

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 making technical changes; amending s. 641.31, F.S.;
29 providing an exception to requirements relating to

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

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

63 627.42394 Health insurance policies; changes to
64 prescription drug formularies; requirements.—

65 (1) At least 60 days before the effective date of any
66 change to a prescription drug formulary during a policy year, an
67 insurer issuing individual or group health insurance policies in
68 this state shall make all of the following notifications:

69 (a) A notification to current and prospective insureds of
70 the change in the formulary, in a readily accessible format on
71 the insurer's website.

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

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

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88 portal through which the treating physician may electronically
89 submit the notice. By January 1, 2025, the commission shall
90 adopt by rule a form for the notice.

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

94 (a) Must authorize coverage for the prescribed drug until
95 the end of the policy year, based solely on the treating
96 physician's certification that the drug is medically necessary;
97 and

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

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

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

102 3. Denying an insured coverage of the drug for which the
103 insured has been previously approved by the 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.

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, at a minimum, include all of the following:

125 (a) A list of all drugs removed from the formulary and the
126 reasons for each 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.

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 do all of the
134 following:

135 (a) Compile the data in the annual reports submitted by
136 health insurers and prepare a report summarizing the data
137 submitted.

138 (b) Make the report publicly accessible on its website.

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

141 Section 2. Paragraph (e) of subsection (5) of section
142 627.6699, Florida Statutes, is amended to read:

143 627.6699 Employee Health Care Access Act.—

144 (5) AVAILABILITY OF COVERAGE.—

145 (e) All health benefit plans issued under this section must

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146 comply with the following conditions:

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

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

168 3. In applying minimum participation requirements with
169 respect to a small employer, a small employer carrier may ~~shall~~
170 not consider as an eligible employee employees or dependents who
171 have qualifying existing coverage in an employer-based group
172 insurance plan or an ERISA qualified self-insurance plan in
173 determining whether the applicable percentage of participation
174 is met. However, a small employer carrier may count eligible

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175 employees and dependents who have coverage under another health
176 plan that is sponsored by that employer.

177 4. A small employer carrier may ~~shall~~ not increase any
178 requirement for minimum employee participation or any
179 requirement for minimum employer contribution applicable to a
180 small employer at any time after the small employer has been
181 accepted for coverage, unless the employer size has changed, in
182 which case the small employer carrier may apply the requirements
183 that are applicable to the new group size.

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

190 6. A small employer carrier may not modify any health
191 benefit plan issued to a small employer with respect to a small
192 employer or any eligible employee or dependent through riders,
193 endorsements, or otherwise to restrict or exclude coverage for
194 certain diseases or medical conditions otherwise covered by the
195 health benefit plan.

196 7. An initial enrollment period of at least 30 days must be
197 provided. An annual 30-day open enrollment period must be
198 offered to each small employer's eligible employees and their
199 dependents. A small employer carrier must provide special
200 enrollment periods as required by s. 627.65615.

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

203 Section 3. Subsection (36) of section 641.31, Florida

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204 Statutes, is amended to read:

205 641.31 Health maintenance contracts.—

206 (36) Except as provided in paragraphs (a), (b), and (c), a
207 health maintenance organization may increase the copayment for
208 any benefit, or delete, amend, or limit any of the benefits to
209 which a subscriber is entitled under the group contract only,
210 upon written notice to the contract holder at least 45 days in
211 advance of the time of coverage renewal. The health maintenance
212 organization may amend the contract with the contract holder,
213 with such amendment to be effective immediately at the time of
214 coverage renewal. The written notice to the contract holder must
215 ~~shall~~ specifically identify any deletions, amendments, or
216 limitations to any of the benefits provided in the group
217 contract during the current contract period which will be
218 included in the group contract upon renewal. This subsection
219 does not apply to any increase ~~increases~~ in benefits. The 45-day
220 notice requirement does ~~shall~~ not apply if benefits are amended,
221 deleted, or limited at the request of the contract holder.

222 (a) At least 60 days before the effective date of any
223 change to a prescription drug formulary during a contract year,
224 a health maintenance organization shall make all of the
225 following notifications:

226 1. A notification to current and prospective subscribers of
227 the change in the formulary, in a readily accessible format on
228 the health maintenance organization's website.

229 2. A notification to any subscriber currently receiving
230 coverage for a prescription drug for which the formulary change
231 modifies coverage and the subscriber's treating physician. Such
232 notification must be sent electronically and by first-class mail

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233 and must include information on the specific drugs involved and
234 a statement that the submission of a notice of medical necessity
235 by the subscriber's treating physician to the health maintenance
236 organization at least 30 days before the effective date of the
237 formulary change will result in continuation of coverage at the
238 existing level.

239 (b) The notice provided by the treating physician to the
240 health maintenance organization must include a completed one-
241 page form in which the treating physician certifies to the
242 health maintenance organization that the prescription drug for
243 the subscriber is medically necessary as defined in s.
244 627.732(2). The treating physician shall submit the notice
245 electronically or by first-class mail. The health maintenance
246 organization may provide the treating physician with access to
247 an electronic portal through which the treating physician may
248 electronically submit the notice. By January 1, 2025, the
249 commission shall adopt by rule a form for the notice.

250 (c) If the treating physician certifies to the health
251 maintenance organization in accordance with paragraph (b) that
252 the prescription drug is medically necessary for the subscriber,
253 the health maintenance organization:

254 1. Must authorize coverage for the prescribed drug until
255 the end of the contract year, based solely on the treating
256 physician's certification that the drug is medically necessary;
257 and

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

- 260 a. Increasing the out-of-pocket costs for the covered drug;
261 b. Moving the covered drug to a more restrictive tier;

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262 c. Denying a subscriber coverage of the drug for which the
263 subscriber has been previously approved by the health
264 maintenance organization; or

265 d. Limiting or reducing coverage of the drug in any other
266 way, including subjecting it to a new prior authorization or
267 step-therapy requirement.

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

269 1. Prohibit the addition of prescription drugs to the list
270 of drugs covered under the contract during the contract year.

271 2. Apply to a grandfathered health plan as defined in s.
272 627.402 or to benefits specified in s. 627.6513.

273 3. Alter or amend s. 465.025, which provides conditions
274 under which a pharmacist may substitute a generically equivalent
275 drug product for a brand name drug product.

276 4. Alter or amend s. 465.0252, which provides conditions
277 under which a pharmacist may dispense a substitute biological
278 product for the prescribed biological product.

279 5. Apply to a Medicaid managed care plan under part IV of
280 chapter 409.

281 (e) A health maintenance organization shall maintain a
282 record of any change in its formulary during a calendar year. By
283 March 1 annually, a health maintenance organization shall submit
284 to the office a report delineating such changes made in the
285 previous calendar year. The annual report must, at a minimum,
286 include all of the following:

287 1. A list of all drugs removed from the formulary and the
288 reasons for each removal.

289 2. A list of all drugs moved to a tier resulting in
290 additional out-of-pocket costs to subscribers.

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291 3. The number of subscribers notified by the health
292 maintenance organization of a change in the formulary.

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

295 (f) By May 1 annually, the office shall do all of the
296 following:

297 1. Compile the data in the annual reports submitted by
298 health maintenance organizations and prepare a report
299 summarizing the data submitted.

300 2. Make the report publicly accessible on its website.

301 3. Submit the report to the Governor, the President of the
302 Senate, and the Speaker of the House of Representatives.

303 Section 4. This act applies to health insurance policies,
304 health benefit plans, and health maintenance contracts entered
305 into or renewed on or after January 1, 2025.

306 Section 5. The Legislature finds that this act fulfills an
307 important state interest.

308 Section 6. This act shall take effect January 1, 2025.