The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 46
INTRODUCER:	Senator Wright and others
SUBJECT:	Health Insurance Cost Sharing
DATE:	April 5, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Thomas	Knudson	BI	**Favorable**
2.			HP	
3.			FP	

I. Summary:

SB 46 creates provisions relating to prescription drug cost-sharing requirements for individual health insurers, group health insurers, and health maintenance organizations. The bill applies to any health insurance policy or health maintenance contract or certificate issued, delivered, or renewed on or after January 1, 2024.

The bill provides that each individual health insurer, group health insurer, or health maintenance organization providing prescription drug coverage, or any pharmacy benefit manager on behalf of such insurer or organization, must apply any amount paid by an insured or subscriber, or by another person on behalf of the insured or subscriber, toward the insured's or subscriber's total contribution to any cost-sharing requirement. The amount paid by, or on behalf of, the insured or subscriber which is applied toward the insured's or subscriber's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

The bill requires each such insurer or organization providing prescription drug coverage to disclose that any amount paid by a policyholder or subscriber, or by another person on behalf of the policyholder or subscriber, must be applied toward the policyholder's or subscriber's total contribution to any cost-sharing requirement.

The bill requires that contracts between such insurers or health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by an insured or subscriber, or by another person on behalf of the insured or subscriber, toward the insured's or subscriber's total contribution to any cost-sharing requirement.

The bill's fiscal impact on state and local government is unknown, but the bill may lead to increased costs for health care coverage.

The bill becomes effective on July 1, 2023.

II. Present Situation:

Prescription drugs are a vitally important part of a person's health regimen, however, the cost of these drugs keep them out of reach for some. Data from a 2019 poll shows 25 percent of Americans reporting difficulty affording their medicine.[1]

Many chronic conditions are treated with biologics[2], brand-name or "specialty" drugs, which can be particularly costly. Researchers studied prices of six specialty drugs between 2014 and 2018 and found that prices rose on average 57 percent, while prices for generics decreased 35 percent.[3] Other research found specialty drugs make up almost 38 percent of personal prescription drug spending, even though they account for a small portion of all prescriptions.[4]

Manufacturers sometimes offer copay assistance coupons to help patients offset the cost of their prescriptions. This assistance is intended to help limit patients' out-of-pocket costs by reducing the amount a patient pays and also may be applied to a patient's annual cost-sharing requirement (such as deductibles).[5]

In order to encourage patients to choose lower cost drug options, some health plans restrict the use of copay coupons toward deductibles by implementing copay adjustment programs. When a patient's health plan uses a copay adjustment program, also known as a copay accumulator or maximizer program, it restricts a manufacturer's coupon from counting toward a patient's annual out-of-pocket maximums. When the value of the coupon is exhausted at the pharmacy counter, the patient must cover the full amount of his or her annual cost-sharing requirement before plan benefits kick in.[6] A recent report shows that nine out of 12 health plans in Florida have copay accumulator adjustment policies.[7]

Although copay adjustment programs might encourage patients to look for cheaper therapeutic alternatives before turning to a more expensive treatment, they can be problematic for

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[1] Kaiser Family Foundation (conducted February 14 - 24, 2019), press-release/poll (last accessed March 30, 2023).
[2] A substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of cancer and other diseases. Biological drugs include antibodies, interleukins, and vaccines. Also called biologic agent and biological agent. National Cancer Institute, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/biological-drug (last accessed March 30, 2023).
[3] Peterson-KFF, Health System Tracker, *What are the recent and forecasted trends in prescription drug spending?*, healthsystemtracker.org/chart (last accessed March 30, 2023).
[4] *Net Spending On Retail Specialty Drugs Grew Rapidly, Especially For Private Insurance And Medicare Part D*, Hill, Miller, and Ding, November 2020, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01830 (last accessed March 30, 2023).
[5] National Conference of State Legislatures, *Copayment Adjustment Programs, February 23, 2023*, https://www.ncsl.org/health/copayment-adjustment-programs (last accessed March 30, 2023).
[6] *Id.*
[7] The Aids Institute, *Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness*, February 2023, p. 33, Report-Copay-Accumulator-Adjustment-Programs (last accessed March 30, 2023).

individuals whose plans involve high cost-sharing or co-insurance—where a patient pays a percentage of the cost rather than a flat amount. Moreover, people with complex conditions, such as cancer, rheumatoid arthritis, and diabetes that must be treated with expensive prescription drugs cannot choose a less expensive drug.[8]

As of February 2023, laws in 16 states[9] and Puerto Rico address the use of copay adjustment programs by insurers or PBMs by requiring any payment or discount made by or on behalf of the patient be applied to a consumer's annual out-of-pocket cost-sharing requirement.[10]

Health Insurance Policies

Florida law requires a contract for the purchase of individual health insurance to contain certain provisions, for instance, provisions on the notice of claim, claim forms, proof of loss, and time for the payment of claims.[11] Health insurance policies must provide for certain mandated coverage,[12] and must contain certain information, such as the consideration for the policy, the time when the insurance takes effect and terminates, and reductions in indemnity.[13]

Group health insurance is health insurance that covers group of persons under a master group plan health insurance policy[14] issued to a group specified under certain Florida provisions.[15] Group health insurance policies must comply with provisions of the Florida Insurance Code relating to the rights of individuals to specified benefits and coverages.[16] Section 641.312, F.S., relating to the Office of Insurance Regulation adopting rules to administer the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act, and the provisions of the Employee Retirement Income Security Act of 1974,[17] relating to internal grievances, apply to all group health insurance policies issued under the Florida Insurance Code except for certain specified policies.[18]

Health Maintenance Organization

A health maintenance organization is any organization authorized under the Florida Insurance Code which:

- Provides, through arrangements with other persons, emergency care, inpatient hospital services, and physician care.

[8] *Id.*
[9] Arizona, Arkansas, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, New York, North Carolina, Oklahoma, Tennessee, Virginia, Washington, and West Virginia.
[10] *Id.*
[11] *See* ss. 627.610 to 627.613, F.S.
[12] Section 627.6011, F.S., provides that "mandatory health benefits" means those benefits in ss. 627.6401-627.64193, F.S. which, for example, includes coverage relating to maternity care, diabetes, osteoporosis, newborn children, mammograms, and breast cancer.
[13] Section 627.602(1), F.S.
[14] Section 627.652(2)(a), F.S., provides group health insurance policies include plans of self-insurance providing health insurance benefits.
[15] Section 627.652(1), F.S.
[16] Section 627.651(1), F.S.
[17] 29 C.F.R. s. 2560.503-1.
[18] Section 627.6513, F.S.

- Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.
- Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract.
- Provides physician services, by physicians licensed under chs. 458, 459, 460, and 461, F.S., directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.
- If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, or 461, F.S., is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary.[19]

A health maintenance organization must apply for and obtain a certificate of authority to operate in Florida.[20] Florida law requires health maintenance organizations to afford certain subscriber protections, including, in part:

- Ensuring that the health care services provided to its subscribers are rendered under reasonable standards of quality care;
- Making sure that subscribers receive quality care from a broad panel of providers; and
- Providing assurance that the health maintenance organization has been independently accredited by a national review organization.

Pharmacy Benefit Managers

A "pharmacy benefit manager" is a person or entity doing business in Florida which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents in Florida.[21] An individual and group health insurer and a health maintain organization's contract with a pharmacy benefit manager for individual and group plans must require the pharmacy benefit manager to do certain tasks, including:

- Update maximum allowable cost pricing information at least every 7 calendar days; and
- Maintain a process that will timely eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.[22]

Such contracts must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug and the availability of a more affordable alternative drug.[23] Finally, the contracts must prohibit a pharmacy benefit manager from requiring an insured to pay an amount for a

[19] Section 641.19(12), F.S.
[20] Section 641.21(1), F.S.
[21] Sections 627.64741(1)(b), 627.6572(1)(b), and 641.314(1)(b), F.S.
[22] Sections 627.64741(2), 627.6572(2), and 641.314(2) F.S.
[23] Sections 627.64741(3), 627.6572(3), and 641.314(3), F.S.

prescription drug at the point of sale that exceeds the lesser of the applicable cost-sharing amount or the retail price of the drug in the absence of prescription drug coverage.[24]

Prescription Drugs

Any health insurer or health maintenance organization that agrees to provide coverage for prescription drugs on an outpatient basis must provide a benefits-identification card which contains specified information, such as the name of the claim processor, the insured's name, and the claims submission name and address.[25] A health insurer or health maintenance organization that provides individual and group health insurance in the state that includes prescription drug coverage must offer medication synchronization and must implement a process for dispensing prescription drugs for the purpose of aligning the refill dates.[26]

III. Effect of Proposed Changes:

Section 1 creates s. 627.6383, F.S., relating to cost-sharing requirements for individual health insurers. The bill defines "cost-sharing requirement" to mean "a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022."

The bill requires, for any health insurance policy issued, delivered, or renewed on or after January 1, 2024, that each individual health insurer providing prescription drug coverage, or any pharmacy benefit manager on behalf of such insurer, must apply any amount paid by an insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The amount paid by, or on behalf of, the insured which is applied toward the insured's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

Section 2 amends s. 627.6385, F.S., to provide that, for any health insurance policy issued, delivered, or renewed on or after January 1, 2024, a health insurer providing prescription drug coverage, whether or not the prescription drug benefits are administered or managed by the health insurer or by a pharmacy benefit manager on behalf of the health insurer, must disclose on its website that any amount paid by a policyholder, or by another person on behalf of the policyholder, must be applied toward the policyholder's total contribution to any cost-sharing requirement.

Section 3 amends s. 627.64741, F.S., relating to pharmacy benefit manager contracts, that, for any insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, a contract between an individual health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by an insured, or by another person on

[24] Sections 627.64741(4), 627.6572(4), and 641.314(4), F.S.
[25] Section 627.4302(2), F.S.
[26] Sections 627.64196(1) and 641.31(44), F.S.

behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The pharmacy benefit manager must disclose to every insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, that the pharmacy benefit manager will apply any amount paid by the insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement.

Section 4 creates s. 627.65715, F.S., relating to cost-sharing requirements for group health insurers. The bill defines "cost-sharing requirement" to mean "a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022."

The bill requires, for any health insurance policy issued, delivered, or renewed on or after January 1, 2024, that each group health insurer providing prescription drug coverage, or any pharmacy benefit manager on behalf of such insurer, must apply any amount paid by an insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The amount paid by, or on behalf of, the insured which is applied toward the insured's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

Section 5 amends s. 627.6572, F.S., relating to pharmacy benefit manager contracts, that, for any insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, a contract between a group health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by an insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The pharmacy benefit manager must disclose to every insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, that the pharmacy benefit manager will apply any amount paid by the insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement.

Section 6 amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, to require small employer carriers to comply with the group health insurer cost-sharing requirements provided in s. 627.65715, F.S., created in section 4 of the bill.

Section 7 amends s. 641.31, F.S.; relating to health maintenance contracts. The bill defines "cost-sharing requirement" to mean "a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022."

The bill requires, for any health maintenance contract or certificate issued, delivered, or renewed on or after January 1, 2024, that each health maintenance organization providing prescription drug coverage, or any pharmacy benefit manager on behalf of such health maintenance organization, must apply any amount paid by a subscriber, or by another person on behalf of the subscriber, toward the subscriber's total contribution to any cost-sharing requirement. The

amount paid by, or on behalf of, the subscriber which is applied toward the subscriber's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the subscriber for a prescription drug.

The bill provides that, for any health maintenance contract issued, delivered, or renewed on or after January 1, 2024, a health maintenance organization providing prescription drug coverage, whether or not the prescription drug benefits are administered or managed by the health maintenance organization or by a pharmacy benefit manager on behalf of the health maintenance organization, must disclose on its website and in every subscriber's health maintenance contract, certificate, or member handbook, that any amount paid by a subscriber, or by another person on behalf of the subscriber, must be applied toward the subscriber's total contribution to any cost-sharing requirement.

Section 8 amends s. 641.314, F.S., relating to pharmacy benefit manager contracts, that, for any subscriber whose health maintenance contract or certificate is issued, delivered, or renewed on or after January 1, 2024, a contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by a subscriber, or by another person on behalf of the subscriber, toward the subscriber's total contribution to any cost-sharing requirement. The pharmacy benefit manager must disclose to every subscriber whose health maintenance contract or certificate is issued, delivered, or renewed on or after January 1, 2024, that the pharmacy benefit manager will apply any amount paid by the subscriber or by another person on behalf of the subscriber toward the subscriber's total contribution to any cost-sharing requirement.

Sections 9 and 10 amend ss. 409.967 and 641.185, F.S., to make conforming changes made necessary by the bill.

Section 11 provides a Legislative declaration that the bill fulfills an important state interest.

Section 12 provides an effective date of July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill's fiscal impact is unknown, but the bill may lead to increased costs for health care coverage. The bill is expected to lead to savings for those able to avoid copay adjustment programs and use copay assistance coupons from drug manufacturers.

C. Government Sector Impact:

The bill's fiscal impact on state and local government is unknown, but the bill may lead to increased costs for health care coverage.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6385, 627.64741, 627.6572, 627.6699, 641.31, 641.314, 409.967, and 641.185.

This bill creates the following sections of the Florida Statutes: 627.6383 and 627.65715.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.