

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  
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  
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,  
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**  
 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.

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  
154 drug during the policy year by:  
155 1. Increasing the out-of-pocket costs for the covered  
156 drug;  
157 2. Moving the covered drug to a more restrictive tier;  
158 3. Denying an insured coverage of the drug for which the  
159 insured has been previously approved for coverage by the  
160 insurer; or  
161 4. Limiting or reducing coverage of the drug in any other  
162 way, including subjecting it to a new prior authorization or  
163 step-therapy requirement.  
164 (4) Subsections (1), (2), and (3) do not:  
165 (a) Prohibit the addition of prescription drugs to the  
166 list of drugs covered under the policy during the policy year.  
167 (b) Apply to a grandfathered health plan as defined in s.  
168 627.402 or to benefits specified in s. 627.6513(1)-(14).  
169 (c) Alter or amend s. 465.025, which provides conditions  
170 under which a pharmacist may substitute a generically equivalent  
171 drug product for a brand name drug product.  
172 (d) Alter or amend s. 465.0252, which provides conditions  
173 under which a pharmacist may dispense a substitute biological  
174 product for the prescribed biological product.  
175 (e) Apply to a Medicaid managed care plan under part IV of

176 chapter 409.

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

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

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

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

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

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

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

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

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

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

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



201 627.6383 Cost-sharing requirements.-

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

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

214 1. Does not have a generic equivalent; or

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

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

220 b. A step-therapy protocol.

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

223 (b) The amount paid by or on behalf of the insured which  
224 is applied toward the insured's total contribution to any cost-  
225 sharing requirement under paragraph (a) includes, but is not

226 limited to, any payment with or any discount through financial  
227 assistance, a manufacturer copay card, a product voucher, or any  
228 other reduction in out-of-pocket expenses made by or on behalf  
229 of the insured for a prescription drug.

230 (c)1. Each health insurer issuing, delivering, or renewing  
231 a policy in this state which provides prescription drug  
232 coverage, regardless of whether the prescription drug benefits  
233 are administered or managed by the insurer or by a pharmacy  
234 benefit manager on behalf of the insurer, shall maintain a  
235 record of any third-party payments, made or remitted on behalf  
236 of an insured, for prescription drugs, which are not applied to  
237 the insured's out-of-pocket obligations, including, but not  
238 limited to, deductibles, copayments, or coinsurance.

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

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

251 (I) The date each payment was made.

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

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

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

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

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

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

264 (3) This section applies to any health insurance policy  
265 issued, delivered, or renewed in this state on or after January  
266 1, 2026.

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

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

273 (2) Each health insurer issuing, delivering, or renewing a  
274 policy in this state which provides prescription drug coverage,  
275 regardless of whether the prescription drug benefits are

276 administered or managed by the health insurer or by a pharmacy  
277 benefit manager on behalf of the health insurer, shall disclose  
278 on its website that any amount paid by a policyholder or by  
279 another person on behalf of the policyholder must be applied  
280 toward the policyholder's total contribution to any cost-sharing  
281 requirement pursuant to s. 627.6383. This subsection applies to  
282 any policy issued, delivered, or renewed in this state on or  
283 after January 1, 2026.

284 (3)~~(2)~~ Each health insurer shall include in every policy  
285 delivered or issued for delivery to any person in this ~~the~~ state  
286 or in materials provided as required by s. 627.64725 a notice  
287 that the information required by this section is available  
288 electronically and the website address ~~of the website~~ where the  
289 information can be accessed. In addition, each health insurer  
290 issuing, delivering, or renewing a policy in this state which  
291 provides prescription drug coverage, regardless of whether the  
292 prescription drug benefits are administered or managed by the  
293 health insurer or by a pharmacy benefit manager on behalf of the  
294 health insurer, shall disclose in every policy that is issued,  
295 delivered, or renewed to any person in this state on or after  
296 January 1, 2026, that any amount paid by a policyholder or by  
297 another person on behalf of the policyholder must be applied  
298 toward the policyholder's total contribution to any cost-sharing  
299 requirement pursuant to s. 627.6383.

300 **Section 4. Paragraph (c) is added to subsection (2) of**

301 **section 627.64741, Florida Statutes, to read:**

302 627.64741 Pharmacy benefit manager contracts.—

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

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

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

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

320 627.65715 Cost-sharing requirements.—

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

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

333       1. Does not have a generic equivalent; or

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

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

339       b. A step-therapy protocol.

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

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

349       (3) (a) Each insurer issuing, delivering, or renewing a  
350 policy in this state which provides prescription drug coverage,

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

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

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

376 include, at a minimum:

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

380 (I) The date each payment was made.

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

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

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

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

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

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

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

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

398 627.6572 Pharmacy benefit manager contracts.—

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



401 manager must require that the pharmacy benefit manager:

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

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

414 **Section 7. Paragraph (e) of subsection (5) of section**  
415 **627.6699, Florida Statutes, is amended to read:**

416 627.6699 Employee Health Care Access Act.—

417 (5) AVAILABILITY OF COVERAGE.—

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

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

425 2. Any requirement used by a small employer carrier in

426 determining whether to provide coverage to a small employer  
427 group, including requirements for minimum participation of  
428 eligible employees and minimum employer contributions, must be  
429 applied uniformly among all small employer groups having the  
430 same number of eligible employees applying for coverage or  
431 receiving coverage from the small employer carrier, except that  
432 a small employer carrier that participates in, administers, or  
433 issues health benefits pursuant to s. 381.0406 which do not  
434 include a preexisting condition exclusion may require as a  
435 condition of offering such benefits that the employer has had no  
436 health insurance coverage for its employees for a period of at  
437 least 6 months. A small employer carrier may vary application of  
438 minimum participation requirements and minimum employer  
439 contribution requirements only by the size of the small employer  
440 group.

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

450 4. A small employer carrier may ~~shall~~ not increase any

451 requirement for minimum employee participation or any  
452 requirement for minimum employer contribution applicable to a  
453 small employer at any time after the small employer has been  
454 accepted for coverage, unless the employer size has changed, in  
455 which case the small employer carrier may apply the requirements  
456 that are applicable to the new group size.

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

463 6. A small employer carrier may not modify any health  
464 benefit plan issued to a small employer with respect to a small  
465 employer or any eligible employee or dependent through riders,  
466 endorsements, or otherwise to restrict or exclude coverage for  
467 certain diseases or medical conditions otherwise covered by the  
468 health benefit plan.

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

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

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

479           641.31 Health maintenance contracts.—

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

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

499           1. Current and prospective subscribers of the change in  
 500 the formulary in a readily accessible format on the health

501 maintenance organization's website; and

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

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

523 (c) If the treating physician certifies to the health  
524 maintenance organization in accordance with paragraph (b) that  
525 the prescription drug is medically necessary for the subscriber,

526 the health maintenance organization:

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

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

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

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

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

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

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

543 1. Prohibit the addition of prescription drugs to the list  
544 of drugs covered under the contract during the contract year.

545 2. Apply to a grandfathered health plan as defined in s.  
546 627.402 or to benefits specified in s. 627.6513(1)-(14).

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

550 4. Alter or amend s. 465.0252, which provides conditions

551 under which a pharmacist may dispense a substitute biological  
552 product for the prescribed biological product.

553 5. Apply to a Medicaid managed care plan under part IV of  
554 chapter 409.

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

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

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

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

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

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

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

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

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

576 3. Submit the report to the Governor, the President of the  
577 Senate, and the Speaker of the House of Representatives.

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

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

592 a. Does not have a generic equivalent; or

593 b. Has a generic equivalent and the subscriber has  
594 obtained authorization for the prescription drug through any of  
595 the following:

596 (I) Prior authorization from the health maintenance  
597 organization or pharmacy benefit manager.

598 (II) A step-therapy protocol.

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



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

608        (c) Each health maintenance organization issuing,  
609 delivering, or renewing a health maintenance contract or  
610 certificate in this state which provides prescription drug  
611 coverage, regardless of whether the prescription drug benefits  
612 are administered or managed by the health maintenance  
613 organization or by a pharmacy benefit manager on behalf of the  
614 health maintenance organization, shall disclose on its website  
615 and in every subscriber's health maintenance contract,  
616 certificate, or member handbook issued, delivered, or renewed in  
617 this state on or after January 1, 2026, that any amount paid by  
618 a subscriber or by another person on behalf of the subscriber  
619 must be applied toward the subscriber's total contribution to  
620 any cost-sharing requirement.

621        (d)1. A health maintenance organization issuing,  
622 delivering, or renewing a health maintenance contract or  
623 certificate in this state which provides prescription drug  
624 coverage, regardless of whether the prescription drug benefits  
625 are administered or managed by the health maintenance

626 organization or by a pharmacy benefit manager on behalf of the  
627 health maintenance organization, shall maintain a record of any  
628 third-party payments, made or remitted on behalf of a  
629 subscriber, for prescription drugs, which are not applied to the  
630 subscriber's out-of-pocket obligations, including, but not  
631 limited to, deductibles, copayments, or coinsurance.

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

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

640 (I) The date each payment was made.

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

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

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

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

649 d. Whether such payments were returned to the third party  
650 who submitted the payment.

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

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

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

658 641.314 Pharmacy benefit manager contracts.—

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

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

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

676           **Section 10. Paragraph (o) of subsection (2) of section**  
 677 **409.967, Florida Statutes, is amended to read:**

678           409.967 Managed care plan accountability.—

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

683           (o) Transparency.—Managed care plans shall comply with ss.  
 684 627.6385(4) ~~ss. 627.6385(3)~~ and 641.54(7).

685           **Section 11. Paragraph (k) of subsection (1) of section**  
 686 **641.185, Florida Statutes, is amended to read:**

687           641.185 Health maintenance organization subscriber  
 688 protections.—

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

696           (k) A health maintenance organization subscriber shall be  
 697 given a copy of the applicable health maintenance contract,  
 698 certificate, or member handbook specifying: all the provisions,  
 699 disclosure, and limitations required pursuant to s. 641.31(1),  
 700 and (4), and (48); the covered services, including those

701 services, medical conditions, and provider types specified in  
702 ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(11), and  
703 641.513; and where and in what manner services may be obtained  
704 pursuant to s. 641.31(4).

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

708 **Section 13.** The Legislature finds that this act fulfills  
709 an important state interest.

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