

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 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

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30 maintenance organization's group contract; requiring
31 health maintenance organizations to provide notice of
32 prescription drug formulary changes within a certain
33 timeframe to current and prospective subscribers and
34 the subscribers' treating physicians; specifying
35 requirements for the content of such notice and the
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
43 requirement and restrictions on coverage modification
44 by health maintenance organizations receiving a notice
45 of medical necessity; providing construction and
46 applicability; requiring health maintenance
47 organizations to maintain a record of formulary
48 changes; requiring health maintenance organizations to
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.

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

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

627.42394 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 notify:

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

(b) Any insured currently receiving coverage for a prescription drug for which the formulary change modifies coverage and the insured's treating physician. Such notification must be sent electronically and by first-class mail and must include information on the specific drugs involved and a statement that the submission of a notice of medical necessity by the insured's treating physician to the insurer at least 30 days before the effective date of the formulary change will result in continuation of coverage at the existing level.

(2) The notice provided by the treating physician to the insurer must include a completed one-page form in which the treating physician certifies to the insurer that the prescription drug for the insured is medically necessary as defined in s. 627.732(2). The treating physician shall submit the notice electronically or by first-class mail. The insurer may provide the treating physician with access to an electronic portal through which the treating physician may electronically

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88 submit the notice. By January 1, 2024, 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.
111 627.402 or to benefits specified in s. 627.6513(1)-(14).

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

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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:

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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
149 continually to a date not more than 63 days before the effective
150 date of his or her new coverage.

151 2. Any requirement used by a small employer carrier in
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
168 respect to a small employer, a small employer carrier shall not
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

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175 plan that is sponsored by that employer.

176 4. A small employer carrier shall not increase any
177 requirement for minimum employee participation or any
178 requirement for minimum employer contribution applicable to a
179 small employer at any time after the small employer has been
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.

183 5. If a small employer carrier offers coverage to a small
184 employer, it must offer coverage to all the small employer's
185 eligible employees and their dependents. A small employer
186 carrier may not offer coverage limited to certain persons in a
187 group or to part of a group, except with respect to late
188 enrollees.

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.

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

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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 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 does ~~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

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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 in 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, 2024, 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

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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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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, 2024.

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, 2024.