

By Senator Rodriguez

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1 A bill to be entitled
2 An act relating to insurer disclosures on prescription
3 drug coverage; creating s. 627.42394, F.S.; requiring
4 individual and group health insurers to provide notice
5 of prescription drug formulary changes within a
6 certain timeframe to current and prospective insureds
7 and the insureds' treating physicians; specifying
8 requirements for the content of such notice and the
9 manner in which it must be provided; specifying
10 requirements for a notice of medical necessity
11 submitted by the treating physician; authorizing
12 insurers to provide certain means for submitting the
13 notice of medical necessity; requiring the Financial
14 Services Commission to adopt a certain form by rule by
15 a specified date; specifying a coverage requirement
16 and restrictions on coverage modification by insurers
17 receiving a notice of medical necessity; providing
18 construction and applicability; requiring insurers to
19 maintain a record of formulary changes; requiring
20 insurers to annually submit a specified report to the
21 Office of Insurance Regulation by a specified date;
22 requiring the office to annually compile certain data
23 and prepare a report, make the report publicly
24 accessible on its website, and submit the report to
25 the Governor and the Legislature by a specified date;
26 creating s. 627.6383, F.S.; defining the term "cost-
27 sharing requirement"; requiring specified individual
28 health insurers and their pharmacy benefit managers to
29 apply payments for prescription drugs by or on behalf

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30 of insureds toward the total contributions of the
31 insureds' cost-sharing requirements under certain
32 circumstances; providing construction; requiring
33 specified individual health insurers to maintain
34 records of certain third-party payments for
35 prescription drugs; providing reporting requirements;
36 providing requirements for the reports; providing
37 applicability; amending s. 627.6385, F.S.; providing
38 disclosure requirements; providing applicability;
39 amending s. 627.64741, F.S.; requiring specified
40 contracts to require pharmacy benefit managers to
41 apply payments by or on behalf of insureds toward the
42 insureds' total contributions to cost-sharing
43 requirements; providing applicability; providing
44 disclosure requirements; creating s. 627.65715, F.S.;
45 defining the term "cost-sharing requirement";
46 requiring specified group health insurers and their
47 pharmacy benefit managers to apply payments for
48 prescription drugs by or on behalf of insureds toward
49 the total contributions of the insureds' cost-sharing
50 requirements under certain circumstances; providing
51 construction; providing disclosure requirements;
52 requiring specified group health insurers to maintain
53 records of certain third-party payments for
54 prescription drugs; providing reporting requirements;
55 providing requirements for the reports; providing
56 applicability; amending s. 627.6572, F.S.; requiring
57 specified contracts to require pharmacy benefit
58 managers to apply payments by or on behalf of insureds

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59 toward the insureds' total contributions to cost-
60 sharing requirements; providing applicability;
61 providing disclosure requirements; amending s.
62 627.6699, F.S.; requiring small employer carriers to
63 comply with certain requirements for prescription drug
64 formulary changes; amending s. 641.31, F.S.; providing
65 an exception to requirements relating to changes in a
66 health maintenance organization's group contract;
67 requiring health maintenance organizations to provide
68 notice of prescription drug formulary changes within a
69 certain timeframe to current and prospective
70 subscribers and the subscribers' treating physicians;
71 specifying requirements for the content of such notice
72 and the manner in which it must be provided;
73 specifying requirements for a notice of medical
74 necessity submitted by the treating physician;
75 authorizing health maintenance organizations to
76 provide certain means for submitting the notice of
77 medical necessity; requiring the commission to adopt a
78 certain form by rule by a specified date; specifying a
79 coverage requirement and restrictions on coverage
80 modification by health maintenance organizations
81 receiving a notice of medical necessity; providing
82 construction and applicability; requiring health
83 maintenance organizations to maintain a record of
84 formulary changes; requiring health maintenance
85 organizations to annually submit a specified report to
86 the office by a specified date; requiring the office
87 to annually compile certain data and prepare a report,

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88 make the report publicly accessible on its website,
89 and submit the report to the Governor and the
90 Legislature by a specified date; defining the term
91 "cost-sharing requirement"; requiring specified health
92 maintenance organizations and their pharmacy benefit
93 managers to apply payments for prescription drugs by
94 or on behalf of subscribers toward the total
95 contributions of the subscribers' cost-sharing
96 requirements under certain circumstances; providing
97 construction; providing disclosure requirements;
98 requiring specified health maintenance organizations
99 to maintain records of certain third-party payments
100 for prescription drugs; providing reporting
101 requirements; providing requirements for the reports;
102 providing applicability; amending s. 641.314, F.S.;
103 requiring specified contracts to require pharmacy
104 benefit managers to apply payments by or on behalf of
105 subscribers toward the subscribers' total
106 contributions to cost-sharing requirements; providing
107 applicability; providing disclosure requirements;
108 amending s. 409.967, F.S.; conforming a cross-
109 reference; amending s. 641.185, F.S.; conforming a
110 provision to changes made by the act; providing
111 applicability; providing a declaration of important
112 state interest; providing an effective date.

113
114 Be It Enacted by the Legislature of the State of Florida:

115
116 Section 1. Section 627.42394, Florida Statutes, is created

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117 to read:

118 627.42394 Health insurance policies; changes to
119 prescription drug formularies; requirements.-

120 (1) At least 60 days before the effective date of any
121 change to a prescription drug formulary during a policy year, an
122 insurer issuing individual or group health insurance policies in
123 the state shall notify:

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

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

136 (2) The notice provided by the treating physician to the
137 insurer must include a completed one-page form in which the
138 treating physician certifies to the insurer that the
139 prescription drug for the insured is medically necessary as
140 defined in s. 627.732(2). The treating physician shall submit
141 the notice electronically or by first-class mail. The insurer
142 may provide the treating physician with access to an electronic
143 portal through which the treating physician may electronically
144 submit the notice. By January 1, 2026, the commission shall
145 adopt by rule a form for the notice.

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

149 (a) Must authorize coverage for the prescribed drug until
150 the end of the policy year, based solely on the treating
151 physician's certification that the drug is medically necessary;
152 and

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

- 155 1. Increasing the out-of-pocket costs for the covered drug;
- 156 2. Moving the covered drug to a more restrictive tier;
- 157 3. Denying an insured coverage of the drug for which the
158 insured has been previously approved for coverage by the
159 insurer; or
- 160 4. Limiting or reducing coverage of the drug in any other
161 way, including subjecting it to a new prior authorization or
162 step-therapy requirement.

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

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

166 (b) Apply to a grandfathered health plan as defined in s.
167 627.402 or to benefits specified in s. 627.6513(1)-(14).

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

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

174 (e) Apply to a Medicaid managed care plan under part IV of

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175 chapter 409.

176 (5) A health insurer shall maintain a record of any change
177 in its formulary during a calendar year. By March 1 of each
178 year, a health insurer shall submit to the office a report
179 delineating such changes made in the previous calendar year. The
180 annual report must include, at a minimum:

181 (a) A list of all drugs removed from the formulary, along
182 with the date of the removal and the reasons for the removal.

183 (b) A list of all drugs moved to a tier resulting in
184 additional out-of-pocket costs to insureds.

185 (c) The number of insureds impacted by a change in the
186 formulary.

187 (d) The number of insureds notified by the insurer of a
188 change in the formulary.

189 (e) The increased cost, by dollar amount, incurred by
190 insureds because of such change in the formulary.

191 (6) By May 1 of each year, the office shall:

192 (a) Compile the data in the annual reports submitted by
193 health insurers under subsection (5) and prepare a report
194 summarizing the data submitted.

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

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

198 Section 2. Section 627.6383, Florida Statutes, is created
199 to read:

200 627.6383 Cost-sharing requirements.—

201 (1) As used in this section, the term "cost-sharing
202 requirement" means a dollar limit, a deductible, a copayment,
203 coinsurance, or any other out-of-pocket expense imposed on an

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204 insured, including, but not limited to, the annual limitation on
205 cost sharing subject to 42 U.S.C. s. 18022.

206 (2) (a) Each health insurer issuing, delivering, or renewing
207 a policy in this state which provides prescription drug
208 coverage, or each pharmacy benefit manager on behalf of such
209 health insurer, shall apply any amount paid for a prescription
210 drug by an insured or by another person on behalf of the insured
211 toward the insured's total contribution to any cost-sharing
212 requirement, if the prescription drug:

213 1. Does not have a generic equivalent; or

214 2. Has a generic equivalent and the insured has obtained
215 authorization for the prescription drug through any of the
216 following:

217 a. Prior authorization from the health insurer or pharmacy
218 benefit manager.

219 b. A step-therapy protocol.

220 c. The exception or appeal process of the health insurer or
221 pharmacy benefit manager.

222 (b) The amount paid by or on behalf of the insured which is
223 applied toward the insured's total contribution to any cost-
224 sharing requirement under paragraph (a) includes, but is not
225 limited to, any payment with or any discount through financial
226 assistance, a manufacturer copay card, a product voucher, or any
227 other reduction in out-of-pocket expenses made by or on behalf
228 of the insured for a prescription drug.

229 (c)1. Each health insurer issuing, delivering, or renewing
230 a policy in this state which provides prescription drug
231 coverage, regardless of whether the prescription drug benefits
232 are administered or managed by the insurer or by a pharmacy

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233 benefit manager on behalf of the insurer, shall maintain a
234 record of any third-party payments, made or remitted on behalf
235 of an insured, for prescription drugs, which are not applied to
236 the insured's out-of-pocket obligations, including, but not
237 limited to, deductibles, copayments, or coinsurance.

238 2. By March 1 of each year, each health insurer issuing,
239 delivering, or renewing a policy in this state which provides
240 prescription drug coverage, regardless of whether the
241 prescription drug benefits are administered or managed by the
242 insurer or by a pharmacy benefit manager on behalf of the
243 insurer, shall submit to the office a report delineating third-
244 party payments, as described in subparagraph 1., which were
245 received in the previous calendar year. The annual report must
246 include, at a minimum:

247 a. A list of all payments received by the health insurer,
248 as described in subparagraph 1., made or remitted by a third
249 party, which must include:

250 (I) The date each payment was made.

251 (II) The prescription drug for which the payment was made.

252 (III) The reason that the payment was not applied to the
253 insured's out-of-pocket obligations.

254 b. The total amount of payments received by the health
255 insurer which were not applied to an insured's out-of-pocket
256 maximum.

257 c. The total number of insureds for which a payment was
258 made which was not applied to an out-of-pocket maximum.

259 d. Whether such payments were returned to the third party
260 who submitted the payment.

261 e. The total amount of payments which were not returned to

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262 the third party who submitted the payment.

263 (3) This section applies to any health insurance policy
264 issued, delivered, or renewed in this state on or after January
265 1, 2026.

266 Section 3. Subsections (2) and (3) of section 627.6385,
267 Florida Statutes, are renumbered as subsections (3) and (4),
268 respectively, present subsection (2) of that section is amended,
269 and a new subsection (2) is added to that section, to read:

270 627.6385 Disclosures to policyholders; calculations of cost
271 sharing.—

272 (2) Each health insurer issuing, delivering, or renewing a
273 policy in this state which provides prescription drug coverage,
274 regardless of whether the prescription drug benefits are
275 administered or managed by the health insurer or by a pharmacy
276 benefit manager on behalf of the health insurer, shall disclose
277 on its website that any amount paid by a policyholder or by
278 another person on behalf of the policyholder must be applied
279 toward the policyholder's total contribution to any cost-sharing
280 requirement pursuant to s. 627.6383. This subsection applies to
281 any policy issued, delivered, or renewed in this state on or
282 after January 1, 2026.

283 (3)~~(2)~~ Each health insurer shall include in every policy
284 delivered or issued for delivery to any person in this ~~the~~ state
285 or in materials provided as required by s. 627.64725 a notice
286 that the information required by this section is available
287 electronically and the website address ~~of the website~~ where the
288 information can be accessed. In addition, each health insurer
289 issuing, delivering, or renewing a policy in this state which
290 provides prescription drug coverage, regardless of whether the

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291 prescription drug benefits are administered or managed by the
292 health insurer or by a pharmacy benefit manager on behalf of the
293 health insurer, shall disclose in every policy that is issued,
294 delivered, or renewed to any person in this state on or after
295 January 1, 2026, that any amount paid by a policyholder or by
296 another person on behalf of the policyholder must be applied
297 toward the policyholder's total contribution to any cost-sharing
298 requirement pursuant to s. 627.6383.

299 Section 4. Paragraph (c) is added to subsection (2) of
300 section 627.64741, Florida Statutes, to read:

301 627.64741 Pharmacy benefit manager contracts.—

302 (2) In addition to the requirements of part VII of chapter
303 626, a contract between a health insurer and a pharmacy benefit
304 manager must require that the pharmacy benefit manager:

305 (c)1. Apply any amount paid by an insured or by another
306 person on behalf of the insured toward the insured's total
307 contribution to any cost-sharing requirement pursuant to s.
308 627.6383. This subparagraph applies to any insured whose
309 insurance policy is issued, delivered, or renewed in this state
310 on or after January 1, 2026.

311 2. Disclose to every insured whose insurance policy is
312 issued, delivered, or renewed in this state on or after January
313 1, 2026, that the pharmacy benefit manager shall apply any
314 amount paid by the insured or by another person on behalf of the
315 insured toward the insured's total contribution to any cost-
316 sharing requirement pursuant to s. 627.6383.

317 Section 5. Section 627.65715, Florida Statutes, is created
318 to read:

319 627.65715 Cost-sharing requirements.—

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320 (1) As used in this section, the term "cost-sharing
321 requirement" means a dollar limit, a deductible, a copayment,
322 coinsurance, or any other out-of-pocket expense imposed on an
323 insured, including, but not limited to, the annual limitation on
324 cost sharing subject to 42 U.S.C. s. 18022.

325 (2) (a) Each insurer issuing, delivering, or renewing a
326 policy in this state which provides prescription drug coverage,
327 or each pharmacy benefit manager on behalf of such insurer,
328 shall apply any amount paid for a prescription drug by an
329 insured or by another person on behalf of the insured toward the
330 insured's total contribution to any cost-sharing requirement, if
331 the prescription drug:

332 1. Does not have a generic equivalent; or

333 2. Has a generic equivalent and the insured has obtained
334 authorization for the prescription drug through any of the
335 following:

336 a. Prior authorization from the health insurer or pharmacy
337 benefit manager.

338 b. A step-therapy protocol.

339 c. The exception or appeal process of the health insurer or
340 pharmacy benefit manager.

341 (b) The amount paid by or on behalf of the insured which is
342 applied toward the insured's total contribution to any cost-
343 sharing requirement under paragraph (a) includes, but is not
344 limited to, any payment with or any discount through financial
345 assistance, a manufacturer copay card, a product voucher, or any
346 other reduction in out-of-pocket expenses made by or on behalf
347 of the insured for a prescription drug.

348 (3) (a) Each insurer issuing, delivering, or renewing a

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349 policy in this state which provides prescription drug coverage,
350 regardless of whether the prescription drug benefits are
351 administered or managed by the insurer or by a pharmacy benefit
352 manager on behalf of the insurer, shall disclose on its website
353 and in every policy issued, delivered, or renewed in this state
354 on or after January 1, 2026, that any amount paid by an insured
355 or by another person on behalf of the insured must be applied
356 toward the insured's total contribution to any cost-sharing
357 requirement.

358 (b)1. Each health insurer issuing, delivering, or renewing
359 a policy in this state which provides prescription drug
360 coverage, regardless of whether the prescription drug benefits
361 are administered or managed by the insurer or by a pharmacy
362 benefit manager on behalf of the insurer, shall maintain a
363 record of any third-party payments, made or remitted on behalf
364 of an insured, for prescription drugs, which are not applied to
365 the insured's out-of-pocket obligations, including, but not
366 limited to, deductibles, copayments, or coinsurance.

367 2. By March 1 of each year, each health insurer issuing,
368 delivering, or renewing a policy in this state which provides
369 prescription drug coverage, regardless of whether the
370 prescription drug benefits are administered or managed by the
371 insurer or by a pharmacy benefit manager on behalf of the
372 insurer, shall submit to the office a report delineating third-
373 party payments, as described in subparagraph 1., which were
374 received in the previous calendar year. The annual report must
375 include, at a minimum:

376 a. A list of all payments received by the health insurer,
377 as described in subparagraph 1., made or remitted by a third

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378 party, which must include:

379 (I) The date each payment was made.

380 (II) The prescription drug for which the payment was made.

381 (III) The reason that the payment was not applied to the
382 insured's out-of-pocket obligations.

383 b. The total amount of payments received by the health
384 insurer which were not applied to an insured's out-of-pocket
385 maximum.

386 c. The total number of insureds for which a payment was
387 made which was not applied to an out-of-pocket maximum.

388 d. Whether such payments were returned to the third party
389 who submitted the payment.

390 e. The total amount of payments which were not returned to
391 the third party who submitted the payment.

392 (4) This section applies to any group health insurance
393 policy issued, delivered, or renewed in this state on or after
394 January 1, 2026.

395 Section 6. Paragraph (c) is added to subsection (2) of
396 section 627.6572, Florida Statutes, to read:

397 627.6572 Pharmacy benefit manager contracts.—

398 (2) In addition to the requirements of part VII of chapter
399 626, a contract between a health insurer and a pharmacy benefit
400 manager must require that the pharmacy benefit manager:

401 (c)1. Apply any amount paid by an insured or by another
402 person on behalf of the insured toward the insured's total
403 contribution to any cost-sharing requirement pursuant to s.
404 627.65715. This subparagraph applies to any insured whose
405 insurance policy is issued, delivered, or renewed in this state
406 on or after January 1, 2026.

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407 2. Disclose to every insured whose insurance policy is
408 issued, delivered, or renewed in this state on or after January
409 1, 2026, that the pharmacy benefit manager shall apply any
410 amount paid by the insured or by another person on behalf of the
411 insured toward the insured's total contribution to any cost-
412 sharing requirement pursuant to s. 627.65715.

413 Section 7. Paragraph (e) of subsection (5) of section
414 627.6699, Florida Statutes, is amended to read:

415 627.6699 Employee Health Care Access Act.—

416 (5) AVAILABILITY OF COVERAGE.—

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

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

424 2. Any requirement used by a small employer carrier in
425 determining whether to provide coverage to a small employer
426 group, including requirements for minimum participation of
427 eligible employees and minimum employer contributions, must be
428 applied uniformly among all small employer groups having the
429 same number of eligible employees applying for coverage or
430 receiving coverage from the small employer carrier, except that
431 a small employer carrier that participates in, administers, or
432 issues health benefits pursuant to s. 381.0406 which do not
433 include a preexisting condition exclusion may require as a
434 condition of offering such benefits that the employer has had no
435 health insurance coverage for its employees for a period of at

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436 least 6 months. A small employer carrier may vary application of
437 minimum participation requirements and minimum employer
438 contribution requirements only by the size of the small employer
439 group.

440 3. In applying minimum participation requirements with
441 respect to a small employer, a small employer carrier may ~~shall~~
442 not consider as an eligible employee employees or dependents who
443 have qualifying existing coverage in an employer-based group
444 insurance plan or an ERISA qualified self-insurance plan in
445 determining whether the applicable percentage of participation
446 is met. However, a small employer carrier may count eligible
447 employees and dependents who have coverage under another health
448 plan that is sponsored by that employer.

449 4. A small employer carrier may ~~shall~~ not increase any
450 requirement for minimum employee participation or any
451 requirement for minimum employer contribution applicable to a
452 small employer at any time after the small employer has been
453 accepted for coverage, unless the employer size has changed, in
454 which case the small employer carrier may apply the requirements
455 that are applicable to the new group size.

456 5. If a small employer carrier offers coverage to a small
457 employer, it must offer coverage to all the small employer's
458 eligible employees and their dependents. A small employer
459 carrier may not offer coverage limited to certain persons in a
460 group or to part of a group, except with respect to late
461 enrollees.

462 6. A small employer carrier may not modify any health
463 benefit plan issued to a small employer with respect to a small
464 employer or any eligible employee or dependent through riders,

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465 endorsements, or otherwise to restrict or exclude coverage for
466 certain diseases or medical conditions otherwise covered by the
467 health benefit plan.

468 7. An initial enrollment period of at least 30 days must be
469 provided. An annual 30-day open enrollment period must be
470 offered to each small employer's eligible employees and their
471 dependents. A small employer carrier must provide special
472 enrollment periods as required by s. 627.65615.

473 8. A small employer carrier shall comply with s. 627.65715
474 for any change to a prescription drug formulary.

475 Section 8. Subsection (36) of section 641.31, Florida
476 Statutes, is amended, and subsection (48) is added to that
477 section, to read:

478 641.31 Health maintenance contracts.—

479 (36) Except as provided in paragraphs (a), (b), and (c), a
480 health maintenance organization may increase the copayment for
481 any benefit, or delete, amend, or limit any of the benefits to
482 which a subscriber is entitled under the group contract only,
483 upon written notice to the contract holder at least 45 days in
484 advance of the time of coverage renewal. The health maintenance
485 organization may amend the contract with the contract holder,
486 with such amendment to be effective immediately at the time of
487 coverage renewal. The written notice to the contract holder must
488 ~~shall~~ specifically identify any deletions, amendments, or
489 limitations to any of the benefits provided in the group
490 contract during the current contract period which will be
491 included in the group contract upon renewal. This subsection
492 does not apply to any increases in benefits. The 45-day notice
493 requirement does ~~shall~~ not apply if benefits are amended,

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494 deleted, or limited at the request of the contract holder.

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

498 1. Current and prospective subscribers of the change in the
499 formulary in a readily accessible format on the health
500 maintenance organization's website; and

501 2. Any subscriber currently receiving coverage for a
502 prescription drug for which the formulary change modifies
503 coverage and the subscriber's treating physician. Such
504 notification must be sent electronically and by first-class mail
505 and must include information on the specific drugs involved and
506 a statement that the submission of a notice of medical necessity
507 by the subscriber's treating physician to the health maintenance
508 organization at least 30 days before the effective date of the
509 formulary change will result in continuation of coverage at the
510 existing level.

511 (b) The notice provided by the treating physician to the
512 health maintenance organization must include a completed one-
513 page form in which the treating physician certifies to the
514 health maintenance organization that the prescription drug for
515 the subscriber is medically necessary as defined in s.
516 627.732(2). The treating physician shall submit the notice
517 electronically or by first-class mail. The health maintenance
518 organization may provide the treating physician with access to
519 an electronic portal through which the treating physician may
520 electronically submit the notice. By January 1, 2026, the
521 commission shall adopt by rule a form for the notice.

522 (c) If the treating physician certifies to the health

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523 maintenance organization in accordance with paragraph (b) that
524 the prescription drug is medically necessary for the subscriber,
525 the health maintenance organization:

526 1. Must authorize coverage for the prescribed drug until
527 the end of the contract year, based solely on the treating
528 physician's certification that the drug is medically necessary;
529 and

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

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

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

534 c. Denying a subscriber coverage of the drug for which the
535 subscriber has been previously approved for coverage by the
536 health maintenance organization; or

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

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

541 1. Prohibit the addition of prescription drugs to the list
542 of drugs covered under the contract during the contract year.

543 2. Apply to a grandfathered health plan as defined in s.
544 627.402 or to benefits specified in s. 627.6513(1)-(14).

545 3. Alter or amend s. 465.025, which provides conditions
546 under which a pharmacist may substitute a generically equivalent
547 drug product for a brand name drug product.

548 4. Alter or amend s. 465.0252, which provides conditions
549 under which a pharmacist may dispense a substitute biological
550 product for the prescribed biological product.

551 5. Apply to a Medicaid managed care plan under part IV of

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552 chapter 409.

553 (e) A health maintenance organization shall maintain a
554 record of any change in its formulary during a calendar year. By
555 March 1 of each year, a health maintenance organization shall
556 submit to the office a report delineating such changes made in
557 the previous calendar year. The annual report must include, at a
558 minimum:

559 1. A list of all drugs removed from the formulary, along
560 with the date of the removal and the reasons for the removal.

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

563 3. The number of subscribers impacted by a change in the
564 formulary.

565 4. The number of subscribers notified by the health
566 maintenance organization of a change in the formulary.

567 5. The increased cost, by dollar amount, incurred by
568 subscribers because of such change in the formulary.

569 (f) By May 1 of each year, the office shall:

570 1. Compile the data in such annual reports submitted by
571 health maintenance organizations and prepare a report
572 summarizing the data submitted;

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

574 3. Submit the report to the Governor, the President of the
575 Senate, and the Speaker of the House of Representatives.

576 (48) (a) As used in this subsection, the term "cost-sharing
577 requirement" means a dollar limit, a deductible, a copayment,
578 coinsurance, or any other out-of-pocket expense imposed on a
579 subscriber, including, but not limited to, the annual limitation
580 on cost sharing subject to 42 U.S.C. s. 18022.

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581 (b)1. Each health maintenance organization issuing,
582 delivering, or renewing a health maintenance contract or
583 certificate in this state which provides prescription drug
584 coverage, or each pharmacy benefit manager on behalf of such
585 health maintenance organization, shall apply any amount paid for
586 a prescription drug by a subscriber or by another person on
587 behalf of the subscriber toward the subscriber's total
588 contribution to any cost-sharing requirement if the prescription
589 drug:

590 a. Does not have a generic equivalent; or
591 b. Has a generic equivalent and the subscriber has obtained
592 authorization for the prescription drug through any of the
593 following:

594 (I) Prior authorization from the health maintenance
595 organization or pharmacy benefit manager.

596 (II) A step-therapy protocol.

597 (III) The exception or appeal process of the health
598 maintenance organization or pharmacy benefit manager.

599 2. The amount paid by or on behalf of the subscriber which
600 is applied toward the subscriber's total contribution to any
601 cost-sharing requirement under subparagraph 1. includes, but is
602 not limited to, any payment with or any discount through
603 financial assistance, a manufacturer copay card, a product
604 voucher, or any other reduction in out-of-pocket expenses made
605 by or on behalf of the subscriber for a prescription drug.

606 (c) Each health maintenance organization issuing,
607 delivering, or renewing a health maintenance contract or
608 certificate in this state which provides prescription drug
609 coverage, regardless of whether the prescription drug benefits

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610 are administered or managed by the health maintenance
611 organization or by a pharmacy benefit manager on behalf of the
612 health maintenance organization, shall disclose on its website
613 and in every subscriber's health maintenance contract,
614 certificate, or member handbook issued, delivered, or renewed in
615 this state on or after January 1, 2026, that any amount paid by
616 a subscriber or by another person on behalf of the subscriber
617 must be applied toward the subscriber's total contribution to
618 any cost-sharing requirement.

619 (d)1. A health maintenance organization issuing,
620 delivering, or renewing a health maintenance contract or
621 certificate in this state which provides prescription drug
622 coverage, regardless of whether the prescription drug benefits
623 are administered or managed by the health maintenance
624 organization or by a pharmacy benefit manager on behalf of the
625 health maintenance organization, shall maintain a record of any
626 third-party payments, made or remitted on behalf of a
627 subscriber, for prescription drugs, which are not applied to the
628 subscriber's out-of-pocket obligations, including, but not
629 limited to, deductibles, copayments, or coinsurance.

630 2. By March 1 of each year, a health maintenance
631 organization shall submit to the office a report delineating
632 third-party payments, as described in subparagraph 1., which
633 were received in the previous calendar year. The annual report
634 must include, at a minimum:

635 a. A list of all payments received by the health
636 maintenance organization, as described in subparagraph 1., made
637 or remitted by a third party, which must include:

638 (I) The date each payment was made.

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639 (II) The prescription drug for which the payment was made.

640 (III) The reason that the payment was not applied to the
 641 subscriber's out-of-pocket obligations.

642 b. The total amount of payments received by the health
 643 maintenance organization which were not applied to a
 644 subscriber's out-of-pocket maximum.

645 c. The total number of subscribers for which a payment was
 646 made which was not applied to an out-of-pocket maximum.

647 d. Whether such payments were returned to the third party
 648 who submitted the payment.

649 e. The total amount of payments which were not returned to
 650 the third party who submitted the payment.

651 (e) This subsection applies to any health maintenance
 652 contract or certificate issued, delivered, or renewed in this
 653 state on or after January 1, 2026.

654 Section 9. Paragraph (c) is added to subsection (2) of
 655 section 641.314, Florida Statutes, to read:

656 641.314 Pharmacy benefit manager contracts.—

657 (2) In addition to the requirements of part VII of chapter
 658 626, a contract between a health maintenance organization and a
 659 pharmacy benefit manager must require that the pharmacy benefit
 660 manager:

661 (c)1. Apply any amount paid by a subscriber or by another
 662 person on behalf of the subscriber toward the subscriber's total
 663 contribution to any cost-sharing requirement pursuant to s.
 664 641.31(48). This subparagraph applies to any subscriber whose
 665 health maintenance contract or certificate is issued, delivered,
 666 or renewed in this state on or after January 1, 2026.

667 2. Disclose to every subscriber whose health maintenance

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668 contract or certificate is issued, delivered, or renewed in this
 669 state on or after January 1, 2026, that the pharmacy benefit
 670 manager shall apply any amount paid by the subscriber or by
 671 another person on behalf of the subscriber toward the
 672 subscriber's total contribution to any cost-sharing requirement
 673 pursuant to s. 641.31(48).

674 Section 10. Paragraph (o) of subsection (2) of section
 675 409.967, Florida Statutes, is amended to read:

676 409.967 Managed care plan accountability.—

677 (2) The agency shall establish such contract requirements
 678 as are necessary for the operation of the statewide managed care
 679 program. In addition to any other provisions the agency may deem
 680 necessary, the contract must require:

681 (o) *Transparency.*—Managed care plans shall comply with ss.
 682 627.6385(4) ~~ss. 627.6385(3)~~ and 641.54(7).

683 Section 11. Paragraph (k) of subsection (1) of section
 684 641.185, Florida Statutes, is amended to read:

685 641.185 Health maintenance organization subscriber
 686 protections.—

687 (1) With respect to the provisions of this part and part
 688 III, the principles expressed in the following statements serve
 689 as standards to be followed by the commission, the office, the
 690 department, and the Agency for Health Care Administration in
 691 exercising their powers and duties, in exercising administrative
 692 discretion, in administrative interpretations of the law, in
 693 enforcing its provisions, and in adopting rules:

694 (k) A health maintenance organization subscriber shall be
 695 given a copy of the applicable health maintenance contract,
 696 certificate, or member handbook specifying: all the provisions,

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697 disclosure, and limitations required pursuant to s. 641.31(1),
698 ~~and (4), and (48)~~; the covered services, including those
699 services, medical conditions, and provider types specified in
700 ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(11), and
701 641.513; and where and in what manner services may be obtained
702 pursuant to s. 641.31(4).

703 Section 12. This act applies to health insurance policies,
704 health benefit plans, and health maintenance contracts entered
705 into or renewed on or after January 1, 2026.

706 Section 13. The Legislature finds that this act fulfills an
707 important state interest.

708 Section 14. This act shall take effect July 1, 2025.