1) At least 60 days before the effective date of any
65	change to a prescription drug formulary during a policy year, an
66	insurer issuing individual or group health insurance policies in
67	this state shall notify:
68	(a) Current and prospective insureds of the change in the
69	formulary in a readily accessible format on the insurer's
70	website; and
71	(b) Any insured currently receiving coverage for a
72	prescription drug for which the formulary change modifies
73	coverage and the insured's treating physician. Such notification
74	must be sent electronically and by first-class mail and must
75	include information on the specific drugs involved and a
76	statement that the submission of a notice of medical necessity
77	by the insured's treating physician to the insurer at least 30
78	days before the effective date of the formulary change will
79	result in continuation of coverage at the existing level.
80	(2) The notice provided by the treating physician to the
81	insurer must include a completed one-page form in which the
82	treating physician certifies to the insurer that the
83	prescription drug for the insured is medically necessary as
84	defined under s. 627.732(2). The treating physician shall submit
85	the notice electronically or by first-class mail. The insurer
86	may provide the treating physician with access to an electronic
87	portal through which the treating physician may electronically

Page 3 of 11

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	39-00762-22 20221100
88	submit the notice. By January 1, 2023, the commission shall
89	adopt by rule a form for the notice.
90	(3) If the treating physician certifies to the insurer in
91	accordance with subsection (2) that the prescription drug is
92	medically necessary for the insured, the insurer:
93	(a) Must authorize coverage for the prescribed drug until
94	the end of the policy year, based solely on the treating
95	physician's certification that the drug is medically necessary;
96	and
97	(b) May not modify the coverage related to the covered drug
98	during the policy year by:
99	1. Increasing the out-of-pocket costs for the covered drug;
100	2. Moving the covered drug to a more restrictive tier;
101	3. Denying an insured coverage of the drug for which the
102	insured has been previously approved for coverage by the
103	insurer; or
104	4. Limiting or reducing coverage of the drug in any other
105	way, including subjecting it to a new prior authorization or
106	step-therapy requirement.
107	(4) Subsections (1), (2), and (3) do not:
108	(a) Prohibit the addition of prescription drugs to the list
109	of drugs covered under the policy during the policy year.
110	(b) Apply to a grandfathered health plan as defined in s.
111	<u>627.402 or to benefits specified in s. 627.6513(1)-(14).</u>
112	(c) Alter or amend s. 465.025, which provides conditions
113	under which a pharmacist may substitute a generically equivalent
114	drug product for a brand name drug product.
115	(d) Alter or amend s. 465.0252, which provides conditions
116	under which a pharmacist may dispense a substitute biological

Page 4 of 11

	39-00762-22 20221100
117	product for the prescribed biological product.
118	(e) Apply to a Medicaid managed care plan under part IV of
119	chapter 409.
120	(5) A health insurer shall maintain a record of any change
121	in its formulary during a calendar year. By March 1 annually, a
122	health insurer shall submit to the office a report delineating
123	such changes made in the previous calendar year. The annual
124	report must include, at a minimum:
125	(a) A list of all drugs removed from the formulary and the
126	reasons for the removal;
127	(b) A list of all drugs moved to a tier resulting in
128	additional out-of-pocket costs to insureds;
129	(c) The number of insureds notified by the insurer of a
130	change in the formulary; and
131	(d) The increased cost, by dollar amount, incurred by
132	insureds because of such change in the formulary.
133	(6) By May 1 annually, the office shall:
134	(a) Compile the data in such annual reports submitted by
135	health insurers and prepare a report summarizing the data
136	submitted;
137	(b) Make the report publicly accessible on its website; and
138	(c) Submit the report to the Governor, the President of the
139	Senate, and the Speaker of the House of Representatives.
140	Section 2. Paragraph (e) of subsection (5) of section
141	627.6699, Florida Statutes, is amended to read:
142	627.6699 Employee Health Care Access Act
143	(5) AVAILABILITY OF COVERAGE.—
144	(e) All health benefit plans issued under this section must
145	comply with the following conditions:

Page 5 of 11

39-00762-22 20221100 146 1. For employers who have fewer than two employees, a late 147 enrollee may be excluded from coverage for no longer than 24 148 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective 149 150 date of his or her new coverage. 2. Any requirement used by a small employer carrier in 151 152 determining whether to provide coverage to a small employer 153 group, including requirements for minimum participation of 154 eligible employees and minimum employer contributions, must be 155 applied uniformly among all small employer groups having the 156 same number of eligible employees applying for coverage or 157 receiving coverage from the small employer carrier, except that 158 a small employer carrier that participates in, administers, or 159 issues health benefits pursuant to s. 381.0406 which do not 160 include a preexisting condition exclusion may require as a 161 condition of offering such benefits that the employer has had no 162 health insurance coverage for its employees for a period of at 163 least 6 months. A small employer carrier may vary application of 164 minimum participation requirements and minimum employer 165 contribution requirements only by the size of the small employer 166 group. 167 3. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not 168 169 consider as an eligible employee employees or dependents who

170 have qualifying existing coverage in an employer-based group 171 insurance plan or an ERISA qualified self-insurance plan in 172 determining whether the applicable percentage of participation 173 is met. However, a small employer carrier may count eligible 174 employees and dependents who have coverage under another health

Page 6 of 11

39-00762-22 20221100 175 plan that is sponsored by that employer. 176 4. A small employer carrier shall not increase any requirement for minimum employee participation or any 177 178 requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been 179 180 accepted for coverage, unless the employer size has changed, in 181 which case the small employer carrier may apply the requirements 182 that are applicable to the new group size. 5. If a small employer carrier offers coverage to a small 183 employer, it must offer coverage to all the small employer's 184 185 eligible employees and their dependents. A small employer 186 carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late 187 enrollees. 188 189 6. A small employer carrier may not modify any health 190 benefit plan issued to a small employer with respect to a small 191 employer or any eligible employee or dependent through riders, 192 endorsements, or otherwise to restrict or exclude coverage for 193 certain diseases or medical conditions otherwise covered by the 194 health benefit plan. 195 7. An initial enrollment period of at least 30 days must be 196 provided. An annual 30-day open enrollment period must be 197 offered to each small employer's eligible employees and their 198 dependents. A small employer carrier must provide special 199 enrollment periods as required by s. 627.65615. 200 8. A small employer carrier shall comply with s. 627.42394 201 for any change to a prescription drug formulary. Section 3. Subsection (36) of section 641.31, Florida 202 203 Statutes, is amended to read:

Page 7 of 11

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	39-00762-22 20221100
204	641.31 Health maintenance contracts
205	(36) Except as provided in paragraphs (a), (b), and (c), a
206	health maintenance organization may increase the copayment for
207	any benefit, or delete, amend, or limit any of the benefits to
208	which a subscriber is entitled under the group contract only,
209	upon written notice to the contract holder at least 45 days in
210	advance of the time of coverage renewal. The health maintenance
211	organization may amend the contract with the contract holder,
212	with such amendment to be effective immediately at the time of
213	coverage renewal. The written notice to the contract holder \underline{must}
214	shall specifically identify any deletions, amendments, or
215	limitations to any of the benefits provided in the group
216	contract during the current contract period which will be
217	included in the group contract upon renewal. This subsection
218	does not apply to any increases in benefits. The 45-day notice
219	requirement <u>does</u> shall not apply if benefits are amended,
220	deleted, or limited at the request of the contract holder.
221	(a) At least 60 days before the effective date of any
222	change to a prescription drug formulary during a contract year,
223	a health maintenance organization shall notify:
224	1. Current and prospective subscribers of the change in the
225	formulary in a readily accessible format on the health
226	maintenance organization's website; and
227	2. Any subscriber currently receiving coverage for a
228	prescription drug for which the formulary change modifies
229	coverage and the subscriber's treating physician. Such
230	notification must be sent electronically and by first-class mail
231	and must include information on the specific drugs involved and
232	a statement that the submission of a notice of medical necessity

Page 8 of 11

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	39-00762-22 20221100
233	by the subscriber's treating physician to the health maintenance
234	organization at least 30 days before the effective date of the
235	formulary change will result in continuation of coverage at the
236	existing level.
237	(b) The notice provided by the treating physician to the
238	health maintenance organization must include a completed one-
239	page form in which the treating physician certifies to the
240	health maintenance organization that the prescription drug for
241	the subscriber is medically necessary as defined under s.
242	627.732(2). The treating physician shall submit the notice
243	electronically or by first-class mail. The health maintenance
244	organization may provide the treating physician with access to
245	an electronic portal through which the treating physician may
246	electronically submit the notice. By January 1, 2023, the
247	commission shall adopt by rule a form for the notice.
248	(c) If the treating physician certifies to the health
249	maintenance organization in accordance with paragraph (b) that
250	the prescription drug is medically necessary for the subscriber,
251	the health maintenance organization:
252	1. Must authorize coverage for the prescribed drug until
253	the end of the contract year, based solely on the treating
254	physician's certification that the drug is medically necessary;
255	and
256	2. May not modify the coverage related to the covered drug
257	during the contract year by:
258	a. Increasing the out-of-pocket costs for the covered drug;
259	b. Moving the covered drug to a more restrictive tier;
260	c. Denying a subscriber coverage of the drug for which the
261	subscriber has been previously approved for coverage by the

Page 9 of 11

	39-00762-22 20221100_
262	health maintenance organization; or
263	d. Limiting or reducing coverage of the drug in any other
264	way, including subjecting it to a new prior authorization or
265	step-therapy requirement.
266	(d) Paragraphs (a), (b), and (c) do not:
267	1. Prohibit the addition of prescription drugs to the list
268	of drugs covered under the contract during the contract year.
269	2. Apply to a grandfathered health plan as defined in s.
270	627.402 or to benefits specified in s. 627.6513(1)-(14).
271	3. Alter or amend s. 465.025, which provides conditions
272	under which a pharmacist may substitute a generically equivalent
273	drug product for a brand name drug product.
274	4. Alter or amend s. 465.0252, which provides conditions
275	under which a pharmacist may dispense a substitute biological
276	product for the prescribed biological product.
277	5. Apply to a Medicaid managed care plan under part IV of
278	chapter 409.
279	(e) A health maintenance organization shall maintain a
280	record of any change in its formulary during a calendar year. By
281	March 1 annually, a health maintenance organization shall submit
282	to the office a report delineating such changes made in the
283	previous calendar year. The annual report must include, at a
284	minimum:
285	1. A list of all drugs removed from the formulary and the
286	reasons for the removal;
287	2. A list of all drugs moved to a tier resulting in
288	additional out-of-pocket costs to subscribers;
289	3. The number of subscribers notified by the health
290	maintenance organization of a change in the formulary; and
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Page 10 of 11

	39-00762-22 20221100_
291	4. The increased cost, by dollar amount, incurred by
292	subscribers because of such change in the formulary.
293	(f) By May 1 annually, the office shall:
294	1. Compile the data in such annual reports submitted by
295	health maintenance organizations and prepare a report
296	summarizing the data submitted;
297	2. Make the report publicly accessible on its website; and
298	3. Submit the report to the Governor, the President of the
299	Senate, and the Speaker of the House of Representatives.
300	Section 4. This act applies to health insurance policies,
301	health benefit plans, and health maintenance contracts entered
302	into or renewed on or after January 1, 2023.
303	Section 5. The Legislature finds that this act fulfills an
304	important state interest.
305	Section 6. This act shall take effect January 1, 2023.

Page 11 of 11