

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Brodeur, Vice Chair

MEETING DATE: Monday, February 6, 2023

TIME: 3:30—5:30 p.m.

PLACE: Pat Thomas Committee Room, 412 Knott Building

MEMBERS: Senator Burton, Chair; Senator Brodeur, Vice Chair; Senators Albritton, Avila, Book, Broxson, Burgess, Calatayud, Davis, Garcia, Harrell, and Osgood

TAB		BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Florida's Regulation of Pharmacy Benefit Managers – Office of Insurance Regulation		Presented
2		Pharmacy Benefit Management within Florida Medicaid – Agency for Health Care Administration		Presented
3		Panel Discussion on Pharmacy Benefit Management of Health Insurance Prescription Coverage		Discussed
Other Related Meeting Documents				

Select Year: 2022 ▼ Go

The 2022 Florida Statutes (including Special Session A)

[Title XXXVII](#)

[Chapter 624](#)

[View Entire](#)

INSURANCE

INSURANCE CODE: ADMINISTRATION AND GENERAL
PROVISIONS

[Chapter](#)

624.490 Registration of pharmacy benefit managers.—

(1) As used in this section, the term “pharmacy benefit manager” means a person or entity doing business in this state which contracts to administer prescription drug benefits on behalf of a health insurer or a health maintenance organization to residents of this state.

(2) Effective January 1, 2019, to conduct business in this state, a pharmacy benefit manager must register with the office. To initially register or renew a registration, a pharmacy benefit manager shall submit:

(a) A nonrefundable fee not to exceed \$500.

(b) A copy of the registrant’s corporate charter, articles of incorporation, or other charter document.

(c) A completed registration form adopted by the commission containing:

1. The name and address of the registrant.

2. The name, address, and official position of each officer and director of the registrant.

(3) The registrant shall report any change in information required by subsection (2) to the office in writing within 60 days after the change occurs.

(4) Upon receipt of a completed registration form, the required documents, and the registration fee, the office shall issue a registration certificate. The certificate may be in paper or electronic form and shall clearly indicate the expiration date of the registration. Registration certificates are nontransferable.

(5) A registration certificate is valid for 2 years after its date of issue. The commission shall adopt by rule an initial registration fee not to exceed \$500 and a registration renewal fee not to exceed \$500, both of which shall be nonrefundable. Total fees may not exceed the cost of administering this section.

(6) A person who fails to register with the office while operating as a pharmacy benefit manager is subject to a fine of \$10,000 for each violation.

(7) The commission shall adopt rules necessary to implement this section.

History.—s. 3, ch. 2018-91; s. 2, ch. 2022-200.

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The 2022 Florida Statutes (including Special Session A)

[Title XXXVII](#)
INSURANCE

[Chapter 624](#)
INSURANCE CODE: ADMINISTRATION AND GENERAL
PROVISIONS

[View Entire
Chapter](#)

624.491 Pharmacy audits.—

(1) A health insurer or health maintenance organization providing pharmacy benefits through a major medical individual or group health insurance policy or a health maintenance contract, respectively, must comply with the requirements of this section when the health insurer or health maintenance organization or any person or entity acting on behalf of the health insurer or health maintenance organization, including, but not limited to, a pharmacy benefit manager as defined in s. [624.490](#)(1), audits the records of a pharmacy licensed under chapter 465. The person or entity conducting such audit must:

(a) Except as provided in subsection (3), notify the pharmacy at least 7 calendar days before the initial onsite audit for each audit cycle.

(b) Not schedule an onsite audit during the first 3 calendar days of a month unless the pharmacist consents otherwise.

(c) Limit the duration of the audit period to 24 months after the date a claim is submitted to or adjudicated by the entity.

(d) In the case of an audit that requires clinical or professional judgment, conduct the audit in consultation with, or allow the audit to be conducted by, a pharmacist.

(e) Allow the pharmacy to use the written and verifiable records of a hospital, physician, or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law.

(f) Reimburse the pharmacy for a claim that was retroactively denied for a clerical error, typographical error, scrivener's error, or computer error if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged, or the error results in actual financial loss to the entity.

(g) Provide the pharmacy with a copy of the preliminary audit report within 120 days after the conclusion of the audit.

(h) Allow the pharmacy to produce documentation to address a discrepancy or audit finding within 10 business days after the preliminary audit report is delivered to the pharmacy.

(i) Provide the pharmacy with a copy of the final audit report within 6 months after the pharmacy's receipt of the preliminary audit report.

(j) Calculate any recoupment or penalties based on actual overpayments and not according to the accounting practice of extrapolation.

(2) This section does not apply to:

(a) Audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods;

(b) Audits of claims paid for by federally funded programs; or

(c) Concurrent reviews or desk audits that occur within 3 business days after transmission of a claim and where no chargeback or recoupment is demanded.

(3) An entity that audits a pharmacy located within a Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force area designated by the United States Department of Health and Human Services and the United States Department of Justice may dispense with the notice requirements of paragraph (1)(a) if such pharmacy has been a member of a credentialed provider network for less than 12 months.

(4) Pursuant to s. 408.7057, and after receipt of the final audit report issued under paragraph (1)(i), a pharmacy may appeal the findings of the final audit report as to whether a claim payment is due and as to the amount of a claim payment.

(5) A health insurer or health maintenance organization that, under terms of a contract, transfers to a pharmacy benefit manager the obligation to pay a pharmacy licensed under chapter 465 for any pharmacy benefit claims arising from services provided to or for the benefit of an insured or subscriber remains responsible for a violation of this section.

History.—s. 1, ch. 2014-85; s. 1, ch. 2022-200.

Note.—Former s. 465.1885.

The 2022 Florida Statutes (including Special Session A)

[Title XXXVII](#)

INSURANCE

[Chapter 627](#)

INSURANCE RATES AND CONTRACTS

[View Entire Chapter](#)

627.64741 Pharmacy benefit manager contracts.—

(1) As used in this section, the term:

(a) “Maximum allowable cost” means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) “Pharmacy benefit manager” means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, 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.

(3) A contract between a health insurer and a pharmacy benefit manager 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, pursuant to s. [465.0244](#).

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) This section applies to contracts entered into or renewed on or after July 1, 2018.

History.—s. 4, ch. 2018-91.

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The 2022 Florida Statutes (including Special Session A)

[Title XXXVII](#)
INSURANCE

[Chapter 627](#)
INSURANCE RATES AND CONTRACTS

[View Entire Chapter](#)

627.6572 Pharmacy benefit manager contracts.—

(1) As used in this section, the term:

(a) “Maximum allowable cost” means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) “Pharmacy benefit manager” means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, 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.

(3) A contract between a health insurer and a pharmacy benefit manager 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, pursuant to s. [465.0244](#).

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) This section applies to contracts entered into or renewed on or after July 1, 2018.

History.—s. 5, ch. 2018-91.

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The 2022 Florida Statutes (including Special Session A)

[Title XXXVII](#)

[Chapter 641](#)

[View Entire Chapter](#)

INSURANCE

HEALTH CARE SERVICE PROGRAMS

641.314 Pharmacy benefit manager contracts.—

(1) As used in this section, the term:

(a) “Maximum allowable cost” means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) “Pharmacy benefit manager” means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(2) A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, 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.

(3) A contract between a health maintenance organization and a pharmacy benefit manager 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, pursuant to s. [465.0244](#).

(4) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring a subscriber to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) This section applies to contracts entered into or renewed on or after July 1, 2018.

History.—s. 6, ch. 2018-91.

The Florida Senate

APPEARANCE RECORD

7261

2/6/2023

Meeting Date

Senate Health Policy

Committee

Deliver both copies of this form to
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Bill Number or Topic

Amendment Barcode (if applicable)

Name **Kevin Jacobs**

Phone **(850) 413-5011**

Address **200 E Gaines St**

Email **kevin.jacobs@flor.com**

Street

Tallahassee

FL

32399

City

State

Zip

Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

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Office of Insurance Regulation

☐ I am not a lobbyist, but received
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S-001 (08/10/2021)



Implementation of Executive Order 22-164; Pharmacy Benefit Managers

Senate Health Policy Committee

February 6, 2023

Executive Order 22-164

On July 8, 2022, Governor Ron DeSantis issued Executive Order 22-164 to increase transparency and accountability in the Pharmaceutical Industrial Complex.

- ☐ Prohibits the use of spread pricing and financial clawbacks.
- ☐ Includes requirement to report data regarding rebates and payments from drug manufactures, insurers, and pharmacies.
- ☐ Directs State Agencies to amend contract language to include provisions in all existing and future contracts.
- ☐ Requires an Agency Audit of all PBMs that provided services for SMMC in the last 5 state fiscal years.



Agency for Health Care Administration Implementation of Executive Order 22-164



3

What is Medicaid?

Medicaid is a federal program through which states partner with the federal government to provide health care coverage to low-income children, families, elders, and people with disabilities.

The federal government establishes basic mandatory program requirements.

States choose whether to participate.

Jointly financed: federal and state governments share the cost.

Each state develops a unique Medicaid program based on federal rules – subject to federal Centers for Medicare and Medicaid Services (CMS) approval.



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Florida Medicaid Delivery System

- A majority of Florida's Medicaid population receives Medicaid services through a managed care delivery system.

Statewide Medicaid Managed Care (SMMC) Program

• 95% of Full Benefit Medicaid Enrollees



5

SMMC: Multiple Managed Care Program Components

Managed Medical Assistance (MMA)

COVERAGE:
Preventive, acute, behavioral, and therapeutics services, including pharmacy and transportation services.

ENROLLMENT:
Most Medicaid recipients must enroll in an MMA plan.

Long-Term Care (LTC)

COVERAGE:
Nursing facility, assisted living, and Home and Community-Based services.

ENROLLMENT:
65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

Requires Nursing Facility level of care or Hospital level of care for individuals diagnosed with cystic fibrosis.

Dental

COVERAGE:
Preventive and therapeutic dental services.

ENROLLMENT:
All Medicaid recipients in managed care and all fully Medicaid eligible fee-for-service individuals.



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Pharmacy Benefit Manager Overview

- A Pharmacy Benefit Manager (PBM) administers prescription drug benefits on behalf of a health plan and/or payer and is primarily responsible for processing and paying claims and creating or maintaining a network of participating pharmacies.
 - In some cases (Not in the Medicaid program), a PBM may also set formularies, negotiate rebates, and implement other utilization management.



7

Florida Medicaid Pharmacy Benefits

- The Agency maintains a Medicaid preferred drug list (PDL), which is a listing of cost-effective, safe and clinically efficient medications for each of the therapeutic classes on the list.
 - Drugs on the PDL generally do not require prior authorization.

Medicaid health plans must provide medically necessary prescription drugs to all their Medicaid members.

The same pharmacy benefit is available to all Florida Medicaid recipients, whether they are in the fee-for-service delivery system or the SMMC program.

Health plans must follow the Agency's PDL.



8

Florida Medicaid Pharmacy Benefits

Statewide Medicaid Managed Care program (SMMC) plans are:

- Paid a capitated rate, which is a per-member, per-month amount that covers the cost of providing the required care and administering the contract.
- Responsible for maintaining a network of providers sufficient to meet the needs of their enrollees, based on network standard established by the Agency.

Required Pharmacy Network Standards for Health Plans

	Maximum time (minutes)	Maximum distance (miles)	Providers per Enrollee
Pharmacy	15	10	1:2,500 enrollees



9

Manufacturer Rebates

The State recoups a significant part of the retail cost of prescriptions reimbursed by Florida Medicaid through rebates paid by pharmaceutical manufacturers for each time their drug is dispensed.

- Rebates required by the federal government
- AHCA-negotiated supplemental rebates



AHCA negotiates rebates on Medicaid prescriptions paid for through fee-for-service and SMMC.



SMMC plans and PBMs are not permitted to negotiate or collect any drug rebates.



AHCA bills the manufacturers for the agreed upon rebate for every prescription filled that has a rebate contract. The cash rebate goes into a trust fund that helps pay for the cost of Medicaid prescriptions.



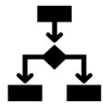
10

Pharmacy Benefits Managers In Florida Medicaid

PBMs are utilized in all lines of health care business—commercial, Medicare, and Medicaid



They work on behalf of insurers to negotiate better rates with pharmacy suppliers.



They administer pharmacy benefits according to the benefit structure dictated by the insurer.



11

PBMs in Florida Medicaid Do NOT:

The services PBMs provide in Florida Medicaid are different than the services PBMs provide in the commercial and Medicare markets.



Create or maintain a formulary of drugs .

The Agency maintains the Preferred Drug List, which is recommended by the Pharmaceutical and Therapeutics Committee.



Negotiate or collect drug rebates from drug manufacturers

The Agency does this for all Medicaid-funded drugs.



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Agency Implementation

- AHCA amended all Managed Care Plan contracts to comply with Executive Order 22-164, effective July 1, 2022 .
 - **Amendments executed October 2022.**
- Amendments:
- Required plans to amend all PBM contracts within 180 days, of contract execution, to comply with the Executive Order, to:
 - ☐ Prohibit Spread Pricing Model
 - ☐ Require Pass-through Pricing Model
 - ☐ Prohibit Financial Clawbacks/ Prohibit Reconciliation of Offsets
- Required plans to submit Annual and Quarterly Reconciliation Reports
- Requiring Inspection and Audit of Financial Records
- Additional Liquidated Damages



13

Requiring Pass-Through Pricing Model:

Agency Contracts between the Managed Care Plan and the PBM must be based on a Pass-Through Pricing model. Spread pricing model is prohibited.

- Pass-Through Pricing model: Managed Care Plan's payment to the PBM for prescription drugs and any related dispensing fees are equivalent to the PBM payment to the dispensing pharmacy or provider.



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Prohibits Reconciliation of Offsets:

- Under the prohibition of “Financial Clawbacks” or Reconciliation Offsets:
- The Managed Care Plan or its PBM is prohibited from recuperating any fees paid to a pharmacy via reconciliation, or any other monetary recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees and any other instance where a fee may be recuperated from a pharmacy and/or provider.
- Fee can be recouped in instances of fraud or abuse, claims adjudicated in error, or payments tied to value based purchasing agreements based on quality outcomes.



15

Requiring Annual and Quarterly Reconciliation Reports:

- The Managed Care Plan and PBM shall provide Annual and Quarterly Reconciliation Reports.
 - The Quarterly Reconciliation Report shall be provided by the 25th of the first month following the last day of the prior quarter to the Agency.
 - First Quarterly report is due July 2023.



16

Requiring Inspection:

- Managed Care Plan's are required to disclose to the Agency all financial terms and arrangements for payment of any kind that apply between the Managed Care Plan or the Managed Care Plan's Pharmacy Benefits Manager and any provider of outpatient drugs, any prescription drug manufacturer, prescription drug wholesaler, or labeler.
- Managed Care Plan must also disclose copies of its PBM pharmacy provider agreement and notate any differences among commercial, preferred, or independently owned pharmacies.



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Audit of Financial Records

- The Agency entered into a contract with third party vendor Meyers and Stauffer to investigate the organizational structures and contractual arrangements, including payment terms, of the pharmacy benefit managers (PBM) utilized by the health plans participating in the Statewide Medicaid Managed Care (SMMC) program.
- Three phases:
 - Risk Assessment
 - Detailed Analysis
 - Detailed Investigational Analysis



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Requiring Additional Liquidated Damages

- Within 180 days following execution of this amendment all Managed Care Plan PBM subcontracts must be updated to reflect Executive order 22-164 provisions.
- Managed Care Plan found in violation of updating their contracts will be subjected to Liquidated damages, contractual sanctions, or other actions deemed necessary by the Agency.
- Failure to provide the necessary data/ reports to the Agency will result in immediate action by the Agency that may include (but not be limited to) sanctions, application of liquidated damages, or reduction of capitation payments in the amount of estimated combined federal and supplemental rebates.



The Florida Senate

APPEARANCE RECORD

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2/6/2022

Meeting Date

Health Policy

Committee

PBMs Tab 2

Bill Number or Topic

Amendment Barcode (if applicable)

Name

Austin Noll

Phone

850-524-7058

Address

2727 Mahan Dr.

Street

Tallahassee

City

FL

State

32308

Zip

Email

Austin.noll@ahca.myflorida.com

Speaking:

☐

For

☐

Against

☒

Information

OR

Waive Speaking:

☐

In Support

☐

Against

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S-001 (08/10/2021)



Connor Rose

Senior Director, State Affairs

Connor Rose is a Senior Director, State Affairs for PCMA. In this role he coordinates and supports state activity for the state affairs team and is responsible for overseeing state legislative and regulatory activity in the Ohio Valley and Southeast regions. Connor educates policy makers about the pharmaceutical supply chain, from manufacturers to pharmacies.

Mr. Rose is a graduate of the University of Kentucky and Elevate Kentucky Class of 2017.



About PCMA

The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs). PBMs administer prescription drug plans for more than 275 million Americans who have health insurance from a variety of sponsors including: commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program (FEHBP), state government employee plans, managed Medicaid plans, and others.



Finding the Formula for Drug Savings

The Role of Pharmacy Benefit Managers in the Health Care System

Why Do Plans Hire PBMs?

Drive Cost Savings for Patients and Payers

PBMs help save patients and payers 40–50% on their annual drug and related medical costs compared to what they would have spent without PBMs.¹

Improve Health Care Quality and Patient Outcomes

- Reduce medication errors through use of drug utilization review programs.
 - Over next 10 years, PBMs will help prevent 1 billion medication errors.²
 - Improve drug therapy and patient adherence, notably in the areas of diabetes and multiple sclerosis.³
- Manage programs to address opioid use issues.

¹ Visante, Return on Investment on PBM Services, February 2020.

² Visante estimates based on IMS Health data and DUR programs studies.

³ Visante estimates based on CDC National Diabetes Statistics Report 2017 and studies demonstrating improved adherence by 10+%.

Pharmacy Benefit Management Services



Claims Processing



Price, Discount and Rebate Negotiations with Pharmaceutical Manufacturers and Drugstores



Formulary Management



Pharmacy Network Management



Mail-service Pharmacy



Specialty Pharmacy



Drug Utilization Review



Disease Management and Adherence Initiatives

3



A Plan Sponsor Is the PBM's Client

- The plan sponsor always has the final say when creating a drug benefit plan.
- There is no one-size-fits-all model because each plan sponsor has unique needs.



Value-Based Contracting



Formulary Management



Preferred Pharmacy Networks



Negotiation of Rebates

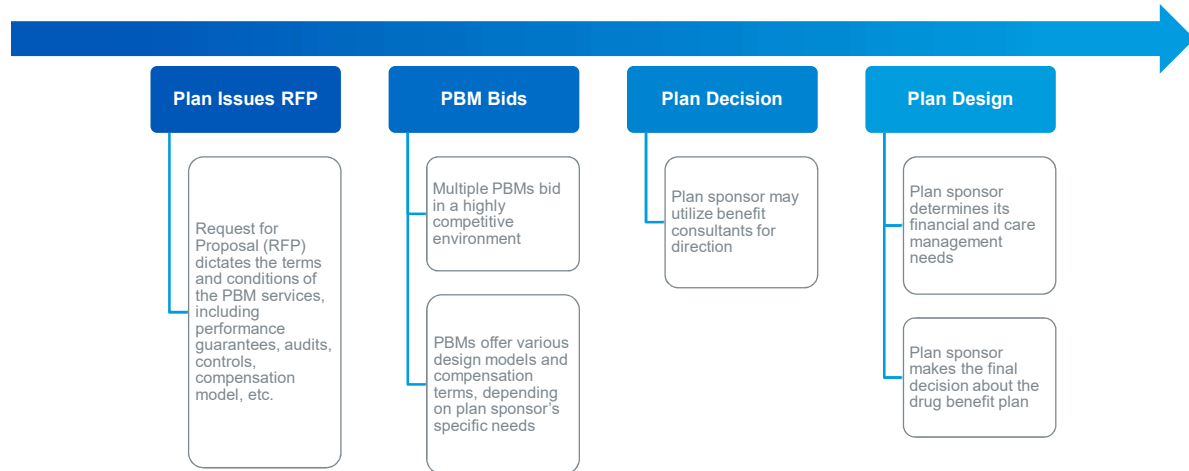


Mail-order/ Specialty Pharmacy

4



The Plan Sponsor Request for Proposal Process



5



Spread Pricing: Risk Mitigation for Clients

- A risk mitigation (spread) pricing model provides employers and other health plan sponsors with cost predictability by giving them a **price-certain** for prescription drug benefit payments to pharmacies.
- This model **holds the client harmless** for their enrollees' pharmacy shopping choices and aligns the interests of the PBM, pharmacy, and plan sponsor to achieve the lowest possible cost.
- If the pharmacy charges more than the rate agreed between the plan sponsor and the PBM, the PBM loses money. If the pharmacy charges less, the PBM earns a margin.
- Spread pricing is a **client-demanded** contracting option that brings predictability to many employer accounts.

6



Varying drug prices across pharmacies

- The same drug can cost different amounts at different pharmacies.
- PBMs help drive savings for patients and plan sponsors by helping to design preferred networks and by providing transparency on where patients may be able to obtain their prescriptions at the lowest cost.



Rx = \$25



Rx = \$12



Rx = \$17



Rx = \$22

7



Tackling High Drug Costs

- **Health plans and PBMs do not have any control over the price the manufacturer sets for a drug** — but PBMs have some tools to drive down drug costs.
- Brand drug manufacturers establish prices within a monopoly established by federal patent law.
- Until other drugs are approved for the same disease or condition, manufacturers have little incentive to reduce their prices.

8



Prescription Drug Rebates

- PBMs are able to bring volume to manufacturers and in some cases, obtain price concessions.
- Rebates reduce the net cost of drugs for payers, **but they aren't available on all drugs**—only where there is competition.
 - 90% of drugs dispensed are generics, with little-to-no rebate in commercial programs.
 - In Medicare Part D, 64% of brands were not eligible for rebates.¹
 - PBM clients get the vast majority of the rebates.^{2, 3}
- Rebates help reduce premiums & cost-sharing, and revenue is included in MLR calculation.
- Plans have no alternative tool at this time that is as effective at forcing manufacturers to compete, bringing down the net cost of drugs.

¹ Millman, "Prescription Drug Rebates and Part D Drug Costs." (July 2018).

² U.S. Government Accountability Office, "Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization." (July 2019).

³ Pew Charitable Trusts, "The Prescription Drug Landscape, Explored." (March 2019).



Kristin Parde
Deputy Vice President
State Policy

Kristin Parde is Deputy Vice President of State Policy for the Pharmaceutical Research and Manufacturers of America (PhRMA), a trade association in Washington, DC, representing the nation's pharmaceutical research and biotechnology companies. Kristin oversees PhRMA's policy agenda in the midatlantic and southeast regions and is the direct policy liaison for Florida. Her areas of expertise include 340B, wholesale drug importation, Medicaid, patient access issues, and civil justice reform. Prior to joining PhRMA, Kristin worked in policy and external affairs at the American Legislative Exchange Council and the Institute for Justice. She is a graduate of the Franciscan University of Steubenville and currently resides with her family in Arlington, Virginia.



Panel Discussion on Pharmacy Benefit Management of Health Insurance Prescription Coverage

Kristin Parde

Deputy Vice President, State Policy

Who is PhRMA?

31 leading, innovative biopharmaceutical research companies in the U.S.

Since 2000, PhRMA member companies have invested

+\$1.1 trillion

in the search for new treatments and cures

Alkermes

AMGEN

astellas

AstraZeneca



Biogen

BiOMARIN

Boehringer Ingelheim

Bristol Myers Squibb

CSL Behring

Daiichi-Sankyo

Eisai

EMD SERONO

Genentech
A Member of the Roche Group

GILEAD
Creating Possible

GSK



IPSEN
Innovation for patient care

Johnson & Johnson

Lilly

Lexell

MERCK
Be well

NOVARTIS

novo nordisk

Otsuka

Pfizer

Sage Therapeutics

sanofi

sunovion

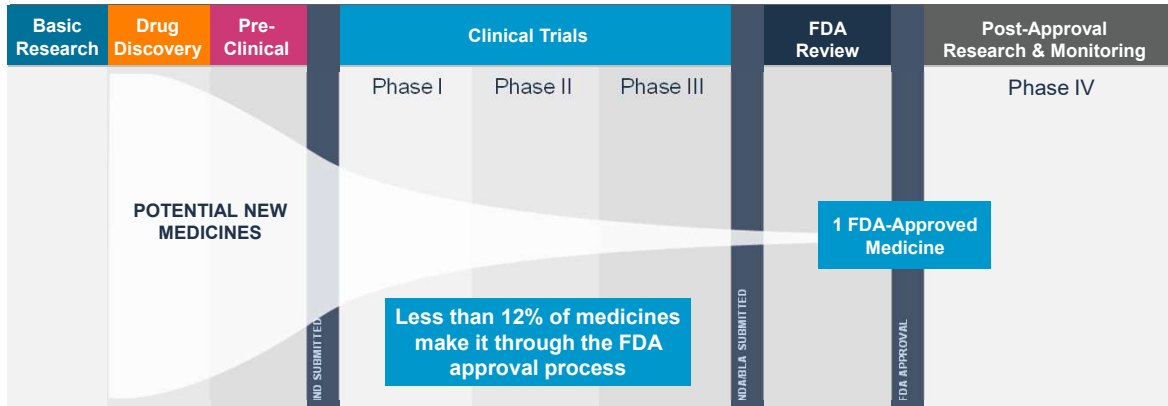
Takeda

unb Inspired by patients. Driven by science.



R&D Process Overview: Lengthy, Costly and Uncertain

Developing a new medicine takes 10 to 15 years and costs an average of \$2.6 billion.¹



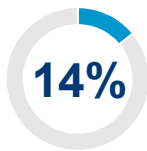
Key: IND= Investigational New Drug Application, NDA= New Drug Application, BLA= Biologics License Application

Sources: PhRMA adaptation of DiMasi J. et al¹, Lo A. et al²

3

Spending on Medicines Is a Small and Stable Share of Total Health Care Spending

Prescription medicines account for just

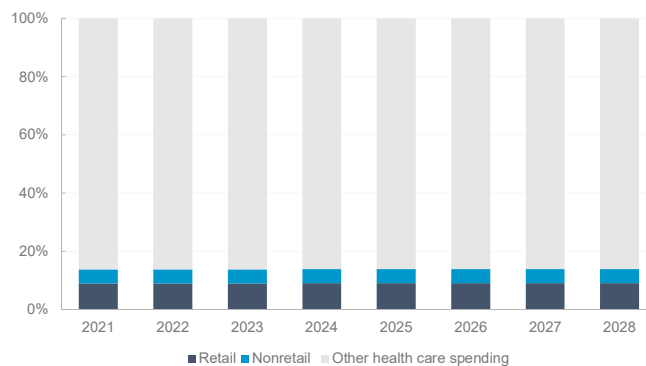


of total health care spending

In 2021, per capita spending on medicines declined by

1%

Projected US Health Care Expenditures Attributable to Retail and Nonretail Prescription Medicines, 2021-2028



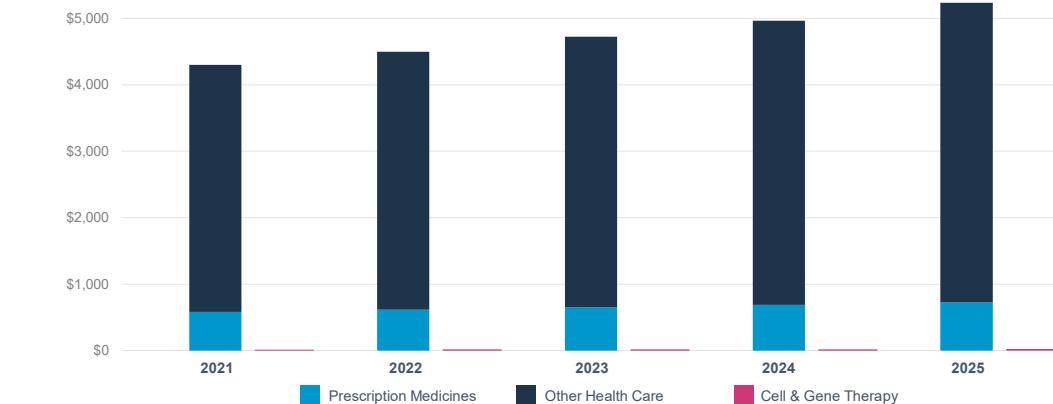
* Excludes spending on COVID-19 vaccines and treatments
Source: Altarum, IQVIA, 2022.

Note: Nonretail prescription medicines are those purchased through physicians' offices, clinics and hospitals and are typically administered to the patient by the provider. Retail prescription medicines are those filled at retail pharmacies or through mail service.

4

A New Era of Medicine is Not Expected to Impact the Share of Total Health Care Spending on Medicines

Projected Spending on Prescription Medicines, Total Health Care, and Anticipated Cell & Gene Therapies (\$B), 2021-2025

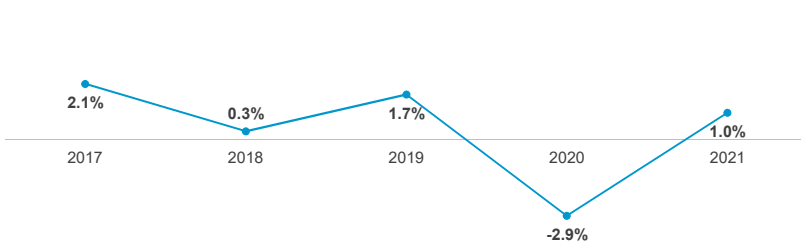


SOURCES: Young & Rubicam (Y&R) et al. Drug Discovery Today, 27(1): 2022; CMS National Health Expenditures (NHE) Projections, 2022; Altarum Institute, "Projections of the Non-Retail Prescription Drug Share of National Health Expenditures," September 2020.

5

Net Prices for Brand Medicines Have Stayed Nearly Flat For The Past Five Years

Average Net Price Growth for Brand Medicines, 2017-2021



On average, a brand medicine's net price is

49%

lower than its list price.



Source: IQVIA, 2022.

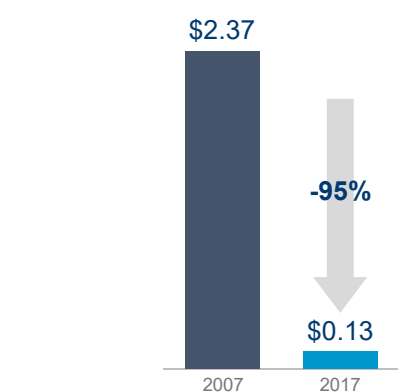
6

Prescription Medicines: Costs in Context www.pfma.org/cost

Unlike Other Aspects of the Health Care System, Medicine Costs Decrease Over Time

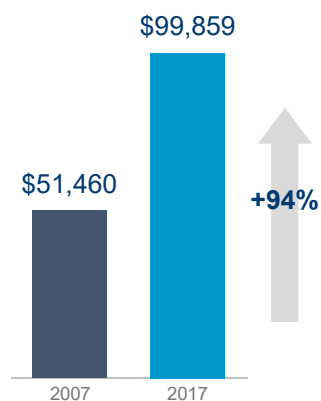
The price of medicines used to prevent cardiovascular disease decreased...

...while the cost of the surgical procedure to treat it increased over a decade.



PFMA
Pharmaceutical Research and Manufacturers of America

Source: IQVIA analysis for PFMA, June 2020; AHRQ HCUP, July 2020.

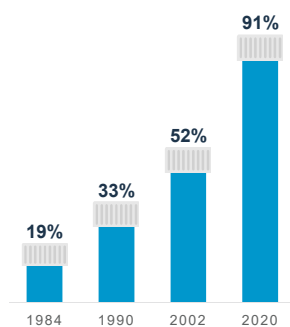


7

Prescription Medicines: Costs in Context www.pfma.org/cost

Generic and Biosimilar Medicines Drive Significant Savings in the Health Care System

91% of All Drugs Dispensed in the United States are Generics



PFMA
Pharmaceutical Research and Manufacturers of America

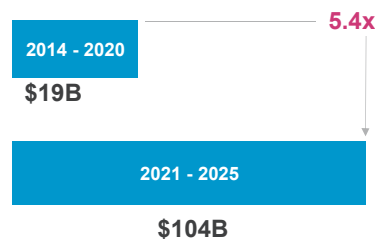
Sources: Drug Channels, AAM, IQVIA.



Nearly
\$2.4 trillion

10-year savings from use of
generic and biosimilars
(2011 - 2020)

Looking Ahead, Biosimilar
Savings Projected to Grow 5x



8

The Influence Pharmacy Benefit Managers (PBMs) Have Over Patient Access and Affordability Continues to Grow

Negotiating power is increasingly concentrated among a small number of PBMs.

Insurers & PBMs determine:

IF MEDICINE IS COVERED
on the formulary

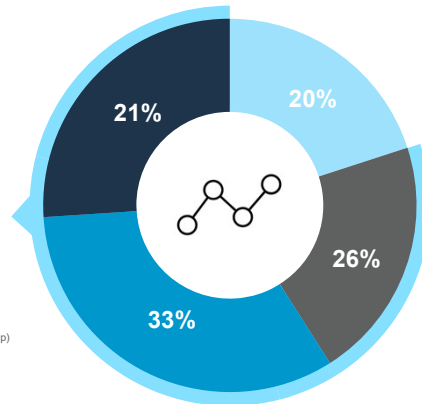
PATIENT OUT-OF-POCKET COST
based on tier placement

ACCESS BARRIERS
like prior authorization or fail first

PROVIDER INCENTIVES
through preferred treatment guidelines and pathways

Top 3 PBMs'
Market Share:
80%

■ OptumRx (UnitedHealthGroup)
■ CVS Caremark
■ Express Scripts
■ All Other

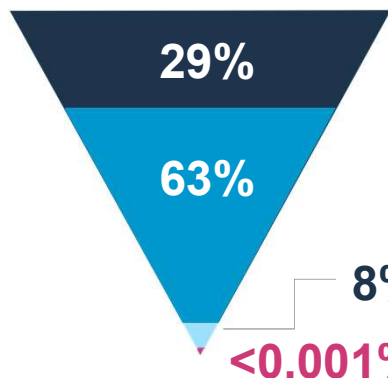


Source: Drug Channels Institute, March 2022.

9

The Majority of Brand Medicines Face Generic and Brand Competition

More than 99% of Part D spending in 2019 was for medicines with competition



Generics, and brands that have generic versions

Brands without their own generic but in classes that include generics

Brands in classes with competing brands (but no generics)

Brand medicines alone in their class

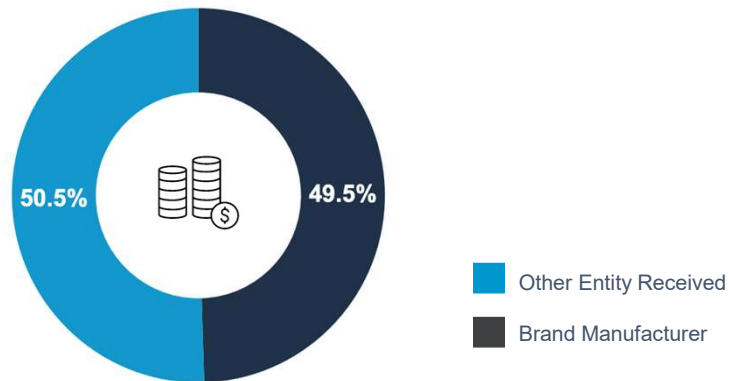


Class analysis is based on USP classification system. Part D plans are generally required to cover two medicines per USP class, and CMS uses USP to review Part D plan formularies to ensure plans meet formulary standards.
Source: Avalere, 2022.

10

More than Half of Every Dollar Spent on Brand Medicines Goes to Entities Who Did Not Develop Them

Percent of Total Spending on Brand Medicines Received by Manufacturers and Other Entities, 2020

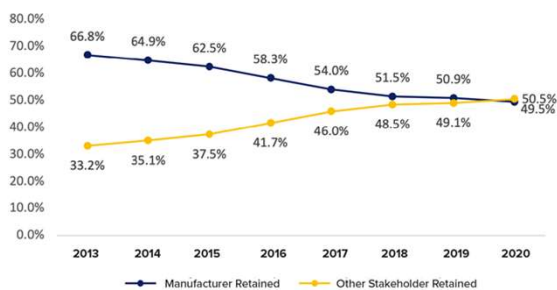


Source: Berkley Research Group, 2022.

11

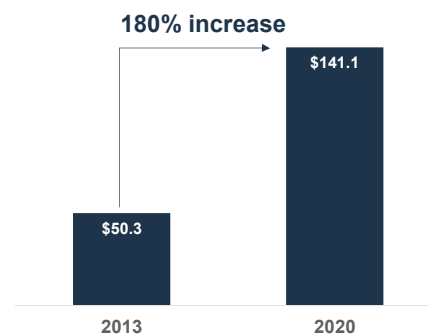
Insurers, PBMs And Others Receive An Increasing Share Of Total Spending On Brand Medicines

Total Brand Medicine Spending (\$B) 2013-2020



Source: Berkley Research Group, 2022.

Total Brand Medicine Spending Received by Payers (\$B)

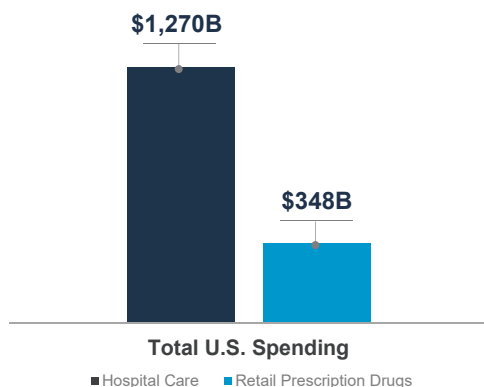


Payers include health plans, PBMs, federal and state governments, and employers

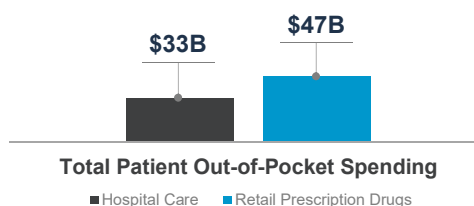
12

Patients Face Higher Out-of-Pocket Costs at the Pharmacy Counter than Other Parts of the Health Care System

Total hospital spending is much higher than total prescription drug spending



Yet, total patient spending on medicines is more than on hospital care



Source: Drug Channels Institute analysis of National Health Expenditure Accounts, Office of the Actuary in the Centers for Medicare & Medicaid Services, December 2021. Outpatient prescription drug figures exclude inpatient prescription drug spending within hospitals and nearly all provider-administered outpatient drugs. Figures in billions.

13

PhRMA Created the Medicine Assistance Tool, or MAT, To Help Patients Navigate Medicine Affordability

MAT makes it easier for those struggling to afford their medicines to find and learn more about various programs that can make prescription medicines more affordable.

The Medicine Assistance Tool Includes:

A search engine to connect patients with

900+

assistance programs offered by biopharmaceutical companies, including some free or nearly free options



Resources to help patients navigate their insurance coverage



Links to biopharmaceutical company websites where information about the cost of a prescription medicine is available



14

Daniel E. Buffington, PharmD, MBA, FAPhA

BIOGRAPHY



Dr. Daniel E. Buffington
President and CEO

Clinical Pharmacology Services, Inc
6285 E. Fowler Ave
Tampa, FL 33617

813-983-1500 Office
813-983-1501 Fax
813-679-0792 Cell

danbuffington@cpshealth.com
cpshealth.com

Dr. Daniel Buffington is the President and Practice Director at Clinical Pharmacology Services, located in Tampa, FL. He is also on faculty at the University of South Florida Colleges of Medicine and Pharmacy.

He studied Biology & Biochemistry at the University of South Florida, completed the Doctor of Pharmacy (PharmD) and Master of Business Administration (MBA) from Mercer University. He also completed his postgraduate training including a Pharmacy Practice Residency and Clinical Pharmacology Fellowship at Emory University.

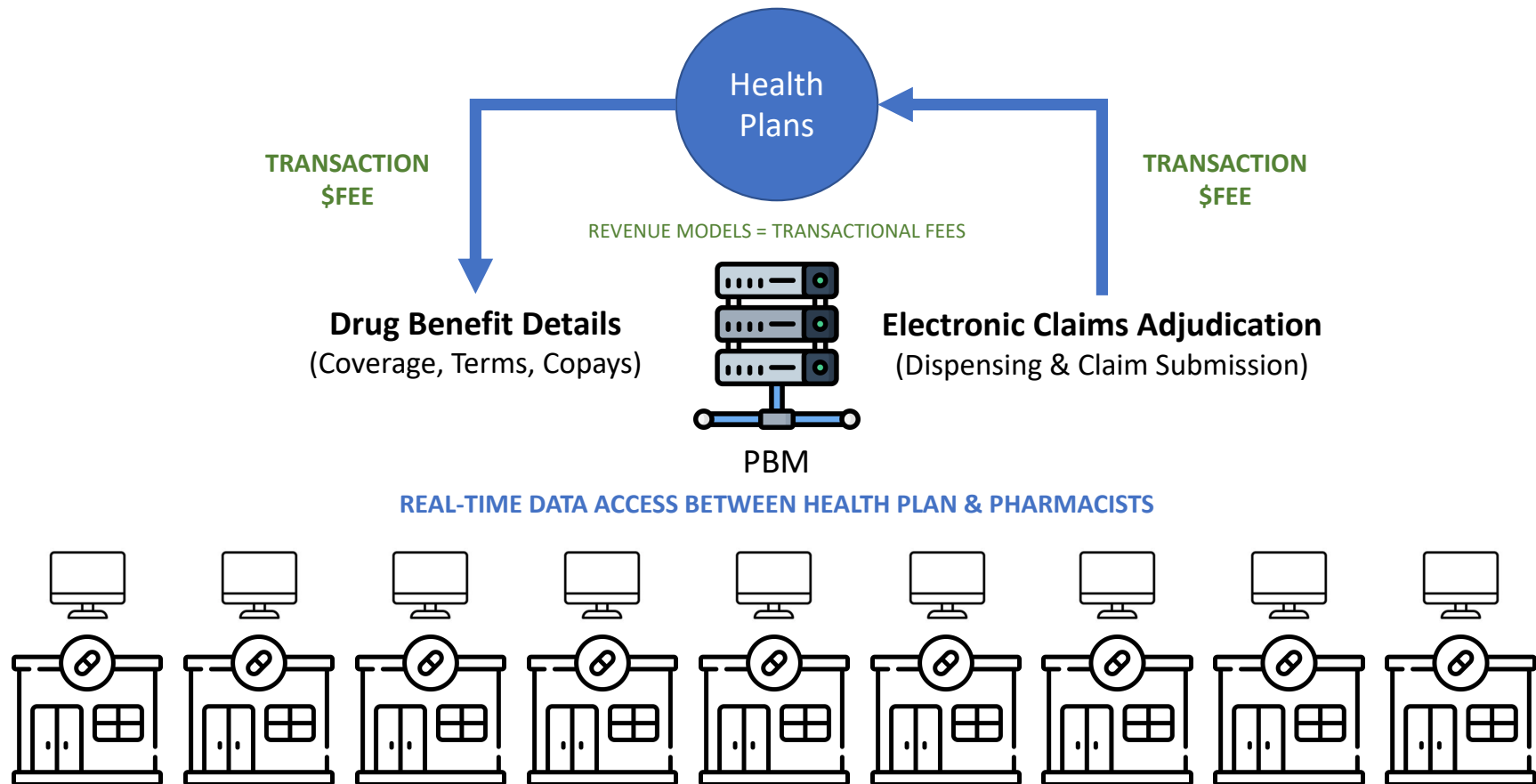
Dr. Buffington, is a Clinical Pharmacology & Toxicology specialist and provides medication therapy management consulting, serves as a principal investigator for Phase II and III clinical trials, and manages a national drug information service that provides clinical support for medical practices, health systems, health plans, and government agencies. The practice also includes a forensic pharmacology division that supports medical examiners, law enforcement, courts, and attorneys.

The practice focuses on patients taking chronic or high-risk medications and provides medication therapy management services to improve health outcomes, patient safety, and medication access.

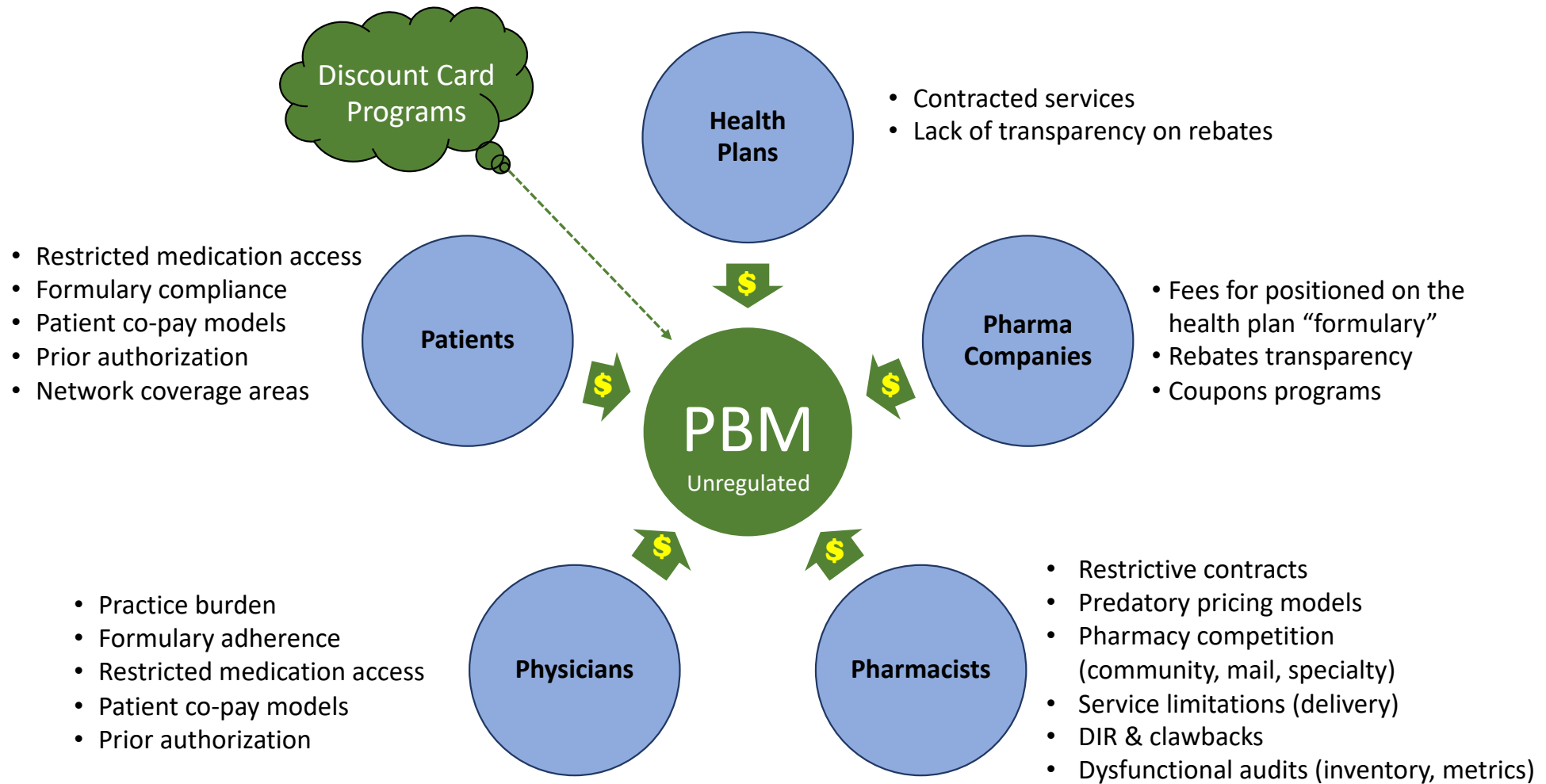
He has served as the President of the Florida Society of Health-Systems Pharmacists (FSHP), President of the Florida Pharmacy Association (FPA), Board of Trustee for the American Pharmacists Association's (APhA) and represents pharmacists on the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel.

His interests include healthcare administration, professional practice models, practice resources for improving medication utilization and patient safety, healthcare service reimbursement, clinical research, and developing specialty analytic tools for emerging electronic medical record systems.

Origin of Pharmacy Benefit Managers (PBM)



Evolution of Pharmacy Benefit Manager Revenue Models (PBM)



JEFFREY T. MARTORANA, M.D., F.A.A.F.P.
Chief Medical Director, Florida Association of Health Plans (FAHP)



MEDICAL TRAINING AND BOARD CERTIFICATION

St. Vincent's Medical Center, Family Practice Residency Program
Jacksonville, Florida Internship and Residency
Diplomat, American Board of Family Practice (Current to 2023)
Florida Medical License: ME0055954 (active)
Virginia Medical License: 0101057242 (active)

EDUCATION

M.D., Medical College of Virginia, Virginia Commonwealth University, Richmond, Virginia
M.A. Graduate Studies, Virginia Institute of Marine Science, The College of William and Mary, Gloucester Point, Virginia
BS Biology, The College of William and Mary, Williamsburg, Virginia

MEMBERSHIPS

Chairman, Florida Drug Utilization Review Board 2014-Present
Chairman, Florida Association of Health Plans 2017-2021
Board Member, Juvenile Diabetes Research Foundation 2017-Present
Member, American Association for Physician Leadership 2016-Present

EXPERIENCE

NAVIHEALTH, Remote, Florida

2021 - 2022

Medical Director (2021 – 2022)

Perform post-acute reviews for national Medicare Advantage providers across all states. Reviews for Long term acute care hospitals, Skilled nursing facilities, and Inpatient rehabilitation facilities.

- Conduct peer to peer discussion regarding leveling of care for member discharge.
- Review and adherence to Center for Medicare and Medicaid services criteria, Milliman and InterQual Guidelines.

SUNSHINE HEALTH, DIVISION OF CENTENE CORPORATION, Sunrise Florida

2013 - 2020 Vice President of

Medical Affairs (2019 - 2020)

Managed physical health and behavioral health physician staff in the administration of benefits for Exchange, Medicaid, Medicare, Child Welfare and Long-Term Care products for the state of Florida.

- Coordinated with provider relations and network to review physician hospital performance and implemented quality and cost savings initiatives, resulting in a 5 percent improvement in health benefit ratio.
- Assisted in the merger and integration health services operations, policies, and processes of the WellCare Plan after acquisition.
- Developed new strategies in the management of private duty nursing resulting in over \$6M annual savings.

JEFFREY T. MARTORANA, M.D., F.A.A.F.P.

Chief Medical Director (2013 - 2018)

State Medical Director for Sunshine Health, a division of Centene Corporation, providing services to Florida Medicaid, Child Welfare, Healthy Kids, Long Term Care, Medicare, and Exchange members. Oversaw UM, Pharmacy, QI, Case Management, Medical Management, and care coordination activities. Interfaced with hospitals, physicians, and ancillary providers to review data and developed opportunities for improving the delivery of quality, timely, evidenced based, and cost-effective healthcare. Supervised 14 medical directors and 13 pharmacists in the management of care to over 1,100,000 fully insured lives in the Florida market.

- Key contributor in the ITN Medicaid procurement resulting in the awarding MMA business in all 11 Florida regions along with the Child Welfare and Long-Term Care specialty contracts for Florida. Identified and implemented UM program vendors in Oncology, Orthopedics, Substance Abuse, and Physical Therapy, resulting in over \$16M in savings.

UNITED HEALTH GROUP, Miramar, Florida

(2003 – 2013)

Market Medical Director (2011 - 2013)

Market Medical Director for South Florida. Oversaw UM programs for inpatient, outpatient, and case management activities for 500,000 members. Forward facing clinical lead in the affordability and cost containment efforts in the market. Supported the network development team in provider negotiations and interactions including physicians, ancillary, and hospital providers. Met with brokers and high volume/profile employer groups in the review of utilization metrics and spend for their respective organizations, in addition, assisted in the development and implementation of programs to improve the health and wellness of their membership.

- Served as Liaison to the local regional and state physician organizations and serve as the focal point in the communication and implementation of United Healthcare initiatives and programs.
- Implemented vendor driven high tech radiology and radiation oncology resulting in \$3-5M annual savings.

Market Medical Director (2005 - 2011)

Market Medical Director for Neighborhood Health Partnership. Oversaw highly aggressive UM programs for inpatient, outpatient and case management activities for gatekeeper model HMO. Also provided support for QI, credentialing, grievance & appeals, along with committee participation at the Regional and National (Chairman) levels.

- Lead the integration efforts for the policies, procedures, vendor alignments and systems conversions of NHP to be consistent and compatible with national United Healthcare (UHC) operations.
- Developed new strategy and UM processes on site of care delivery for specialty pharmacy resulting in significant decrease in medical and pharmacy spend.

Medical Director (2003 - 2005)

Statewide Medical Director for the Florida AmeriChoice Health Plan, a division of UHG, providing medical services to the Florida Medicaid and Healthy Kid enrollees. Activities included all statewide UM, QI, Pharmacy, and medical management coordination. Provided direction for contracting and strategic business development for growth and expansion from 6 to 14 counties in the Florida markets.

- Interacted regularly with state Agency for Health Care Administration leadership, as well as met with and provided informational briefs to State Senators and Congressional members to discuss issues relating to the provision of health services for Medicaid recipients, and HMO perspectives regarding the Governors Medicaid Reform initiative.
- Partnered with AHCA in the development and implementation of a Florida Medicaid Formulary.

CIGNA HEALTHCARE OF VIRGINIA, Virginia Beach, Virginia

2000 - 2003

Associate Medical Director

Senior executive in the satellite Virginia Beach office, responsible for all UM, Quality, Case Management, and Credentialing for the Hampton Roads Market. Additional responsibilities included oversight and direction for all prior authorization activities and UM coordination statewide. Chaired the Quality Management, Credentialing Committees for the Hampton Roads Region. Provided direction for strategic contracting and business development for the Southeastern Virginia Regional Market. Client servicing, program management and relationships included Northrop Grumman, and Virginia Beach City and Schools.

JEFFREY T. MARTORANA, M.D., F.A.A.F.P.

SENTARA HEALTH SYSTEM, Virginia Beach, Virginia

1998 - 2000

Medical Director

Responsible for utilization management of a large integrated delivery system, consisting of five acute care hospitals and six nursing and rehabilitation centers. In addition, responsible for 300,000-covered lives. Oversaw Medicaid program from both a health plan coverage and hospital system perspective as well as indigent community in Norfolk Virginia.

HUMANA INC., NORTHEAST FLORIDA REGION, Jacksonville, Florida

1994 - 1997

Medical Director

Directed the utilization management staff in daily concurrent inpatient and outpatient utilization management. Regularly interacted with facilities and physician providers to optimize patient care and the delivery of health services. Involved in all aspects of market functions, contracting, regulatory compliance, risk management, strategic development, product sales and retention.

- Served as Liaison to the local regional and state physician organizations and serve as the focal point in the communication and implementation of United Healthcare initiatives and programs.
- Implemented vendor driven high tech radiology and radiation oncology resulting in \$3-5M annual savings.

FAMILY MEDICAL CENTERS, Jacksonville, Florida

1991 - 1994

Family Practitioner

Provided comprehensive medical care in outpatient, acute inpatient and sub-acute-skilled and custodial nursing home settings. Delivery of care included neonatal nursery, pediatrics, adult ICU and general medical hospital care. Chaired the Credentialing Committee for a thirty-physician primary care group. Facilitated the conversion of the centers from that of an ambulatory/acute focus to full spectrum family care for indemnity, fee for service, and capitated managed care contracts.

ST. VINCENT'S MEDICAL PLAN, Jacksonville, Florida

1993 - 1996

Medical Director (concurrent with Humana position)

Conducted utilization review for plan providers both in and outpatient settings. Developed and implemented plan benefit scope, pre-certification procedures, pharmacy benefits, and healthcare maintenance guidelines.

AMBULATORY CARE, INC., Jacksonville, Florida

1989 - 1994

Staff Physician

Provided routine, urgent, and emergent care in an outpatient clinic setting. Services included minor trauma, workers compensation, DOT pre-employment physicals, drug screening, and routine medical care.



[Katie Scanlan, Director of Pharmacy Operations](#)

Katie currently serves as the Senior Director of Pharmacy Administration for Publix Super Markets. In this role, she develops and directs the strategy for the pharmacy administration team which encompasses the areas of procurement, managed care, new business, technology, data & analytics, and clinical services. Katie began her career with Publix in 2007 where she worked as pharmacist and Pharmacy Manager for 5 years before transitioning to the corporate office, where she has held a variety of roles including Clinical Pharmacist, Manager of Managed Care, Sr. Manager of Specialty Pharmacy, and Director of Central and Specialty Pharmacy. Drug Store News recognized Katie in 2019 in the Rising Star Category and in 2021 in the Business Excellence category for their Top Women in Health, Wellness, & Beauty awards. She was elected member-at-large for NACDS's Policy Council beginning in January 2022. Katie earned her bachelor's degree from Boston College in 2001 and her Doctor of Pharmacy degree from The University of Georgia College of Pharmacy in 2007.



Florida Senate Committee on Health Policy

Monday, February 6, 2023

Lucas Coody, PharmD

Lucas Coody, PharmD is a practicing community pharmacist and the Director of Government Affairs at AlignRx. Dr. Coody graduated from Southwestern Oklahoma State University College of Pharmacy in May of 2016 and has since received numerous awards for his contributions to the pharmacy profession. He has written or consulted on legislation involving pharmacy practice, pharmacy benefit managers (PBMs), and pharmacy services administrative organizations (PSAOs) in over 40 states. Lucas resides in Elgin, OK with his wife of 6 years and two daughters, ages 1 and 3.

AlignRx is a PSAO that assists community pharmacies with “back-office” tasks such as contracting, payment reconciliation, and reimbursement appeals. AlignRx is proud to work with thousands of community pharmacies across the United States, including many in the State of Florida. AlignRx is a wholesaler agnostic PSAO, meaning we are not affiliated with any wholesalers and pharmacies are encouraged to purchase products from the most affordable sources. The AlignRx Government Affairs Department provides legislative and regulatory updates to our member pharmacies and staff. The Government Affairs Department also works with state departments and officials to ensure that PBMs are following applicable laws.



844-alignrx



PO Box 8400 Edmond, Ok 73083-8400



alignrx.org

Pharmacy Services Administrative Organizations: *What You Need to Know*

A Pharmacy Services Administrative Organization (PSAO) interacts with healthcare insurers and pharmacy benefit managers (PBMs) on behalf of independent community pharmacies. Because community pharmacies comprise an approximately 35 percent share of the overall retail pharmacy market in the U.S., the PSAO serves a critical function to help sustain these businesses.

A majority of the nearly 22,000 independent community pharmacies in the U.S. voluntarily outsource some administrative services to a PSAO, providing these small business owners and healthcare providers support to allow them to spend more time at the pharmacy counter and, ultimately, on patient care.

The core function of a PSAO is to contract with a group of independent pharmacies, generally for an affordable monthly fee (around \$200, the sole source of revenue for the PSAO). By doing so, PSAOs amplify the voices of independent pharmacies with third-party payers and PBMs and create administrative efficiencies, allowing these small businesses to better use limited resources.

PSAOs Provide Administrative Services to Independent Pharmacies

While PSAOs are primarily focused on decreasing administrative burdens for community pharmacists, these organizations also support contract negotiation and communication with PBMs or insurers.

Services Provided By PSAOs:	PSAOs Do Not:
Managing insurer and PBM relationships , including fielding questions about claims, contracting, reimbursement, and payer/PBM audits	Dictate reimbursement rates
Ensuring pharmacy clients understand their rights and responsibilities regarding responding to or appealing audit findings	Set Maximum Allowable Cost (MAC) rates
Assisting with regulation compliance and credentialing	Determine formulary listings or patient coverage
Aggregating claims to a single payment from a third-party payer on behalf of a PSAO's member pharmacies; individual payments are then disbursed to a PSAO's members	Retain any portion of pharmacy reimbursement
Managing and analyzing pharmacies' payment and drug dispensing data to identify claims that have not been paid or were paid incorrectly	Create Direct and Indirect Remuneration (DIR)* fees — or retain any portion of DIR or dispensing fees
	Accept all contract terms
	Create networks or plan structures
	<i>*In fact, PSAOs provide tools to help improve patient outcomes, which can in turn reduce DIR fees for pharmacies.</i>

Local independent pharmacists are some of the most accessible and trusted healthcare professionals in their communities. Supporting, managing and growing these businesses involve multiple full-time jobs, and PSAOs provide pharmacists the value-added services to help them make a difference in the health of their customers and neighbors.



Enhance pharmacy performance through tools, technology and resources, supported by expertise from industry professionals.



Simplify pharmacy administration and enhance efficiency through central pay, reconciliation services, credentialing programs, claims processing support and other offerings.



Empower community pharmacies and enable staff to focus their time and attention on helping patients.

Together We Are Stronger

A PSAO partnership grants you a seat at the table with payers—an important step in getting your voice heard. Imagine the value you could gain from a partnership that truly reflects the goals of your pharmacy business.

AlignRx offers a one-stop shop of data-driven solutions that help enhance pharmacy and community health outcomes.

We understand having access to contracts is not enough. We take one step further with a selective approach to contract access that is complemented by best practices in clinical and business approaches. Review our comprehensive portfolio of PSAO, reconciliation, audit, and clinical services to learn how we can add value to your pharmacy business as a strategic partner.



Core PSAO Services

Managed Care Contracting

Set your pharmacy business on solid footing. Reap the benefits of our long-standing relationships with regional and national health plans and payers. Designed to enhance and sustain dispensing revenue, our managed care contracting program offers multiple chain codes for access to contracts that are best suited to your needs.

Direct Contract Consulting

Align emerging opportunities with your strategic goals. Explore traditional and non-traditional service contracts with expert advice. Our contract review process comprises intelligent data analysis and projection; evaluation of current to proposed rates; and breakdown of cost of goods and overhead costs. We also recommend an acceptable counteroffer based on a thorough analysis of contract rates.

The Quality Center

Maximize your ROI from patient interactions and meet performance goals. Access a personalized, web-based toolkit for actionable insight into patient behavioral patterns. Key features include a user-friendly dashboard, MTM dashboard, and single sign-on access to EQuIPP®.

Compliance Guardian®

Build a culture of compliance and preserve patient access. Maintain in-network status with a customized web-based solution that offers training modules on HIPAA Security and FWA; OIG and GSA exclusion verification; and attestation support. Having quick and easy access to important documentation that shows proof of compliance in the event of an audit can help you avoid penalties.

Learn more about our solutions.

844-ALIGNRX (844-254-4679), option 6 | sales@alignrx.org | AlignRx.org

ClaimGuard

Maximize reimbursement. Reduce your administrative burden with a solution for the research, analysis, and submission of generic MAC claims reimbursed below cost. Key features include automated processes driven by claims data and wholesaler invoice cost tables; flagging of discrepancies between claims payment and invoice cost; and monthly follow-up on your behalf with PBMs to improve response rates.

Central Pay | Additional fee applies

Maintain a steady cash flow. Conveniently aggregate payments and boost your cash flow with a centralized program for efficient reimbursement. Our differentiated program operates on a same-day payment policy so all funds received from a payer on a given day are disbursed on that same day, ensuring you have sufficient cash on hand.

True Script Reporter

Save time with custom reporting on reimbursement data. Track aggregate payments and electronic remittance advice (835) files with the help of an easy-to-use, web-based reporting platform. You can adapt and utilize exportable report options to support your financial reporting.

Ancillary PSAO Services

Claims Reconciliation

eRecon® |

Leave no money on the table. Optimize efficiency and focus more time on your patients with our automated claims reconciliation and accounts receivable solution. This industry-leading solution combines technology and live, US-based customer support to deliver tangible results. Key features include transaction-based accounting, manual remit assistance, and monthly accounting reports of paid claims that can be used for tax and auditing purposes.

Ensure Pay |

Approach each reimbursement cycle with confidence. Effectively manage your reimbursement data to increase accuracy and reduce processing time with our 835 file management program. Elect to have 835 files provided to a reconciliation vendor of your choice and/or uploaded into pharmacy operating software with certain vendors.

Audit Protection

RxProtect® |

Safeguard your investment. Gain peace of mind knowing you can take proactive steps to identify your pharmacy's audit risk and minimize financial liability. Our multi-level program combines education, claims review, and real-time consultation services to deliver an all-in-one solution for protecting your bottom line. Key features include audit tips, technician training, onsite audit assistance (additional fees apply), high-risk claims report, and audit/appeal support, including hard copy review.

Clinical Services

Cost varies by program

Establish a blueprint for excellence. Explore opportunities to boost revenue by monetizing your clinical expertise. Our clinical program goes beyond dispensing to offer pioneering approaches for improving clinical outcomes. Key features include a CPESN® participating pharmacy network for clinical services, local and regional revenue opportunities, COVID-19 vaccine network, RxEvolution participating network, adherence metric support, and DIR fee mitigation.

The Florida Senate
APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Bill Number or Topic

Amendment Barcode (if applicable)

Meeting Date

2/6
Health Policy

Committee

Name

Connor Rose

Phone

859 797 1820

Address

325 TH St NW

Email

Crose@pcmanet.org

Street

Washington

DC

20001

City

State

Zip

Speaking:

☐

For

☐

Against

☒

Information

OR

Waive Speaking:

☐

In Support

☐

Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐

I am appearing without
compensation or sponsorship.

☒

I am a registered lobbyist,
representing:

PCMA

☐

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022 Joint Rules.pdf \(flsenate.gov\)](#)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

2/6/2023

Meeting Date

The Florida Senate
APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Pharmacy Benefits

Bill Number or Topic

Amendment Barcode (if applicable)

Name

Lucas Coody

Phone

580-350-0789

Address

103 London Drive

Email

lcoody@alignrx.org

Street

Elgin

City

OK

State

73538

Zip

Speaking:

☐

For

☐

Against

☒

Information

OR

Waive Speaking:

☐

In Support

☐

Against

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S-001 (08/10/2021)

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Bill Number or Topic

Amendment Barcode (if applicable)

Meeting Date

Committee

Name

Phone

Address

Email

Street

City

State

Zip

Speaking:



For



Against



Information

OR

Waive Speaking:



In Support



Against

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compensation or sponsorship.



I am a registered lobbyist,
representing:



I am not a lobbyist, but received
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(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022 Joint Rules.pdf \(flsenate.gov\)](#)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2-6-2023

Meeting Date

Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name

Kristin Parde

Phone

703-209-6321

Address

950 F Street, NW

Email

Kparde@phrma.org

Street

City

Washington

State

DC

Zip

20004

Speaking:

☐

For

☐

Against

☒

Information

OR

Waive Speaking:

☐

In Support

☐

Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐

I am appearing without
compensation or sponsorship.

☒

I am a registered lobbyist,
representing:

☐

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022 Joint Rules.pdf \(flsenate.gov\)](#)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

CourtSmart Tag Report

Room: KB 412
Caption: Health Policy Committee

Case No.: -
Judge:

Type:

Started: 2/6/2023 3:31:20 PM
Ends: 2/6/2023 5:29:17 PM **Length:** 01:57:58

3:31:19 PM Meeting called to order by Chair Burton
3:31:25 PM Attendance Roll call. A quorum is present
3:31:41 PM Senator Book is excused from today's meeting
3:32:14 PM Chair Burton takes up Tab 1: Florida's Regulation of Pharmacy Benefit Managers – Office of Insurance Regulation
3:33:14 PM Appearance and presentation by Mr. Kevin Jacobs, Deputy Chief of Staff for Government & Cabinet Operations/ Office of Insurance Regulation
3:33:35 PM Overview of Office Insurance Regulation by Mr. Jacobs
3:36:05 PM Comment by Chair Burton
3:37:07 PM Chair Burton take up Tab 2: Pharmacy Benefit Management within Florida Medicaid – Agency for Health Care Administration
3:37:45 PM Appearance and presentation by Mr. Austin Noll, AHCA's Deputy Secretary for Medicaid Policy, Quality, and Operations
3:38:03 PM Mr. Noll begins the presentation
3:38:48 PM Executive Order 22-164 slide
3:39:21 PM Overview about Medicaid Program by Mr. Noll
3:39:39 PM Mr. Noll talked about Florida Medicaid Delivery System
3:40:12 PM Mr. Noll talked about the Multiple Managed Care Program Components
3:40:42 PM Pharmacy Benefit Manager Overview
3:41:29 PM Florida Medicaid Pharmacy Benefits
3:42:04 PM Mr. Noll talked about the Manufacturer Rebates
3:43:02 PM Mr. Noll talked about the Agency Implementation
3:44:09 PM Mr. Noll talked about the Requiring Pass
3:44:59 PM Prohibits Reconciliation of Offsets
3:45:27 PM Requiring Annual and Quarterly
3:46:00 PM Inspection Requirement
3:46:23 PM Audit of Financial Records
3:46:49 PM Additional Requirement
3:47:33 PM Presentation concluded
3:47:36 PM Chair Burton ask Members for questions
3:47:41 PM Question by Senator Davis
3:48:03 PM Response by Mr. Noll
3:48:41 PM Question by Senator Davis
3:48:51 PM Response by Mr. Noll
3:48:58 PM Question by Senator Davis
3:49:05 PM Response by Mr. Noll
3:49:34 PM Question by Senator Brodeur
3:50:38 PM Response by Mr. Noll
3:51:19 PM Question by Senator Garcia
3:51:52 PM Response by Mr. Noll
3:52:18 PM Question by Senator Harrell
3:52:45 PM Response by Mr. Noll
3:53:14 PM Comment by Senator Harrell
3:53:25 PM Response by Mr. Noll
3:54:11 PM Question by Senator Avila
3:54:25 PM Response by Mr. Noll
3:55:04 PM Comment by Chair Burton
3:55:16 PM Chair Burton Take up Tab 3, Panel Discussion on Pharmacy Benefit Management of Health Insurance Prescription Coverage
3:55:46 PM Appearance and public testimony by Dan Buffington with Florida Pharmacy Association starts introductions
4:03:51 PM Appearance and public testimony by Kristin Parde with Pharmaceutical Research and Manufacturers of

America begins introduction

4:10:17 PM Appearance and public testimony by Lucas Coody with AlignRx begins introduction

4:17:54 PM Appearance and public testimony by Jeffrey Martorano with the Florida Association of Health Plans begins introduction

4:26:13 PM Appearance and public testimony by Connor Rose with Pharmaceutical Care Management Association begins introduction

4:36:24 PM Comment by Chair Burton

4:36:32 PM Appearance and public testimony by Katie Scanlan with Publix begins introduction

4:39:50 PM Chair Burton ask Members for questions

4:39:59 PM Question by Senator Harrell

4:41:30 PM Response by Dan Buffington

4:44:28 PM Response by Connor Rose

4:46:19 PM Follow up by Senator Harrell

4:47:03 PM Response by Connor Rose

4:47:46 PM Response by Dan Buffington

4:49:06 PM Question by Senator Brodeur

4:49:46 PM Response by Connor Rose

4:49:54 PM Question by Senator Brodeur

4:50:15 PM Response by Connor Rose

4:50:33 PM Comment by Senator Brodeur

4:50:52 PM Response by Connor Rose

4:51:10 PM Question by Senator Brodeur

4:51:17 PM Response by Connor Rose

4:52:00 PM Question by Senator Brodeur

4:52:09 PM Response by Connor Rose

4:52:39 PM Comment by Senator Brodeur

4:52:59 PM Question by Senator Osgood

4:53:30 PM Response by Lucas Coody

4:55:15 PM Response by Jeffrey Martorana

4:55:19 PM Question by Senator Osgood

4:56:48 PM Comment by Chair Burton

4:57:55 PM Response by Kristin Parde

4:59:25 PM Question by Senator Brodeur

5:00:02 PM Response by Connor Rose

5:00:38 PM Response by Dan Buffington

5:00:50 PM Question by Senator Garcia

5:01:58 PM Response by Connor Rose

5:02:54 PM Question by Senator Garcia

5:04:06 PM Response by Connor Rose

5:04:24 PM Question by Senator Garcia

5:05:36 PM Response by Dan Buffington

5:06:20 PM Response by Kristin Parde

5:07:37 PM Question by Senator Davis

5:09:00 PM Response by Dan Buffington

5:09:47 PM Question by Senator Davis

5:09:56 PM Response by Kristin Parde

5:11:00 PM Question by Senator Davis

5:12:19 PM Response by Kristin Parde

5:12:45 PM Question by Senator Brodeur

5:13:30 PM Response by Katie Scanlan

5:14:14 PM Question by Senator Brodeur

5:14:38 PM Response by Katie Scanlan

5:14:43 PM Question by Senator Avila

5:15:28 PM Response by Jeffrey Martorana

5:15:54 PM Question by Senator Avila

5:16:55 PM Response by Jeffrey Martorana

5:16:58 PM Comment by Senator Avila

5:17:02 PM Response by Jeffrey Martorana

5:17:07 PM Comment by Senator Avila

5:17:25 PM Response by Jeffrey Martorana

5:17:35 PM Response by Dan Buffington

5:18:37 PM Question by Senator Avila

5:19:07 PM	Response by Connor Rose
5:20:18 PM	Question by Senator Avila
5:21:13 PM	Response by Lucas Coody
5:23:08 PM	Question by Senator Osgood
5:24:21 PM	Response by Dan Buffington
5:24:54 PM	Comment by Senator Osgood
5:25:48 PM	Question by Chair Burton
5:25:58 PM	Response by Jeffrey Martorana
5:26:23 PM	Question by Chair Burton
5:26:41 PM	Response by Jeffrey Martorana
5:27:06 PM	Comment by Senator Harrell
5:28:00 PM	Chair Burton thanks panelist for their attendance
5:28:26 PM	No further business, Senator Avila moves to adjourn
5:29:17 PM	Meeting adjourned
5:29:17 PM	



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Appropriations
Appropriations Committee on Education
Appropriations Committee on Health and Human
Services
Children, Families, and Elder Affairs
Education Postsecondary
Health Policy
Judiciary
Rules

JOINT COMMITTEE:

Joint Legislative Budget Commission

SENATOR LAUREN BOOK

Democratic Leader
35th District

February 1, 2023

The Honorable Colleen Burton, Chair
Committee on Health Policy
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Burton:

I respectfully request to be excused from your Committee on Health Policy scheduled for February 6, 2023 at 3:30 PM. I regret that I have an unavoidable conflict and sincerely apologize for any inconvenience this may cause.

Thank you for your consideration. Please feel free to contact me at (850) 487-5035 if you have any questions.

Kindest Regards,

A handwritten signature in cursive script that reads "Lauren Book".

Senator Lauren Book
Minority Leader
Florida Senate, District 35

cc: Allen Brown, Staff Director
Anhar Al-Asadi, Committee Administrative Assistant

REPLY TO:

- ☐ 967 Nob Hill Road, Plantation, Florida 33324 (954) 424-6674
- ☐ 228 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5035

Senate's Website: www.flsenate.gov

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore