By Senator Rodriguez

40-00510-26 20261166__

A bill to be entitled

An act relating to insurer disclosures on prescription drug coverage; creating s. 627.42394, F.S.; requiring individual and group health insurers to provide notice of prescription drug formulary changes within a certain timeframe to current and prospective insureds and the insureds' treating physicians; specifying requirements for the content of such notice and the manner in which it must be provided; specifying requirements for a notice of medical necessity submitted by the treating physician; authorizing insurers to provide certain means for submitting the notice of medical necessity; requiring the Financial Services Commission to adopt a certain form by rule by a specified date; specifying a coverage requirement and restrictions on coverage modification by insurers receiving a notice of medical necessity; providing construction and applicability; requiring insurers to maintain a record of formulary changes; requiring insurers to annually submit a specified report to the Office of Insurance Regulation by a specified date; requiring the office to annually compile certain data and prepare a report, make the report publicly accessible on its website, and submit the report to the Governor and the Legislature by a specified date; creating s. 627.6383, F.S.; defining the term "cost-sharing requirement"; requiring specified individual health insurers and their pharmacy benefit managers to apply payments for prescription drugs by or on behalf

of insureds toward the insureds' total contributions to cost-sharing requirements under certain circumstances; providing construction; requiring specified individual health insurers to maintain records of certain third-party payments for prescription drugs; providing reporting requirements relating to third-party payments for prescription drugs; providing requirements for the reports; providing applicability; amending s. 627.6385, F.S.; providing disclosure requirements relating to a policyholder's total cost-sharing requirement for prescription drugs; providing applicability; amending s. 627.64741, F.S.; requiring that specified contracts require pharmacy benefit managers to apply payments by or on behalf of insureds toward the insureds' total contributions to cost-sharing requirements; providing applicability; providing disclosure requirements relating to a policyholder's total cost-sharing requirement for prescription drugs; creating s. 627.65715, F.S.; defining the term "cost-sharing requirement"; requiring specified group health insurers and their pharmacy benefit managers to apply payments for prescription drugs by or on behalf of insureds toward the insureds' total contributions to cost-sharing requirements under certain circumstances; providing construction; providing disclosure requirements relating to an insured person's total cost-sharing requirement for prescription drugs; requiring specified group health insurers to maintain

records of certain third-party payments for prescription drugs; providing reporting requirements; providing requirements for the reports; providing applicability; amending s. 627.6572, F.S.; requiring that specified contracts require pharmacy benefit managers to apply payments by or on behalf of insureds toward the insureds' total contributions to cost-sharing requirements; providing applicability; providing disclosure requirements; amending s. 627.6699, F.S.; requiring small employer carriers to comply with certain requirements for prescription drug formulary changes; amending s. 641.31, F.S.; providing an exception to requirements relating to changes in a health maintenance organization's group contract; requiring health maintenance organizations to provide notice of prescription drug formulary changes within a certain timeframe to current and prospective subscribers and the subscribers' treating physicians; specifying requirements for the content of such notice and the manner in which it must be provided; specifying requirements for a notice of medical necessity submitted by the treating physician; authorizing health maintenance organizations to provide certain means for submitting the notice of medical necessity; requiring the commission to adopt a certain form by rule by a specified date; specifying a coverage requirement and restrictions on coverage modification by health maintenance organizations receiving a notice of medical necessity; providing

construction and applicability; requiring health maintenance organizations to maintain a record of formulary changes; requiring health maintenance organizations to annually submit a specified report to the office by a specified date; requiring the office to annually compile certain data and prepare a report, make the report publicly accessible on its website, and submit the report to the Governor and the Legislature by a specified date; defining the term "cost-sharing requirement"; requiring specified health maintenance organizations and their pharmacy benefit managers to apply payments for prescription drugs by or on behalf of subscribers toward the subscribers' total contributions to cost-sharing requirements under certain circumstances; providing construction; providing disclosure requirements relating to the subscriber's total contributions to cost-sharing requirements; requiring specified health maintenance organizations to maintain records of certain third-party payments for prescription drugs; providing reporting requirements; providing requirements for the reports; providing applicability; amending s. 641.314, F.S.; requiring that specified contracts require pharmacy benefit managers to apply payments by or on behalf of subscribers toward the subscribers' total contributions to cost-sharing requirements; providing applicability; providing disclosure requirements relating to a subscriber's total cost-sharing requirement for prescription drugs; amending s.

409.967, F.S.; conforming a cross-reference; amending s. 641.185, F.S.; conforming a provision to changes made by the act; providing applicability; providing a declaration of important state interest; providing an effective date.

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

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

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

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

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

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

(2) The notice of medical necessity provided by the

treating physician to the insurer must include a completed one-page form in which the treating physician certifies to the insurer that the prescription drug for the insured is medically necessary as defined in s. 627.732(2). The treating physician shall submit the notice electronically or by first-class mail. The insurer may provide the treating physician with access to an electronic portal through which the treating physician may electronically submit the notice. By January 1, 2027, the commission shall adopt by rule a form for the notice.

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

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

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

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

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

3. Denying an insured coverage of the drug for which the insured has been previously approved for coverage by the insurer; or

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

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

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

(b) Apply to a grandfathered health plan as defined in s. 627.402 or to benefits specified in s. 627.6513.

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

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

(e) Apply to a Medicaid managed care plan under part IV of chapter 409.

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

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

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

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

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

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

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

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

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

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

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

627.6383 Cost-sharing requirements.—

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

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

1. Does not have a generic equivalent; or

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

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

b. A step-therapy protocol.

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

(b) The amount paid by or on behalf of the insured which is applied toward the insured's total contribution to any cost-

sharing requirement under paragraph (a) includes, but is not limited to, any payment with or any discount through financial assistance, a manufacturer copay card, a product voucher, or any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

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

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

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

(I) The date each payment was made.

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

(III) The reason that the payment was not applied to the

insured's out-of-pocket obligations.

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

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

d. Whether such payments were returned to the third party that submitted the payment.

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

(3) This section applies to any health insurance policy issued, delivered, or renewed in this state on or after January 1, 2027.

Section 3. Present subsections (2) and (3) of section 627.6385, Florida Statutes, are redesignated as subsections (3) and (4), respectively, a new subsection (2) is added to that section, and present subsection (2) of that section is amended, to read:

627.6385 Disclosures to policyholders; calculations of cost sharing.—

(2) Each health insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the health insurer or by a pharmacy benefit manager on behalf of the health insurer, shall disclose on its website that any amount paid by a policyholder or by another person on behalf of the policyholder must be applied toward the policyholder's total contribution to any cost-sharing requirement pursuant to s. 627.6383. This subsection applies to

any policy issued, delivered, or renewed in this state on or after January 1, 2027.

(3)~~(2)~~ Each health insurer shall include in every policy delivered or issued for delivery to any person in this ~~the~~ state or in materials provided as required by s. 627.64725 a notice that the information required by this section is available electronically and the website address ~~of the website~~ where the information can be accessed. In addition, each health insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the health insurer or by a pharmacy benefit manager on behalf of the health insurer, shall disclose in every policy that is issued, delivered, or renewed to any person in this state on or after January 1, 2027, that any amount paid by a policyholder or by another person on behalf of the policyholder must be applied toward the policyholder's total contribution to any cost-sharing requirement pursuant to s. 627.6383.

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

627.64741 Pharmacy benefit manager contracts.—

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

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

on or after January 1, 2027.

2. Disclose to every insured whose insurance policy is issued, delivered, or renewed in this state on or after January 1, 2027, that the pharmacy benefit manager is required to apply any amount paid by the insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement pursuant to s. 627.6383.

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

627.65715 Cost-sharing requirements.—

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

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

1. Does not have a generic equivalent; or

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

a. Prior authorization from the insurer or pharmacy benefit manager.

b. A step-therapy protocol.

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

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

(3)(a) Each insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the insurer or by a pharmacy benefit manager on behalf of the insurer, shall disclose on its website and in every policy issued, delivered, or renewed in this state on or after January 1, 2027, that any amount paid by an insured or by another person on behalf of the insured must be applied toward the insured's total contribution to any cost-sharing requirement.

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

2. By March 1 of each year, each health insurer issuing,

delivering, or renewing a policy in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the insurer or by a pharmacy benefit manager on behalf of the insurer, shall submit to the office a report delineating third-party payments, as described in subparagraph 1., which were received in the previous calendar year. The annual report must include, at a minimum:

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

(I) The date each payment was made.

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

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

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

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

d. Whether such payments were returned to the third party that submitted the payment.

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

(4) This section applies to any group health insurance policy issued, delivered, or renewed in this state on or after January 1, 2027.

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

627.6572 Pharmacy benefit manager contracts.—

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

(c)1. Apply any amount paid by an insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement pursuant to s. 627.65715. This subparagraph applies to any insured whose insurance policy is issued, delivered, or renewed in this state on or after January 1, 2027.

2. Disclose to every insured whose insurance policy is issued, delivered, or renewed in this state on or after January 1, 2027, that the pharmacy benefit manager is required to apply any amount paid by the insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement pursuant to s. 627.65715.

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

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

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

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

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer

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

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

4. A small employer carrier may ~~shall~~ not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements

that are applicable to the new group size.

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

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

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

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

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

641.31 Health maintenance contracts.—

(36) Except as provided in paragraphs (a), (b), and (c), a health maintenance organization may increase the copayment for any benefit, or delete, amend, or limit any of the benefits to which a subscriber is entitled under the group contract only, upon written notice to the contract holder at least 45 days in

advance of the time of coverage renewal. The health maintenance organization may amend the contract with the contract holder, with such amendment to be effective immediately at the time of coverage renewal. The written notice to the contract holder must ~~shall~~ specifically identify any deletions, amendments, or limitations to any of the benefits provided in the group contract during the current contract period which will be included in the group contract upon renewal. This subsection does not apply to any increases in benefits. The 45-day notice requirement does ~~shall~~ not apply if benefits are amended, deleted, or limited at the request of the contract holder.

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

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

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

(b) The notice of medical necessity provided by the treating physician to the health maintenance organization must

include a completed one-page form in which the treating physician certifies to the health maintenance organization that the prescription drug for the subscriber is medically necessary as defined in s. 627.732(2). The treating physician shall submit the notice electronically or by first-class mail. The health maintenance organization may provide the treating physician with access to an electronic portal through which the treating physician may electronically submit the notice. By January 1, 2027, the commission shall adopt by rule a form for the notice.

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

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

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

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

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

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

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

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

1. Prohibit the addition of prescription drugs to the list

of drugs covered under the contract during the contract year.

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

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

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

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

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

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

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

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

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

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

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

1. Compile the data in the annual reports submitted by

health maintenance organizations under paragraph (e) and prepare a report summarizing such data;

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

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

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

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

a. Does not have a generic equivalent; or

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

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

(II) A step-therapy protocol.

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

2. The amount paid by or on behalf of the subscriber which

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

(c) Each health maintenance organization issuing, delivering, or renewing a health maintenance contract or certificate in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the health maintenance organization or by a pharmacy benefit manager on behalf of the health maintenance organization, shall disclose on its website and in every subscriber's health maintenance contract, certificate, or member handbook issued, delivered, or renewed in this state on or after January 1, 2027, that any amount paid by a subscriber or by another person on behalf of the subscriber must be applied toward the subscriber's total contribution to any cost-sharing requirement.

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

limited to, deductibles, copayments, or coinsurance.

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

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

(I) The date each payment was made.

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

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

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

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

d. Whether such payments were returned to the third party that submitted the payment.

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

(e) This subsection applies to any health maintenance contract, certificate, or member handbook issued, delivered, or renewed in this state on or after January 1, 2027.

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

641.314 Pharmacy benefit manager contracts.—

(2) In addition to the requirements of part VII of chapter

626, a contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager:

(c)1. Apply any amount paid by a subscriber or by another person on behalf of the subscriber toward the subscriber's total contribution to any cost-sharing requirement pursuant to s. 641.31(48). This subparagraph applies to any subscriber whose health maintenance contract or certificate is issued, delivered, or renewed in this state on or after January 1, 2027.

2. Disclose to every subscriber whose health maintenance contract or certificate is issued, delivered, or renewed in this state on or after January 1, 2027, that the pharmacy benefit manager is required to apply any amount paid by the subscriber or by another person on behalf of the subscriber toward the subscriber's total contribution to any cost-sharing requirement pursuant to s. 641.31(48).

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

409.967 Managed care plan accountability.—

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

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

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

641.185 Health maintenance organization subscriber protections.—

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

(k) A health maintenance organization subscriber shall be given a copy of the applicable health maintenance contract, certificate, or member handbook specifying: all the provisions, disclosure, and limitations required pursuant to s. 641.31(1), ~~and~~ (4), and (48); the covered services, including those services, medical conditions, and provider types specified in ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(11), and 641.513; and where and in what manner services may be obtained pursuant to s. 641.31(4).

Section 12. This act applies to health insurance policies, health benefit plans, and health maintenance contracts entered into or renewed on or after January 1, 2027.

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

Section 14. This act shall take effect July 1, 2026.