COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Andrade offered the following:
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5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Subsection (16) is added to section 499.012,
8 Florida Statutes, to read:
9 499.012 Permit application requirements.—
10 (16) A permit for a prescription drug manufacturer or a
11 nonresident prescription drug manufacturer is subject to the
12 requirements of s. 499.026.
13 Section 2. Section 499.026, Florida Statutes, is created
14 to read:
15 499.026 Prescription drug price increases.—
16 (1) As used in this section, the term:

17 (a) "Drug Price Increase" means a manufacturer price
18 increase equal to or greater than 15 percent of the price of a
19 drug for a brand-name prescription drug with a wholesale
20 acquisition cost of $50 or more, or a manufacturer price
21 increase equal to or greater than 25 percent of the price of a
22 drug for a generic prescription drug or a biosimilar drug with a
23 wholesale acquisition cost of $25 or more, for a 30-day supply.
24 (b) "Health insurer" means a health insurer issuing major
25 medical coverage through an individual or group policy or a
26 health maintenance organization issuing major medical coverage
27 through an individual or group contract, regulated under chapter
28 627 or chapter 641.
29 (c) "Manufacturer" means any person holding a prescription
30 drug manufacturer permit or a nonresident prescription drug
31 manufacturer permit under s. 499.01.
32 (d) "Wholesale acquisition cost" means that term as
33 defined in 42 U.S.C. § 1395w-3a.
34 (2) At least 60 days before the effective date of any drug
35 price increase, a manufacturer must provide notification of the
36 upcoming drug price increase and the amount of the drug price
37 increase to every health insurer that covers the drug. A
38 manufacturer must make the notification using the contact list
39 published by the Office of Insurance Regulation pursuant to ss.
40 627.42394 and 641.3131. Notification shall be presumed to occur
41 on the date that a manufacturer attempts to communicate with the

42 applicable point of contact published by the Office of Insurance
43 Regulation.
44 (3) By April 1 of each year, a manufacturer must submit a
45 report to the department and the Office of Insurance Regulation
46 on each drug price increase made during the previous calendar
47 year. At a minimum, the report shall include:
48 (a) A list of all drugs affected by the drug price
49 increase and both the dollar amount of each drug price increase
50 and the percentage increase of each drug price increase,
51 relative to the previous price of the drug.
52 (b) A complete description of the factors contributing to
53 the drug price increase.
54 Section 3. Section 624.491, Florida Statutes, is created
55 to read:
56 624.491 Pharmacy audits.—
57 (1) A health insurer or health maintenance organization
58 providing pharmacy benefits through a major medical individual
59 or group health policy or health maintenance contract,
60 respectively, shall comply with the requirements of this section
61 when the insurer or health maintenance organization or any
62 entity acting on behalf of the insurer or health maintenance
63 organization, including, but not limited to, a pharmacy benefit
64 manager, audits the records of a pharmacy licensed under chapter
65 465. This section does not apply to audits in which suspected
66 fraudulent activity or other intentional or willful

67 misrepresentation is evidenced by a physical review, review of
68 claims data or statements, or other investigative methods;
69 audits of claims paid for by federally funded programs; or
70 concurrent reviews or desk audits that occur within 3 business
71 days of transmission of a claim and where no chargeback or
72 recoupment is demanded. An entity that audits a pharmacy located
73 within a Health Care Fraud Prevention and Enforcement Action
74 Team (HEAT) Task Force area designated by the United States
75 Department of Health and Human Services and the United States
76 Department of Justice may dispense with the notice requirements
77 if such pharmacy has been a member of a credentialed provider
78 network for less than 12 months.
79 (2) An entity conducting a pharmacy audit shall:
80 (a) Notify the pharmacy at least 7 calendar days before
81 the initial onsite audit for each audit cycle.
82 (b) Ensure the audit is not initiated during the first 3
83 calendar days of a month unless the pharmacist consents
84 otherwise.
85 (c) Limit the audit period to 24 months after the date a
86 claim is submitted to or adjudicated by the entity.
87 (d) Provide a preliminary audit report to the pharmacy
88 within 120 days after the conclusion of the audit.
89 (e) Provide a final audit report to the pharmacy within 6
90 months after having providing the preliminary audit report.

91 Section 4. Section 627.42394, Florida Statutes, is created
92 to read:
93 627.42394 Formulary changes resulting from drug price
94 increases.—
95 (1) A health insurer issuing a major medical individual or
96 group policy shall submit, and update as necessary, contact
97 information for a single point-of-contact for use by
98 prescription drug manufacturers to comply with s. 499.026. The
99 Office shall maintain and publish a list of such points of
100 contact.
101 (2) A health insurer issuing a major medical individual or
102 group policy must provide written notice to affected insureds at
103 least 30 days in advance of making a drug formulary change
104 resulting from a drug price increase reported pursuant to s.
105 499.026.
106 (3) This section applies to policies entered into or
107 renewed on or after January 1, 2021.
108 Section 5. Section 627.64741, Florida Statutes, is amended
109 to read:
110 627.64741 Pharmacy benefit manager contracts.—
111 (1) As used in this section, the term:
112 (a) "Administrative fee" means a fee or payment under a
113 contract between a health insurer and a pharmacy benefit manager
114 associated with the pharmacy benefit manager's administration of

115 the insurer's prescription drug benefit programs that is paid by
116 the insurer to the pharmacy benefit manager.
117 (b) (a) "Maximum allowable cost" means the per-unit amount
118 that a pharmacy benefit manager reimburses a pharmacist for a
119 prescription drug, excluding dispensing fees, prior to the
120 application of copayments, coinsurance, and other cost-sharing
121 charges, if any.
122 (c) (b) "Pharmacy benefit manager" means a person or entity
123 doing business in this state which contracts to administer or
124 manage prescription drug benefits on behalf of a health insurer
125 to residents of this state.
126 (d) "Rebate" means all discounts and other negotiated
127 price concessions based on utilization of a prescription drug
128 and paid by the pharmaceutical manufacturer or other entity,
129 other than an insured, to the pharmacy benefit manager after the
130 claim has been adjudicated at the pharmacy.
131 (e) "Spread pricing" means any amount a pharmacy benefit
132 manager charges or receives from a health insurer for payment of
133 a prescription drug or pharmacy service that is greater than the
134 amount the pharmacy benefit manager paid to the pharmacist or
135 pharmacy that filled the prescription or provided the pharmacy
136 service.
137 (2) A contract between a health insurer and a pharmacy
138 benefit manager must require that the pharmacy benefit manager:

139 (a) Update maximum allowable cost pricing information at
140 least every 7 calendar days.
141 (b) Maintain a process that will, in a timely manner,
142 eliminate drugs from maximum allowable cost lists or modify drug
143 prices to remain consistent with changes in pricing data used in
144 formulating maximum allowable cost prices and product
145 availability.
146 (3) A contract between a health insurer and a pharmacy
147 benefit manager must prohibit the pharmacy benefit manager from
148 limiting a pharmacist's ability to disclose whether the cost-
149 sharing obligation exceeds the retail price for a covered
150 prescription drug, and the availability of a more affordable
151 alternative drug, pursuant to s. 465.0244.
152 (4) A contract between a health insurer and a pharmacy
153 benefit manager must prohibit the pharmacy benefit manager from
154 requiring an insured to make a payment for a prescription drug
155 at the point of sale in an amount that exceeds the lesser of:
156 (a) The applicable cost-sharing amount; or
157 (b) The retail price of the drug in the absence of
158 prescription drug coverage.
159 (5) A contract between a health insurer and a pharmacy
160 benefit manager must require the pharmacy benefit manager to
161 report annually the following to the insurer:
162 (a) The aggregate amount of rebates the pharmacy benefit
163 manager received in association with claims administered on

164 behalf of the insurer and the aggregate amount of such rebates
165 the pharmacy benefit manager received that were not passed
166 through to the insurer.
167 (b) The aggregate amount of administrative fees paid to
168 the pharmacy benefit manager by the insurer for the
169 administration of the insurer's prescription drug benefit
170 programs.
171 (c) The types and aggregate amounts of any fees or
172 remittances paid to the pharmacy benefit manager by pharmacies.
173 The pharmacy benefit manager shall distinguish between fees paid
174 by covered entities, as defined in 42 U.S.C. § 256b, and fees
175 paid by pharmacies which are not covered entities.
176 (d) The aggregate amount of revenue generated by the
177 pharmacy benefit manager through the use of spread pricing in
178 association with the administration of the insurer's pharmacy
179 benefit programs.
180 (6) Not later than June 30, 2021, and annually thereafter,
181 a health insurer shall submit a report to the office that
182 includes the information provided by its contracted pharmacy
183 benefit managers under subsection (5). The office shall publish
184 on its website an analysis of the reported information required
185 to be provided to the insurer under subsection (5) in an
186 aggregated amount for each pharmacy benefit manager.
187 (7) ~~(5)~~ This section applies to contracts entered into or
188 renewed on or after July 1, 2020~~2018~~.

189 Section 6. Section 627.6572, Florida Statutes, is amended
190 to read:
191 627.6572 Pharmacy benefit manager contracts.—
192 (1) As used in this section, the term:
193 (a) "Administrative fee" means a fee or payment under a
194 contract between a health insurer and a pharmacy benefit manager
195 associated with the pharmacy benefit manager's administration of
196 the insurer's prescription drug benefit programs that is paid by
197 the insurer to the pharmacy benefit manager.
198 (b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount
199 that a pharmacy benefit manager reimburses a pharmacist for a
200 prescription drug, excluding dispensing fees, prior to the
201 application of copayments, coinsurance, and other cost-sharing
202 charges, if any.
203 (c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity
204 doing business in this state which contracts to administer or
205 manage prescription drug benefits on behalf of a health insurer
206 to residents of this state.
207 (d) "Rebate" means all discounts and other negotiated
208 price concessions based on utilization of a prescription drug
209 and paid by the pharmaceutical manufacturer or other entity,
210 other than an insured, to the pharmacy benefit manager after the
211 claim has been adjudicated at the pharmacy.
212 (e) "Spread pricing" means any amount a pharmacy benefit
213 manager charges or receives from a health insurer for payment of

214 a prescription drug or pharmacy service that is greater than the
215 amount the pharmacy benefit manager paid to the pharmacist or
216 pharmacy that filled the prescription or provided the pharmacy
217 service.
218 (2) A contract between a health insurer and a pharmacy
219 benefit manager must require that the pharmacy benefit manager:
220 (a) Update maximum allowable cost pricing information at
221 least every 7 calendar days.
222 (b) Maintain a process that will, in a timely manner,
223 eliminate drugs from maximum allowable cost lists or modify drug
224 prices to remain consistent with changes in pricing data used in
225 formulating maximum allowable cost prices and product
226 availability.
227 (3) A contract between a health insurer and a pharmacy
228 benefit manager must prohibit the pharmacy benefit manager from
229 limiting a pharmacist's ability to disclose whether the cost-
230 sharing obligation exceeds the retail price for a covered
231 prescription drug, and the availability of a more affordable
232 alternative drug, pursuant to s. 465.0244.
233 (4) A contract between a health insurer and a pharmacy
234 benefit manager must prohibit the pharmacy benefit manager from
235 requiring an insured to make a payment for a prescription drug
236 at the point of sale in an amount that exceeds the lesser of:
237 (a) The applicable cost-sharing amount; or

238 (b) The retail price of the drug in the absence of
239 prescription drug coverage.
240 (5) A contract between a health insurer and a pharmacy
241 benefit manager must require the pharmacy benefit manager to
242 report annually the following to the insurer:
243 (a) The aggregate amount of rebates the pharmacy benefit
244 manager received in association with claims administered on
245 behalf of the insurer and the aggregate amount of such rebates
246 the pharmacy benefit manager received that were not passed
247 through to the insurer.
248 (b) The aggregate amount of administrative fees paid to
249 the pharmacy benefit manager by the insurer for the
250 administration of the insurer's prescription drug benefit
251 programs.
252 (c) The types and aggregate amounts of any fees or
253 remittances paid to the pharmacy benefit manager by pharmacies.
254 The pharmacy benefit manager shall distinguish between fees paid
255 by covered entities, as defined in 42 U.S.C. § 256b, and fees
256 paid by pharmacies which are not covered entities.
257 (d) The aggregate amount of revenue generated by the
258 pharmacy benefit manager through the use of spread pricing in
259 association with the administration of the insurer's pharmacy
260 benefit programs.
261 (6) Not later than June 30, 2021, and annually thereafter,
262 a health insurer shall submit a report to the office that

263 includes the information provided by its contracted pharmacy
264 benefit managers under subsection (5). The office shall publish
265 on its website an analysis of the reported information required
266 to be provided under subsection (5) in an aggregated amount for
267 each pharmacy benefit manager.
268 (7)~~(5)~~ This section applies to contracts entered into or
269 renewed on or after July 1, 2020~~2018~~.
270 Section 7. Section 641.3131, Florida Statutes, is created
271 to read:
272 641.3131 Formulary changes resulting from drug price
273 increases.—
274 (1) A health maintenance organization issuing a major
275 medical or other comprehensive coverage contract shall submit,
276 and update as necessary, contact information for a single point-
277 of-contact for use by prescription drug manufacturers to comply
278 with s. 499.026. The Office shall maintain and publish a list of
279 such points of contact.
280 (2) A health maintenance organization issuing a major
281 medical or other comprehensive coverage contract must provide
282 written notice to affected subscribers at least 30 days in
283 advance of making a drug formulary change resulting from a drug
284 price increase reported pursuant to s. 499.026.
285 (3) This section applies to contracts entered into or
286 renewed on or after January 1, 2021.

287 Section 8. Section 641.314, Florida Statutes, is amended
288 to read:
289 641.314 Pharmacy benefit manager contracts.—
290 (1) As used in this section, the term:
291 (a) “Administrative fee” means a fee or payment under a
292 contract between a health maintenance organization and a
293 pharmacy benefit manager associated with the pharmacy benefit
294 manager's administration of the health maintenance
295 organization's prescription drug benefit programs that is paid
296 by the health maintenance organization to the pharmacy benefit
297 manager.
298 (b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount
299 that a pharmacy benefit manager reimburses a pharmacist for a
300 prescription drug, excluding dispensing fees, prior to the
301 application of copayments, coinsurance, and other cost-sharing
302 charges, if any.
303 (c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity
304 doing business in this state which contracts to administer or
305 manage prescription drug benefits on behalf of a health
306 maintenance organization to residents of this state.
307 (d) “Rebate” means all discounts and other negotiated
308 price concessions based on utilization of a prescription drug
309 and paid by the pharmaceutical manufacturer or other entity,
310 other than a subscriber, to the pharmacy benefit manager after
311 the claim has been adjudicated at the pharmacy.

312 (e) "Spread pricing" means any amount a pharmacy benefit
313 manager charges or receives from a health maintenance
314 organization for payment of a prescription drug or pharmacy
315 service that is greater than the amount the pharmacy benefit
316 manager paid to the pharmacist or pharmacy that filled the
317 prescription or provided the pharmacy service.
318 (2) A contract between a health maintenance organization
319 and a pharmacy benefit manager must require that the pharmacy
320 benefit manager:
321 (a) Update maximum allowable cost pricing information at
322 least every 7 calendar days.
323 (b) Maintain a process that will, in a timely manner,
324 eliminate drugs from maximum allowable cost lists or modify drug
325 prices to remain consistent with changes in pricing data used in
326 formulating maximum allowable cost prices and product
327 availability.
328 (3) A contract between a health maintenance organization
329 and a pharmacy benefit manager must prohibit the pharmacy
330 benefit manager from limiting a pharmacist's ability to disclose
331 whether the cost-sharing obligation exceeds the retail price for
332 a covered prescription drug, and the availability of a more
333 affordable alternative drug, pursuant to s. 465.0244.
334 (4) A contract between a health maintenance organization
335 and a pharmacy benefit manager must prohibit the pharmacy
336 benefit manager from requiring a subscriber to make a payment

337 for a prescription drug at the point of sale in an amount that
338 exceeds the lesser of:
339 (a) The applicable cost-sharing amount; or
340 (b) The retail price of the drug in the absence of
341 prescription drug coverage.
342 (5) A contract between a health maintenance organization
343 and a pharmacy benefit manager must require the pharmacy benefit
344 manager to report annually the following to the health
345 maintenance organization:
346 (a) The aggregate amount of rebates the pharmacy benefit
347 manager received in association with claims administered on
348 behalf of the health maintenance organization and the aggregate
349 amount of such rebates the pharmacy benefit manager received
350 that were not passed through to the health maintenance
351 organization.
352 (b) The aggregate amount of administrative fees paid to
353 the pharmacy benefit manager by the health maintenance
354 organization for the administration of the health maintenance
355 organization's prescription drug benefit programs.
356 (c) The types and aggregate amounts of any fees or
357 remittances paid to the pharmacy benefit manager by pharmacies.
358 The pharmacy benefit manager shall distinguish between fees paid
359 by covered entities, as defined in 42 U.S.C. § 256b, and fees
360 paid by pharmacies which are not covered entities.

361 (d) The aggregate amount of revenue generated by the
362 pharmacy benefit manager through the use of spread pricing in
363 association with the administration of the health maintenance
364 organization's pharmacy benefit programs.
365 (6) Not later than June 30, 2021, and annually thereafter,
366 a health maintenance organization shall submit a report to the
367 office that includes the information provided by its contracted
368 pharmacy benefit managers under subsection (5). The office shall
369 publish on its website an analysis of the reported information
370 required to be provided to the health maintenance organization
371 under subsection (5) in an aggregated amount for each pharmacy
372 benefit manager.
373 (7) ~~(5)~~ This section applies to contracts entered into or
374 renewed on or after July 1, 2020 ~~2018~~.
375 Section 9. (1) The Agency for Health Care Administration
376 shall contract for an independent analysis of pharmacy benefit
377 management practices under the Statewide Medicaid Managed Care
378 program. The analysis shall outline the types of pharmacy
379 benefit pricing contracts in place between managed care plans
380 and contracted pharmacy benefit managers and between managed
381 care plans or pharmacy benefit managers and pharmacies. At a
382 minimum, the analysis shall include:
383 (a) An examination of the fees paid to each contracted
384 pharmacy benefit manager by each managed care plan.

385 (b) An examination of the fees charged to pharmacies by
386 each managed care plan or contracted pharmacy benefit manager.
387 (c) A determination of spread pricing revenues retained by
388 each managed care plan or contracted pharmacy benefit manager.
389 (2) For purposes of this section, the term "pharmacy
390 benefit manager" means a person or entity doing business in this
391 state which contracts to administer or manage prescription drug
392 benefits on behalf of a managed care plan.
393 (3) For purposes of this section, the term "spread
394 pricing" refers to any amount a managed care plan or pharmacy
395 benefit manager received from the Medicaid program for payment
396 of a prescription drug that is greater than that paid to the
397 pharmacist or pharmacy that filled a prescription for that
398 prescription drug.
399 (4) The agency shall submit the completed analysis to the
400 Governor, the President of the Senate, and the Speaker of the
401 House of Representatives by June 30, 2020.
402 Section 10. The Agency for Health Care Administration
403 shall conduct an analysis of managed care plan pharmacy networks
404 under the Statewide Medicaid Managed Care program to ensure that
405 enrollees have sufficient choice of pharmacies within
406 established geographic parameters. The agency must also analyze
407 the composition of each managed care plan pharmacy network to
408 determine the market share of large chain pharmacies, small

409 chain pharmacies, and independent pharmacies, respectively. The
410 analysis shall include:
411 (a) An examination of the pharmacy contracting patterns by
412 each managed care plan or contracted pharmacy benefit manager.
413 (b) An examination of any financial relationship between a
414 managed care provider or contracted pharmacy benefit manager and
415 its contracted pharmacies. The analysis shall examine whether a
416 managed care plan or pharmacy benefit manager establishes a
417 network which favors pharmacies in which the managed care plan
418 or pharmacy benefit manager owns a controlling or substantial
419 financial interest.
420 (2) For purposes of this section, the term “pharmacy
421 benefit manager” means a person or entity doing business in this
422 state which contracts to administer or manage prescription drug
423 benefits on behalf of a managed care plan.
424 (3) The agency shall submit the completed analysis to the
425 Governor, the President of the Senate, and the Speaker of the
426 House of Representatives by June 30, 2020.
427 Section 11. This act shall take effect upon becoming law.
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430 ---
431 **T I T L E A M E N D M E N T**
432 Remove everything before the enacting clause and insert:

433 An act relating to prescription drug price transparency;
434 amending s. 499.012, F.S.; providing that permits for
435 prescription drug manufacturers and nonresident prescription
436 drug manufacturers are subject to specified requirements;
437 creating s. 499.026, F.S.; providing definitions; requiring
438 prescription drug manufacturers to provide notice of drug price
439 increases to insurers; requiring prescription drug manufacturers
440 to provide an annual report on drug price increases to the
441 Department of Business and Professional Regulation and the
442 Office of Insurance Regulation; providing reporting
443 requirements; creating s. 624.491, F.S.; providing timelines and
444 documentation requirements for pharmacy audits conducted by
445 certain health insurers, health maintenance organizations, or
446 their agents; providing that such requirements do not apply to
447 audits in which certain conditions are met; creating s.
448 627.42394. F.S.; requiring insurers to establish a single point
449 of contact for manufacturer reporting of drug price increases;
450 requiring the Office of Insurance Regulation to publish and
451 maintain a list of such contacts; requiring insurers to provide
452 written notice to insureds in advance of formulary changes
453 resulting from manufacturer drug price increases; providing
454 applicability; amending s. 627.64741, F.S.; providing
455 definitions; requiring reporting requirements in contracts
456 between health insurers and pharmacy benefit managers; requiring
457 health insurers to submit an annual report to the office;

458 requiring the office to publish such reports and analyses of
459 specified information; revising applicability; amending s.
460 627.6572, F.S.; providing definitions; requiring reporting
461 requirements in contracts between health insurers and pharmacy
462 benefit managers; requiring health insurers to submit an annual
463 report to the office; requiring the office to publish such
464 reports and analyses of specified information; revising
465 applicability; creating s. 641.3131, F.S.; requiring health
466 maintenance organizations to establish a single point of contact
467 for manufacturer reporting of drug price increases; requiring
468 the Office of Insurance Regulation to publish and maintain a
469 list of such contacts; requiring health maintenance
470 organizations to provide written notice to subscribers in
471 advance of formulary changes resulting from manufacturer drug
472 price increases; providing applicability; amending s. 641.314,
473 F.S.; providing definitions; requiring reporting requirements in
474 contracts between health maintenance organizations and pharmacy
475 benefit managers; requiring health maintenance organizations to
476 submit an annual report to the office; requiring the office to
477 publish such reports and analyses of specified information;
478 revising applicability; requiring the Agency for Health Care
479 Administration to contract for an independent analysis of
480 pharmacy benefit practices under the Statewide Medicaid Managed
481 Care program; defining terms; requiring the Agency for Health
482 Care Administration to conduct an analysis of pharmacy networks

483 under the Statewide Medicaid Managed Care program; defining
484 terms; providing an effective date.