

**By** Senator Rodriguez

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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

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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

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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

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88 construction and applicability; requiring health  
89 maintenance organizations to maintain a record of  
90 formulary changes; requiring health maintenance  
91 organizations to annually submit a specified report to  
92 the office by a specified date; requiring the office  
93 to annually compile certain data and prepare a report,  
94 make the report publicly accessible on its website,  
95 and submit the report to the Governor and the  
96 Legislature by a specified date; defining the term  
97 "cost-sharing requirement"; requiring specified health  
98 maintenance organizations and their pharmacy benefit  
99 managers to apply payments for prescription drugs by  
100 or on behalf of subscribers toward the subscribers'  
101 total contributions to cost-sharing requirements under  
102 certain circumstances; providing construction;  
103 providing disclosure requirements relating to the  
104 subscriber's total contributions to cost-sharing  
105 requirements; requiring specified health maintenance  
106 organizations to maintain records of certain third-  
107 party payments for prescription drugs; providing  
108 reporting requirements; providing requirements for the  
109 reports; providing applicability; amending s. 641.314,  
110 F.S.; requiring that specified contracts require  
111 pharmacy benefit managers to apply payments by or on  
112 behalf of subscribers toward the subscribers' total  
113 contributions to cost-sharing requirements; providing  
114 applicability; providing disclosure requirements  
115 relating to a subscriber's total cost-sharing  
116 requirement for prescription drugs; amending s.

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117        409.967, F.S.; conforming a cross-reference; amending  
118        s. 641.185, F.S.; conforming a provision to changes  
119        made by the act; providing applicability; providing a  
120        declaration of important state interest; providing an  
121        effective date.

122  
123        Be It Enacted by the Legislature of the State of Florida:

124  
125        Section 1. Section 627.42394, Florida Statutes, is created  
126        to read:

127        627.42394 Health insurance policies; changes to  
128        prescription drug formularies; requirements.-

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

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

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

145        (2) The notice of medical necessity provided by the

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

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

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

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

164 1. Increasing the out-of-pocket costs for the covered drug;  
165 2. Moving the covered drug to a more restrictive tier;  
166 3. Denying an insured coverage of the drug for which the  
167 insured has been previously approved for coverage by the  
168 insurer; or

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

172 (4) Subsections (1), (2), and (3) do not:  
173 (a) Prohibit the addition of prescription drugs to the list  
174 of drugs covered under the policy during the policy year.

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175        (b) Apply to a grandfathered health plan as defined in s.  
176 627.402 or to benefits specified in s. 627.6513.

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

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

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

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

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

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

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

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

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

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

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

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204                   (b) Make the report publicly accessible on its website.  
205                   (c) Submit the report to the Governor, the President of the  
206 Senate, and the Speaker of the House of Representatives.

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

209                   627.6383 Cost-sharing requirements.—

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

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

222                   1. Does not have a generic equivalent; or

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

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

228                   b. A step-therapy protocol.

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

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

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

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

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

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

259 (I) The date each payment was made.  
260 (II) The prescription drug for which the payment was made.  
261 (III) The reason that the payment was not applied to the

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262       insured's out-of-pocket obligations.

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

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

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

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

272       (3) This section applies to any health insurance policy  
273       issued, delivered, or renewed in this state on or after January  
274       1, 2027.

275       Section 3. Present subsections (2) and (3) of section  
276 627.6385, Florida Statutes, are redesignated as subsections (3)  
277 and (4), respectively, a new subsection (2) is added to that  
278 section, and present subsection (2) of that section is amended,  
279 to read:

280       627.6385 Disclosures to policyholders; calculations of cost  
281 sharing.—

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

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

293 (3)(2) Each health insurer shall include in every policy  
294 delivered or issued for delivery to any person in this the state  
295 or in materials provided as required by s. 627.64725 a notice  
296 that the information required by this section is available  
297 electronically and the website address of the website where the  
298 information can be accessed. In addition, each health insurer  
299 issuing, delivering, or renewing a policy in this state which  
300 provides prescription drug coverage, regardless of whether the  
301 prescription drug benefits are administered or managed by the  
302 health insurer or by a pharmacy benefit manager on behalf of the  
303 health insurer, shall disclose in every policy that is issued,  
304 delivered, or renewed to any person in this state on or after  
305 January 1, 2027, that any amount paid by a policyholder or by  
306 another person on behalf of the policyholder must be applied  
307 toward the policyholder's total contribution to any cost-sharing  
308 requirement pursuant to s. 627.6383.

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

311 627.64741 Pharmacy benefit manager contracts.—

312 (2) In addition to the requirements of part VII of chapter  
313 626, a contract between a health insurer and a pharmacy benefit  
314 manager must require that the pharmacy benefit manager:

315 (c)1. Apply any amount paid by an insured or by another  
316 person on behalf of the insured toward the insured's total  
317 contribution to any cost-sharing requirement pursuant to s.  
318 627.6383. This subparagraph applies to any insured whose  
319 insurance policy is issued, delivered, or renewed in this state

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320 on or after January 1, 2027.

321 2. Disclose to every insured whose insurance policy is  
322 issued, delivered, or renewed in this state on or after January  
323 1, 2027, that the pharmacy benefit manager is required to apply  
324 any amount paid by the insured or by another person on behalf of  
325 the insured toward the insured's total contribution to any cost-  
326 sharing requirement pursuant to s. 627.6383.

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

329 627.65715 Cost-sharing requirements.—

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

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

342 1. Does not have a generic equivalent; or

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

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

348 b. A step-therapy protocol.

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

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

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

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

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

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

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

389           (I) The date each payment was made.

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

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

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

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

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

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

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

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

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407 627.6572 Pharmacy benefit manager contracts.—

408 (2) In addition to the requirements of part VII of chapter  
409 626, a contract between a health insurer and a pharmacy benefit  
410 manager must require that the pharmacy benefit manager:

411 (c)1. Apply any amount paid by an insured or by another  
412 person on behalf of the insured toward the insured's total  
413 contribution to any cost-sharing requirement pursuant to s.  
414 627.65715. This subparagraph applies to any insured whose  
415 insurance policy is issued, delivered, or renewed in this state  
416 on or after January 1, 2027.

417 2. Disclose to every insured whose insurance policy is  
418 issued, delivered, or renewed in this state on or after January  
419 1, 2027, that the pharmacy benefit manager is required to apply  
420 any amount paid by the insured or by another person on behalf of  
421 the insured toward the insured's total contribution to any cost-  
422 sharing requirement pursuant to s. 627.65715.

423 Section 7. Paragraph (e) of subsection (5) of section  
424 627.6699, Florida Statutes, is amended to read:

425 627.6699 Employee Health Care Access Act.—

426 (5) AVAILABILITY OF COVERAGE.—

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

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

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

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

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

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

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465 that are applicable to the new group size.

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

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

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

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

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

488 641.31 Health maintenance contracts.—

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

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

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

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

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

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

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523 include a completed one-page form in which the treating  
524 physician certifies to the health maintenance organization that  
525 the prescription drug for the subscriber is medically necessary  
526 as defined in s. 627.732(2). The treating physician shall submit  
527 the notice electronically or by first-class mail. The health  
528 maintenance organization may provide the treating physician with  
529 access to an electronic portal through which the treating  
530 physician may electronically submit the notice. By January 1,  
531 2027, the commission shall adopt by rule a form for the notice.

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

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

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

542 a. Increasing the out-of-pocket costs for the covered drug;  
543 b. Moving the covered drug to a more restrictive tier;  
544 c. Denying a subscriber coverage of the drug for which the  
545 subscriber has been previously approved for coverage by the  
546 health maintenance organization; or  
547 d. Limiting or reducing coverage of the drug in any other  
548 way, including subjecting it to a new prior authorization or  
549 step-therapy requirement.

550 (d) Paragraphs (a), (b), and (c) do not:  
551 1. Prohibit the addition of prescription drugs to the list

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552 of drugs covered under the contract during the contract year.

553 2. Apply to a grandfathered health plan as defined in s.

554 627.402 or to benefits specified in s. 627.6513.

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

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

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

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

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

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

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

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

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

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

580 1. Compile the data in the annual reports submitted by

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

583 2. Make the report publicly accessible on its website; and  
584 3. Submit the report to the Governor, the President of the  
585 Senate, and the Speaker of the House of Representatives.

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

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

600 a. Does not have a generic equivalent; or  
601 b. Has a generic equivalent and the subscriber has obtained  
602 authorization for the prescription drug through any of the  
603 following:

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

606 (II) A step-therapy protocol.

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

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

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

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

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

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639 limited to, deductibles, copayments, or coinsurance.

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

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

648 (I) The date each payment was made.

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

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

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

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

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

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

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

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

666 641.314 Pharmacy benefit manager contracts.—

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

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668 626, a contract between a health maintenance organization and a  
669 pharmacy benefit manager must require that the pharmacy benefit  
670 manager:

671 (c)1. Apply any amount paid by a subscriber or by another  
672 person on behalf of the subscriber toward the subscriber's total  
673 contribution to any cost-sharing requirement pursuant to s.  
674 641.31(48). This subparagraph applies to any subscriber whose  
675 health maintenance contract or certificate is issued, delivered,  
676 or renewed in this state on or after January 1, 2027.

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

684 Section 10. Paragraph (o) of subsection (2) of section  
685 409.967, Florida Statutes, is amended to read:

686 409.967 Managed care plan accountability.—

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

691 (o) Transparency.—Managed care plans shall comply with ss.  
692 627.6385(4) and 641.54(7) ss. 627.6385(3) and 641.54(7).

693 Section 11. Paragraph (k) of subsection (1) of section  
694 641.185, Florida Statutes, is amended to read:

695 641.185 Health maintenance organization subscriber  
696 protections.—

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

704       (k) A health maintenance organization subscriber shall be  
705 given a copy of the applicable health maintenance contract,  
706 certificate, or member handbook specifying: all the provisions,  
707 disclosure, and limitations required pursuant to s. 641.31(1),  
708 and (4), and (48); the covered services, including those  
709 services, medical conditions, and provider types specified in  
710 ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(11), and  
711 641.513; and where and in what manner services may be obtained  
712 pursuant to s. 641.31(4).

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

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

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