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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/28/2023	.	
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The Committee on Health Policy (Brodeur) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. This act may be cited as the "Prescription Drug
6 Reform Act."
7 Section 2. Subsection (29) is added to section 499.005,
8 Florida Statutes, to read:
9 499.005 Prohibited acts.—It is unlawful for a person to
10 perform or cause the performance of any of the following acts in

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11 this state:
12 (29) Failure to accurately complete and timely submit
13 reportable drug price increase forms and reports as required
14 under this part and rules adopted thereunder.
15 Section 3. Subsection (16) is added to section 499.012,
16 Florida Statutes, to read:
17 499.012 Permit application requirements.—
18 (16) A permit for a prescription drug manufacturer or a
19 nonresident prescription drug manufacturer is subject to the
20 requirements of s. 499.026.
21 Section 4. Section 499.026, Florida Statutes, is created to
22 read:
23 499.026 Notification of manufacturer prescription drug
24 price increases.—
25 (1) As used in this section, the term:
26 (a) "Course of therapy" means the recommended daily dose
27 units of a prescription drug pursuant to its prescribing label
28 for 30 days or the recommended daily dose units of a
29 prescription drug pursuant to its prescribing label for a normal
30 course of treatment which is less than 30 days.
31 (b) "Manufacturer" means a person holding a prescription
32 drug manufacturer permit or a nonresident prescription drug
33 manufacturer permit under s. 499.01.
34 (c) "Prescription drug" has the same meaning as in s.
35 499.003 and includes biological products but is limited to those
36 prescription drugs and biological products intended for human
37 use.
38 (d) "Reportable drug price increase" means, for a
39 prescription drug with a wholesale acquisition cost of at least

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40 $100 for a course of therapy before the effective date of an
41 increase:
42 1. Any increase of 15 percent or more of the wholesale
43 acquisition cost during the preceding 12-month period; or
44 2. Any increase of 40 percent or more of the wholesale
45 acquisition cost during the preceding 3 calendar years.
46 (e) “Wholesale acquisition cost” means, with respect to a
47 prescription drug or biological product, the manufacturer’s list
48 price for the prescription drug or biological product to
49 wholesalers or direct purchasers in the United States, not
50 including prompt pay or other discounts, rebates, or reductions
51 in price, for the most recent month for which the information is
52 available, as reported in wholesale price guides or other
53 publications of drug or biological product pricing data.
54 (2) On the effective date of a manufacturer’s reportable
55 drug price increase, the manufacturer must provide notification
56 of each reportable drug price increase to the department on a
57 form prescribed by the department. The form must require the
58 manufacturer to specify all of the following:
59 (a) The proprietary and nonproprietary names of the
60 prescription drug, as applicable.
61 (b) The wholesale acquisition cost before the reportable
62 drug price increase.
63 (c) The dollar amount of the reportable drug price
64 increase.
65 (d) The percentage amount of the reportable drug price
66 increase from the wholesale acquisition cost before the
67 reportable drug price increase.
68 (e) A statement regarding whether a change or improvement

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69 in the prescription drug necessitates the reportable drug price
70 increase. If so, the manufacturer must describe the change or
71 improvement.
72 (f) The intended uses of the prescription drug.
73
74 This subsection does not prohibit a manufacturer from notifying
75 other parties, such as pharmacy benefit managers, of a drug
76 price increase before the effective date of the drug price
77 increase.
78 (3) By April 1 of each year, each manufacturer shall submit
79 a report to the department on a form prescribed by the
80 department. A report is not deemed to be submitted until
81 approved by the department. The report must include all of the
82 following:
83 (a) A list of all prescription drugs affected by a
84 reportable drug price increase during the previous calendar year
85 and both the dollar amount of each reportable drug price
86 increase and the percentage increase of each reportable drug
87 price increase relative to the previous wholesale acquisition
88 cost of the prescription drug. The prescription drugs must be
89 identified using their proprietary names and nonproprietary
90 names, as applicable.
91 (b) If more than one form has been filed under this section
92 for previous reportable drug price increases, the percentage
93 increase of the prescription drug from the earliest form filed
94 to the most recent form filed.
95 (c) The intended uses of each prescription drug listed in
96 the report and whether the prescription drug manufacturer
97 benefits from market exclusivity for such drug.

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98 (d) The length of time the prescription drug has been
99 available for purchase.
100 (e) A complete description of the factors contributing to
101 each reportable drug price increase. The factors must be
102 provided with such specificity as to explain the need or
103 justification for each reportable drug price increase. The
104 department may request additional information from a
105 manufacturer relating to the need or justification of any
106 reportable drug price increase before approving the
107 manufacturer's report.
108 (f) Any action that the manufacturer has filed to extend a
109 patent report after the first extension has been granted.
110 (4)(a) The department shall submit all forms and reports
111 submitted by manufacturers to the Agency for Health Care
112 Administration, to be posted on the agency's website pursuant to
113 s. 408.062. The agency may not post on its website any of the
114 information provided pursuant to paragraph (2)(e), paragraph
115 (3)(e), or paragraph (3)(f) which is marked as a trade secret.
116 The agency shall compile all information on the forms and
117 reports submitted by manufacturers and make it available upon
118 request to the Governor, the President of the Senate, and the
119 Speaker of the House of Representatives.
120 (b) Except for information provided pursuant to paragraph
121 (2)(e), paragraph (3)(e), or paragraph (3)(f), a manufacturer
122 may not claim a public records exemption for a trade secret
123 under s. 119.0715 for any information required by the department
124 under this section. Department employees remain protected from
125 liability for release of forms and reports pursuant to s.
126 119.0715(4).

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127 (5) The department, in consultation with the Agency for
128 Health Care Administration, shall adopt rules to implement this
129 section.
130 (a) The department shall adopt necessary emergency rules
131 pursuant to s. 120.54(4) to implement this section. If an
132 emergency rule adopted under this section is held to be
133 unconstitutional or an invalid exercise of delegated legislative
134 authority and becomes void, the department may adopt an
135 emergency rule pursuant to this section to replace the rule that
136 has become void. If the emergency rule adopted to replace the
137 void emergency rule is also held to be unconstitutional or an
138 invalid exercise of delegated legislative authority and becomes
139 void, the department must follow the nonemergency rulemaking
140 procedures of the Administrative Procedure Act to replace the
141 rule that has become void.
142 (b) For emergency rules adopted under this section, the
143 department need not make the findings required under s.
144 120.54(4)(a). Emergency rules adopted under this section are
145 also exempt from:
146 1. Sections 120.54(3)(b) and 120.541. Challenges to
147 emergency rules adopted under this section are subject to the
148 time schedules provided in s. 120.56(5).
149 2. Section 120.54(4)(c) and remain in effect until replaced
150 by rules adopted under the nonemergency rulemaking procedures of
151 the Administrative Procedure Act.
152 Section 5. Paragraph (a) of subsection (10) of section
153 624.307, Florida Statutes, is amended, and paragraph (b) of that
154 subsection is republished, to read:
155 624.307 General powers; duties.—

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156 (10)(a) The Division of Consumer Services shall perform the
157 following functions concerning products or services regulated by
158 the department or office:
159 1. Receive inquiries and complaints from consumers.
160 2. Prepare and disseminate information that the department
161 deems appropriate to inform or assist consumers.
162 3. Provide direct assistance to and advocacy for consumers
163 who request such assistance or advocacy.
164 4. With respect to apparent or potential violations of law
165 or applicable rules committed by a person or entity licensed by
166 the department or office, report apparent or potential
167 violations to the office or to the appropriate division of the
168 department, which may take any additional action it deems
169 appropriate.
170 5. Designate an employee of the division as the primary
171 contact for consumers on issues relating to sinkholes.
172 6. Designate an employee of the division as the primary
173 contact for consumers and pharmacies on issues relating to
174 pharmacy benefit managers. The division must refer to the office
175 any consumer complaint that alleges conduct that may constitute
176 a violation of part VII of chapter 626 or for which a pharmacy
177 benefit manager does not respond in accordance with paragraph
178 (b).
179 (b) Any person licensed or issued a certificate of
180 authority by the department or the office shall respond, in
181 writing, to the division within 20 days after receipt of a
182 written request for documents and information from the division
183 concerning a consumer complaint. The response must address the
184 issues and allegations raised in the complaint and include any

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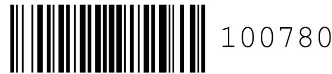
185 requested documents concerning the consumer complaint not
186 subject to attorney-client or work-product privilege. The
187 division may impose an administrative penalty for failure to
188 comply with this paragraph of up to $2,500 per violation upon
189 any entity licensed by the department or the office and $250 for
190 the first violation, $500 for the second violation, and up to
191 $1,000 for the third or subsequent violation upon any individual
192 licensed by the department or the office.
193 Section 6. Subsection (1) of section 624.490, Florida
194 Statutes, is amended to read:
195 624.490 Registration of pharmacy benefit managers.—
196 (1) As used in this section, the term “pharmacy benefit
197 manager” has the same meaning as in s. 626.88 ~~means a person or~~
198 ~~entity doing business in this state which contracts to~~
199 ~~administer prescription drug benefits on behalf of a health~~
200 ~~insurer or a health maintenance organization to residents of~~
201 ~~this state~~.
202 Section 7. Subsections (1) and (5) of section 624.491,
203 Florida Statutes, are amended to read:
204 624.491 Pharmacy audits.—
205 (1) A pharmacy benefits plan or program as defined in s.
206 626.8825 ~~health insurer or health maintenance organization~~
207 providing pharmacy benefits ~~through a major medical individual~~
208 ~~or group health insurance policy or a health maintenance~~
209 ~~contract, respectively,~~ must comply with the requirements of
210 this section when the pharmacy benefits plan or program ~~health~~
211 ~~insurer or health maintenance organization~~ or any person or
212 entity acting on behalf of the pharmacy benefits plan or program
213 ~~health insurer or health maintenance organization~~, including,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214 but not limited to, a pharmacy benefit manager as defined in s.
215 626.88 ~~s. 624.490(1)~~, audits the records of a pharmacy licensed
216 under chapter 465. The person or entity conducting such audit
217 must:
218 (a) Except as provided in subsection (3), notify the
219 pharmacy at least 7 calendar days before the initial onsite
220 audit for each audit cycle.
221 (b) Not schedule an onsite audit during the first 3
222 calendar days of a month unless the pharmacist consents
223 otherwise.
224 (c) Limit the duration of the audit period to 24 months
225 after the date a claim is submitted to or adjudicated by the
226 entity.
227 (d) In the case of an audit that requires clinical or
228 professional judgment, conduct the audit in consultation with,
229 or allow the audit to be conducted by, a pharmacist.
230 (e) Allow the pharmacy to use the written and verifiable
231 records of a hospital, physician, or other authorized
232 practitioner, which are transmitted by any means of
233 communication, to validate the pharmacy records in accordance
234 with state and federal law.
235 (f) Reimburse the pharmacy for a claim that was
236 retroactively denied for a clerical error, typographical error,
237 scrivener’s error, or computer error if the prescription was
238 properly and correctly dispensed, unless a pattern of such
239 errors exists, fraudulent billing is alleged, or the error
240 results in actual financial loss to the entity.
241 (g) Provide the pharmacy with a copy of the preliminary
242 audit report within 120 days after the conclusion of the audit.

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243 (h) Allow the pharmacy to produce documentation to address
244 a discrepancy or audit finding within 10 business days after the
245 preliminary audit report is delivered to the pharmacy.
246 (i) Provide the pharmacy with a copy of the final audit
247 report within 6 months after the pharmacy's receipt of the
248 preliminary audit report.
249 (j) Calculate any recoupment or penalties based on actual
250 overpayments and not according to the accounting practice of
251 extrapolation.
252 (5) A pharmacy benefits plan or program ~~health insurer or~~
253 ~~health maintenance organization~~ that, under terms of a contract,
254 transfers to a pharmacy benefit manager the obligation to pay a
255 pharmacy licensed under chapter 465 for any pharmacy benefit
256 claims arising from services provided to or for the benefit of
257 an insured or subscriber remains responsible for a violation of
258 this section.
259 Section 8. Subsection (1) of section 626.88, Florida
260 Statutes, is amended, and subsection (6) is added to that
261 section, to read:
262 626.88 Definitions.—For the purposes of this part, the
263 term:
264 (1) "Administrator" means ~~is~~ any person who directly or
265 indirectly solicits or effects coverage of, collects charges or
266 premiums from, or adjusts or settles claims on residents of this
267 state in connection with authorized commercial self-insurance
268 funds or with insured or self-insured programs which provide
269 life or health insurance coverage or coverage of any other
270 expenses described in s. 624.33(1); ~~or~~ any person who, through a
271 health care risk contract as defined in s. 641.234 with an

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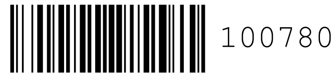
272 insurer or health maintenance organization, provides billing and
273 collection services to health insurers and health maintenance
274 organizations on behalf of health care providers; or a pharmacy
275 benefit manager. The term does not include~~, other than~~ any of
276 the following ~~persons~~:
277 (a) An employer or wholly owned direct or indirect
278 subsidiary of an employer, on behalf of such employer's
279 employees or the employees of one or more subsidiary or
280 affiliated corporations of such employer.
281 (b) A union on behalf of its members.
282 (c) An insurance company which is either authorized to
283 transact insurance in this state or is acting as an insurer with
284 respect to a policy lawfully issued and delivered by such
285 company in and pursuant to the laws of a state in which the
286 insurer was authorized to transact an insurance business.
287 (d) A health care services plan, health maintenance
288 organization, professional service plan corporation, or person
289 in the business of providing continuing care, possessing a valid
290 certificate of authority issued by the office, and the sales
291 representatives thereof, if the activities of such entity are
292 limited to the activities permitted under the certificate of
293 authority.
294 (e) An entity that is affiliated with an insurer and that
295 only performs the contractual duties, between the administrator
296 and the insurer, of an administrator for the direct and assumed
297 insurance business of the affiliated insurer. The insurer is
298 responsible for the acts of the administrator and is responsible
299 for providing all of the administrator's books and records to
300 the insurance commissioner, upon a request from the insurance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301 commissioner. For purposes of this paragraph, the term “insurer”
302 means a licensed insurance company, health maintenance
303 organization, prepaid limited health service organization, or
304 prepaid health clinic.
305 (f) A nonresident entity licensed in its state of domicile
306 as an administrator if its duties in this state are limited to
307 the administration of a group policy or plan of insurance and no
308 more than a total of 100 lives for all plans reside in this
309 state.
310 (g) An insurance agent licensed in this state whose
311 activities are limited exclusively to the sale of insurance.
312 (h) A person appointed as a managing general agent in this
313 state, whose activities are limited exclusively to the scope of
314 activities conveyed under such appointment.
315 (i) An adjuster licensed in this state whose activities are
316 limited to the adjustment of claims.
317 (j) A creditor on behalf of such creditor’s debtors with
318 respect to insurance covering a debt between the creditor and
319 its debtors.
320 (k) A trust and its trustees, agents, and employees acting
321 pursuant to such trust established in conformity with 29 U.S.C.
322 s. 186.
323 (l) A trust exempt from taxation under s. 501(a) of the
324 Internal Revenue Code, a trust satisfying the requirements of
325 ss. 624.438 and 624.439, or any governmental trust as defined in
326 s. 624.33(3), and the trustees and employees acting pursuant to
327 such trust, or a custodian and its agents and employees,
328 including individuals representing the trustees in overseeing
329 the activities of a service company or administrator, acting

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330 pursuant to a custodial account which meets the requirements of
331 s. 401(f) of the Internal Revenue Code.
332 (m) A financial institution which is subject to supervision
333 or examination by federal or state authorities or a mortgage
334 lender licensed under chapter 494 who collects and remits
335 premiums to licensed insurance agents or authorized insurers
336 concurrently or in connection with mortgage loan payments.
337 (n) A credit card issuing company which advances for and
338 collects premiums or charges from its credit card holders who
339 have authorized such collection if such company does not adjust
340 or settle claims.
341 (o) A person who adjusts or settles claims in the normal
342 course of such person's practice or employment as an attorney at
343 law and who does not collect charges or premiums in connection
344 with life or health insurance coverage.
345 (p) A person approved by the department who administers
346 only self-insured workers' compensation plans.
347 (q) A service company or service agent and its employees,
348 authorized in accordance with ss. 626.895-626.899, serving only
349 a single employer plan, multiple-employer welfare arrangements,
350 or a combination thereof.
351 (r) Any provider or group practice, as defined in s.
352 456.053, providing services under the scope of the license of
353 the provider or the member of the group practice.
354 (s) Any hospital providing billing, claims, and collection
355 services solely on its own and its physicians' behalf and
356 providing services under the scope of its license.
357 (t) A corporation not for profit whose membership consists
358 entirely of local governmental units authorized to enter into

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359 risk management consortiums under s. 112.08.
360
361 A person who provides billing and collection services to health
362 insurers and health maintenance organizations on behalf of
363 health care providers shall comply with the provisions of ss.
364 627.6131, 641.3155, and 641.51(4).
365 (6) "Pharmacy benefit manager" means a person or an entity
366 doing business in this state which contracts to administer
367 prescription drug benefits on behalf of a pharmacy benefits plan
368 or program as defined in s. 626.8825. The term includes, but is
369 not limited to, a person or an entity that performs one or more
370 of the following services:
371 (a) Pharmacy claims processing.
372 (b) Administration or management of pharmacy discount card
373 programs.
374 (c) Managing pharmacy networks or pharmacy reimbursement.
375 (d) Paying or managing claims for pharmacist services
376 provided to covered persons.
377 (e) Developing or managing a clinical formulary, including
378 utilization management or quality assurance programs.
379 (f) Pharmacy rebate administration.
380 (g) Managing patient compliance, therapeutic intervention,
381 or generic substitution programs.
382 (h) Administration or management of a mail-order pharmacy
383 program.
384 Section 9. Present subsections (3) through (6) of section
385 626.8805, Florida Statutes, are redesignated as subsections (4)
386 through (7), respectively, a new subsection (3) and subsection
387 (8) are added to that section, and subsection (1) and present

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388 subsection (3) of that section are amended, to read:
389 626.8805 Certificate of authority to act as administrator.—
390 (1) It is unlawful for any person to act as or hold himself
391 or herself out to be an administrator in this state without a
392 valid certificate of authority issued by the office pursuant to
393 ss. 626.88-626.894. A pharmacy benefit manager that is
394 registered with the office under s. 624.490 as of June 30, 2023,
395 may continue to operate until January 1, 2024, as an
396 administrator without a certificate of authority and is not in
397 violation of the requirement to possess a valid certificate of
398 authority as an administrator during that timeframe. To qualify
399 for and hold authority to act as an administrator in this state,
400 an administrator must otherwise be in compliance with this code
401 and with its organizational agreement. The failure of any
402 person, excluding a pharmacy benefit manager, to hold such a
403 certificate while acting as an administrator shall subject such
404 person to a fine of not less than $5,000 or more than $10,000
405 for each violation. A person who, on or after January 1, 2024,
406 does not hold a certificate of authority to act as an
407 administrator while operating as a pharmacy benefit manager is
408 subject to a fine of $10,000 per violation per day.
409 (3) An applicant that is a pharmacy benefit manager must
410 also submit all of the following:
411 (a) A complete biographical statement on forms prescribed
412 by the commission, an independent investigation report, and
413 fingerprints obtained pursuant to chapter 624 of all of the
414 individuals referred to in paragraph (2)(c).
415 (b) A self-disclosure of any administrative, civil, or
416 criminal complaints, settlements, or discipline of the

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417 applicant, or any of the applicant's affiliates, which relate to
418 a violation of the insurance laws, including pharmacy benefit
419 manager laws, in any state.
420 (c) A statement attesting to compliance with the network
421 requirements in s. 626.8825 beginning January 1, 2024.
422 (4)(a)~~(3)~~ The applicant shall make available for inspection
423 by the office copies of all contracts relating to services
424 provided by the administrator to insurers or other persons using
425 the services of the administrator.
426 (b) An applicant that is a pharmacy benefit manager shall
427 also make available for inspection by the office:
428 1. Copies of all contract templates with any pharmacy as
429 defined in s. 465.003; and
430 2. Copies of all subcontracts to support its operations.
431 (8) A pharmacy benefit manager is exempt from fees
432 associated with the initial application and the annual filing
433 fees in s. 626.89.
434 Section 10. Section 626.8814, Florida Statutes, is amended
435 to read:
436 626.8814 Disclosure of ownership or affiliation.—
437 (1) Each administrator shall identify to the office any
438 ownership interest or affiliation of any kind with any insurance
439 company responsible for providing benefits directly or through
440 reinsurance to any plan for which the administrator provides
441 administrative services.
442 (2) Pharmacy benefit managers shall also identify to the
443 office any ownership affiliation of any kind with any pharmacy
444 which, either directly or indirectly, through one or more
445 intermediaries:

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446 (a) Has an investment or ownership interest in a pharmacy
447 benefit manager holding a certificate of authority issued under
448 this part;
449 (b) Shares common ownership with a pharmacy benefit manager
450 holding a certificate of authority issued under this part; or
451 (c) Has an investor or a holder of an ownership interest
452 which is a pharmacy benefit manager holding a certificate of
453 authority issued under this part.
454 (3) A pharmacy benefit manager shall report any change in
455 information required by subsection (2) to the office in writing
456 within 60 days after the change occurs.
457 Section 11. Section 626.8825, Florida Statutes, is created
458 to read:
459 626.8825 Pharmacy benefit manager transparency and
460 accountability.—
461 (1) DEFINITIONS.—As used in this section, the term:
462 (a) "Adjudication transaction fee" means a fee charged by
463 the pharmacy benefit manager to the pharmacy for electronic
464 claim submissions.
465 (b) "Affiliated pharmacy" means a pharmacy that, either
466 directly or indirectly through one or more intermediaries:
467 1. Has an investment or ownership interest in a pharmacy
468 benefit manager holding a certificate of authority issued under
469 this part;
470 2. Shares common ownership with a pharmacy benefit manager
471 holding a certificate of authority issued under this part; or
472 3. Has an investor or a holder of an ownership interest
473 which is a pharmacy benefit manager holding a certificate of
474 authority issued under this part.

475 (c) “Brand name or generic effective rate” means the
476 contractual rate set forth by a pharmacy benefit manager for the
477 reimbursement of covered brand name or generic drugs, calculated
478 using the total payments in the aggregate, by drug type, during
479 the performance period. The effective rates are typically
480 calculated as a discount from industry benchmarks, such as
481 average wholesale price or wholesale acquisition cost.
482 (d) “Covered person” means a person covered by,
483 participating in, or receiving the benefit of a pharmacy
484 benefits plan or program.
485 (e) “Direct and indirect remuneration fees” means price
486 concessions that are paid to the pharmacy benefit manager by the
487 pharmacy retrospectively and that cannot be calculated at the
488 point of sale. The term may also include discounts, chargebacks
489 or rebates, cash discounts, free goods contingent on a purchase
490 agreement, upfront payments, coupons, goods in kind, free or
491 reduced-price services, grants, or other price concessions or
492 similar benefits from manufacturers, pharmacies, or similar
493 entities.
494 (f) “Dispensing fee” means a fee intended to cover
495 reasonable costs associated with providing the drug to a covered
496 person. This cost includes the pharmacist’s services and the
497 overhead associated with maintaining the facility and equipment
498 necessary to operate the pharmacy.
499 (g) “Effective rate guarantee” means the minimum ingredient
500 cost reimbursement a pharmacy benefit manager guarantees it will
501 pay for pharmacist services during the applicable measurement
502 period.
503 (h) “Erroneous claims” means pharmacy claims submitted in

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504 error, including, but not limited to, unintended, incorrect,
505 fraudulent, or test claims.
506 (i) "Incentive payment" means a retrospective monetary
507 payment made as a reward or recognition by the pharmacy benefits
508 plan or program or pharmacy benefit manager to a pharmacy for
509 meeting or exceeding predefined pharmacy performance metrics as
510 related to quality measures, such as Healthcare Effectiveness
511 Data and Information Set measures.
512 (j) "Maximum allowable cost appeal pricing adjustment"
513 means a retrospective positive payment adjustment made to a
514 pharmacy by the pharmacy benefits plan or program or by the
515 pharmacy benefit manager pursuant to an approved maximum
516 allowable cost appeal request submitted by the same pharmacy to
517 dispute the amount reimbursed for a drug based on the pharmacy
518 benefit manager's listed maximum allowable cost price.
519 (k) "Monetary recoupments" means rescinded or recouped
520 payments from a pharmacy or provider by the pharmacy benefits
521 plan or program or by the pharmacy benefit manager.
522 (l) "Network" means a group of pharmacies that agree to
523 provide pharmacist services to covered persons on behalf of a
524 pharmacy benefits plan or program or a group of pharmacy
525 benefits plans or programs in exchange for payment for such
526 services. The term includes a pharmacy that generally dispenses
527 outpatient prescription drugs to covered persons.
528 (m) "Network reconciliation offsets" means a process during
529 annual payment reconciliation between a pharmacy benefit manager
530 and a pharmacy which allows the pharmacy benefit manager to
531 offset an amount for overperformance or underperformance of
532 contractual guarantees across guaranteed line items, channels,

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533 networks, or payors, as applicable.
534 (n) “Participation contract” means any agreement between a
535 pharmacy benefit manager and pharmacy for the provision and
536 reimbursement of pharmacist services and any exhibits,
537 attachments, amendments, or addendums to such agreement.
538 (o) “Pass-through pricing model” means a payment model used
539 by a pharmacy benefit manager in which the payments made by the
540 pharmacy benefits plan or program to the pharmacy benefit
541 manager for the covered outpatient drugs are:
542 1. Equivalent to the payments the pharmacy benefit manager
543 makes to a dispensing pharmacy or provider for such drugs,
544 including any contracted professional dispensing fee between the
545 pharmacy benefit manager and its network of pharmacies. Such
546 dispensing fee would be paid if the pharmacy benefits plan or
547 program was making the payments directly.
548 2. Passed through in their entirety by the pharmacy
549 benefits plan or program or by the pharmacy benefit manager to
550 the pharmacy or provider that dispenses the drugs, and the
551 payments are made in a manner that is not offset by any
552 reconciliation.
553 (p) “Pharmacist” has the same meaning as in s. 465.003.
554 (q) “Pharmacist services” means products, goods, and
555 services or any combination of products, goods, and services
556 provided as part of the practice of the profession of pharmacy
557 as defined in s. 465.003 or otherwise covered by a pharmacy
558 benefits plan or program.
559 (r) “Pharmacy” has the same meaning as in s. 465.003.
560 (s) “Pharmacy benefit manager” has the same meaning as in
561 s. 626.88.

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562 (t) “Pharmacy benefits plan or program” means a plan or
563 program that pays for, reimburses, covers the cost of, or
564 provides access to discounts on pharmacist services provided by
565 one or more pharmacies to covered persons who reside in, are
566 employed by, or receive pharmacist services from this state. The
567 term includes, but is not limited to, health maintenance
568 organizations, health insurers, self-insured employer health
569 plans, discount card programs, and government-funded health
570 plans, including the Statewide Medicaid Managed Care program
571 established pursuant to part IV of chapter 409 and the state
572 group insurance program pursuant to part I of chapter 110.
573 (u) “Rebate” means all payments that accrue to a pharmacy
574 benefit manager or its pharmacy benefits plan or program client,
575 directly or indirectly, from a pharmaceutical manufacturer,
576 including, but not limited to, discounts, administration fees,
577 credits, incentives, or penalties associated directly or
578 indirectly in any way with claims administered on behalf of a
579 pharmacy benefits plan or program client.
580 (v) “Spread pricing” is the practice in which a pharmacy
581 benefit manager charges a pharmacy benefits plan or program a
582 different amount for pharmacist services than the amount the
583 pharmacy benefit manager reimburses a pharmacy for such
584 pharmacist services.
585 (w) “Usual and customary price” means the amount charged to
586 cash customers for a pharmacist service exclusive of sales tax
587 or other amounts claimed.
588 (2) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A
589 PHARMACY BENEFITS PLAN OR PROGRAM.—In addition to any other
590 requirements in the Florida Insurance Code, all contractual

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591 arrangements executed, amended, adjusted, or renewed on or after
592 July 1, 2023, which are applicable to pharmacy benefits covered
593 on or after January 1, 2024, between a pharmacy benefit manager
594 and a pharmacy benefits plan or program must:
595 (a) Use a pass-through pricing model, remaining consistent
596 with the prohibition in paragraph (3)(c).
597 (b) Exclude terms that allow for the direct or indirect
598 engagement in the practice of spread pricing unless the pharmacy
599 benefit manager passes along the entire amount of such
600 difference to the pharmacy benefits plan or program as allowable
601 under paragraph (a).
602 (c) Ensure that funds received in relation to providing
603 services for a pharmacy benefits plan or program or a pharmacy
604 are received by the pharmacy benefit manager in trust for the
605 pharmacy benefits plan or program or pharmacy, as applicable,
606 and are used or distributed only pursuant to the pharmacy
607 benefit manager’s contract with the pharmacy benefits plan or
608 program or with the pharmacy or as otherwise required by
609 applicable law.
610 (d) Require the pharmacy benefit manager to calculate a
611 covered person’s defined cost-sharing obligation at the point of
612 sale based on a price that is reduced by an amount equal to at
613 least 100 percent of all rebates received, or to be received, in
614 connection with the dispensing or administration of the covered
615 prescription drug, if the contractual arrangement delegates the
616 negotiation of rebates to the pharmacy benefit manager. All
617 rebates above the defined cost-sharing obligation must be passed
618 to the pharmacy benefits plan or program for the purpose of
619 reducing premiums. This paragraph does not preclude a pharmacy

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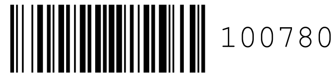
620 benefits plan or program from decreasing a covered person's
621 defined cost-sharing obligation by an amount greater than that
622 provided for under this paragraph. The commission shall adopt
623 rules to implement this paragraph.
624 (e) Include network adequacy requirements that meet or
625 exceed the Medicare Part D program standards for convenient
626 access to network pharmacies set forth in 42 C.F.R. s. 423.120,
627 and that:
628 1. Do not limit a network to solely include affiliated
629 pharmacies;
630 2. Require a pharmacy benefit manager to offer a provider
631 contract to licensed pharmacies physically located on the
632 physical site of providers that are:
633 a. Within the pharmacy benefits plan's or program's
634 geographic service area and that have been specifically
635 designated as essential providers by the Agency for Health Care
636 Administration pursuant to s. 409.975(1)(a);
637 b. Designated as a Cancer Center of Excellence under s.
638 381.925, regardless of the pharmacy benefits plan's or program's
639 geographic service area;
640 c. Organ transplant hospitals, regardless of the pharmacy
641 benefits plan's or program's geographic service area;
642 d. Hospitals licensed as specialty children's hospitals as
643 defined in s. 395.002; or
644 e. Regional perinatal intensive care centers as defined in
645 s. 383.16(2), regardless of the pharmacy benefits plan's or
646 program's geographic service area.
647
648 Such provider contracts must be solely for the administration or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649 dispensing of covered prescription drugs, including biological
650 products, that are administered through infusions, intravenously
651 injected, inhaled during a surgical procedure, or a covered
652 parenteral drug, as part of onsite outpatient care;
653 3. Do not require a covered person to receive a
654 prescription drug by United States mail, common carrier, local
655 courier, third-party company or delivery service, or pharmacy
656 direct delivery. This subparagraph does not prohibit a pharmacy
657 benefit manager from operating mail order or delivery programs
658 on an opt-in basis at the sole discretion of a covered person;
659 4. Prohibit a requirement for a covered person to receive
660 pharmacist services from an affiliated pharmacy or an affiliated
661 health care provider for the in-person administration of covered
662 prescription drugs; offering or implementing pharmacy networks
663 that require or provide a promotional item or an incentive,
664 defined as anything other than a reduced copay or premium of a
665 covered drug, to a covered person to use an affiliated pharmacy
666 or an affiliated health care provider for the in-person
667 administration of covered prescription drugs; or advertising,
668 marketing, or promoting an affiliated pharmacy to covered
669 persons. Subject to the foregoing, a pharmacy benefit manager
670 may include an affiliated pharmacy in communications to covered
671 persons regarding network pharmacies and prices, provided that
672 the pharmacy benefit manager includes information, such as links
673 to all nonaffiliated network pharmacies, in such communications
674 and that the information provided is accurate and of equal
675 prominence. This paragraph may not be construed to prohibit a
676 pharmacy benefit manager from entering into an agreement with an
677 affiliated pharmacy to provide pharmacist services to covered

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678 persons.
679 (f) Prohibit the ability of a pharmacy benefit manager to
680 condition participation in one pharmacy network on participation
681 in any other pharmacy network or penalize a pharmacy for
682 exercising its prerogative not to participate in a specific
683 pharmacy network.
684 (g) Prohibit a pharmacy benefit manager from instituting a
685 network that requires a pharmacy to meet accreditation standards
686 inconsistent with or more stringent than applicable federal and
687 state requirements for licensure and operation as a pharmacy in
688 this state.
689 (3) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A
690 PARTICIPATING PHARMACY.—In addition to other requirements in the
691 Florida Insurance Code, a participation contract executed,
692 amended, adjusted, or renewed on or after July 1, 2023, that
693 applies to pharmacist services on or after January 1, 2024,
694 between a pharmacy benefit manager and one or more pharmacies or
695 pharmacists, must include, in substantial form, terms that
696 ensure compliance with all of the following requirements, and
697 that, except to the extent not allowed by law, shall supersede
698 any contractual terms in the participation contract to the
699 contrary:
700 (a) At the time of adjudication for electronic claims or
701 the time of reimbursement for nonelectronic claims, the pharmacy
702 benefit manager shall provide the pharmacy with a remittance,
703 including such detailed information as is necessary for the
704 pharmacy or pharmacist to identify the reimbursement schedule
705 for the specific network applicable to the claim and which is
706 the basis used by the pharmacy benefit manager to calculate the

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707 amount of reimbursement paid. This information must include, but
708 is not limited to, the applicable network reimbursement ID or
709 plan ID as defined in the most current version of the National
710 Council for Prescription Drug Programs (NCPDP) Telecommunication
711 Standard Implementation Guide, or its nationally recognized
712 successor industry guide. The commission shall adopt rules to
713 implement this paragraph.
714 (b) The pharmacy benefit manager must ensure that any basis
715 of reimbursement information is communicated to a pharmacy in
716 accordance with the NCPDP Telecommunication Standard
717 Implementation Guide, or its nationally recognized successor
718 industry guide, when performing reconciliation for any effective
719 rate guarantee, and that such basis of reimbursement information
720 communicated is accurate, corresponds with the applicable
721 network rate, and may be relied upon by the pharmacy.
722 (c) A prohibition of financial clawbacks or reconciliation
723 offsets. A pharmacy benefit manager may not recoup direct or
724 indirect remuneration fees, dispensing fees, brand name or
725 generic effective rate adjustments through reconciliation, or
726 any other monetary recoupments as related to discounts, multiple
727 network reconciliation offsets, adjudication transaction fees,
728 and any other instance when a fee may be recouped from a
729 pharmacy. For purposes of this section, the terms “financial
730 clawbacks” or “reconciliation offsets” do not include:
731 1. Any incentive payments provided by the pharmacy benefit
732 manager to a network pharmacy for meeting or exceeding
733 predefined quality measures, such as Healthcare Effectiveness
734 Data and Information Set measures; recoupment due to an
735 erroneous claim, fraud, waste, or abuse; a claim adjudicated in

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736 error; a maximum allowable cost appeal pricing adjustment; or an
737 adjustment made as part of a pharmacy audit pursuant to s.
738 624.491.
739 2. Any recoupment that is returned to the state for
740 programs in chapter 409 or the state group insurance program in
741 s. 110.123.
742 (d) A pharmacy benefit manager may not unilaterally change
743 the terms of any participation contract.
744 (e) Unless otherwise prohibited by law, a pharmacy benefit
745 manager may not prohibit a pharmacy or pharmacist from:
746 1. Offering mail or delivery services on an opt-in basis at
747 the sole discretion of the covered person.
748 2. Mailing or delivering a prescription drug to a covered
749 person upon his or her request.
750 3. Charging a shipping or handling fee to a covered person
751 requesting a prescription drug be mailed or delivered if the
752 pharmacy or pharmacist discloses to the covered person before
753 the mailing or delivery the amount of the fee that will be
754 charged and that the fee may not be reimbursable by the covered
755 person’s pharmacy benefits plan or program.
756 (f) The pharmacy benefit manager must provide a pharmacy,
757 upon its request, a list of pharmacy benefits plans or programs
758 in which the pharmacy is a part of the network. Updates to the
759 list must be communicated to the pharmacy within 7 days. The
760 pharmacy benefit manager may not restrict the pharmacy or
761 pharmacist from disclosing this information to the public.
762 (g) The pharmacy benefit manager must ensure that the
763 Electronic Remittance Advice contains claim level payment
764 adjustments in accordance with the American National Standards

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765 Institute Accredited Standards Committee, X12 format, and
766 includes or is accompanied by the appropriate level of detail
767 for the pharmacy to reconcile any debits or credits, including,
768 but not limited to, pharmacy NCPDP or NPI identifier, date of
769 service, prescription number, refill number, adjustment code, if
770 applicable, and transaction amount.
771 (h) The pharmacy benefit manager shall provide a reasonable
772 administrative appeal procedure to allow a pharmacy or
773 pharmacist to challenge the maximum allowable cost pricing
774 information and the reimbursement made under the maximum
775 allowable cost as defined in s. 627.64741 for a specific drug as
776 being below the acquisition cost available to the challenging
777 pharmacy or pharmacist.
778 1. The administrative appeal procedure must include a
779 telephone number and e-mail address, or a website, for the
780 purpose of submitting the administrative appeal. The appeal may
781 be submitted by the pharmacy or an agent of the pharmacy
782 directly to the pharmacy benefit manager or through a pharmacy
783 service administration organization. The pharmacy or pharmacist
784 must be given at least 30 business days after a maximum
785 allowable cost update or after an adjudication for an electronic
786 claim or reimbursement for a nonelectronic claim to file the
787 administrative appeal.
788 2. The pharmacy benefit manager must respond to the
789 administrative appeal within 30 business days after receipt of
790 the appeal.
791 3. If the appeal is upheld, the pharmacy benefit manager
792 must:
793 a. Update the maximum allowable cost pricing information to

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794 at least the acquisition cost available to the pharmacy;
795 b. Permit the pharmacy or pharmacist to reverse and rebill
796 the claim in question;
797 c. Provide to the pharmacy or pharmacist the national drug
798 code on which the increase or change is based; and
799 d. Make the increase or change effective for each similarly
800 situated pharmacy or pharmacist who is subject to the applicable
801 maximum allowable cost pricing information.
802 4. If the appeal is denied, the pharmacy benefit manager
803 must provide to the pharmacy or pharmacist the national drug
804 code and the name of the national or regional pharmaceutical
805 wholesalers operating in this state which have the drug
806 currently in stock at a price below the maximum allowable cost
807 pricing information.
808 5. Every 90 days, a pharmacy benefit manager shall report
809 to the office the total number of appeals received and denied in
810 the preceding 90-day period for each specific drug for which an
811 appeal was submitted pursuant to this paragraph.
812 Section 12. Section 626.8827, Florida Statutes, is created
813 to read:
814 626.8827 Pharmacy benefit manager prohibited practices.—In
815 addition to other prohibitions in this part, a pharmacy benefit
816 manager may not do any of the following:
817 (1) Prohibit, restrict, or penalize in any way a pharmacy
818 or pharmacist from disclosing to any person any information that
819 the pharmacy or pharmacist deems appropriate, including, but not
820 limited to, information regarding any of the following:
821 (a) The nature of treatment, risks, or alternatives
822 thereto.

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823 (b) The availability of alternate treatment, consultations,
824 or tests.
825 (c) The decision of utilization reviewers or similar
826 persons to authorize or deny pharmacist services.
827 (d) The process used to authorize or deny pharmacist
828 services or benefits.
829 (e) Information on financial incentives and structures used
830 by the pharmacy benefits plan or program.
831 (f) Information that may reduce the costs of pharmacist
832 services.
833 (g) Whether the cost-sharing obligation exceeds the retail
834 price for a covered prescription drug and the availability of a
835 more affordable alternative drug, pursuant to s. 465.0244.
836 (2) Prohibit, restrict, or penalize in any way a pharmacy
837 or pharmacist from disclosing information to the office, the
838 Agency for Health Care Administration, Department of Management
839 Services, law enforcement, or state and federal governmental
840 officials, provided that the recipient of the information
841 represents it has the authority, to the extent provided by state
842 or federal law, to maintain proprietary information as
843 confidential; and before disclosure of information designated as
844 confidential, the pharmacist or pharmacy marks as confidential
845 any document in which the information appears or requests
846 confidential treatment for any oral communication of the
847 information.
848 (3) Communicate at the point-of-sale, or otherwise require,
849 a cost-sharing obligation for the covered person in an amount
850 that exceeds the lesser of:
851 (a) The applicable cost-sharing amount under the applicable

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852 pharmacy benefits plan or program; or
853 (b) The usual and customary price, as defined in s.
854 626.8825, of the pharmacist services.
855 (4) Transfer or share records relative to prescription
856 information containing patient-identifiable or prescriber-
857 identifiable data to an affiliated pharmacy for any commercial
858 purpose other than the limited purposes of facilitating pharmacy
859 reimbursement, formulary compliance, or utilization review on
860 behalf of the applicable pharmacy benefits plan or program.
861 (5) Fail to make any payment due to a pharmacy for an
862 adjudicated claim with a date of service before the effective
863 date of a pharmacy's termination from a pharmacy benefit network
864 unless payments are withheld because of actual fraud on the part
865 of the pharmacy or except as otherwise required by law.
866 (6) Terminate the contract of, penalize, or disadvantage a
867 pharmacist or pharmacy due to a pharmacist or pharmacy:
868 (a) Disclosing information about pharmacy benefit manager
869 practices in accordance with this act;
870 (b) Exercising any of its prerogatives under this part; or
871 (c) Sharing any portion, or all, of the pharmacy benefit
872 manager contract with the office pursuant to a complaint or a
873 query regarding whether the contract is in compliance with this
874 act.
875 (7) Fail to comply with the requirements in s. 626.8825 or
876 s. 624.491.
877 Section 13. Section 626.8828, Florida Statutes, is created
878 to read:
879 626.8828 Investigations and examinations of pharmacy
880 benefit managers; expenses; penalties.—

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881 (1) The office may investigate administrators who are
882 pharmacy benefit managers and applicants for authorization as
883 provided in ss. 624.307 and 624.317. The office shall review any
884 referral made pursuant to s. 624.307(10) and shall investigate
885 any referral that, as determined by the Commissioner of
886 Insurance Regulation or his or her designee, reasonably
887 indicates a possible violation of this part.
888 (2)(a) The office shall examine the business and affairs of
889 each pharmacy benefit manager at least biennially. The biennial
890 examination of each pharmacy benefit manager must be a
891 systematic review for the purpose of determining the pharmacy
892 benefit manager's compliance with all provisions of this part
893 and all other laws or rules applicable to pharmacy benefit
894 managers and must include a detailed review of the pharmacy
895 benefit manager's compliance with ss. 626.8825 and 626.8827. The
896 first 2-year cycle for conducting biennial reviews begins July
897 1, 2023. By January 1 of the year following a 2-year cycle, the
898 office must deliver to the Governor, the President of the
899 Senate, and the Speaker of the House of Representatives a report
900 summarizing the results of the biennial examinations during the
901 most recent 2-year cycle which includes detailed descriptions of
902 any violations committed by each pharmacy benefit manager and
903 detailed reporting of actions taken by the office against each
904 pharmacy benefit manager for such violations.
905 (b) The office also may conduct additional examinations as
906 often as it deems advisable or necessary for the purpose of
907 ascertaining compliance with this part and any other laws or
908 rules applicable to pharmacy benefit managers or applicants for
909 authorization.

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910 (c) If a referral made pursuant to s. 624.307(10)
911 reasonably indicates a pattern or practice of violations of this
912 part by a pharmacy benefit manager, the office must begin an
913 examination of the pharmacy benefit manager or include findings
914 related to such referral within an ongoing examination.
915 (d) Based on the findings of an examination that a pharmacy
916 benefit manager or an applicant for authorization has exhibited
917 a pattern or practice of knowing and willful violations of s.
918 626.8825 or s. 626.8827, the office may, pursuant to chapter
919 120, order a pharmacy benefit manager to file all contracts
920 between the pharmacy benefit manager and pharmacies or pharmacy
921 benefits plans or programs and any policies, guidelines, rules,
922 protocols, standard operating procedures, instructions, or
923 directives that govern or guide the manner in which the pharmacy
924 benefit manager or applicant conducts business related to such
925 knowing and willful violations for review and inspection for the
926 following 36-month period. Such documents are public records and
927 are not trade secrets or otherwise exempt from s. 119.07(1). As
928 used in this section, the term:
929 1. “Contracts” means any contract to which s. 626.8825 is
930 applicable.
931 2. “Knowing and willful” means any act of commission or
932 omission which is committed intentionally, as opposed to
933 accidentally, and which is committed with knowledge of the act’s
934 unlawfulness or with reckless disregard as to the unlawfulness
935 of the act.
936 (e) Examinations may be conducted by an independent
937 professional examiner under contract to the office, in which
938 case payment must be made directly to the contracted examiner by

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939 the pharmacy benefit manager examined in accordance with the
940 rates and terms agreed to by the office and the examiner. The
941 commission shall adopt rules providing for the types of
942 independent professional examiners who may conduct examinations
943 under this section, which types must include, but need not be
944 limited to, independent certified public accountants, actuaries,
945 investment specialists, information technology specialists, or
946 others meeting criteria specified by commission rule. The rules
947 must also require that:
948 1. The rates charged to the pharmacy benefit manager being
949 examined are consistent with rates charged by other firms in a
950 similar profession and are comparable with the rates charged for
951 comparable examinations.
952 2. The firm selected by the office to perform the
953 examination has no conflicts of interest which might affect its
954 ability to independently perform its responsibilities for the
955 examination.
956 (3) In making investigations and examinations of pharmacy
957 benefit managers and applicants for authorization, the office
958 and such pharmacy benefit manager are subject to all of the
959 following provisions:
960 (a) Section 624.318, as to the conduct of examinations.
961 (b) Section 624.319, as to examination and investigation
962 reports.
963 (c) Section 624.321, as to witnesses and evidence.
964 (d) Section 624.322, as to compelled testimony.
965 (e) Section 624.324, as to hearings.
966 (f) Section 624.34, as to fingerprinting.
967 (g) Any other provision of chapter 624 applicable to the

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968 investigation or examination of a licensee under this part.
969 (4)(a) A pharmacy benefit manager must maintain an accurate
970 record of all contracts and records with all pharmacies and
971 pharmacy benefits plans or programs for the duration of the
972 contract, and for 5 years thereafter. Such contracts must be
973 made available to the office and kept in a form accessible to
974 the office.
975 (b) The office may order any pharmacy benefit manager or
976 applicant to produce any records, books, files, contracts,
977 advertising and solicitation materials, or other information and
978 may take statements under oath to determine whether the pharmacy
979 benefit manager or applicant is in violation of the law or is
980 acting contrary to the public interest.
981 (5)(a) Notwithstanding s. 624.307(3), each pharmacy benefit
982 manager and applicant for authorization must pay to the office
983 the expenses of the examination or investigation. Such expenses
984 include actual travel expenses, a reasonable living expense
985 allowance, compensation of the examiner, investigator, or other
986 person making the examination or investigation, and necessary
987 costs of the office directly related to the examination or
988 investigation. Such travel expenses and living expense
989 allowances are limited to those expenses necessarily incurred on
990 account of the examination or investigation and shall be paid by
991 the examined pharmacy benefit manager or applicant together with
992 compensation upon presentation by the office to such pharmacy
993 benefit manager or applicant of such charges and expenses after
994 a detailed statement has been filed by the examiner and approved
995 by the office.
996 (b) All moneys collected from pharmacy benefit managers and

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997 applicants for authorization pursuant to this subsection shall
998 be deposited into the Insurance Regulatory Trust Fund, and the
999 office may make deposits from time to time into such fund from
1000 moneys appropriated for the operation of the office.
1001 (c) Notwithstanding s. 112.061, the office may pay to the
1002 examiner, investigator, or person making such examination or
1003 investigation out of such trust fund the actual travel expenses,
1004 reasonable living expense allowance, and compensation in
1005 accordance with the statement filed with the office by the
1006 examiner, investigator, or other person, as provided in
1007 paragraph (a).
1008 (6) In addition to any other enforcement authority
1009 available to the office, the office shall impose an
1010 administrative fine of $5,000 for each violation of s. 626.8825
1011 or s. 626.8827. Each instance of a violation of such sections by
1012 a pharmacy benefit manager against each individual pharmacy or
1013 prescription benefits plan or program constitutes a separate
1014 violation. Notwithstanding any other provision of law, there is
1015 no limitation on aggregate fines issued pursuant to this
1016 section. The proceeds from any administrative fine shall be
1017 deposited into the General Revenue Fund.
1018 (7) Failure by a pharmacy benefit manager to pay expenses
1019 incurred or administrative fines imposed under this section is
1020 grounds for the denial, suspension, or revocation of its
1021 certificate of authority.
1022 Section 14. Section 626.89, Florida Statutes, is amended to
1023 read:
1024 626.89 Annual financial statement and filing fee; notice of
1025 change of ownership; pharmacy benefit manager filings.—

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1026 (1) Each authorized administrator shall annually file with
1027 the office a full and true statement of its financial condition,
1028 transactions, and affairs within 3 months after the end of the
1029 administrator’s fiscal year or within such extension of time as
1030 the office for good cause may have granted. The statement must
1031 be for the preceding fiscal year and must be in such form and
1032 contain such matters as the commission prescribes and must be
1033 verified by at least two officers of the administrator.
1034 (2) Each authorized administrator shall also file an
1035 audited financial statement performed by an independent
1036 certified public accountant. The audited financial statement
1037 must ~~shall~~ be filed with the office within 5 months after the
1038 end of the administrator’s fiscal year and be for the preceding
1039 fiscal year. An audited financial statement prepared on a
1040 consolidated basis must include a columnar consolidating or
1041 combining worksheet that must be filed with the statement and
1042 must comply with the following:
1043 (a) Amounts shown on the consolidated audited financial
1044 statement must be shown on the worksheet;
1045 (b) Amounts for each entity must be stated separately; and
1046 (c) Explanations of consolidating and eliminating entries
1047 must be included.
1048 (3) At the time of filing its annual statement, the
1049 administrator shall pay a filing fee in the amount specified in
1050 s. 624.501 for the filing of an annual statement by an insurer.
1051 (4) In addition, the administrator shall immediately notify
1052 the office of any material change in its ownership.
1053 (5) A pharmacy benefit manager shall also notify the office
1054 within 30 days after any administrative, civil, or criminal

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1055 complaints, settlements, or discipline of the pharmacy benefit
1056 manager or any of its affiliates which relate to a violation of
1057 the insurance laws, including pharmacy benefit laws in any
1058 state.
1059 (6) A pharmacy benefit manager shall also annually submit
1060 to the office a statement attesting to its compliance with the
1061 network requirements of s. 626.8825.
1062 (7) The commission may by rule require all or part of the
1063 statements or filings required under this section to be
1064 submitted by electronic means in a computer-readable form
1065 compatible with the electronic data format specified by the
1066 commission.
1067 Section 15. Subsection (5) is added to section 627.42393,
1068 Florida Statutes, to read:
1069 627.42393 Step-therapy protocol.—
1070 (5) This section applies to a pharmacy benefit manager
1071 acting on behalf of a health insurer.
1072 Section 16. Subsections (2), (3), and (4) of section
1073 627.64741, Florida Statutes, are amended to read:
1074 627.64741 Pharmacy benefit manager contracts.—
1075 (2) In addition to the requirements of part VII of chapter
1076 626, a contract between a health insurer and a pharmacy benefit
1077 manager must require that the pharmacy benefit manager:
1078 (a) Update maximum allowable cost pricing information at
1079 least every 7 calendar days.
1080 (b) Maintain a process that will, in a timely manner,
1081 eliminate drugs from maximum allowable cost lists or modify drug
1082 prices to remain consistent with changes in pricing data used in
1083 formulating maximum allowable cost prices and product

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1084 availability.
1085 ~~(3) A contract between a health insurer and a pharmacy~~
1086 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1087 ~~limiting a pharmacist’s ability to disclose whether the cost-~~
1088 ~~sharing obligation exceeds the retail price for a covered~~
1089 ~~prescription drug, and the availability of a more affordable~~
1090 ~~alternative drug, pursuant to s. 465.0244.~~
1091 ~~(4) A contract between a health insurer and a pharmacy~~
1092 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1093 ~~requiring an insured to make a payment for a prescription drug~~
1094 ~~at the point of sale in an amount that exceeds the lesser of:~~
1095 ~~(a) The applicable cost-sharing amount; or~~
1096 ~~(b) The retail price of the drug in the absence of~~
1097 ~~prescription drug coverage.~~
1098 Section 17. Subsections (2), (3), and (4) of section
1099 627.6572, Florida Statutes, are amended to read:
1100 627.6572 Pharmacy benefit manager contracts.—
1101 (2) In addition to the requirements of part VII of chapter
1102 626, a contract between a health insurer and a pharmacy benefit
1103 manager must require that the pharmacy benefit manager:
1104 (a) Update maximum allowable cost pricing information at
1105 least every 7 calendar days.
1106 (b) Maintain a process that will, in a timely manner,
1107 eliminate drugs from maximum allowable cost lists or modify drug
1108 prices to remain consistent with changes in pricing data used in
1109 formulating maximum allowable cost prices and product
1110 availability.
1111 ~~(3) A contract between a health insurer and a pharmacy~~
1112 ~~benefit manager must prohibit the pharmacy benefit manager from~~

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1113 ~~limiting a pharmacist’s ability to disclose whether the cost-~~
1114 ~~sharing obligation exceeds the retail price for a covered~~
1115 ~~prescription drug, and the availability of a more affordable~~
1116 ~~alternative drug, pursuant to s. 465.0244.~~
1117 ~~(4) A contract between a health insurer and a pharmacy~~
1118 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1119 ~~requiring an insured to make a payment for a prescription drug~~
1120 ~~at the point of sale in an amount that exceeds the lesser of:~~
1121 ~~(a) The applicable cost-sharing amount; or~~
1122 ~~(b) The retail price of the drug in the absence of~~
1123 ~~prescription drug coverage.~~
1124 Section 18. Paragraph (e) is added to subsection (46) of
1125 section 641.31, Florida Statutes, to read:
1126 641.31 Health maintenance contracts.—
1127 (46)
1128 (e) This subsection applies to a pharmacy benefit manager
1129 acting on behalf of a health maintenance organization.
1130 Section 19. Subsections (2), (3), and (4) of section
1131 641.314, Florida Statutes, are amended to read:
1132 641.314 Pharmacy benefit manager contracts.—
1133 (2) In addition to the requirements of part VII of chapter
1134 626, a contract between a health maintenance organization and a
1135 pharmacy benefit manager must require that the pharmacy benefit
1136 manager:
1137 (a) Update maximum allowable cost pricing information at
1138 least every 7 calendar days.
1139 (b) Maintain a process that will, in a timely manner,
1140 eliminate drugs from maximum allowable cost lists or modify drug
1141 prices to remain consistent with changes in pricing data used in

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1142 formulating maximum allowable cost prices and product
1143 availability.
1144 ~~(3) A contract between a health maintenance organization~~
1145 ~~and a pharmacy benefit manager must prohibit the pharmacy~~
1146 ~~benefit manager from limiting a pharmacist's ability to disclose~~
1147 ~~whether the cost-sharing obligation exceeds the retail price for~~
1148 ~~a covered prescription drug, and the availability of a more~~
1149 ~~affordable alternative drug, pursuant to s. 465.0244.~~
1150 ~~(4) A contract between a health maintenance organization~~
1151 ~~and a pharmacy benefit manager must prohibit the pharmacy~~
1152 ~~benefit manager from requiring a subscriber to make a payment~~
1153 ~~for a prescription drug at the point of sale in an amount that~~
1154 ~~exceeds the lesser of:~~
1155 ~~(a) The applicable cost-sharing amount; or~~
1156 ~~(b) The retail price of the drug in the absence of~~
1157 ~~prescription drug coverage.~~
1158 Section 20. (1) This act establishes requirements for
1159 pharmacy benefit managers as defined in s. 626.88, Florida
1160 Statutes, including, without limitation, pharmacy benefit
1161 managers in their performance of services for or otherwise on
1162 behalf of a pharmacy benefits plan or program as defined in s.
1163 626.8825, Florida Statutes, which includes coverage pursuant to
1164 Titles XVIII, XIX, or XXI of the Social Security Act, 42 U.S.C.
1165 ss. 1395 et seq., 1396 et seq., and 1397aa et seq., known as
1166 Medicare, Medicaid, or any other similar coverage under a state
1167 or Federal Government funded health plan, including the
1168 Statewide Medicaid Managed Care program established pursuant to
1169 part IV of chapter 409, Florida Statutes, and the state group
1170 insurance program pursuant to part I of chapter 110, Florida

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1171 Statutes.
1172 (2) This act is not intended, nor may it be construed, to
1173 conflict with existing, relevant federal law.
1174 (3) If any provision of this act or its application to any
1175 person or circumstances is held invalid, the invalidity does not
1176 affect other provisions or applications of this act which can be
1177 given effect without the invalid provision or application, and
1178 to this end the provisions of this act are severable.
1179 Section 21. The sum of $1.5 million is hereby appropriated
1180 to the Office of Insurance Regulation to implement this act.
1181 Section 22. This act shall take effect July 1, 2023.
1182
1183 ================= T I T L E A M E N D M E N T ================
1184 And the title is amended as follows:
1185 Delete everything before the enacting clause
1186 and insert:
1187 A bill to be entitled
1188 An act relating to prescription drugs; providing a
1189 short title; amending s. 499.005, F.S.; specifying
1190 additional prohibited acts related to the Florida Drug
1191 and Cosmetic Act; amending s. 499.012, F.S.; providing
1192 that prescription drug manufacturer and nonresident
1193 prescription drug manufacturer permitholders are
1194 subject to specified requirements; creating s.
1195 499.026, F.S.; defining terms; requiring certain drug
1196 manufacturers to notify the Department of Business and
1197 Professional Regulation of reportable drug price
1198 increases on a specified form on the effective date of
1199 such increase; providing requirements for the form;

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1200 providing construction; requiring such manufacturers
1201 to submit certain reports to the department by a
1202 specified date each year; providing requirements for
1203 the reports; authorizing the department to request
1204 certain additional information from the manufacturer
1205 before approving the report; requiring the department
1206 to submit the forms and reports to the Agency for
1207 Health Care Administration to be posted on the
1208 agency's website; prohibiting the agency from posting
1209 on its website certain submitted information that is
1210 marked as a trade secret; requiring the agency to
1211 compile all information from the submitted forms and
1212 reports and make it available to the Governor and the
1213 Legislature upon request; prohibiting manufacturers
1214 from claiming a public records exemption for trade
1215 secrets for certain information provided in such forms
1216 or reports; providing that department employees remain
1217 protected from liability for releasing the forms and
1218 reports as public records; authorizing the department,
1219 in consultation with the agency, to adopt rules;
1220 providing for emergency rulemaking; amending s.
1221 624.307, F.S.; requiring the Division of Consumer
1222 Services of the Department of Financial Services to
1223 designate an employee as the primary contact for
1224 consumer complaints involving pharmacy benefit
1225 managers; requiring the division to refer certain
1226 complaints to the Office of Insurance Regulation;
1227 amending s. 624.490, F.S.; revising the definition of
1228 the term "pharmacy benefit manager"; amending s.

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1229 624.491, F.S.; revising provisions related to pharmacy
1230 audits; amending s. 626.88, F.S.; revising the
1231 definition of the term “administrator”; defining the
1232 term “pharmacy benefit manager”; amending s. 626.8805,
1233 F.S.; providing a grandfathering provision for certain
1234 pharmacy benefit managers operating as administrators;
1235 providing a penalty for certain persons who do not
1236 hold a certificate of authority to act as an
1237 administrator on or after a specified date; providing
1238 additional requirements for pharmacy benefit managers
1239 applying for a certificate of authority to act as an
1240 administrator; exempting pharmacy benefit managers
1241 from certain fees; amending s. 626.8814, F.S.;
1242 requiring pharmacy benefit managers to identify
1243 certain ownership affiliations to the office;
1244 requiring pharmacy benefit managers to report any
1245 change in such information to the office within a
1246 specified timeframe; creating s. 626.8825, F.S.;
1247 defining terms; providing requirements for certain
1248 contracts between a pharmacy benefit manager and a
1249 pharmacy benefits plan or program or a participating
1250 pharmacy; requiring the Financial Services Commission
1251 to adopt rules; specifying requirements for certain
1252 administrative appeal procedures that such contracts
1253 with participating pharmacies must include; requiring
1254 pharmacy benefit managers to submit reports on
1255 submitted appeals to the office every 90 days;
1256 creating s. 626.8827, F.S.; specifying prohibited
1257 practices for pharmacy benefit managers; creating s.

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1258 626.8828, F.S.; authorizing the office to investigate
1259 administrators that are pharmacy benefit managers and
1260 certain applicants; requiring the office to review
1261 certain referrals and investigate them under certain
1262 circumstances; providing for biennial reviews of
1263 pharmacy benefit managers; authorizing the office to
1264 conduct additional examinations; requiring the office
1265 to conduct an examination under certain circumstances;
1266 providing procedures and requirements for such
1267 examinations; defining the terms "contracts" and
1268 "knowing and willful"; providing that independent
1269 professional examiners under contract with the office
1270 may conduct examinations of pharmacy benefit managers;
1271 requiring the commission to adopt specified rules;
1272 specifying provisions that apply to such
1273 investigations and examinations; providing
1274 recordkeeping requirements for pharmacy benefit
1275 managers; authorizing the office to order the
1276 production of such records and other specified
1277 information; authorizing the office to take statements
1278 under oath; requiring pharmacy benefit managers and
1279 applicants subjected to an investigation or
1280 examination to pay the associated expenses; specifying
1281 covered expenses; providing for collection of such
1282 expenses; providing for the deposit of certain moneys
1283 into the Insurance Regulatory Trust Fund; authorizing
1284 the office to pay examiners, investigators, and other
1285 persons from such fund; providing administrative
1286 penalties; providing grounds for administrative action

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1287 against a certificate of authority; amending s.
1288 626.89, F.S.; requiring pharmacy benefit managers to
1289 notify the office of specified complaints,
1290 settlements, or discipline within a specified
1291 timeframe; requiring pharmacy benefit managers to
1292 annually submit a certain attestation statement to the
1293 office; amending s. 627.42393, F.S.; providing that
1294 certain step-therapy protocol requirements apply to a
1295 pharmacy benefit manager acting on behalf of a health
1296 insurer; amending ss. 627.64741 and 627.6572, F.S.;
1297 conforming provisions to changes made by the act;
1298 amending s. 641.31, F.S.; providing that certain step-
1299 therapy protocol requirements apply to a pharmacy
1300 benefit manager acting on behalf of a health
1301 maintenance organization; amending s. 641.314, F.S.;
1302 conforming a provision to changes made by the act;
1303 providing legislative intent, construction, and
1304 severability; providing an appropriation; providing an
1305 effective date.