1 A bill to be entitled
2 An act relating to consumer protection from nonmedical
3 changes to prescription drug formularies; amending s.
4 110.123, F.S.; providing that certain provisions
5 prohibiting nonmedical changes to prescription drug
6 formularies do not apply to the state group insurance
7 program; creating s. 627.42393, F.S.; limiting, under
8 specified circumstances, changes to a health insurance
9 policy prescription drug formulary during a policy
10 year; providing construction and applicability;
11 amending s. 627.6699, F.S.; requiring small employer
12 carriers to limit changes to prescription drug
13 formularies under certain circumstances; amending s.
14 641.31, F.S.; limiting, under specified circumstances,
15 changes to a health maintenance contract prescription
16 drug formulary during a contract year; providing
17 construction and applicability; providing a
18 declaration of important state interest; providing an
19 effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Paragraph (k) is added to subsection (3) of
24 section 110.123, Florida Statutes, to read:
25 110.123 State group insurance program.—

26 (3) STATE GROUP INSURANCE PROGRAM.—
27 (k) Sections 627.42393 and 641.31(36)(a) do not apply to
28 the state group insurance program.
29 Section 2. Section 627.42393, Florida Statutes, is created
30 to read:
31 627.42393 Insurance policies; limiting changes to
32 prescription drug formularies.—
33 (1) Other than at the time of coverage renewal, an
34 individual or group insurance policy that is delivered, issued
35 for delivery, renewed, amended, or continued in this state and
36 that provides medical, major medical, or similar comprehensive
37 coverage may not:
38 (a) Remove a covered prescription drug from its list of
39 covered drugs during the policy year unless the United States
40 Food and Drug Administration has issued a statement about the
41 drug which calls into question the clinical safety of the drug,
42 or the manufacturer of the drug has notified the United States
43 Food and Drug Administration of a manufacturing discontinuance
44 or potential discontinuance of the drug as required by s. 506C
45 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. s. 356c.
46 (b) Reclassify a drug to a more restrictive drug tier or
47 increase the amount that an insured must pay for a copayment,
48 coinsurance, or deductible for prescription drug benefits, or
49 reclassify a drug to a higher cost-sharing tier during the
50 policy year.

51 (2) This section does not prohibit the addition of
52 prescription drugs to the list of drugs covered under the policy
53 during the policy year.
54 (3) This section does not apply to a grandfathered health
55 plan as defined in s. 627.402 or to benefits set forth in s.
56 627.6513(1)-(14).
57 (4) This section does not alter or amend s. 465.025, which
58 provides conditions under which a pharmacist may substitute a
59 generically equivalent drug product for a brand name drug
60 product.
61 (5) This section does not alter or amend s. 465.0252,
62 which provides conditions under which a pharmacist may dispense
63 a substitute biological product for the prescribed biological
64 product.
65 Section 3. Paragraph (e) of subsection (5) of section
66 627.6699, Florida Statutes, is amended to read:
67 627.6699 Employee Health Care Access Act.—
68 (5) AVAILABILITY OF COVERAGE.—
69 (e) All health benefit plans issued under this section
70 must comply with the following conditions:
71 1. For employers who have fewer than two employees, a late
72 enrollee may be excluded from coverage for no longer than 24
73 months if he or she was not covered by creditable coverage
74 continually to a date not more than 63 days before the effective
75 date of his or her new coverage.

76 2. Any requirement used by a small employer carrier in
77 determining whether to provide coverage to a small employer
78 group, including requirements for minimum participation of
79 eligible employees and minimum employer contributions, must be
80 applied uniformly among all small employer groups having the
81 same number of eligible employees applying for coverage or
82 receiving coverage from the small employer carrier, except that
83 a small employer carrier that participates in, administers, or
84 issues health benefits pursuant to s. 381.0406 which do not
85 include a preexisting condition exclusion may require as a
86 condition of offering such benefits that the employer has had no
87 health insurance coverage for its employees for a period of at
88 least 6 months. A small employer carrier may vary application of
89 minimum participation requirements and minimum employer
90 contribution requirements only by the size of the small employer
91 group.
92 3. In applying minimum participation requirements with
93 respect to a small employer, a small employer carrier shall not
94 consider as an eligible employee employees or dependents who
95 have qualifying existing coverage in an employer-based group
96 insurance plan or an ERISA qualified self-insurance plan in
97 determining whether the applicable percentage of participation
98 is met. However, a small employer carrier may count eligible
99 employees and dependents who have coverage under another health
100 plan that is sponsored by that employer.

101 4. A small employer carrier shall not increase any
102 requirement for minimum employee participation or any
103 requirement for minimum employer contribution applicable to a
104 small employer at any time after the small employer has been
105 accepted for coverage, unless the employer size has changed, in
106 which case the small employer carrier may apply the requirements
107 that are applicable to the new group size.
108 5. If a small employer carrier offers coverage to a small
109 employer, it must offer coverage to all the small employer's
110 eligible employees and their dependents. A small employer
111 carrier may not offer coverage limited to certain persons in a
112 group or to part of a group, except with respect to late
113 enrollees.
114 6. A small employer carrier may not modify any health
115 benefit plan issued to a small employer with respect to a small
116 employer or any eligible employee or dependent through riders,
117 endorsements, or otherwise to restrict or exclude coverage for
118 certain diseases or medical conditions otherwise covered by the
119 health benefit plan.
120 7. An initial enrollment period of at least 30 days must
121 be provided. An annual 30-day open enrollment period must be
122 offered to each small employer's eligible employees and their
123 dependents. A small employer carrier must provide special
124 enrollment periods as required by s. 627.65615.
125 8. A small employer carrier must limit changes to

126 prescription drug formularies as required by s. 627.42393.
127 Section 4. Subsection (36) of section 641.31, Florida
128 Statutes, is amended to read:
129 641.31 Health maintenance contracts.—
130 (36) A health maintenance organization may increase the
131 copayment for any benefit, or delete, amend, or limit any of the
132 benefits to which a subscriber is entitled under the group
133 contract only, upon written notice to the contract holder at
134 least 45 days in advance of the time of coverage renewal. The
135 health maintenance organization may amend the contract with the
136 contract holder, with such amendment to be effective immediately
137 at the time of coverage renewal. The written notice to the
138 contract holder must ~~shall~~ specifically identify any deletions,
139 amendments, or limitations to any of the benefits provided in
140 the group contract during the current contract period which will
141 be included in the group contract upon renewal. This subsection
142 does not apply to any increases in benefits. The 45-day notice
143 requirement does ~~shall~~ not apply if benefits are amended,
144 deleted, or limited at the request of the contract holder.
145 (a) Other than at the time of coverage renewal, a health
146 maintenance organization that provides medical, major medical,
147 or similar comprehensive coverage may not:
148 1. Remove a covered prescription drug from its list of
149 covered drugs during the contract year unless the United States
150 Food and Drug Administration has issued a statement about the

151 drug which calls into question the clinical safety of the drug,
152 or the manufacturer of the drug has notified the United States
153 Food and Drug Administration of a manufacturing discontinuance
154 or potential discontinuance of the drug as required by s. 506C
155 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. s. 356c.
156 2. Reclassify a drug to a more restrictive drug tier or
157 increase the amount that an insured must pay for a copayment,
158 coinsurance, or deductible for prescription drug benefits, or
159 reclassify a drug to a higher cost-sharing tier during the
160 contract year.
161 (b) This subsection does not:
162 1. Prohibit the addition of prescription drugs to the list
163 of drugs covered during the contract year.
164 2. Apply to a grandfathered health plan as defined in s.
165 627.402 or to benefits set forth in s. 627.6513(1)-(14).
166 3. Alter or amend s. 465.025, which provides conditions
167 under which a pharmacist may substitute a generically equivalent
168 drug product for a brand name drug product.
169 4. Alter or amend s. 465.0252, which provides conditions
170 under which a pharmacist may dispense a substitute biological
171 product for the prescribed biological product.
172 Section 5. The Legislature finds that this act fulfills an
173 important state interest.
174 Section 6. This act shall take effect January 1, 2018.

CODING: Words stricken are deletions; words underlined are additions.