FLORIDA HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 697 **TITLE:** Drug Prices and Coverage **SPONSOR(S):** Kincart Jonsson	**COMPANION BILLS:** SB 1158 (Grall); CS/CS/SB 1760 (Brodeur) **LINKED BILLS:** None **RELATED BILLS:** None

FINAL HOUSE FLOOR ACTION: 108 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Approved

SUMMARY

Effect of the Bill:
The bill regulates relationships between pharmacy benefit managers (PBMs) and pharmacies. It makes it unlawful for a PBM to require a pharmacy to take a loss when dispensing a drug, or to reimburse a nonaffiliated pharmacy less than an affiliated pharmacy. The bill requires PBMs to allow in-network pharmacies to submit consolidated appeals comprised of multiple adjudicated claims for the identical drug and supply, and with dates of service in the same month. The bill excludes a pharmacy benefits plan or program which only serves beneficiaries of a Program of All-Inclusive Care for the Elderly organization from current PBM law governing the terms and conditions of contracts between pharmacy benefits plans or programs and PBMs.

The bill also makes temporary changes to eligibility and benefits for the Ryan White Part B AIDS Drug Assistance Program (ADAP), applicable through June 30, 2026, to cover a deficit and to override certain changes in Department of Health (DOH) policy. The bill appropriates $30,901,993 in current year nonrecurring funds to ADAP through the end of Fiscal Year 2025-2026 to support the program, and requires the DOH to adopt emergency rules to implement these temporary changes. The bill requires DOH to submit monthly reports to the Governor's Office and the Legislature beginning April 1, 2026, including data on revenues and expenditures, drug rebates and offsets, enrollees, drug utilization, and financial status of the program. The bill was approved by the Governor on March 24, 2026, ch. 2026-4, L.O.F., and will become effective on July 1, 2026, except as otherwise provided.

Fiscal or Economic Impact:
The bill has a significant, negative fiscal impact on DOH to fund the ADAP program, and appropriates funds for this purpose.

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ANALYSIS

EFFECT OF THE BILL:

Pharmacy Benefit Managers

The bill creates new regulatory requirements for pharmacy benefit managers (PBMs) concerning business practices and pharmacy contracts.

Pharmacy Reimbursement

The bill makes it unlawful for a PBM to prohibit or restrict a pharmacy from declining to dispense a prescription drug or biological product for less than the pharmacy's actual acquisition cost. (Section 2). This provision prevents a PBM from forcing a pharmacy to take a loss when dispensing a drug.

The bill also makes it unlawful for a PBM to reimburse a nonaffiliated pharmacy less than the PBM reimburses an affiliated pharmacy. (Section 2). This provision prevents a PBM from leveraging the market power of its parent healthcare conglomerate over non-affiliated pharmacies.

Contractual Regulation

Claims Appeals

The bill requires contracts between a PBM and an in-network pharmacy to include terms allow a pharmacy to submit a consolidated appeal comprised of multiple adjudicated claims featuring the identical drug and day supply, provided they also share dates of service occurring within the same calendar month. (Section 1). This revises current law for PBMs to provide a reasonable administrative appeal procedure that allows a pharmacy to appeal the PBM's maximum allowable cost pricing information and the corresponding reimbursement for a specific drug that the pharmacy argues is below its acquisition cost. Currently, PBMs adjudicate such appeals on a claim-by-claim basis. Under the bill, consolidated appeals will promote administrative efficiencies for all parties involved.

Program of All-Inclusive Care for the Elderly (PACE) Exemption

The bill excludes a pharmacy benefits plan or program which only serves beneficiaries of a PACE organization from current PBM law governing the terms and conditions of contracts between pharmacy benefits plan or program and PBMs. (Section 1). PACE organizations, which serve certain elderly adults at risk of nursing home care, are already subject to oversight and regular audits by the federal government. Under the bill, this exemption eliminates current duplicative PBM oversight and auditing activities relating to contractual matters between a pharmacy benefits plan or program and PBMs by the Office of Insurance Regulation because the federal Centers for Medicare and Medicaid Services, in cooperation with the Agency for Health Care Administration, already perform oversight and auditing activities over PACE organizations.

Ryan White AIDS Drug Assistance Program

The bill makes temporary changes to eligibility and benefits for the Ryan White AIDS Drug Assistance Program (APAP), applicable through June 30, 2026, to cover a deficit and to codify or override certain Department of Health (DOH) policy changes.[1] Specifically, the bill:

- Appropriates $30,901,993 in current year nonrecurring funds from the DOH Grants and Donations Trust Fund to supplement ADAP through the end of Fiscal Year (FY) 2025-2026;
- Restores the income eligibility threshold ceiling of 400% of the federal poverty level (FPL), overriding the 2026 DOH change to 130% FPL; and
- Eliminates purchase of health insurance coverage through the ADAP Premium Plus Insurance Program as a benefit, limiting benefits to medications distributed and directly dispensed by DOH, codifying a 2026 DOH policy change.

Under the bill (and under the DOH policy changes), ADAP enrollees previously participating in the ADAP Premium Plus Insurance Program component will pay for their own insurance and migrate to ADAP Program for Medication Co-Payment and Medication Deductibles, or drop their insurance and migrate to the medication-only ADAP benefit. This applies to approximately 9,174 ADAP participants.[2]

In addition, the bill requires DOH to apply the ADAP drug formularies in existence on March 1, 2026, with no changes. This codifies policy changes made by DOH that removed Biktarvy from the ADAP Formulary but kept Biktarvy on the ADAP Self-Insured Formulary. This also codifies a policy change made by DOH that restricted Descovy on both formularies to those patients with a creatinine clearance of less than 60 milliliters per minute, enforced by prior authorization requirements.

[1] *See* Christine Sexton, "DOH anticipates AIDS drug fix will become law," *Florida Phoenix*, (Mar. 12, 2026) https://floridapolitics.com/archives/784798-doh-anticipates-aids-drug-fix-will-become-law/ (last visited Mar. 16, 2026).
[2] *See* Email from Lauren Cassedy, Chief of Staff, Department of Health on January 12, 2026, on file with the Health and Human Services Committee.

The bill requires DOH to submit monthly reports to the Governor's Office and the Legislature beginning April 1, 2026, including data on revenues and expenditures, drug rebates and offsets, enrollees, drug utilization, and financial status of the program.

The bill makes all provisions relating to the ADAP effective upon becoming law. (Section 3).

The bill was approved by the Governor on March 24, 2026, ch. 2026-4, L.O.F., and will become effective on July 1, 2026, except as otherwise provided. (Section 4).

RULEMAKING:

The bill expressly requires DOH to adopt emergency rules to implement the bill's temporary changes to eligibility and benefits for ADAP. The bill expressly exempts such emergency rules from the requirements of s. 120.54(4)(c), F.S., and makes those rules effective through June 30, 2026, notwithstanding the current 90-day limit on emergency rules.[3] (Section 3). One day after the Governor signed the bill into law, DOH adopted new emergency rules to supersede the March emergency rules which were in effect before the bill became law.[4]

With the new emergency rules in effect, the administrative challenge to the March emergency rules was dismissed on March 26, 2026.[5]

Lawmaking is a legislative power; however, the Legislature may delegate a portion of such power to executive branch agencies to create rules that have the force of law. To exercise this delegated power, an agency must have a grant of rulemaking authority and a law to implement.

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The bill has a significant, negative fiscal impact on DOH. The bill appropriates a nonrecurring sum of $30,901,933 from the Grants and Donations Trust Fund to DOH to implement the bill's changes to the Ryan White Part B ADAP through June 30, 2026. (Section 3).

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Ryan White HIV/AIDS Program

The Human Immunodeficiency Virus (HIV) is an immune system debilitating virus that gradually destroys the immune system and inhibits the body's ability to fight off infections and disease. If untreated, HIV can develop into acquired immunodeficiency syndrome (AIDS), which is the most advanced stage of an HIV infection.[6] HIV can be transmitted from an infected person through sexual contact, exposure to infected blood or blood products, sharing of contaminated needles and syringes, transplantation of infected organs or tissue, or from mother to child during

[3] If an agency finds that an immediate danger to the public health, safety, or welfare requires emergency action, or if the Legislature authorizes the agency to adopt emergency rules and finds that all conditions specified in this paragraph are met, current law authorizes the agency to adopt, within the authority granted to the agency under the State Constitution or delegated to it by the Legislature, any rule necessitated by the immediate danger or legislative finding. The agency may adopt a rule by any procedure which is fair under the circumstances if certain statutory conditions are met. s. 120.54(4)(a), F.S.

[4] Florida Administrative Register, "Issue Vol. 52 / No. 58," *Department of State*, Section IV: Emergency Rules (Mar. 25, 2026) https://flrules.org/BigDoc/View_Section.asp?Issue=4609&Section=4 (last visited Mar. 27, 2026).

[5] *AIDS Healthcare Foundation, Inc.*, Docket No.:26-001421RE, "Final Order of Dismissal. CASE CLOSED," (Mar. 26, 2026) https://www.doah.state.fl.us/DocDoc/2026/001421/26001421DWH-032626-10433621.pdf (last visited Mar. 27, 2026).

[6] National Institutes of Health, "HIV and AIDS: The Basics," *U.S. Department of Health & Human Services* (last reviewed May 28, 2025) https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-and-aids-basics (last visited March 24, 2026).

pregnancy, childbirth, or breastfeeding.[7] In 2024, 4,463 Floridians were diagnosed with HIV, 1,973 were diagnosed with AIDS, and 581 people in Florida died from HIV/AIDs.[8]

There is currently no effective cure for HIV. However, the symptoms and risk of transmission of HIV can be effectively mitigated through medication. Antiretroviral therapy (ART) is the standard treatment protocol for people with HIV.[9] ART is recommended for everyone with HIV, and treatment should begin as soon as possible after diagnosis.[10] In order to be effective, ART requires strict adherence to a treatment regimen. Treatment adherence includes starting HIV treatment, keeping all medical appointments, and taking HIV medicines exactly as prescribed. Poor adherence increases a person's risk of developing drug-resistant HIV, transmission of HIV to others, and can cause long-term immune system damage.[11]

The federal Ryan White[12] HIV/AIDS Program was established by Congress in 1990 under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The purpose of the CARE Act was "to provide emergency assistance to localities disproportionately affected by the HIV epidemic and to make financial assistance to States and other public and private nonprofit entities to provide for the development, organization, coordination, and operations of more effective and cost-efficient systems for the delivery of essential services to individuals and families with HIV disease."[13]

Ryan White AIDS Drug Assistance Program

The state Ryan White AIDS Drug Assistance Program (ADAP) is a federally-funded, state administered prescription medication program for low-income people diagnosed with HIV administered by the Department of Health (DOH); under current law, DOH must conduct a communicable disease prevention and control program that includes a program for the prevention and control of HIV/AIDS.[14]. The federal grant for Florida's ADAP is $92,354,788 in Fiscal Year 2025-2026.[15]

[7] "The HIV/AIDS Epidemic in the United States: The Basics," *KFF* (last updated Oct. 9, 2024) https://www.kff.org/hiv-aids/the-hiv-aids-epidemic-in-the-united-states-the-basics/ (last visited March 24, 2026).
[8] Division of Public Health Statistics and Performance Management, "FLHealthCHARTS: Deaths From Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)," *Department of Health* https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=Death.DataViewer&cid=0122 (last visited Mar. 16, 2026). Division of Public Health Statistics and Performance Management, "FLHealthCHARTS: Human Immunodeficiency Virus (HIV) Diagnoses," *Department of Health* https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0471 (last visited Mar. 16, 2026). Division of Public Health Statistics and Performance Management, "FLHealthCHARTS: Acquired Immunodeficiency Syndrome (AIDS) Diagnoses," *Department of Health* https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=HIVAIDS.DataViewer&cid=0141 (last visited Mar. 16, 2026).
[9] National Institutes of Health, "HIV Treatment: FDA-Approved HIV Medicines," *U.S. Department of Health & Human Services* (last reviewed Mar. 20, 2026) https://hivinfo.nih.gov/understanding-hiv/fact-sheets/fda-approved-hiv-medicines (last visited March 24, 2026).
[10] *Supra*, FN 6.
[11] National Institutes of Health, "HIV Treatment Adherence," *U.S. Department of Health & Human Services* (last reviewed Jan. 13, 2025) https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-treatment-adherence (last visited March 24, 2026).
[12] Ryan White was 13 years old when he was diagnosed with AIDS in 1984 after receiving an HIV-contaminated blood transfusion. Ryan became an AIDS activist after facing discrimination and harassment following his diagnosis. In 1990, Ryan died from AIDS at age 18. For more information on Ryan White, *see*, Markel, H., "Remembering Ryan White, the teen who fought against the stigma of AIDS," *PBS News*, (Apr. 8, 2026) https://www.pbs.org/newshour/health/remembering-ryan-white-the-teen-who-fought-against-the-stigma-of-aids (last visited March 18, 2026). *See also*, Health Resources & Services Administration, "*Who Was Ryan White?*" *U.S. Department of Health & Human Services*, (last updated Feb. 2022) https://ryanwhite.hrsa.gov/about/ryan-white# (last visited March 18, 2026).
[13] Ryan White CARE Act of 1990. P.L. 101-381 § 2 Purpose
[14] S. 381.003(1)(b), F.S., s. 381.003(2), F.S.
[15] Email from Lauren Cassedy, Chief of Staff, Department of Health on January 12, 2026, on file with the Health and Human Services Committee.

Eligibility and Enrollment

DOH determines eligibility for ADAP assistance. To qualify, a person must document both his or her HIV positive status and household income level of no more than 400% of the federal poverty level (FPL), which is $63,840 for an individual.[16] In addition, a prospective ADAP client must lack health insurance or, if insured, lack adequate prescription drug coverage. DOH will not accept clients into the program who are confined to a hospital, nursing home, hospice, or correctional facility. If DOH determines a prospective client is eligible for ADAP, DOH sends the new client an eligibility letter to initiate an enrollment appointment. New clients must bring a prescription for at least one antiretroviral to their enrollment appointments.[17]

In 2025, 30,408 people were enrolled in ADAP.[18]

Benefits

ADAP provides access to medications to eligible clients either directly or by purchase of health insurance,[19] including coverage for HIV medications such as Biktarvy[20] and Descovy.[21]

Medication-Only Coverage

The medication-only benefit is for uninsured ADAP enrollees. It provides access to HIV/AIDS drugs on the ADAP Formulary, which lists all the medications covered by the program.[22] Uninsured clients pick up their ADAP prescription medications at the onsite pharmacy of the local county health department; this transaction is called direct dispense. However, if the county health department lacks an onsite pharmacy, CVS Specialty Pharmacy fulfills ADAP prescription orders.[23]

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[16] Rule 64D-4.003, F.A.C., version effective: October 12, 2022 to February 23, 2026. The U.S. Department of Health & Human Services annually publishes poverty income guidelines to help federal and state governments determine financial eligibility for certain programs. Office of the Assistant Secretary for Planning and Evaluation, "Frequently Asked Questions Related to the Poverty Guidelines and Poverty," *U.S. Department of Health & Human Services* https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/frequently-asked-questions-related-poverty-guidelines-poverty (last visited Mar. 27, 2026); Office of the Assistant Secretary for Planning and Evaluation, "2026 Poverty Guidelines: 48 Contiguous States," *U.S. Department of Health and Human Services*, https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf (last visited Mar. 31, 2026).

[17] "AIDS Drugs Assistance Program," *Department of Health*, https://www.floridahealth.gov/individual-family-health/injury-prevention-wellness/hiv-aids/hiv-aids-management/ (last visited Mar. 27, 2026).

[18] Email from Lauren Cassedy, Chief of Staff, Department of Health on January 12, 2026, on file with the Health and Human Services Committee.

[19] *Supra*, FN 17.

[20] Manufactured by Gilead Sciences, Inc., Biktarvy is a complete HIV treatment (i.e., daily one-tablet regimen) that works by preventing HIV from multiplying within the body, lowering HIV blood levels, and decreasing the risk of a person developing AIDs and HIV-related illness. Biktarvy is not a preexposure prophylaxis (PrEP) medicine; PrEP medicines are intended to prevent HIV and Truvada, Descovy, Apreture, and Yeztugo are examples of PrEP medicines. There is currently no generic version of Biktarvy. Malini Ghoshal, "All About Biktarvy," *Healthline Media*, (last updated Oct. 3, 2025) https://www.healthline.com/health/drugs/biktarvy (last visited Mar. 19, 2026). Melisa Puckey, "Biktarvy," *Drugs.com*, (last updated Oc.t 28, 2025) https://www.drugs.com/biktarvy.html (last visited Mar. 19, 2026).

[21] Manufactured by Gilead Sciences, Inc., Descovy is part of an HIV regimen (an HIV regimen contains two to three HIV medications from a minimum of two drug classes) to reduce a person's risk of contracting HIV by blocking the virus's ability to make copies of itself. Descovy is a PrEP medicine and a HIV treatment medicine. There is currently no generic version of Descovy. Jessica Caporuscio, "All About Descovy," *Healthline Media*, (last updated Oct. 21, 2025) https://www.healthline.com/health/drugs/descovy (last visited Mar. 19, 2026). Carmen Pope, "Descovy," Drugs.com, (last updated Feb. 2, 2026) https://www.drugs.com/descovy.html (last visited Mar. 19, 2026). Tess Catlett, "PrEP vs. PEP: What Do They Do?" *Healthline Media*, (last updated Jul. 1, 2024) https://www.healthline.com/health/hiv-aids/hiv-prevention/prep-vs-pep-infographic#1 (last visited Mar. 19, 2026).

[22] The ADAP Formulary as it existed in September 2024 is memorialized in Exhibit D of the AIDS Healthcare Foundation's January 2026 unpromulgated rule challenge petition against the Department of Health, which is located at the following link: *AIDS Healthcare Foundation, Inc., and Recipient One v. Florida Department of Health*, Docket No.: 26-000529RU, "Petition Challenging Agency Statements as Unpromulgated Rules and Request for Expedited Hearing filed," Exhibit D (Jan. 27, 2026) https://www.doah.state.fl.us/DocDoc/2026/000529/26000529_408_01272026_135915415_e.pdf (last visited Mar. 31, 2026).

[23] *Supra*, FN 17. DOH contracts with CVS Specialty Pharmacy to provide specialty pharmacy services. CVS Specialty Pharmacy is not a local CVS store. It is a mail-order pharmacy located in Pennsylvania. ADAP prescriptions will be filled at this pharmacy and sent to a location of

In 2025, 16,627 ADAP clients were enrolled in the direct-dispense, medication-only component of ADAP.[24]

ADAP Premium Plus Insurance Program

The ADAP Premium Plus Insurance Program (Program) is a component of ADAP designed to assist clients who have insurance but lack adequate access to expensive HIV/AIDS medications. The Program provides assistance with insurance premiums, copays, and/or deductibles,[25] to make covered medications more affordable for clients enrolled in Medicare, employer-sponsored insurance (including COBRA plans[26]), or a federal ACA marketplace exchange health plan.[27] To receive these cost-sharing benefits, clients must:

- Use the ADAP contracted insurance benefits manager to enroll in an ADAP approved plan to receive insurance premium assistance;
- Need insurance policy pharmaceutical coverage to the extent that payment cannot be made or cannot reasonably be expected to be made by another payer source; and
- Use an ADAP contracted pharmacy to receive premium assistance, medications co-payment and/or deductible.[28]

In addition to the criteria above, an ADAP client with a health insurance plan purchased through the federally facilitated marketplace exchange may receive premium assistance, provided that he or she qualifies for a federal premium tax credit, arranges for the advanced payment of premium tax credit, directs payment of the advanced premium tax credit to his or her insurance provider, and provides all supporting documentation to ADAP.[29]

The Program provides access to HIV/AIDS drugs on the ADAP Self-Insured Formulary, which lists all the medications covered by the program. If a medication is not listed on the drug formulary, then ADAP will not cover the medication cost-sharing. Clients with insurance will obtain their medications from a CVS retail store or other participating pharmacy.

In 2025, 9,174 ADAP clients received insurance through ADAP Premium Plus Insurance Program.[30]

Nationwide ADAP Cost-Containment Trends

About half of the states currently find federal funding for ADAP insufficient and are considering, or have already made, cost-containment measures to keep ADAP expenditures within funding levels. For example, Delaware, Kansas, Pennsylvania, and Rhode Island reduced income eligibility for their respective ADAPs. Some states downsized their ADAP prescription drug formularies, including Arizona, Louisiana, Michigan, Nevada, and Pennsylvania. Some states reduced funding for ADAP medical and support services, increased provider recertification standards, implemented annual client spending caps, or restricted or eliminated health insurance

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the client's choosing. *See also* "Frequently Asked Questions," *CVS Specialty Pharmacy*, https://www.cvsspecialty.com/get-started/specialty/faq.html (last visited Mar. 27, 2026).

[24] Email from Lauren Cassedy, Chief of Staff, Department of Health on January 12, 2026, on file with the Health and Human Services Committee.

[25] Rule 64D-4.002(5), F.A.C. Version effective: October 12, 2022 to February 23, 2026.

[26] The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan. "Continuation of Health Coverage (COBRA), *U.S. Department of Labor* https://www.dol.gov/general/topic/health-plans/cobra (last visited Mar. 27, 2026).

[27] *Supra*, FN 17.

[28] Rule 64D-4.007(2), F.A.C. Version effective: November 1, 2022 to February 23, 2026.

[29] Rule 64D-4.007(3), F.A.C. Version effective: November 1, 2022 to February 23, 2026.

[30] Email from Lauren Cassedy, Chief of Staff, Department of Health on January 12, 2026, on file with the Health and Human Services Committee.

assistance. As of February 2026, no state implemented a client waiting list, although Arkansas, Louisiana, and New Jersey were considering it.[31]

One analysis attributes ADAP funding insufficiency to four developments beyond the states' control.[32] First, federal funding remains nominally flat and has not kept up with inflation, increased enrollment, and increased costs; in other words, the federal fiscal year 2025 appropriation of $438.8 million has similar purchasing power as the federal fiscal year 1999 appropriation of $434.0 million, expressed in 1996 dollars. Second, the number of clients served by ADAP across the country increased from 165,382 in 2007 to 257,644 in 2024, whereas annual appropriations per client served dropped from about $3,600 in 2007 to approximately $1,700 in 2024. Third, the annual average wholesale price (AWP) of HIV/AIDS prescription drugs increased from a range of $24,970 to $35,160 in 2012 to a range of $36,080 to $48,000 in 2018. By 2025, the recommended two-pill regimen annual AWPs ranged from $34,320 to $65,196, and the annual AWP for Biktarvy reached $61,000, which is up from $33,840 in 2018.[33] Fourth, the expiration of the enhanced version of the federal Patient Protection and Affordable Care Act (PPACA) premium tax credits, the average premium increase in PPACA marketplace exchange health plans, and the Medicare Part D out-of-pocket cap on prescription drugs through the federal Inflation Reduction Act all contribute to rising insurance costs.

Florida ADAP Cost-Containment Policy Changes

Florida experienced similar cost inflation. For example, the table below records the average insurance premium costs per month across the last 6 calendar years and estimates the 2026 figure.[34]

Average Insurance Premium Costs per Month							
Year	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Amount	**$650.54**	**$774.62**	**$982.86**	**$1,108.74**	**$1,262.07**	**$1,344.40**	**$2,361.20**

In January 2026, the DOH restricted ADAP eligibility and benefits, citing rising health care insurance premiums nationwide and insufficient federal Ryan White Grant funding. To this end, DOH decided to reduce the income eligibility from 400% FPL to 130 % FPL ($20,748 for an individual).[35]

DOH also decided to eliminate the ADAP Premium Plus Insurance Program, and discontinue covering premium assistance for full major medical coverage as a benefit. Instead, DOH planned to provide assistance for paying copayments and deductibles for covered medications, for those enrollees who purchase insurance without the premium assistance, calling this the ADAP Program for Medication Co-Payment and Medication Deductibles.[36]

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[31] "ADAP Watch: February 2026," *National Association of State and Territorial AIDS Directors* (last updated Feb. 9, 2026) https://nastad.org/resources/nastad-adap-watch-february-2026 (last visited Mar. 18, 2026).

[32] Lindsey Dawson and Jennifer Kates, "Constrained Budgets Lead States to Restrict HIV Drug Access Through Ryan White," *KFF* (Mar. 2, 2026) https://www.kff.org/hiv-aids/constrained-budgets-lead-states-to-restrict-hiv-drug-access-through-ryan-white/ (last visited Mar. 18, 2026).

[33] "Pricing Report Biktarvy," *National Drug Codes List*, Pricing History Table, https://ndclist.com/ndc/61958-2501/package/61958-2501-1/price (last visited Mar. 27, 2026). While ADAPs do not pay the full AWP because of price discounts through the 340B drug pricing program and supplemental manufacturer rebates, increasing drug costs may still affect them.

[34] Email from Lauren Cassedy, Chief of Staff, Department of Health on January 20, 2026, on file with the Health and Human Services Committee.

[35] Office of the Assistant Secretary for Planning and Evaluation, "2026 Poverty Guidelines: 48 Contiguous States," *U.S. Department of Health and Human Services*, https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf (last visited Mar. 31, 2026).

[36] The DOH Policy change to the ADAP Premium Plus Insurance Program is memorialized in Exhibit A of the AIDS Healthcare Foundation's January 2026 unpromulgated rule challenge petition against the Department of Health, which is located at the following link: *AIDS Healthcare Foundation, Inc., and Recipient One v. Florida Department of Health*, Docket No.: 26-000529RU, "Petition Challenging Agency Statements as Unpromulgated Rules and Request for Expedited Hearing filed," Exhibit D (Jan. 27, 2026) https://www.doah.state.fl.us/DocDoc/2026/000529/26000529_408_01272026_135915415_e.pdf (last visited Mar. 31, 2026). The first appearance of the new DOH program name "ADAP Program for Medication Co-Payment and Medication Deductibles" is the February

In addition, DOH changed the drugs covered under the program. DOH issued a new ADAP Formulary, applicable to uninsured, direct-dispense enrollees, which removed Biktarvy from coverage.[37] Descovy remains on the ADAP Formulary; however, DOH will require prior authorization for Descovy beginning on April 1, 2026, by restricting Descovy to clients with a creatinine clearance of less than 60 milliliters per minute.[38] DOH also issued a new ADAP Self-Insured Formulary, applicable to the enrollees in the new Medication Co-Payment and Deductibles program. It makes Biktarvy available to insured ADAP participants.[39] However, while Descovy remains on the ADAP Self-Insured Formulary, it is subject to the same clinical criteria as in the ADAP Formulary.[40]

DOH gave the public a two-month transitional grace period to adapt, making the changes effective April 1. DOH asserted these changes would prevent a program spending deficit of $120 million.[41] The table below records the benefit changes and ADAP cash flow before and after DOH policy changes.[42]

ADAP Benefits and Funding Summary			
Service Model	**Current Law**		**DOH 2026 Policy Changes** (March - December estimates)
	2025 Model	**2026 Model**	
Eligibility Cap	400% FPL	400% FPL	130% FPL
Benefits	Direct Dispense/CVS Caremark Premium Plus Insurance	Direct Dispense/CVS Caremark Premium Plus Insurance	Direct Dispense/CVS Caremark **Medication Copay & Deductibles**
Biktarvy	Both Formularies	Both Formularies	ADAP Self-Insured Formulary Only
Descovy	Both Formularies	Both Formularies	Clinical Criteria/Prior Authorization (April - Dec. estimate)
Clients	30,408	30,408	18,861
Revenue	$284,741,409	$284,741,409	$156,732,396
Spending	$403,052,142	$489,493,240	$136,270,030
Surplus/Deficit	($118,310,733)	($204,751,831)	$20,462,366

emergency rules 64DER26-1 and 64DER26-3. Florida Administrative Register, "Issue Vol. 52 / No. 39," *Department of State*, Section IV: Emergency Rules (Feb. 26, 2026) https://flrules.org/BigDoc/View_Section.asp?Issue=4590&Section=4 (last visited Mar. 27, 2026).

[37] *Id*. Scroll down to the "ADAP Medication ADAP Formulary Workgroup" tab. Under this tab, select "Medications Covered by ADAP" and select "Medications Covered by ADAP (Self-Insured)" to review both drug formularies.

[38] *Id*. Scroll down to the "ADAP Medication ADAP Formulary Workgroup" tab. Under this tab, select "Descovy Prior Authorization Form, which can also be accessed at: https://www.floridahealth.gov/wp-content/uploads/2026/03/Descovy-PA-Form_2026.pdf . HIV Elimination Services, Community Services Department, "Protecting HIV Care Through Sustainable 340B Solutions," *Palm Beach County*, (Mar. 13, 2026) https://discover.pbc.gov/communityservices/PDF/Florida%20ADAP%20Changes%203.13.2026.pdf#search=ADAP (last visited Mar. 18, 2026). "Florida Health: ADP Formulary Update April 1, 2026 | Pharmacy Guidance," *Department of Health*, https://discover.pbc.gov/communityservices/PDF/Update%20ADAP%20Guidance%20-%20Pharmacies%201.pdf (last visited Mar. 18, 2026). Note that this hyperlink directs the reader to the Palm Beach County government website, as this file could not be readily located on the Department of Health's website.

[39] *Id*. Scroll down to the "ADAP Medication ADAP Formulary Workgroup" tab. Under this tab, select "Medications Covered by ADAP" and select "Medications Covered by ADAP (Self-Insured)" to review both drug formularies.

[40] *Id*. Scroll down to the "ADAP Medication ADAP Formulary Workgroup" tab. Under this tab, select "Descovy Prior Authorization Form, which can also be accessed at: https://www.floridahealth.gov/wp-content/uploads/2026/03/Descovy-PA-Form_2026.pdf . HIV Elimination Services, Community Services Department, "Protecting HIV Care Through Sustainable 340B Solutions," *Palm Beach County*, (Mar. 13, 2026) https://discover.pbc.gov/communityservices/PDF/Florida%20ADAP%20Changes%203.13.2026.pdf#search=ADAP (last visited Mar. 18, 2026). "Florida Health: ADAP Formulary Update April 1, 2026 | Pharmacy Guidance," *Department of Health*, https://discover.pbc.gov/communityservices/PDF/Update%20ADAP%20Guidance%20-%20Pharmacies%201.pdf (last visited Mar. 18, 2026). Note that this hyperlink directs the reader to the Palm Beach County government website, as this file could not be readily located on the Department of Health's website.

[41] *Supra*, FN 17.

[42] Email from Lauren Cassedy, Chief of Staff, Department of Health on January 12, 2026, on file with the Health and Human Services Committee.

On January 27, 2026, the AIDS Healthcare Foundation, Inc., challenged the DOH policy change as an unpromulgated rule.[43] DOH responded by publishing a notice of emergency rulemaking on February 11, 2026, and secured an automatic stay of the administrative action.[44] After DOH published the February emergency rules to implement the adjustments to ADAP eligibility and benefits,[45] AIDS Healthcare Foundation, Inc., argued the February emergency rules constituted an invalid exercise of delegated legislative authority.[46] In a related civil legal proceeding against DOH, the Second Judicial Circuit of Florida denied, on March 23, 2026, the AIDS Healthcare Foundation request for an emergency injunction to stop the February emergency rules from taking effect.[47]

DOH superseded the February emergency rules on by issuing new emergency rules on March 15, 2026, which established new ADAP eligibility and benefits changes. The March emergency rules included the same income eligibility change as in the February emergency rules, but conditioned the income eligibility change upon the legislative outcome of this bill: should this bill become law before April 1, 2026, the income eligibility will be restored to 400% FPL; if the bill does not become law by April 1, the 130% FPL income eligibility in the emergency rule will apply. The March emergency rules also subject ADAP enrollment and services to available funding.[48]

Other than the conditional income eligibility changes, the March emergency rules include the same policy changes to the formularies and the ADAP Premium Plus Insurance Program, and maintain the Medication Co-Payment and Deductibles program created by the February emergency rules.[49]

According to DOH, the March emergency rules are an attempt to mitigate the risk that approximately 32,000 ADAP enrollees in Florida lose access to HIV/AIDs prescription drugs and experience increased viral loads, which could elevate and facilitate the transmission of HIV/AIDs within the state, and to ensure the greatest number of Floridians can receive some form of direct dispense medication within the constraints of available ADAP funding.[50]

With the March emergency rules in effect, the administrative law judge dismissed the administrative proceeding relating to the February rules on March 17, 2026.[51]

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[43] *AIDS Healthcare Foundation, Inc., and Recipient One v. Florida Department of Health*, Docket No.: 26-000529RU, "Petition Challenging Agency Statements as Unpromulgated Rules and Request for Expedited Hearing filed," (Jan. 27, 2026) https://www.doah.state.fl.us/DocDoc/2026/000529/26000529_408_01272026_135915415_e.pdf (last visited Mar. 18, 2026).
[44] *AIDS Healthcare Foundation Inc*., Docket No.:26-000529RU, "Order Canceling Hearing and Staying Proceeding," (Feb. 12, 2026) https://www.doah.state.fl.us/DocDoc/2026/000529/26000529OCH-021226-03220720.pdf (last visited Mar. 18. 2026).
[45] Florida Administrative Register, "Issue Vol. 52 / No. 39," *Department of State*, Section IV: Emergency Rules (Feb. 26, 2026) https://flrules.org/BigDoc/View_Section.asp?Issue=4590&Section=4 (last visited Mar. 27, 2026).
[46] *AIDS Healthcare Foundation Inc*., Docket No.:26-001089RE, "Petition Challenging the Validity of Emergency Rules 64DER26-1, 64DER26-2, and 64DER26-3 filed," pp. 14 (Feb. 26, 2026) https://www.doah.state.fl.us/ALJ/searchDOAH/docket.asp?T=3/18/2026%203:06:30%20PM (last visited Mar. 18, 2026).
[47] *See* Christine Sexton, "Florida court rejects AIDS Healthcare Foundation's bid for emergency injunction to stop cuts," *Florida Phoenix*, (Mar. 24, 2026) https://www.wlrn.org/health/2026-03-24/florida-court-rejects-aids-healthcare-foundations-bid-for-emergency-injunction-to-stop-cuts (last visited Mar. 24, 2026). *See also AIDS Healthcare Foundation, Inc., and Recipient One v. Florida Department of Health*, Docket No.: 2026-CA-00386 (2d. Jud. Cir. March 23, 2026). Plaintiff's Notice of Voluntary Dismissal submitted to the Circuit Court of the Second Judicial Circuit in and for Leon County, Mar. 25, 2026, on file with the Health and Human Services Committee. Plaintiffs filed dismissal because this bill became law.
[48] Florida Administrative Register, "Issue Vol. 52 / No. 51," *Department of State*, Section IV: Emergency Rules (Mar. 16, 2026) https://flrules.org/BigDoc/View_Section.asp?Issue=4602&Section=4 (last visited Mar. 18, 2026).
[49] *See* Florida Administrative Register, "Issue Vol. 52 / No. 39," *Department of State*, Section IV: Emergency Rules (Feb. 26, 2026) https://flrules.org/BigDoc/View_Section.asp?Issue=4590&Section=4 (last visited Mar. 27, 2026). *See* Florida Administrative Register, "Issue Vol. 52 / No. 51," *Department of State*, Section IV: Emergency Rules (Mar. 16, 2026) https://flrules.org/BigDoc/View_Section.asp?Issue=4602&Section=4 (last visited Mar. 18, 2026).
[50] *Supra*, FN 48.
[51] *AIDS Healthcare Foundation, Inc*., Docket No.:26-001089RE, "Final Order of Dismissal. CASE CLOSED," (Mar. 17, 2026) https://www.doah.state.fl.us/DocDoc/2026/001089/26001089DWH-031726-07595462.pdf (last visited Mar. 27, 2026).

Health Coverage Plans

Commercial Health Insurers

The Office of Insurance Regulation (OIR) reports that the individual health insurance market in Florida covers about 4.4 million people, and another 2.1 million receive coverage through the group health insurance market. Total premiums for the commercial market exceeded $45.9 billion in 2024 with approximately $31.4 billion in the individual market and $14.4 billion in the group market.[52]

The Florida Health Insurance Advisory Board (FHIAB) advises OIR, AHCA, the Department of Financial Services, other executive departments, and the Legislature on health insurance issues. As of year-end 2024, FHIAB reports that health insurance coverage by market segment consisted of:

- Individual Coverage – 4,444,258 covered lives, an increase of 22.4% from 2023.
- Small Group (1-50 members) – 355,416 covered lives, a decrease of 11.2% from 2023.
- Large Group (51+ members) – 1,731,416 covered lives, a decrease of 3.2% from 2023.
- Total Market – 6,531,543 covered lives, an increase of 12.2% from 2023.[53]

Health Maintenance Organizations

A health maintenance organization (HMO) offers cost-sensitive health insurance plans geared towards preventative health care and characterized by strict in-network, referral-based care coordination, with exceptions for emergencies, managed by the plan beneficiary's designated primary care physician.[54] HMOs must have an OIR-issued certificate of authority and an AHCA-issued Health Care Provider Certificate to operate in Florida.[55] Once an HMO is issued a certificate, the HMO may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services, including drugs, to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum.[56] As of March 27, 2026, OIR reports there are 64 HMOs.[57]

State Employee Group Insurance Program

The State Employee Group Insurance Program (SGI Program) is governed by ch. 110, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS). The SGI Program is an optional benefit for all state employees, and includes health, life, dental, vision, disability, and other supplemental insurance benefits. The SGI program covers over 360,000 state employees, dependents, and retirees. The SGI Program typically makes benefits changes on a plan year basis, January 1 through December 31.

As part of the SGI Program, DMS is required to maintain the State Employee Prescription Drug Program (Prescription Drug Plan).[58] DMS contracts with Optum Rx, a pharmacy benefit manager, to administer the Prescription Drug Plan.[59] For Fiscal Year 2024-2025, DSGI estimates that the State Employee Group Insurance

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[52] Florida Health Insurance Advisory Board, *2025 Florida Health Insurance Market Report*, Florida Office of Insurance Regulation (adopted Dec. 19, 2025) https://floir.gov/docs-sf/default-source/fhiab/florida-health-insurance-market-reports/fhiab-2025-market-report---final-as-approved-2.pdf (last visited Feb, 23, 2026).
[53] *Id*.
[54] *See* Chief Financial Officer, "Health Insurance and Health Maintenance Organizations: a guide for consumers" Department of Financial Services, (Jul. 2025) https://myfloridacfo.com/docs-sf/consumer-services-libraries/consumerservices-documents/understanding-coverage/consumer-guides/health-insurance-guide.pdf?sfvrsn=5546b2b_4 (last visited Feb. 23, 2026).
[55] S. 641.21(1), F.S.
[56] S. 641.19(4), F.S., s. 641.31(1), F.S.
[57] Office of Insurance Regulation, "Active Company Search," https://companysearch.floir.gov/ (last visited Mar. 27, 2026). For the "Company Type" row, select "Health Maintenance Organization (HMO)" and click "Search" for inquiry results.
[58] S. 110.12315, F.S.
[59] Department of Management Services, *myFlorida, Prescription Drug Plan*, https://www.mybenefits.myflorida.com/myhealth/prescription_drug_plan (last visited Feb. 23, 2026).

Program spent $1.22 billion on prescription drug claims for covered beneficiaries and an additional $5.1 million on pharmacy benefit manager claims administration.[60]

Florida Medicaid and the Program of All-Inclusive Care for the Elderly (PACE)

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid Program, licensing and regulating health facilities, and providing health care quality and price information to Floridians.[61] The Department of Children and Families makes Medicaid eligibility determinations.[62] For January 2026, Florida Medicaid recorded a monthly enrollment total of 3,945,922 people, with 72.3% enrolled in managed care plans, 27.5% enrolled in the fee-for-service program, and 0.1% enrolled in the Program of All-Inclusive Care for the Elderly (PACE).[63, 64]

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[65] The federal government also sets the minimum mandatory benefits to be covered in every state's Medicaid program.[66] Under federal Medicaid law, prescription drug coverage is an optional benefit states may choose to cover; Florida Medicaid covers prescription drugs.[67]

Drug Manufacturer Rebates

The Medicaid Drug Rebate Program (MDRP) is a federally negotiated rebate program that helps State Medicaid agencies obtain rebates from drug manufacturers in return for outpatient coverage of the manufacturer's brand-name drugs. The rebate amount is the sum of a basic rebate[68] plus an inflation rebate.[69]

In addition to federally negotiated rebates, Florida Medicaid also negotiates for state-only manufacturer rebates, also known as state supplemental rebates. Current law specifies the threshold amount of supplemental rebates at 14% of the average manufacturer's price on the last day of the quarter. In addition, current law authorizes Florida Medicaid to require generic drug manufacturers to provide a minimum rebate of 15.1% of the average manufacturer price for the generic drug. There is no upper limit on the supplemental rebate amount.[70]

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[60] DSGI estimates that the state preferred provider organization plans spent $644.3 million on prescription drug claims plus another $2.7 million on PBM administration, the state health maintenance plans spent $570.7 million on prescription drug claims plus another $2.4 million on PBM administration, and the Medicare Advantage prescription drug plans spent $9.6 million. Division of State Group Insurance, "State Employees' Group Health Self-Insurance Trust Fund: Report on Financial Outlook for the Fiscal Years Ending June 30, 2025 through June 30, 2030," Department of Management Services, Ex. III: Financial Outlook by Fiscal Year, pp. 9 (Aug. 11, 2025) https://www.edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf (last visited Feb. 23, 2026).

[61] Office of Program Policy Analysis and Government Accountability, *Agency for Health Care Administration*, https://oppaga.fl.gov/ProgramSummary/ProgramDetail?programNumber=5048 (last visited Feb. 23, 2026).

[62] S. 409.902, F.S.

[63] The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. Medicaid, PACE, https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE (last visited Feb. 23, 2026).

[64] Florida Agency for Health Care Administration, Current Comprehensive Medicaid Managed Care Enrollment Reports, (Jan. 2026) https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited Feb. 23, 2026). Select the "Medicaid" tab on the lower toolbar of the Excel Spreadsheet.

[65] Title 42 U.S.C. §§ 1396-1396w -5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725).

[66] S. 409.905, F.S. Florida Medicaid Managed Care sets a minimum benefit package that build on top of the federal minimum benefits package. S. 409.973, F.S.

[67] S. 409.973(1)(x), F.S.

[68] The basic rebate is the greater of 23.1% of the average manufacturer price or the average manufacturer price minus the Medicaid best price. The Medicaid best price is the manufacturer's net price for a drug and is inclusive of all applicable discounts, rebates, or other transactions that adjust prices.

[69] The inflation rebate is an amount that offsets the increase in a manufacturer's gross price for a drug above inflation.

[70] S. 409.912(5)(a), F.S. AHCA may negotiate an amount lower than 14% of the average manufacturer price if the federal and/or supplemental rebate equal or exceeds 29%.

Prescription Drug Coverage and Utilization Management

AHCA administers a prescription-drug spending-control program for Florida Medicaid which includes the use of a preferred drug list (PDL) and various utilization management techniques. The PDL is recommended by gubernatorially appointed Pharmaceutical and Therapeutics (P&T) Committee, which considers which drugs are medically appropriate, cost-effective therapeutic drugs for Medicaid enrollees. The P&T Committee also makes recommendations regarding the use of prior authorization. Current law requires the PDL to include at least two drugs in each therapeutic class, if feasible. AHCA requires prior authorization for Medicaid-covered prescription drugs not on the PDL.[71]

Medicaid managed care plans must follow the AHCA prescription drug coverage and utilization management requirements and use the preferred drug list, and may not establish their own preferred drug list. The plans establish the pharmacy networks, and may limit the size of pharmacy networks based on need, competitive bidding, price negotiations, credentialing, or similar criteria.[72]

Program of All-Inclusive Care for the Elderly (PACE)

PACE provides pre-paid, capitated, comprehensive health care services to adults aged 55 years or older who need a nursing home level of care but can live safely in their communities for as long as it is medically and socially feasible.[73] PACE organizations must provide a benefits package to PACE participants that includes all Medicare-covered services, all Medicaid-covered services specified in the state plan, and other services determined necessary to improve and maintain the participants overall health; this includes prescription drugs.[74] PACE organizations have agreements with the federal Centers for Medicare & Medicaid Services (CMS) and the state administering agency (i.e., AHCA in Florida). Through December 2025, AHCA reports there are 16 operational PACE organizations, 10 applicants seeking approval for PACE organization status, and 3,858 total participants receiving benefits through PACE organizations.[75]

Oversight and Audits

Under federal law, CMS audits the operations of PACE organizations. For the first three years of a PACE organization's trial period, CMS audits its operations, which includes analyzing fiscal soundness, service capacity, substantial compliance with federal law, and other factors. Beyond the first three years, CMS audits the PACE organization as appropriate, taking into account the performance levels and substantial compliance. For each audit, CMS must work in cooperation with the state administering agency (i.e., AHCA in Florida).[76] CMS may take corrective action for violations revealed by an audit, including sanctions and termination of an organization's PACE status.[77]

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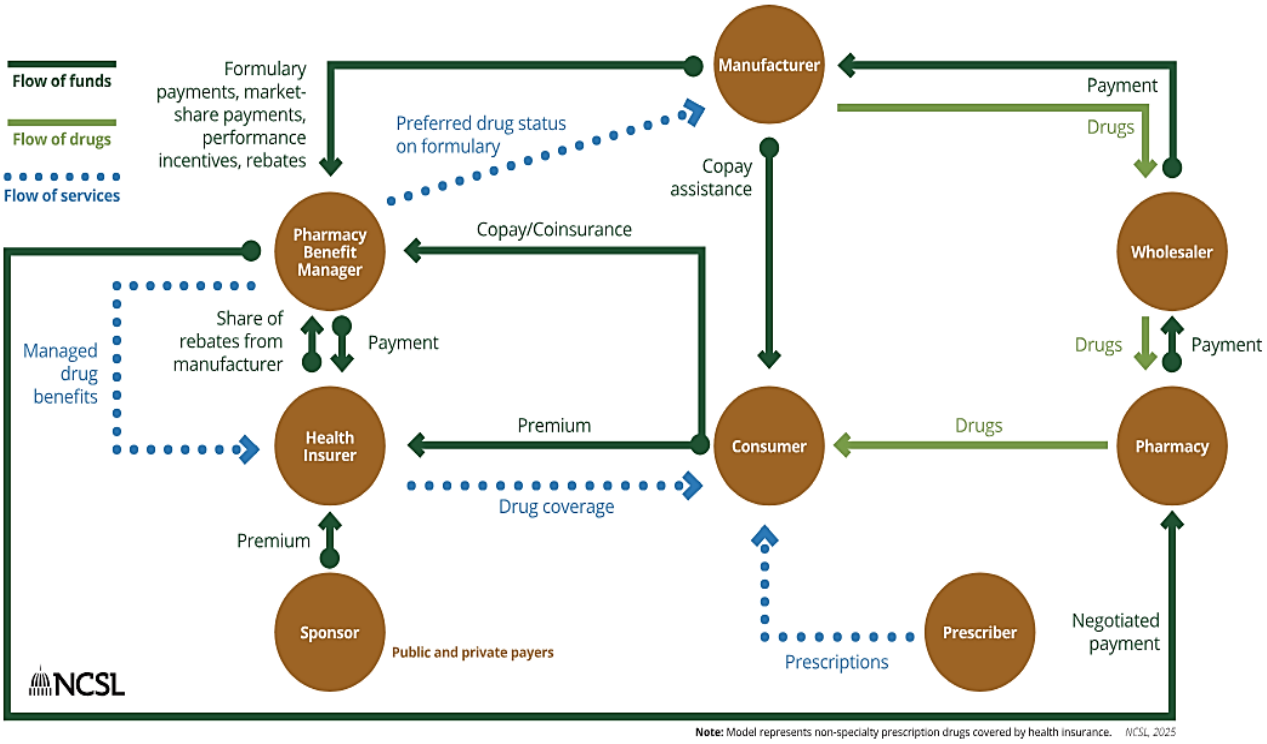
[71] S. 409.912, F.S., s. 409.912(5)(a), F.S., s. 409.91195, F.S., s. 409.91196, F.S.
[72] *Id*.
[73] 42 C.F.R. § 460.2. "Florida Medicaid's Covered Services and HCBS Waivers: Program of All-Inclusive Care for the Elderly," *Agency for Health Care Administration*, https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/program-of-all-inclusive-care-for-the-elderly (last visited Feb. 26, 2026).
[74] 42 C.F.R. §§ 460.6. 460.92. The benefit limitations under Medicare and Medicaid and the conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, and other cost-sharing do not apply to PACE participants, who must receive such benefits solely through the PACE organization. 42 C.F.R. §§ 460.90. "Florida Medicaid's Covered Services and HCBS Waivers: Program of All-Inclusive Care for the Elderly," *Agency for Health Care Administration*, https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/program-of-all-inclusive-care-for-the-elderly (last visited Feb. 26, 2026).
[75] "Program of All-Inclusive Care for the Elderly, Monthly Report: December 2025," *Agency for Health Care Administration*, (Feb. 4, 2026) https://ahca.myflorida.com/content/download/28203/file/December%202025%20PACE%20Report.pdf (last visited Feb. 26, 2026).
[76] 42 U.S.C. §§ 1395eee(e)(4), 1396u-4(e)(4).
[77] 42 C.F.R. § 460.194

Pharmacy Benefit Managers

To manage drug costs, a health plan sponsor typically contracts a pharmacy benefit manager (PBM) to build their prescription drug benefit package. As a contracted professional service, the PBM develops the health plan's prescription drug formulary and organizes a network of pharmacies where plan beneficiaries can pick up their prescriptions at reduced prices. A PBM who contracts to administer prescription drug benefits in Florida on behalf of a health plan sponsor must be licensed as an insurance administrator by obtaining a certificate of authority from OIR.[78] A certificate of authority issued to a PBM remains valid, unless OIR suspends or revokes the certificate, so long as the PBM conducts business in Florida.[79] As of March 27, 2026, OIR regulates 71 PBMs.[80]

As an insurance administrator, a PBM acts in a fiduciary capacity[81] on behalf of the health plan sponsor,[82] and negotiates directly with drug manufacturers and pharmacies interested in selling their drugs and pharmacist services, respectively, to the health plan's beneficiaries. PBMs can manage utilization of a prescription drug and its overall cost by making the drug's out-of-pocket cost higher or lower. As a result, the placement of prescription drugs on a formulary can affect utilization of a drug. Through negotiations, PBMs secure reduced drug prices or arrange rebate deals with drug manufacturers and drug manufacturers receive a steady volume of beneficiary demand for their drugs. The inclusion of a pharmacy within a health plan's pharmacy network can increase customer volume for that pharmacy. Through negotiations, PBMs gain favorable reimbursement rates with pharmacies. In return, in-network pharmacies enjoy a steady volume of beneficiary demand for their services.

The prescription drug supply chain is a complex machine where PBMs directly or indirectly influence most individualized transactions amongst industry participants, as the infographic below illustrates.[83]



[78] S. 626.8805(1), F.S. If a PBM lacks a valid certificate of authority to act as an administrator, the PBM is subject to a fine of $10,000 per violation per day.
[79] S. 626.8805(6), F.S.
[80] Office of Insurance Regulation, "Active Company Search," https://companysearch.floir.gov/ (last visited Mar. 27, 2026). For the "Company Type" row, select "Pharmacy Benefit Manager" and click "Search" for inquiry results.
[81] Fiduciary representation contemplates a legally cognizable relationship of trust where an intermediary figure advances the interests of a principal for the primary and direct benefit of the principal's designated beneficiary.
[82] S. 626.883, F.S.
[83] "Prescription Drug Supply Chain," *National Conference of State Legislatures* (updated Feb. 23, 2026) https://www.ncsl.org/health/prescription-drug-supply-chain (last visited Jan. 22, 2026).

In recent years, state governments have focused on PBMs for several reasons, including their business practices, market consolidation, and lack of transparency, all of which factor into concerns that PBMs themselves have played a role in increasing drug prices, even as they work to manage pharmacy benefits and costs for insurers.[84]

Unlawful Activity

OIR also takes enforcement action against PBMs that commit the following unlawful business activities, pursuant to s. 626.8827, F.S.:

- Prohibiting, restricting, or penalizing a pharmacy from disclosing to any person:
  - The nature of treatment, risks, or alternatives.
  - The availability of alternate treatment, consultations, or tests.
  - The decision of, or the process used by, utilization reviewers to authorize or deny pharmacist services or benefits.
  - Information on financial incentives and structures used by the health plan sponsor.
  - Information that may reduce the costs of pharmacist services.
  - Whether the cost-sharing obligation exceeds the retail price for a covered prescription drug and the availability of a more affordable alternative drug.
  - Other information the pharmacy deems appropriate to disclose.
- Prohibiting, restricting, or penalizing a pharmacy from disclosing confidential proprietary information to certain state agencies,[85] provided that the pharmacy marks such information as confidential or requests confidential treatment for any oral communication of such information.
- Communicating at the point-of-sale, or otherwise require, a cost-sharing obligation for the plan beneficiary in an amount that exceeds the lesser of:
  - The applicable cost-sharing amount under the applicable pharmacy benefits plan or program; or
  - The usual and customary price[86] of the pharmacist services.
- Transferring or sharing records relative to prescription information containing patient-identifiable or prescriber-identifiable data to an affiliated pharmacy for any commercial purpose other than the limited purposes of facilitating pharmacy reimbursement, formulary compliance, or utilization review on behalf of the applicable pharmacy benefits plan or program.
- Failing to make any payment due to a pharmacy for an adjudicated claim with a date of service before the effective date of a pharmacy's termination from a pharmacy benefit network.[87]
- Terminating the contract of, penalize, or disadvantage a pharmacy that lawfully discloses information about PBM practices, exercises statutorily reserved prerogatives, or shares its contractual agreement with OIR pursuant to a compliant or query.
- Failing to pay a pharmacy for any pharmacy benefit claim, provided that the health plan sponsor delegates the obligation of payment to the PBM.
- Failing to comply with contractual requirements as specified in 626.8825(2), F.S.

As an OIR-regulated entity, PBMs must cooperate with biennial examinations and ad hoc investigations, make available certain documents and records, and comply with recordkeeping requirements. OIR must impose an administrative fine of $5,000 for each contractual violation and, or each unlawful activity discovered; a PBM's

[84] Meredith Freed, Julliette Cubanski, and Elizabeth Williams, "What to Know About Pharmacy Benefit Managers (PBMs) and Federal Efforts at Regulation," *KFF* (Dec. 18, 2025) https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/ (last visited Feb. 23, 2026).
[85] These state agencies include OIR, AHCA, the Department of Management Services, law enforcement, or state and federal governmental officials.
[86] The usual and customary price means the amount charged to cash customers for a pharmacist service exclusive of sales tax or other amounts claimed. s. 626.8825, F.S.
[87] However, a PBM may withhold payment because of fraud on the part of the pharmacy or when other law requires.

failure to pay is grounds for the denial, suspension, or revocation of its certificate of authority.[88] OIR has approximately 38 ongoing PBM investigations, as of September 2025.[89]

Contractual Regulation

Current law sets many parameters on PBM contracts with health plan sponsors and pharmacies, including requiring or prohibiting certain terms and conditions.

With respect to its contractual agreements with health plan sponsors, PBMs must incorporate the following terms and conditions, pursuant to s. 626.8825(2), F.S.:

- Use a pass-through pricing model[90] without applying financial clawbacks, reconciliation offsets, or offsets to adjudicated claims.
- Prohibit spread pricing.[91]
- Use accounting measures to ensure a health plan sponsor's payment for services rendered to the PBM is allocated pursuant to the terms of the contract.
- Pass 100% of manufacturer rebates to offset plan beneficiary cost-sharing obligations and premium amounts, provided the contract delegates rebate negotiation to the PBM.[92]
- Include federally complaint pharmacy network adequacy requirements.
- Prohibit conditioning a pharmacy's participation in one pharmacy network upon its participation in another pharmacy network.
- Prohibit penalizing a pharmacy from exercising its prerogative not to participate in a specific pharmacy network.
- Prohibit requiring that in-network pharmacies meet accreditation standards inconsistent with or more stringent than federal and state requirements for licensure as a pharmacy (except specialty networks).
- Provide a 60-day continuity-of-care period concerning drug formulary changes, during which plan beneficiaries may access covered drugs on the formulary at the current price.

With respect to its contractual agreements with pharmacies, PBMs must incorporate the following terms and conditions, pursuant to s. 626.8825(3), F.S.

- Provide detailed remittance information that helps pharmacies identify the appropriate reimbursement schedule at the time of claim adjudication and ensure that claim level payment adjustments comply with nationally standardized protocols.
- Use nationally standardized reconciliation protocol for any effective rate guarantee.
- Prohibit financial clawbacks, reconciliations offsets, or offsets to adjudicated claims.
- Prohibit PBM from charging, withholding, or recouping direct or indirect remuneration fees, dispensing fees, or brand name or generic rate adjustments through reconciliation.[93]

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[88] S. 626.8828, F.S.

[89] Email from Seth Stubbs, Director of Legislative & Cabinet Affairs, Office of Insurance Regulation, on September 19, 2025. On file with the Health & Human Services Committee.

[90] A pass-through pricing model is where the health plan sponsor pays the PBM for covered outpatient drugs which are 1) equivalent to the payments the PBM makes to a dispensing pharmacy or provider for such drugs, including any contracted professional dispensing fee between the PBM and in-network pharmacies, and which are 2) passed through in their entirety by the health plan sponsor or by the PBM to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation. S. 626.8825(1)(p), F.S.

[91] Spread pricing occurs when a PBM charges a health plan sponsor a different amount for pharmacist services than the amount the PBM reimburses a pharmacy for the same pharmacist services. s. 626.8825(1)(w), F.S.

[92] The manufacturer rebate pass-through payment does not apply to PBM contracts involving Medicaid managed care plans.

[93] This prohibition does not apply to recoupments returned to Medicaid or the State Group Insurance Program. This prohibition also does not apply to PBM incentive payments to network pharmacies for meeting or exceeding quality metrics. This prohibition also does not apply to recoupment due to erroneous claims, fraud, waste, or abuse. This prohibition also does not apply to a claim adjudicated in error, a maximum allowable cost appeal pricing adjustment, or an adjustment made as part of a pharmacy audit.

- Prohibit PBM from charging, withholding, or recouping amounts related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when a free may be recouped from a pharmacy.[94]
- Prohibit PBM from unilaterally changing the terms of any participation contract.
- Allow pharmacy to offer mail or delivery services if plan beneficiary generally opts in to such services or specifically requests such services.
- Allow pharmacy to charge a shipping and handling fee if pharmacy discloses the amount to the plan beneficiary as well as the possibility of not being reimbursed for those fees.
- Provide upon a pharmacy's request a list of health plan sponsors in which the pharmacy is part of the network.[95]

As of March 27, 2026, 10,926 pharmacies have active permits issued by the Department of Health (DOH).[96]

Maximum Allowable Cost and Reimbursement Appeals

Current law requires a PBM's contractual agreement with a pharmacy to provide a reasonable administrative appeal procedure that allows a pharmacy to appeal the PBM's maximum allowable cost pricing information and the corresponding reimbursement for a specific drug that the pharmacy argues is below its acquisition cost. Every 90 days, OIR-regulated PBMs must report to OIR the total number of appeals received and denied for each specific drug in the preceding 90-day period and supply its explanations or reasonings for each denial.[97]

Vertical Integration

Vertical integration describes a form of marketplace consolidation by which a parent conglomerate company stacks different lines of business under its corporate umbrella for the purpose of owning and integrating a greater share of its supply chain. In practice, vertical integration activities may include reinvesting capital to bring emerging companies to scale, distributing acute financial risk across business assets in-house to mitigate supply chain disruptions, and building new markets for goods and services along its supply chain that challenge the status quo.[98] An example of this in the healthcare sector is a hospital system buying or affiliating with entities providing lower levels of care, such as physician practices, laboratories, or imaging clinics. In contrast to vertical integration, horizontal integration occurs when business rivals within the same line of business acquire or merge with each other to exercise greater market share over remaining competitors. An example of this in the healthcare sector is one hospital system or health insurer buying or merging with another hospital system or health insurer, respectively.

Vertical integration of the healthcare sector reflects a recent shift towards risk-based contracting amongst payers and providers, where a parent healthcare conglomerate builds a vertically integrated network of different lines of business (e.g., insurance, PBM, primary care, pharmacy, etc.) to distribute acute financial risks for individual

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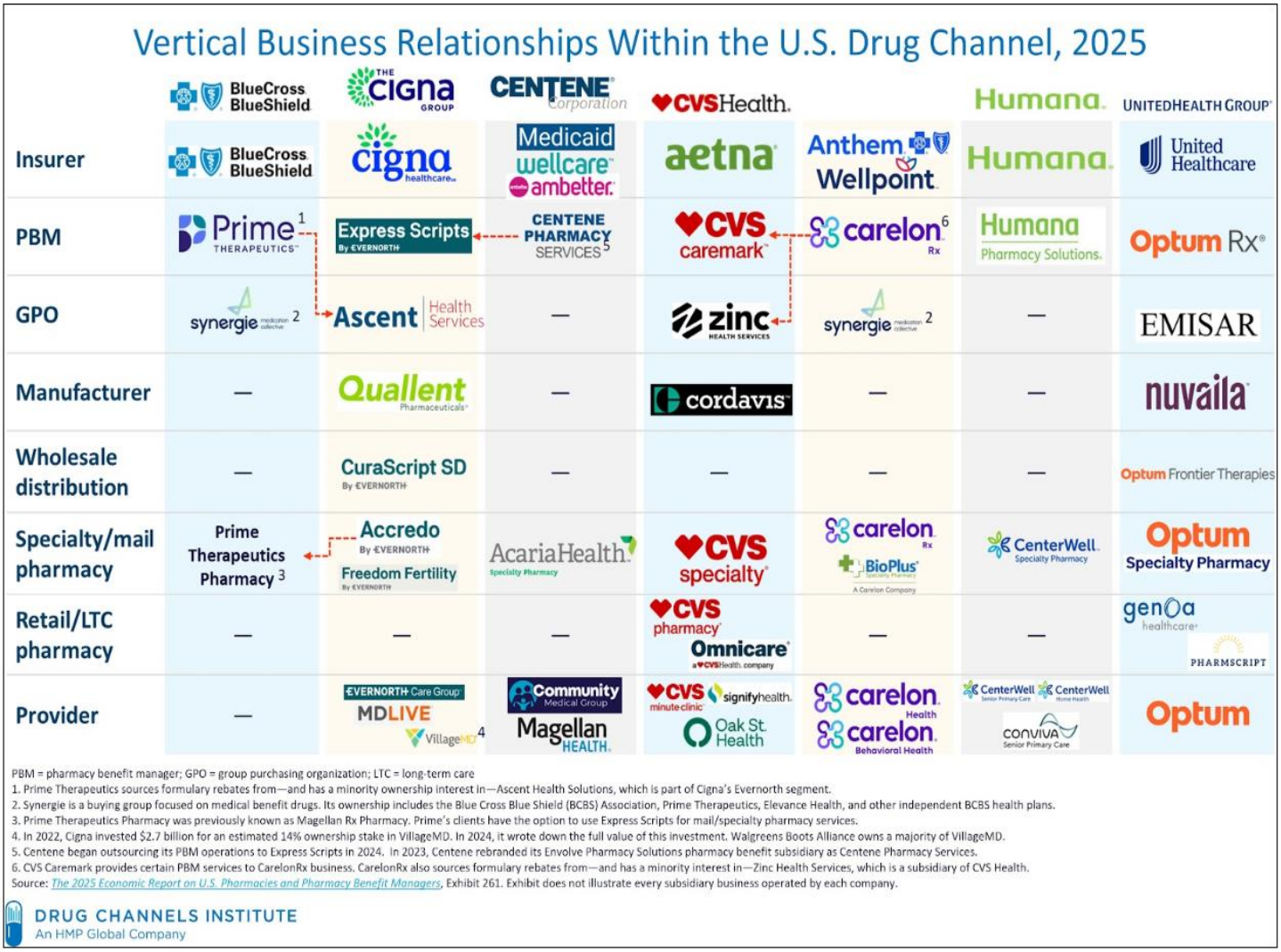
[94] *Id*.
[95] The PBM must communicate list updates to the pharmacy within 7 days, and the PBM cannot restrict the pharmacy from publicly disclosing the list.
[96] Division of Medical Quality Assurance, "License Verification," Department of Health, https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited Mar. 27, 2026). In the "Profession" row, select "Pharmacy" and in the "License Status" row, select "Practicing statuses only", and click "Search" for inquiry results.
[97] S. 626.8825(3)(h), F.S.
[98] Mark Messina, "Exploring Vertical Integration in the Supply Chain," *Forbes* (Dec. 29. 2022) https://www.forbes.com/councils/forbestechcouncil/2022/12/29/exploring-vertical-integration-in-the-supply-chain/ (last visited Mar. 27, 2026). *See* James Barlow, "The Power of Diversification and Vertical Integration for Growth," *Forbes*, (Sept. 24, 2024) https://www.forbes.com/councils/forbesbusinesscouncil/2024/09/24/the-power-of-diversification-and-vertical-integration-for-growth/ (last visited Mar. 27, 2026). *See* Marc Emmer, "Why Vertical Integration Is the Path To Strategic Advantage," Forbes, (Jan. 29, 2024) https://www.forbes.com/councils/forbesbusinesscouncil/2024/01/29/why-vertical-integration-is-the-path-to-strategic-advantage/ (last visited Mar. 27, 2026).

business segments across the entire healthcare delivery supply chain. While vertical mergers may create pro-competitive administrative efficiencies, they also create anticompetitive effects.[99]

As the below infographic illustrates, a handful of parent healthcare conglomerates control the prescription drug supply chain in the United States through vertical integration by acquiring lines of business in manufacturing, distribution, prescription drug coverage and reimbursement, PBMs, prescribing providers, and pharmacy fulfillment.[100]



For 2024, nearly 80% of all equivalent prescription claims were processed by three PBMs: the CVS Caremark business of CVS Health, the Express Scripts business of Cigna, and the Optum Rx business of UnitedHealth Group. Five of the six largest PBMs are now owned by organizations that also own a health insurer.[101]

[99] *See* Kevin Hahm and Brian Miller, "A Framework for Evaluating Vertical Integration Among Payers and Providers," *American Bar Association*, 39 Fall Antitrust 45 (Fall 2024) https://www.americanbar.org/content/dam/aba/publications/antitrust/magazine/2024/vol-39-issue-1/framework-evaluating-vertical-integration.pdf (last visited Feb. 23, 2026). *See* Zachary Levison, Jamie Godwin, Scott Hulver, and Tricia Neuman, "Ten Things to Know About Consolidation in Health Care Provider Markets," *KFF*, (Apr. 19, 2024) https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/ (last visited Mar. 27, 2026).

[100] Drug Channels Institute, "Drug Channels: Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers" (Apr. 2025) https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html (last visited Feb. 23, 2026).

[101] Adam Fein, "The Top Pharmacy Benefit Mangers of 2024: Market Share and Key Industry Developments," *The Drug Channels Institute* (Mar. 31, 2025) https://www.drugchannels.net/2025/03/the-top-pharmacy-benefit-managers-of.html (last visited Feb. 23, 2026).

In 2025, the FTC analyzed 51 specialty generic drugs[102] dispensed from 2017 to 2022 for members of commercial health plans and Medicare Part D prescription drug plans managed by CVS Caremark, Express Scripts, and Optum Rx as a part of its ongoing study of the PBM industry. The FTC found that these three PBMs marked up numerous specialty generic drugs by hundreds and thousands of precent, with the majority of the most highly marked up drugs dispensed by the PBM's own affiliated pharmacies. The FTC believes this dispensing pattern indicates that these PBMs may be steering highly profitable prescriptions to their own affiliated pharmacies. The FTC also found that CVS Caremark, Express Scripts, and Optum Rx reimbursed their affiliated pharmacies at a higher rate than they paid unaffiliated pharmacies on nearly every specialty generic drug examined. Collectively, these companies generated more than $7.3 billion in revenue from dispensing drugs in excess of the drugs' estimated acquisition costs plus an additional $1.4 billion from spread pricing. [103]

In the same analysis, the FTC observed that these specialty generic drug dispensing practices account for 12% of aggregated operating income in 2021 as reported by the parent healthcare conglomerates' business segments.[104]

Affiliated Businesses

In practice, a PBM can hold an ownership interest in an insurer or a pharmacy, or vice versa, or a parent conglomerate company can hold the PBM and the insurer or pharmacy as sister companies by affiliation under common ownership through vertical integration. In both cases, the PBM must disclose such business relationships to OIR. Current law requires PBMs to disclose to OIR any ownership interests or affiliations of any kind with:

- Any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the PBM provides administrative services; and
- Any pharmacy which, either directly or indirectly, through one or more intermediaries:
  - Has an investment or ownership interest in an OIR-regulated PBM;
  - Share common ownership with an OIR-regulated PBM; or
  - Has an investor or a holder of an ownership interest which is an OIR-regulated PBM.[105]

Not all affiliated businesses are vertically integrated into a parent conglomerate, but all businesses within a parent conglomerate are affiliated business.

RECENT LEGISLATION:

YEAR	BILL #/SUBJECT	HOUSE/*SENATE* SPONSOR(S)	OTHER INFORMATION
2023	CS/CS/SB 1550 - Prescription Drugs	Chaney/ *Brodeur*	Became law July 1, 2023.

[102] Historically, specialty drugs necessitated special handing and administration. The FTC asserts this is not necessarily the case anymore and that there is no standard definition. Instead, the FTC states specialty drugs are characterized by a variety of factors, including their high cost.
[103] Federal Trade Commission, "FTC Releases Second Interim Staff Report on Prescription Drug Middlemen," (Jan. 14, 2025) https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen (last visited Feb. 23, 2026).
[104] *Id.*
[105] S. 626.8814, F.S. A PBM must also formally report any change ownership interests or affiliations to OIR within 60 days after the change occurs.