By Senator Brodeur

10-00822D-23 20231550__

1 A bill to be entitled
2 An act relating to prescription drugs; providing a
3 short title; amending s. 499.005, F.S.; specifying
4 additional prohibited acts related to the Florida Drug
5 and Cosmetic Act; amending s. 499.012, F.S.; providing
6 that prescription drug manufacturer and nonresident
7 prescription drug manufacturer permitholders are
8 subject to specified requirements; creating s.
9 499.026, F.S.; defining terms; requiring certain drug
10 manufacturers to notify the Department of Business and
11 Professional Regulation of reportable drug price
12 increases on a specified form on the effective date of
13 such increase; providing requirements for the form;
14 providing construction; requiring such manufacturers
15 to submit certain reports to the department by a
16 specified date each year; providing requirements for
17 the reports; authorizing the department to request
18 certain additional information from the manufacturer
19 before approving the report; requiring the department
20 to submit the forms and reports to the Agency for
21 Health Care Administration to be posted on the
22 agency’s website; prohibiting manufacturers from
23 claiming a public records exemption for trade secrets
24 for any information provided in such notifications or
25 reports; providing that department employees remain
26 protected from liability for releasing the forms and
27 reports as public records; authorizing the department,
28 in consultation with the agency, to adopt rules;
29 providing for emergency rulemaking; amending s.

10-00822D-23 20231550__

30 624.307, F.S.; requiring the Division of Consumer
31 Services of the Department of Financial Services to
32 designate an employee as the primary contact for
33 consumer complaints involving pharmacy benefit
34 managers; requiring the division to refer certain
35 complaints to the Office of Insurance Regulation;
36 amending s. 624.490, F.S.; revising the definition of
37 the term “pharmacy benefit manager”; amending s.
38 626.88, F.S.; revising the definition of the term
39 “administrator”; defining the term “pharmacy benefit
40 manager”; amending s. 626.8805, F.S.; providing a
41 grandfathering provision for certain pharmacy benefit
42 managers operating as administrators; providing a
43 penalty for certain persons who do not hold a
44 certificate of authority to act as an administrator on
45 or after a specified date; providing additional
46 requirements for pharmacy benefit managers applying
47 for a certificate of authority to act as an
48 administrator; exempting pharmacy benefit managers for
49 certain fees; amending s. 626.8814, F.S.; requiring
50 pharmacy benefit managers to identify certain
51 ownership affiliations to the office; requiring
52 pharmacy benefit managers to report any change in such
53 information to the office within a specified
54 timeframe; creating s. 626.8825, F.S.; defining terms;
55 providing requirements for certain contracts between a
56 pharmacy benefit manager and a pharmacy benefits plan
57 or program or a participating pharmacy; specifying
58 requirements for certain administrative appeal

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59 procedures that such contracts with participating
60 pharmacies must include; requiring pharmacy benefit
61 managers to submit reports on submitted appeals to the
62 office every 90 days; creating s. 626.8827, F.S.;
63 specifying prohibited practices for pharmacy benefit
64 managers; creating s. 626.8828, F.S.; authorizing the
65 office to investigate administrators that are pharmacy
66 benefit managers and certain applicants; requiring the
67 office to review certain referrals and investigate
68 them under certain circumstances; providing for
69 biennial reviews of pharmacy benefit managers;
70 authorizing the office to conduct additional
71 examinations; requiring the office to conduct an
72 examination under certain circumstances; providing
73 procedures and requirements for such examinations;
74 defining the terms “contracts” and “knowing and
75 willful”; specifying provisions that apply to such
76 investigations and examinations; providing
77 recordkeeping requirements for pharmacy benefit
78 managers; authorizing the office to order the
79 production of such records and other specified
80 information; authorizing the office to take statements
81 under oath; requiring pharmacy benefit managers and
82 applicants subjected to an investigation or
83 examination to pay the associated expenses; specifying
84 covered expenses; providing for collection of such
85 expenses; providing for the deposit of certain moneys
86 into the Insurance Regulatory Trust Fund; authorizing
87 the office to pay examiners, investigators, and other

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88 persons from such fund; providing administrative
89 penalties; providing grounds for administrative action
90 against a certificate of authority; amending s.
91 626.89, F.S.; requiring pharmacy benefit managers to
92 notify the office of specified complaints,
93 settlements, or discipline within a specified
94 timeframe; requiring pharmacy benefit managers to
95 annually submit a certain attestation statement to the
96 office; amending s. 627.42393, F.S.; providing that
97 certain step-therapy protocol requirements apply to a
98 pharmacy benefit manager acting on behalf of a health
99 insurer; amending ss. 627.64741 and 627.6572, F.S.;
100 conforming provisions to changes made by the act;
101 amending s. 641.31, F.S.; providing that certain step-
102 therapy protocol requirements apply to a pharmacy
103 benefit manager acting on behalf of a health
104 maintenance organization; amending s. 641.314, F.S.;
105 conforming a provision to changes made by the act;
106 amending s. 624.491, F.S.; conforming a cross-
107 reference; providing legislative intent, construction,
108 and severability; providing an appropriation;
109 providing an effective date.
110
111 Be It Enacted by the Legislature of the State of Florida:
112
113 Section 1. This act may be cited as the "Prescription Drug
114 Reform Act."
115 Section 2. Subsection (29) is added to section 499.005,
116 Florida Statutes, to read:

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10-00822D-23 20231550__

117 499.005 Prohibited acts.—It is unlawful for a person to
118 perform or cause the performance of any of the following acts in
119 this state:
120 (29) Failure to accurately complete and timely submit
121 reportable drug price increase forms and reports as required
122 under this part and rules adopted thereunder.
123 Section 3. Subsection (16) is added to section 499.012,
124 Florida Statutes, to read:
125 499.012 Permit application requirements.—
126 (16) A permit for a prescription drug manufacturer or a
127 nonresident prescription drug manufacturer is subject to the
128 requirements of s. 499.026.
129 Section 4. Section 499.026, Florida Statutes, is created to
130 read:
131 499.026 Notification of manufacturer prescription drug
132 price increases.—
133 (1) As used in this section, the term:
134 (a) "Course of therapy" means the recommended daily dose
135 units of a prescription drug pursuant to its prescribing label
136 for 30 days or the recommended daily dose units of a
137 prescription drug pursuant to its prescribing label for a normal
138 course of treatment which is less than 30 days.
139 (b) "Manufacturer" means a person holding a prescription
140 drug manufacturer permit or a nonresident prescription drug
141 manufacturer permit under s. 499.01.
142 (c) "Prescription drug" has the same meaning as in s.
143 499.003 and includes biological products but is limited to those
144 prescription drugs and biological products intended for human
145 use.

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146 (d) “Reportable drug price increase” means, for a
147 prescription drug with a wholesale acquisition cost of at least
148 $100 for a course of therapy before the effective date of an
149 increase:
150 1. Any increase of 15 percent or more of the wholesale
151 acquisition cost during the preceding 12-month period; or
152 2. Any increase of 40 percent or more of the wholesale
153 acquisition cost during the preceding 3 calendar years.
154 (e) “Wholesale acquisition cost” means, with respect to a
155 prescription drug or biological product, the manufacturer’s list
156 price for the prescription drug or biological product to
157 wholesalers or direct purchasers in the United States, not
158 including prompt pay or other discounts, rebates, or reductions
159 in price, for the most recent month for which the information is
160 available, as reported in wholesale price guides or other
161 publications of drug or biological product pricing data.
162 (2) On the effective date of a manufacturer’s reportable
163 drug price increase, the manufacturer must provide notification
164 of each reportable drug price increase to the department on a
165 form prescribed by the department. The form must require the
166 manufacturer to specify all of the following:
167 (a) The proprietary and nonproprietary names of the
168 prescription drug, as applicable.
169 (b) The wholesale acquisition cost before the reportable
170 drug price increase.
171 (c) The dollar amount of the reportable drug price
172 increase.
173 (d) The percentage amount of the reportable drug price
174 increase from the wholesale acquisition cost before the

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175 reportable drug price increase.
176 (e) A statement regarding whether a change or improvement
177 in the prescription drug necessitates the reportable drug price
178 increase. If so, the manufacturer must describe the change or
179 improvement.
180 (f) The intended uses of the prescription drug.
181
182 This subsection does not prohibit a manufacturer from notifying
183 other parties, such as pharmacy benefit managers, of a drug
184 price increase before the effective date of the drug price
185 increase.
186 (3) By April 1 of each year, each manufacturer shall submit
187 a report to the department on a form prescribed by the
188 department. A report is not deemed to be submitted until
189 approved by the department. At a minimum, the report must
190 include all of the following:
191 (a) A list of all prescription drugs affected by a
192 reportable drug price increase during the previous calendar year
193 and both the dollar amount of each reportable drug price
194 increase and the percentage increase of each reportable drug
195 price increase relative to the previous wholesale acquisition
196 cost of the prescription drug. The prescription drugs shall be
197 identified using their proprietary names and nonproprietary
198 names, as applicable.
199 (b) If more than one form has been filed under this section
200 for previous reportable drug price increases, the percentage
201 increase of the prescription drug from the earliest form filed
202 to the most recent form filed.
203 (c) The intended uses of each prescription drug listed in

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204 the report and whether the prescription drug manufacturer
205 benefits from market exclusivity for such drug.
206 (d) The length of time the prescription drug has been
207 available for purchase.
208 (e) A complete description of the factors contributing to
209 each reportable drug price increase. The factors must be
210 provided with such specificity as to explain the need or
211 justification for each reportable drug price increase. The
212 department may request additional information from a
213 manufacturer relating to the need or justification of any
214 reportable drug price increase before approving the
215 manufacturer's report.
216 (f) Any action that the manufacturer has filed to extend a
217 patent report after the first extension has been granted.
218 (4)(a) The department shall submit all forms and reports
219 submitted by manufacturers to the Agency for Health Care
220 Administration, to be posted on the agency's website pursuant to
221 s. 408.062.
222 (b) A manufacturer may not claim a public records exemption
223 for a trade secret under s. 119.0715 for any information
224 required by the department under this section. Department
225 employees remain protected from liability for release of forms
226 and reports pursuant to s. 119.0715(4).
227 (5) The department, in consultation with the Agency for
228 Health Care Administration, shall adopt rules to implement this
229 section.
230 (a) The department shall adopt necessary emergency rules
231 pursuant to s. 120.54(4) to implement this section. If an
232 emergency rule adopted under this section is held to be

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233 unconstitutional or an invalid exercise of delegated legislative
234 authority and becomes void, the department may adopt an
235 emergency rule pursuant to this section to replace the rule that
236 has become void. If the emergency rule adopted to replace the
237 void emergency rule is also held to be unconstitutional or an
238 invalid exercise of delegated legislative authority and becomes
239 void, the department shall follow the nonemergency rulemaking
240 procedures of the Administrative Procedure Act to replace the
241 rule that has become void.
242 (b) For emergency rules adopted under this section, the
243 department need not make the findings required under s.
244 120.54(4)(a). Emergency rules adopted under this section are
245 also exempt from:
246 1. Sections 120.54(3)(b) and 120.541. Challenges to
247 emergency rules adopted under this section are subject to the
248 time schedules provided in s. 120.56(5).
249 2. Section 120.54(4)(c), and remain in effect until
250 replaced by rules adopted under the nonemergency rulemaking
251 procedures of the Administrative Procedure Act.
252 Section 5. Paragraph (a) of subsection (10) of section
253 624.307, Florida Statutes, is amended, and paragraph (b) of that
254 subsection is republished, to read:
255 624.307 General powers; duties.—
256 (10)(a) The Division of Consumer Services shall perform the
257 following functions concerning products or services regulated by
258 the department or office:
259 1. Receive inquiries and complaints from consumers.
260 2. Prepare and disseminate information that the department
261 deems appropriate to inform or assist consumers.

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262 3. Provide direct assistance to and advocacy for consumers
263 who request such assistance or advocacy.
264 4. With respect to apparent or potential violations of law
265 or applicable rules committed by a person or entity licensed by
266 the department or office, report apparent or potential
267 violations to the office or to the appropriate division of the
268 department, which may take any additional action it deems
269 appropriate.
270 5. Designate an employee of the division as the primary
271 contact for consumers on issues relating to sinkholes.
272 6. Designate an employee of the division as the primary
273 contact for consumers on issues relating to pharmacy benefit
274 managers. The division must refer to the office any consumer
275 complaint that alleges conduct that may constitute a violation
276 of part VII of chapter 626 or for which a pharmacy benefit
277 manager does not respond in accordance with paragraph (b).
278 (b) Any person licensed or issued a certificate of
279 authority by the department or the office shall respond, in
280 writing, to the division within 20 days after receipt of a
281 written request for documents and information from the division
282 concerning a consumer complaint. The response must address the
283 issues and allegations raised in the complaint and include any
284 requested documents concerning the consumer complaint not
285 subject to attorney-client or work-product privilege. The
286 division may impose an administrative penalty for failure to
287 comply with this paragraph of up to $2,500 per violation upon
288 any entity licensed by the department or the office and $250 for
289 the first violation, $500 for the second violation, and up to
290 $1,000 for the third or subsequent violation upon any individual

291 licensed by the department or the office.
292 Section 6. Subsection (1) of section 624.490, Florida
293 Statutes, is amended to read:
294 624.490 Registration of pharmacy benefit managers.—
295 (1) As used in this section, the term “pharmacy benefit
296 manager” has the same meaning as in s. 626.88 ~~means a person or~~
297 ~~entity doing business in this state which contracts to~~
298 ~~administer prescription drug benefits on behalf of a health~~
299 ~~insurer or a health maintenance organization to residents of~~
300 ~~this state~~.
301 Section 7. Subsection (1) of section 626.88, Florida
302 Statutes, is amended, and subsection (6) is added to that
303 section, to read:
304 626.88 Definitions.—For the purposes of this part, the
305 term:
306 (1) “Administrator” means ~~is~~ any person who directly or
307 indirectly solicits or effects coverage of, collects charges or
308 premiums from, or adjusts or settles claims on residents of this
309 state in connection with authorized commercial self-insurance
310 funds or with insured or self-insured programs which provide
311 life or health insurance coverage or coverage of any other
312 expenses described in s. 624.33(1); ~~or~~ any person who, through a
313 health care risk contract as defined in s. 641.234 with an
314 insurer or health maintenance organization, provides billing and
315 collection services to health insurers and health maintenance
316 organizations on behalf of health care providers; or a pharmacy
317 benefit manager. The term does not include~~, other than~~ any of
318 the following ~~persons~~:
319 (a) An employer or wholly owned direct or indirect

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320 subsidiary of an employer, on behalf of such employer’s
321 employees or the employees of one or more subsidiary or
322 affiliated corporations of such employer.
323 (b) A union on behalf of its members.
324 (c) An insurance company which is either authorized to
325 transact insurance in this state or is acting as an insurer with
326 respect to a policy lawfully issued and delivered by such
327 company in and pursuant to the laws of a state in which the
328 insurer was authorized to transact an insurance business.
329 (d) A health care services plan, health maintenance
330 organization, professional service plan corporation, or person
331 in the business of providing continuing care, possessing a valid
332 certificate of authority issued by the office, and the sales
333 representatives thereof, if the activities of such entity are
334 limited to the activities permitted under the certificate of
335 authority.
336 (e) An entity that is affiliated with an insurer and that
337 only performs the contractual duties, between the administrator
338 and the insurer, of an administrator for the direct and assumed
339 insurance business of the affiliated insurer. The insurer is
340 responsible for the acts of the administrator and is responsible
341 for providing all of the administrator’s books and records to
342 the insurance commissioner, upon a request from the insurance
343 commissioner. For purposes of this paragraph, the term “insurer”
344 means a licensed insurance company, health maintenance
345 organization, prepaid limited health service organization, or
346 prepaid health clinic.
347 (f) A nonresident entity licensed in its state of domicile
348 as an administrator if its duties in this state are limited to

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349 the administration of a group policy or plan of insurance and no
350 more than a total of 100 lives for all plans reside in this
351 state.
352 (g) An insurance agent licensed in this state whose
353 activities are limited exclusively to the sale of insurance.
354 (h) A person appointed as a managing general agent in this
355 state, whose activities are limited exclusively to the scope of
356 activities conveyed under such appointment.
357 (i) An adjuster licensed in this state whose activities are
358 limited to the adjustment of claims.
359 (j) A creditor on behalf of such creditor's debtors with
360 respect to insurance covering a debt between the creditor and
361 its debtors.
362 (k) A trust and its trustees, agents, and employees acting
363 pursuant to such trust established in conformity with 29 U.S.C.
364 s. 186.
365 (l) A trust exempt from taxation under s. 501(a) of the
366 Internal Revenue Code, a trust satisfying the requirements of
367 ss. 624.438 and 624.439, or any governmental trust as defined in
368 s. 624.33(3), and the trustees and employees acting pursuant to
369 such trust, or a custodian and its agents and employees,
370 including individuals representing the trustees in overseeing
371 the activities of a service company or administrator, acting
372 pursuant to a custodial account which meets the requirements of
373 s. 401(f) of the Internal Revenue Code.
374 (m) A financial institution which is subject to supervision
375 or examination by federal or state authorities or a mortgage
376 lender licensed under chapter 494 who collects and remits
377 premiums to licensed insurance agents or authorized insurers

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378 concurrently or in connection with mortgage loan payments.
379 (n) A credit card issuing company which advances for and
380 collects premiums or charges from its credit card holders who
381 have authorized such collection if such company does not adjust
382 or settle claims.
383 (o) A person who adjusts or settles claims in the normal
384 course of such person's practice or employment as an attorney at
385 law and who does not collect charges or premiums in connection
386 with life or health insurance coverage.
387 (p) A person approved by the department who administers
388 only self-insured workers' compensation plans.
389 (q) A service company or service agent and its employees,
390 authorized in accordance with ss. 626.895-626.899, serving only
391 a single employer plan, multiple-employer welfare arrangements,
392 or a combination thereof.
393 (r) Any provider or group practice, as defined in s.
394 456.053, providing services under the scope of the license of
395 the provider or the member of the group practice.
396 (s) Any hospital providing billing, claims, and collection
397 services solely on its own and its physicians' behalf and
398 providing services under the scope of its license.
399 (t) A corporation not for profit whose membership consists
400 entirely of local governmental units authorized to enter into
401 risk management consortiums under s. 112.08.
402
403 A person who provides billing and collection services to health
404 insurers and health maintenance organizations on behalf of
405 health care providers shall comply with the provisions of ss.
406 627.6131, 641.3155, and 641.51(4).

407 (6) “Pharmacy benefit manager” means a person or entity
408 doing business in this state which contracts to administer
409 prescription drug benefits on behalf of a pharmacy benefits plan
410 or program as defined in s. 626.8825. The term includes, but is
411 not limited to, a person or entity that performs one or more of
412 the following services:
413 (a) Pharmacy claims processing.
414 (b) Administration or management of pharmacy discount card
415 programs.
416 (c) Managing pharmacy networks or pharmacy reimbursement.
417 (d) Paying or managing claims for pharmacist services
418 provided to covered persons.
419 (e) Developing or managing a clinical formulary, including
420 utilization management or quality assurance programs.
421 (f) Pharmacy rebate administration.
422 (g) Managing patient compliance, therapeutic intervention,
423 or generic substitution programs.
424 Section 8. Present subsections (3) through (6) of section
425 626.8805, Florida Statutes, are redesignated as subsection (4)
426 through (7), respectively, a new subsection (3) and subsection
427 (8) are added to that section, and subsection (1) and present
428 subsection (3) of that section are amended, to read:
429 626.8805 Certificate of authority to act as administrator.—
430 (1) It is unlawful for any person to act as or hold himself
431 or herself out to be an administrator in this state without a
432 valid certificate of authority issued by the office pursuant to
433 ss. 626.88-626.894. A pharmacy benefit manager that is
434 registered with the office under s. 624.490 as of June 30, 2023,
435 may continue to operate until January 1, 2024, as an

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436 administrator without a certificate of authority and is not in
437 violation of the requirement to possess a valid certificate of
438 authority as an administrator during that timeframe. To qualify
439 for and hold authority to act as an administrator in this state,
440 an administrator must otherwise be in compliance with this code
441 and with its organizational agreement. The failure of any
442 person, excluding a pharmacy benefit manager, to hold such a
443 certificate while acting as an administrator shall subject such
444 person to a fine of not less than $5,000 or more than $10,000
445 for each violation. A person who, on or after January 1, 2024,
446 does not hold a certificate of authority to act as an
447 administrator while operating as a pharmacy benefit manager is
448 subject to a fine of $10,000 per violation per day.
449 (3) An applicant that is a pharmacy benefit manager must
450 also submit all of the following:
451 (a) A complete biographical statement on forms prescribed
452 by the commission, an independent investigation report, and
453 fingerprints obtained pursuant to chapter 624, of all of the
454 individuals referred to in paragraph (2)(c).
455 (b) A self-disclosure of any administrative, civil, or
456 criminal complaints, settlements, or discipline of the
457 applicant, or any of the applicant's affiliates, which relate to
458 a violation of the insurance laws, including pharmacy benefit
459 manager laws, in any state.
460 (c) A statement attesting to compliance with the network
461 requirements in s. 626.8825 beginning January 1, 2024.
462 (4)(a) The applicant shall make available for inspection by
463 the office copies of all contracts relating to services provided
464 by the administrator to insurers or other persons using the

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465 services of the administrator.
466 (b) An applicant that is a pharmacy benefit manager shall
467 also make available for inspection by the office:
468 1. Copies of all contract templates with any pharmacy as
469 defined in s. 465.003; and
470 2. Copies of all subcontracts to support its operations.
471 (8) A pharmacy benefit manager is exempt from fees
472 associated with the initial application and the annual filing
473 fees in s. 626.89.
474 Section 9. Section 626.8814, Florida Statutes, is amended
475 to read:
476 626.8814 Disclosure of ownership or affiliation.—
477 (1) Each administrator shall identify to the office any
478 ownership interest or affiliation of any kind with any insurance
479 company responsible for providing benefits directly or through
480 reinsurance to any plan for which the administrator provides
481 administrative services.
482 (2) Pharmacy benefit managers shall also identify to the
483 office any ownership affiliation of any kind with any pharmacy
484 which, either directly or indirectly, through one or more
485 intermediaries:
486 (a) Has an investment or ownership interest in a pharmacy
487 benefit manager holding a certificate of authority issued under
488 this part;
489 (b) Shares common ownership with a pharmacy benefit manager
490 holding a certificate of authority issued under this part; or
491 (c) Has an investor or a holder of an ownership interest
492 which is a pharmacy benefit manager holding a certificate of
493 authority issued under this part.

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10-00822D-23 20231550__

494 (3) A pharmacy benefit manager shall report any change in
495 information required by subsection (2) to the office in writing
496 within 60 days after the change occurs.
497 Section 10. Section 626.8825, Florida Statutes, is created
498 to read:
499 626.8825 Pharmacy benefit manager transparency and
500 accountability.—
501 (1) DEFINITIONS.—As used in this section, the term:
502 (a) "Adjudication transaction fee" means a fee charged by
503 the pharmacy benefit manager to the pharmacy for electronic
504 claim submissions.
505 (b) "Affiliated pharmacy" means a pharmacy that, either
506 directly or indirectly through one or more intermediaries:
507 1. Has an investment or ownership interest in a pharmacy
508 benefit manager holding a certificate of authority issued under
509 this part;
510 2. Shares common ownership with a pharmacy benefit manager
511 holding a certificate of authority issued under this part; or
512 3. Has an investor or a holder of an ownership interest
513 which is a pharmacy benefit manager holding a certificate of
514 authority issued under this part.
515 (c) "Brand name or generic effective rate" means the
516 contractual rate set forth by a pharmacy benefit manager for the
517 reimbursement of covered brand name or generic drugs, calculated
518 using the total payments in the aggregate, by drug type, during
519 the performance period. The effective rates are typically
520 calculated as a discount from industry benchmarks, such as
521 average wholesale price or wholesale acquisition cost.
522 (d) "Covered person" means a person covered by,

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523 participating in, or receiving the benefit of a pharmacy
524 benefits plan or program.
525 (e) “Direct and indirect remuneration fees” means price
526 concessions that are paid to the pharmacy benefit manager by the
527 pharmacy retrospectively and that cannot be calculated at the
528 point of sale. The term may also include discounts, chargebacks
529 or rebates, cash discounts, free goods contingent on a purchase
530 agreement, upfront payments, coupons, goods in kind, free or
531 reduced-price services, grants, or other price concessions or
532 similar benefits from manufacturers, pharmacies, or similar
533 entities.
534 (f) “Dispensing fee” means a fee intended to cover
535 reasonable costs associated with providing the drug to a covered
536 person. This cost includes the pharmacist’s services and the
537 overhead associated with maintaining the facility and equipment
538 necessary to operate the pharmacy.
539 (g) “Effective rate guarantee” means the minimum ingredient
540 cost reimbursement a pharmacy benefit manager guarantees it will
541 pay for pharmacist services during the applicable measurement
542 period.
543 (h) “Erroneous claims” means pharmacy claims submitted in
544 error, including, but not limited to, unintended, incorrect,
545 fraudulent, or test claims.
546 (i) “Incentive payment” means a retrospective monetary
547 payment made as a reward or recognition by the pharmacy benefits
548 plan or program or pharmacy benefit manager to a pharmacy for
549 meeting or exceeding predefined pharmacy performance metrics as
550 related to quality measure, such as Healthcare Effectiveness
551 Data and Information Set measures.

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552 (j) “Maximum allowable cost appeal pricing adjustment”
553 means a retrospective positive payment adjustment made to a
554 pharmacy by the pharmacy benefits plan or program or by the
555 pharmacy benefit manager pursuant to an approved maximum
556 allowable cost appeal request submitted by the same pharmacy to
557 dispute the amount reimbursed for a drug based on the pharmacy
558 benefit manager’s listed maximum allowable cost price.
559 (k) “Monetary recoupments” means rescinded or recouped
560 payments from a pharmacy or provider by the pharmacy benefits
561 plan or program or by the pharmacy benefit manager.
562 (l) “Network” means a pharmacy or group of pharmacies that
563 agree to provide pharmacist services to covered persons on
564 behalf of a pharmacy benefits plan or program or a group of
565 pharmacy benefits plans or programs in exchange for payment for
566 such services. The term includes a pharmacy that generally
567 dispenses outpatient prescription drugs to covered persons or
568 dispenses particular types of prescription drugs, provides
569 pharmacist services to particular types of covered persons, or
570 dispenses prescriptions in particular health care settings,
571 including networks of specialty, institutional, or long-term
572 care facilities.
573 (m) “Network reconciliation offsets” means a process during
574 annual payment reconciliation between a pharmacy benefit manager
575 and a pharmacy which allows the pharmacy benefit manager to
576 offset an amount for overperformance or underperformance of
577 contractual guarantees across guaranteed line items, channels,
578 networks, or payers, as applicable.
579 (n) “Participation contract” means any agreement between a
580 pharmacy benefit manager and pharmacy for the provision and

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581 reimbursement of pharmacist services and any exhibits,
582 attachments, amendments, or addendums to such agreement.
583 (o) "Pass-through pricing model" means a payment model used
584 by a pharmacy benefit manager in which the payments made by the
585 pharmacy benefits plan or program to the pharmacy benefit
586 manager for the covered outpatient drugs are:
587 1. Equivalent to the payments the pharmacy benefit manager
588 makes to a dispensing pharmacy or provider for such drugs,
589 including any contracted professional dispensing fee between the
590 pharmacy benefit manager and its network of pharmacies. Such
591 dispensing fee would be paid if the pharmacy benefits plan or
592 program was making the payments directly.
593 2. Passed through in their entirety by the pharmacy
594 benefits plan or program or by the pharmacy benefit manager to
595 the pharmacy or provider that dispenses the drugs, and the
596 payments are made in a manner that is not offset by any
597 reconciliation.
598 (p) "Pharmacist" means a pharmacist as defined in s.
599 465.003.
600 (q) "Pharmacist services" means products, goods, and
601 services or any combination of products, goods, and services
602 provided as part of the practice of the profession of pharmacy
603 as defined in s. 465.003 or otherwise covered by a pharmacy
604 benefits plan or program.
605 (r) "Pharmacy" means a pharmacy as defined in s. 465.003.
606 (s) "Pharmacy benefit manager" has the same meaning as in
607 s. 626.88.
608 (t) "Pharmacy benefits plan or program" means a plan or
609 program that pays for, reimburses, covers the cost of, or

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10-00822D-23 20231550__

610 provides access to discounts on pharmacist services provided by
611 one or more pharmacies to covered persons who reside in, are
612 employed by, or receive pharmacist services from this state. The
613 term includes, but is not limited to, health maintenance
614 organizations, health insurers, self-insured employer health
615 plans, discount card programs, and government-funded health
616 plans, including the Statewide Medicaid Managed Care program
617 established pursuant to part IV of chapter 409 and the state
618 group insurance program pursuant to part I of chapter 110.
619 (u) "Rebate" means all payments that accrue to a pharmacy
620 benefit manager or its pharmacy benefits plan or program client,
621 directly or indirectly, from a pharmaceutical manufacturer,
622 including, but not limited to, discounts, administration fees,
623 credits, incentives, or penalties associated directly or
624 indirectly in any way with claims administered on behalf of a
625 pharmacy benefits plan or program client.
626 (v) "Spread pricing" is the practice in which a pharmacy
627 benefit manager charges a pharmacy benefits plan or program a
628 different amount for pharmacist services than the amount the
629 pharmacy benefit manager reimburses a pharmacy for such
630 pharmacist services.
631 (w) "Usual and customary price" means the amount charged to
632 cash customers for a pharmacist service exclusive of sales tax
633 or other amounts claimed.
634 (2) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A
635 PHARMACY BENEFITS PLAN OR PROGRAM.—In addition to any other
636 requirements in the Florida Insurance Code, all contractual
637 arrangements executed, amended, adjusted, or renewed on or after
638 July 1, 2023, which are applicable to pharmacy benefits covered

639 on or after January 1, 2024, between a pharmacy benefit manager
640 and a pharmacy benefits plan or program must:
641 (a) Use a pass-through pricing model, remaining consistent
642 with the prohibition in paragraph (3)(c).
643 (b) Exclude terms that allow for the direct or indirect
644 engagement in the practice of spread pricing unless the pharmacy
645 benefit manager passes along the entire amount of such
646 difference to the pharmacy benefits plan or program as allowable
647 under paragraph (a).
648 (c) Ensure that funds received in relation to providing
649 services for a pharmacy benefits plan or program or a pharmacy
650 are received by the pharmacy benefit manager in trust for the
651 pharmacy benefits plan or program or pharmacy, as applicable,
652 and are used or distributed only pursuant to the pharmacy
653 benefit manager's contract with the pharmacy benefits plan or
654 program or with the pharmacy or as otherwise required by
655 applicable law.
656 (d) Include network adequacy requirements that meet or
657 exceed the Medicare Part D program standards for convenient
658 access to network pharmacies set forth in 42 C.F.R. s. 423.120,
659 and that:
660 1. Do not limit a network to solely include affiliated
661 pharmacies;
662 2. Require a pharmacy benefit manager to offer a provider
663 contract to licensed pharmacies physically located on the
664 physical site of providers within the pharmacy benefits plan's
665 or program's geographic service area which have been
666 specifically designated as essential providers by the Agency for
667 Health Care Administration pursuant to s. 409.975(1)(a), and

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668 Florida cancer hospitals that meet the criteria in s.
669 409.975(1)(b), regardless of the pharmacy benefits plan’s or
670 program’s geographic service area, solely for the administration
671 or dispensing of covered prescription drugs, including
672 biological products, that are administered through infusions,
673 intravenously injected, inhaled during a surgical procedure, or
674 a covered parenteral drug, as part of onsite outpatient care;
675 3. Do not require a covered person to receive a
676 prescription drug by United States mail, common carrier, local
677 courier, third-party company or delivery service, or pharmacy
678 direct delivery. This subparagraph does not prohibit a pharmacy
679 benefit manager from operating mail order or delivery programs
680 on an opt-in basis at the sole discretion of a covered person;
681 4. Prohibit a requirement for a covered person to receive
682 pharmacist services from an affiliated pharmacy or an affiliated
683 health care provider for the in-person administration of covered
684 prescription drugs; offering or implementing pharmacy networks
685 that require or incentivize a covered person to use an
686 affiliated pharmacy or an affiliated health care provider for
687 the in-person administration of covered prescription drugs; or
688 advertising, marketing, or promoting an affiliated pharmacy to
689 covered persons. Subject to the foregoing, a pharmacy benefit
690 manager may include an affiliated pharmacy in communications to
691 covered persons regarding network pharmacies and prices,
692 provided that the pharmacy benefit manager includes information,
693 such as links to all nonaffiliated network pharmacies, in such
694 communications and that the information provided is accurate and
695 of equal prominence. This paragraph may not be construed to
696 prohibit a pharmacy benefit manager from entering into an

697 agreement with an affiliated pharmacy to provide pharmacist
698 services to covered persons.
699 (e) Prohibit the ability of a pharmacy benefit manager to
700 condition participation in one pharmacy network on participation
701 in any other pharmacy network or penalize a pharmacy for
702 exercising its prerogative not to participate in a specific
703 pharmacy network.
704 (f) Prohibit a pharmacy benefit manager from instituting a
705 network that requires a pharmacy to meet accreditation standards
706 inconsistent with or more stringent than applicable federal and
707 state requirements for licensure and operation as a pharmacy in
708 this state.
709 (3) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A
710 PARTICIPATING PHARMACY.—In addition to other requirements in the
711 Florida Insurance Code, a participation contract executed,
712 amended, adjusted, or renewed on or after July 1, 2023, that
713 applies to pharmacist services on or after January 1, 2024,
714 between a pharmacy benefit manager and one or more pharmacies or
715 pharmacists, must include, in substantial form, terms that
716 ensure compliance with all of the following requirements, and
717 which, except to the extent not allowed by law, shall supersede
718 any contractual terms in the participation contract to the
719 contrary:
720 (a) At the time of adjudication for electronic claims or
721 the time of reimbursement for non-electronic claims, the
722 pharmacy benefit manager shall provide the pharmacy with a
723 remittance, including such detailed information as is necessary
724 for the pharmacy or pharmacist to identify the reimbursement
725 schedule for the specific network applicable to the claim and

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726 which is the basis used by the pharmacy benefit manager to
727 calculate the amount of reimbursement paid. This information
728 must include, but is not limited to, the applicable network
729 reimbursement ID or plan ID as defined in the most current
730 version of the National Council for Prescription Drug Programs
731 (NCPDP) Telecommunication Standard Implementation Guide, or its
732 nationally recognized successor industry guide. The office shall
733 adopt rules to implement this paragraph.
734 (b) The pharmacy benefit manager must ensure that any basis
735 of reimbursement information is communicated to a pharmacy in
736 accordance with the NCPDP Telecommunication Standard
737 Implementation Guide, or its nationally recognized successor
738 industry guide, when performing reconciliation for any effective
739 rate guarantee, and that such basis of reimbursement information
740 communicated is accurate, corresponds with the applicable
741 network rate, and may be relied upon by the pharmacy.
742 (c) A prohibition of financial clawbacks or reconciliation
743 offsets. A pharmacy benefit manager may not recoup direct or
744 indirect remuneration fees, dispensing fees, brand name or
745 generic effective rate adjustments through reconciliation, or
746 any other monetary recoupments as related to discounts, multiple
747 network reconciliation offsets, adjudication transaction fees,
748 and any other instance when a fee may be recouped from a
749 pharmacy. For purposes of this section, the terms “financial
750 clawbacks” or “reconciliation offsets” do not include:
751 1. Any incentive payments provided by the pharmacy benefit
752 manager to a network pharmacy for meeting or exceeding
753 predefined quality measures, such as Healthcare Effectiveness
754 Data and Information Set measures; recoupment due to an

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755 erroneous claim, fraud, waste, or abuse; a claim adjudicated in
756 error; a maximum allowable cost appeal pricing adjustment; or an
757 adjustment made as part of a pharmacy audit pursuant to s.
758 624.491.
759 2. Any recoupment that is returned to the state for
760 programs in chapter 409 or the state group insurance program in
761 s. 110.123.
762 (d) A pharmacy benefit manager may not unilaterally change
763 the terms of any participation contract.
764 (e) The pharmacy benefit manager must provide a pharmacy,
765 upon its request, a list of pharmacy benefits plans or programs
766 in which the pharmacy is a part of the network. Updates to the
767 list must be communicated to the pharmacy within 7 days. The
768 pharmacy benefit manager may not restrict the pharmacy or
769 pharmacist from disclosing this information to the public.
770 (f) The pharmacy benefit manager must ensure that the
771 Electronic Remittance Advice contains claim level payment
772 adjustments in accordance with American National Standards
773 Institute Accredited Standard Committee, X12 format, and must
774 include or be accompanied by the appropriate level of detail for
775 the pharmacy to reconcile any debits or credits, including, but
776 not limited to, pharmacy NCPDP or NPI identifier, date of
777 service, prescription number, refill number, adjustment code, if
778 applicable, and transaction amount.
779 (g) The pharmacy benefit manager shall provide a reasonable
780 administrative appeal procedure to allow a pharmacy or
781 pharmacist to challenge the maximum allowable cost pricing
782 information and the reimbursement made under the maximum
783 allowable cost for a specific drug as being below the

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784 acquisition cost available to the challenging pharmacy or
785 pharmacist.
786 1. The administrative appeal procedure must include a
787 telephone number and e-mail address, or a website, for the
788 purpose of submitting the administrative appeal. The appeal may
789 be submitted directly to the pharmacy benefit manager or through
790 a pharmacy service administration organization. The pharmacy or
791 pharmacist must be given at least 30 business days after a
792 maximum allowable cost update or after an adjudication for an
793 electronic claim or reimbursement for a non-electronic claim to
794 file the administrative appeal.
795 2. The pharmacy benefit manager must respond to the
796 administrative appeal within 30 business days after receipt of
797 the appeal.
798 3. If the appeal is upheld, the pharmacy benefit manager
799 must:
800 a. Update the maximum allowable cost pricing information to
801 at least the acquisition cost available to the pharmacy;
802 b. Permit the pharmacy or pharmacist to reverse and rebill
803 the claim in question;
804 c. Provide to the pharmacy or pharmacist the national drug
805 code on which the increase or change is based; and
806 d. Make the increase or change effective for each similarly
807 situated pharmacy or pharmacist who is subject to the applicable
808 maximum allowable cost pricing information.
809 4. If the appeal is denied, the pharmacy benefit manager
810 must provide to the pharmacy or pharmacist the national drug
811 code and the name of the national or regional pharmaceutical
812 wholesalers operating in this state which have the drug

813 currently in stock at a price below the maximum allowable cost
814 pricing information.
815 5. If the drug with the national drug code provided by the
816 pharmacy benefit manager is not available below the acquisition
817 cost to the pharmacy or pharmacist from the pharmaceutical
818 wholesaler from whom the pharmacy or pharmacist purchases the
819 majority of drugs for resale, the pharmacy benefits manager must
820 adjust the maximum allowable cost pricing information above the
821 acquisition cost to the pharmacy or pharmacist and permit the
822 pharmacy or pharmacist to reverse and rebill each claim affected
823 by the pharmacy's or pharmacist's inability to procure the drug
824 at a cost that is equal to or less than the previously
825 challenged maximum allowable cost.
826 6. Every 90 days, a pharmacy benefit manager shall report
827 to the office the total number of appeals received and denied in
828 the preceding 90-day period for each specific drug for which an
829 appeal was submitted pursuant to this paragraph.
830 Section 11. Section 626.8827, Florida Statutes, is created
831 to read:
832 626.8827 Pharmacy benefit manager prohibited practices.—In
833 addition to other prohibitions in this part, a pharmacy benefit
834 manager may not do any of the following:
835 (1) Prohibit, restrict, or penalize in any way a pharmacy
836 or pharmacist from disclosing to any person any information that
837 the pharmacy or pharmacist deems appropriate, including, but not
838 limited to, information regarding any of the following:
839 (a) The nature of treatment, risks, or alternatives
840 thereto.
841 (b) The availability of alternate treatment, consultations,

842 or tests.
843 (c) The decision of utilization reviewers or similar
844 persons to authorize or deny pharmacist services.
845 (d) The process used to authorize or deny pharmacist
846 services or benefits.
847 (e) Information on financial incentives and structures used
848 by the pharmacy benefits plan or program.
849 (f) Information that may reduce the costs of pharmacist
850 services.
851 (g) Whether the cost-sharing obligation exceeds the retail
852 price for a covered prescription drug and the availability of a
853 more affordable alternative drug, pursuant to s. 465.0244.
854 (2) Prohibit, restrict, or penalize in any way a pharmacy
855 or pharmacist from disclosing information to the office, the
856 Agency for Health Care Administration, Department of Management
857 Services, law enforcement, or state and federal governmental
858 officials, provided that the recipient of the information
859 represents it has the authority, to the extent provided by state
860 or federal law, to maintain proprietary information as
861 confidential; and before disclosure of information designated as
862 confidential, the pharmacist or pharmacy marks as confidential
863 any document in which the information appears or requests
864 confidential treatment for any oral communication of the
865 information.
866 (3) Communicate at the point-of-sale, or otherwise require,
867 a cost-sharing obligation for the covered person in an amount
868 that exceeds the lesser of:
869 (a) The applicable cost-sharing amount under the applicable
870 pharmacy benefits plan or program; or

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871 (b) The usual and customary price, as defined in s.
872 626.8825, of the pharmacist services.
873 (4) Transfer or share records relative to prescription
874 information containing patient-identifiable or prescriber-
875 identifiable data to an affiliated pharmacy for any commercial
876 purpose other than the limited purposes of facilitating pharmacy
877 reimbursement, formulary compliance, or utilization review on
878 behalf of the applicable pharmacy benefits plan or program.
879 (5) Fail to make any payment due to a pharmacy for an
880 adjudicated claim with a date of service before the effective
881 date of a pharmacy's termination from a pharmacy benefit network
882 unless payments are withheld because of actual fraud on the part
883 of the pharmacy or except as otherwise required by law.
884 (6) Terminate the contract of, penalize, or disadvantage a
885 pharmacist or pharmacy due to a pharmacist or pharmacy:
886 (a) Disclosing information about pharmacy benefit manager
887 practices in accordance with this act;
888 (b) Exercising any of its prerogatives under this part; or
889 (c) Sharing any portion, or all, of the pharmacy benefit
890 manager contract with the office pursuant to a complaint or a
891 query regarding whether the contract is in compliance with this
892 act.
893 (7) Fail to comply with the requirements in s. 626.8825.
894 Section 12. Section 626.8828, Florida Statutes, is created
895 to read:
896 626.8828 Investigations and examinations of pharmacy
897 benefit managers; expenses; penalties.—
898 (1) The office may investigate administrators who are
899 pharmacy benefit managers and applicants for authorization as

900 provided in ss. 624.307 and 624.317. The office must review any
901 referral made pursuant to s. 624.307(10) and must investigate
902 any referral that, as determined by the Commissioner of
903 Insurance Regulation or his or her designee, reasonably
904 indicates a possible violation of this part.
905 (2)(a) The office shall examine the business and affairs of
906 each pharmacy benefit manager at least biennially. The biennial
907 examination of each pharmacy benefit manager must be a
908 systematic review for the purpose of determining the pharmacy
909 benefit manager's compliance with all provisions of this part
910 and all other laws or rules applicable to pharmacy benefit
911 managers and must include a detailed review of the pharmacy
912 benefit manager's compliance with ss. 626.8825 and 626.8827. The
913 first 2-year cycle for conducting biennial reviews begins July
914 1, 2023. By January 1 of the year following a 2-year cycle, the
915 office must deliver to the Governor, the President of the
916 Senate, and the Speaker of the House of Representatives a report
917 summarizing the results of the biennial examinations during the
918 most recent 2-year cycle which includes detailed descriptions of
919 any violations committed by each pharmacy benefit manager and
920 detailed reporting of actions taken by the office against each
921 pharmacy benefit manager for such violations.
922 (b) The office also may conduct additional examinations as
923 often as it deems advisable or necessary for the purpose of
924 ascertaining compliance with this part and any other laws or
925 rules applicable to pharmacy benefit managers or applicants for
926 authorization.
927 (c) If a referral made pursuant to s. 624.307(10)
928 reasonably indicates a pattern or practice of violations of this

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929 part by a pharmacy benefit manager, the office must begin an
930 examination of the pharmacy benefit manager or include findings
931 related to such referral within an ongoing examination.
932 (d) Based on the findings of an examination that a pharmacy
933 benefit manager or an applicant for authorization has exhibited
934 a pattern or practice of knowing and willful violations of s.
935 626.8825 or s. 626.8827, the office may, pursuant to chapter
936 120, order a pharmacy benefit manager to file all contracts
937 between the pharmacy benefit manager and pharmacies or pharmacy
938 benefits plans or programs and any policies, guidelines, rules,
939 protocols, standard operating procedures, instructions, or
940 directives that govern or guide the manner in which the pharmacy
941 benefit manager or applicant conducts business related to such
942 knowing and willful violations for review and inspection for the
943 following 36-month period. Such documents are public records and
944 are not trade secrets or otherwise exempt from s. 119.07(1). As
945 used in this section, the term:
946 1. “Contracts” means any contract to which s. 626.8825 is
947 applicable.
948 2. “Knowing and willful” means any act of commission or
949 omission which is committed intentionally, as opposed to
950 accidentally, and which is committed with knowledge of the act’s
951 unlawfulness or with reckless disregard as to the unlawfulness
952 of the act.
953 (e) Examinations may be conducted by an independent
954 professional examiner under contract to the office, in which
955 case payment must be made directly to the contracted examiner by
956 the pharmacy benefit manager examined in accordance with the
957 rates and terms agreed to by the office and the examiner.

958 (3) In making investigations and examinations of pharmacy
959 benefit managers and applicants for authorization, the office
960 and such pharmacy benefit manager is subject to all of the
961 following provisions:
962 (a) Section 624.318, as to the conduct of examinations.
963 (b) Section 624.319, as to examination and investigation
964 reports.
965 (c) Section 624.321, as to witnesses and evidence.
966 (d) Section 624.322, as to compelled testimony.
967 (e) Section 624.324, as to hearings.
968 (f) Section 624.34, as to fingerprinting.
969 (g) Any other provision of chapter 624 applicable to the
970 investigation or examination of a licensee under this part.
971 (4)(a) A pharmacy benefit manager must maintain an accurate
972 record of all contracts and records with all pharmacies and
973 pharmacy benefits plans or programs for the duration of the
974 contract, and for 5 years thereafter. Such contracts must be
975 made available to the office and kept in a form accessible to
976 the office.
977 (b) The office may order any pharmacy benefit manager or
978 applicant to produce any records, books, files, contracts,
979 advertising and solicitation materials, or other information and
980 may take statements under oath to determine whether the pharmacy
981 benefit manager or applicant is in violation of the law or is
982 acting contrary to the public interest.
983 (5)(a) Notwithstanding s. 624.307(3), each pharmacy benefit
984 manager and applicant for authorization must pay to the office
985 the expenses of the examination or investigation. Such expenses
986 include actual travel expenses, reasonable living expense

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987 allowance, compensation of the examiner, investigator, or other
988 person making the examination or investigation, and necessary
989 costs of the office directly related to the examination or
990 investigation. Such travel expense and living expense allowances
991 are limited to those expenses necessarily incurred on account of
992 the examination or investigation and shall be paid by the
993 examined pharmacy benefit manager or applicant together with
994 compensation upon presentation by the office to such pharmacy
995 benefit manager or applicant of such charges and expenses after
996 a detailed statement has been filed by the examiner and approved
997 by the office.
998 (b) All moneys collected from pharmacy benefit managers and
999 applicants for authorization pursuant to this subsection shall
1000 be deposited into the Insurance Regulatory Trust Fund, and the
1001 office may make deposits from time to time into such fund from
1002 moneys appropriated for the operation of the office.
1003 (c) Notwithstanding s. 112.061, the office may pay to the
1004 examiner, investigator, or person making such examination or
1005 investigation out of such trust fund the actual travel expenses,
1006 reasonable living expense allowance, and compensation in
1007 accordance with the statement filed with the office by the
1008 examiner, investigator, or other person, as provided in
1009 paragraph (a).
1010 (6) In addition to any other enforcement authority
1011 available to the office, the office shall impose an
1012 administrative fine of $5,000 for each violation of s. 626.8825
1013 or s. 626.8827. Each instance of a violation of such sections by
1014 a pharmacy benefit manager against each individual pharmacy or
1015 prescription benefits plan or program constitutes a separate

1016 violation. Notwithstanding any other provision of law, there is
1017 no limitation on aggregate fines issued pursuant to this
1018 section. The proceeds from any administrative fine shall be
1019 deposited into the General Revenue Fund.
1020 (7) Failure by a pharmacy benefit manager to pay expenses
1021 incurred or administrative fines imposed under this section is
1022 grounds for the denial, suspension, or revocation of its
1023 certificate of authority.
1024 Section 13. Section 626.89, Florida Statutes, is amended,
1025 to read:
1026 626.89 Annual financial statement and filing fee; notice of
1027 change of ownership; pharmacy benefit manager filings.—
1028 (1) Each authorized administrator shall annually file with
1029 the office a full and true statement of its financial condition,
1030 transactions, and affairs within 3 months after the end of the
1031 administrator’s fiscal year or within such extension of time as
1032 the office for good cause may have granted. The statement must
1033 be for the preceding fiscal year and must be in such form and
1034 contain such matters as the commission prescribes and must be
1035 verified by at least two officers of the administrator.
1036 (2) Each authorized administrator shall also file an
1037 audited financial statement performed by an independent
1038 certified public accountant. The audited financial statement
1039 must ~~shall~~ be filed with the office within 5 months after the
1040 end of the administrator’s fiscal year and be for the preceding
1041 fiscal year. An audited financial statement prepared on a
1042 consolidated basis must include a columnar consolidating or
1043 combining worksheet that must be filed with the statement and
1044 must comply with the following:

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10-00822D-23 20231550__

1045 (a) Amounts shown on the consolidated audited financial
1046 statement must be shown on the worksheet;
1047 (b) Amounts for each entity must be stated separately; and
1048 (c) Explanations of consolidating and eliminating entries
1049 must be included.
1050 (3) At the time of filing its annual statement, the
1051 administrator shall pay a filing fee in the amount specified in
1052 s. 624.501 for the filing of an annual statement by an insurer.
1053 (4) In addition, the administrator shall immediately notify
1054 the office of any material change in its ownership.
1055 (5) A pharmacy benefit manager shall also notify the office
1056 within 15 days after any administrative, civil, or criminal
1057 complaints, settlements, or discipline of the pharmacy benefit
1058 manager or any of its affiliates which relate to a violation of
1059 the insurance laws, including pharmacy benefit laws in any
1060 state.
1061 (6) A pharmacy benefit manager shall also annually submit
1062 to the office a statement attesting to its compliance with the
1063 network requirements of s. 626.8825.
1064 (7) The commission may by rule require all or part of the
1065 statements or filings required under this section to be
1066 submitted by electronic means in a computer-readable form
1067 compatible with the electronic data format specified by the
1068 commission.
1069 Section 14. Subsection (5) is added to section 627.42393,
1070 Florida Statutes, to read:
1071 627.42393 Step-therapy protocol.—
1072 (5) This section applies to a pharmacy benefit manager
1073 acting on behalf of a health insurer.

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1074 Section 15. Subsections (2), (3), and (4) of section
1075 627.64741, Florida Statutes, are amended to read:
1076 627.64741 Pharmacy benefit manager contracts.—
1077 (2) In addition to the requirements of part VII of chapter
1078 626, a contract between a health insurer and a pharmacy benefit
1079 manager must require that the pharmacy benefit manager:
1080 (a) Update maximum allowable cost pricing information at
1081 least every 7 calendar days.
1082 (b) Maintain a process that will, in a timely manner,
1083 eliminate drugs from maximum allowable cost lists or modify drug
1084 prices to remain consistent with changes in pricing data used in
1085 formulating maximum allowable cost prices and product
1086 availability.
1087 ~~(3) A contract between a health insurer and a pharmacy~~
1088 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1089 ~~limiting a pharmacist's ability to disclose whether the cost-~~
1090 ~~sharing obligation exceeds the retail price for a covered~~
1091 ~~prescription drug, and the availability of a more affordable~~
1092 ~~alternative drug, pursuant to s. 465.0244.~~
1093 ~~(4) A contract between a health insurer and a pharmacy~~
1094 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1095 ~~requiring an insured to make a payment for a prescription drug~~
1096 ~~at the point of sale in an amount that exceeds the lesser of:~~
1097 ~~(a) The applicable cost-sharing amount; or~~
1098 ~~(b) The retail price of the drug in the absence of~~
1099 ~~prescription drug coverage.~~
1100 Section 16. Subsections (2), (3), and (4), of section
1101 627.6572, Florida Statutes, are amended to read:
1102 627.6572 Pharmacy benefit manager contracts.—

1103 (2) In addition to the requirements of part VII of chapter
1104 626, a contract between a health insurer and a pharmacy benefit
1105 manager must require that the pharmacy benefit manager:
1106 (a) Update maximum allowable cost pricing information at
1107 least every 7 calendar days.
1108 (b) Maintain a process that will, in a timely manner,
1109 eliminate drugs from maximum allowable cost lists or modify drug
1110 prices to remain consistent with changes in pricing data used in
1111 formulating maximum allowable cost prices and product
1112 availability.
1113 ~~(3) A contract between a health insurer and a pharmacy~~
1114 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1115 ~~limiting a pharmacist's ability to disclose whether the cost-~~
1116 ~~sharing obligation exceeds the retail price for a covered~~
1117 ~~prescription drug, and the availability of a more affordable~~
1118 ~~alternative drug, pursuant to s. 465.0244.~~
1119 ~~(4) A contract between a health insurer and a pharmacy~~
1120 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1121 ~~requiring an insured to make a payment for a prescription drug~~
1122 ~~at the point of sale in an amount that exceeds the lesser of:~~
1123 ~~(a) The applicable cost-sharing amount; or~~
1124 ~~(b) The retail price of the drug in the absence of~~
1125 ~~prescription drug coverage.~~
1126 Section 17. Paragraph (e) is added to subsection (46) of
1127 section 641.31, Florida Statutes, to read:
1128 641.31 Health maintenance contracts.—
1129 (46)
1130 (e) This subsection applies to a pharmacy benefit manager
1131 acting on behalf of a health maintenance organization.

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1132 Section 18. Subsections (2), (3), and (4) of section
1133 641.314, Florida Statutes, are amended to read:
1134 641.314 Pharmacy benefit manager contracts.—
1135 (2) <u>In addition to the requirements of part VII of chapter</u>
1136 <u>626,</u> a contract between a health maintenance organization and a
1137 pharmacy benefit manager must require that the pharmacy benefit
1138 manager:
1139 (a) Update maximum allowable cost pricing information at
1140 least every 7 calendar days.
1141 (b) Maintain a process that will, in a timely manner,
1142 eliminate drugs from maximum allowable cost lists or modify drug
1143 prices to remain consistent with changes in pricing data used in
1144 formulating maximum allowable cost prices and product
1145 availability.
1146 ~~(3) A contract between a health maintenance organization~~
1147 ~~and a pharmacy benefit manager must prohibit the pharmacy~~
1148 ~~benefit manager from limiting a pharmacist's ability to disclose~~
1149 ~~whether the cost-sharing obligation exceeds the retail price for~~
1150 ~~a covered prescription drug, and the availability of a more~~
1151 ~~affordable alternative drug, pursuant to s. 465.0244.~~
1152 ~~(4) A contract between a health maintenance organization~~
1153 ~~and a pharmacy benefit manager must prohibit the pharmacy~~
1154 ~~benefit manager from requiring a subscriber to make a payment~~
1155 ~~for a prescription drug at the point of sale in an amount that~~
1156 ~~exceeds the lesser of:~~
1157 ~~(a) The applicable cost-sharing amount; or~~
1158 ~~(b) The retail price of the drug in the absence of~~
1159 ~~prescription drug coverage.~~
1160 Section 19. Subsection (1) of section 624.491, Florida

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1161 Statutes, is amended to read:
1162 624.491 Pharmacy audits.—
1163 (1) A health insurer or health maintenance organization
1164 providing pharmacy benefits through a major medical individual
1165 or group health insurance policy or a health maintenance
1166 contract, respectively, must comply with the requirements of
1167 this section when the health insurer or health maintenance
1168 organization or any person or entity acting on behalf of the
1169 health insurer or health maintenance organization, including,
1170 but not limited to, a pharmacy benefit manager as defined in s.
1171 626.88 ~~s. 624.490(1)~~, audits the records of a pharmacy licensed
1172 under chapter 465. The person or entity conducting such audit
1173 must:
1174 (a) Except as provided in subsection (3), notify the
1175 pharmacy at least 7 calendar days before the initial onsite
1176 audit for each audit cycle.
1177 (b) Not schedule an onsite audit during the first 3
1178 calendar days of a month unless the pharmacist consents
1179 otherwise.
1180 (c) Limit the duration of the audit period to 24 months
1181 after the date a claim is submitted to or adjudicated by the
1182 entity.
1183 (d) In the case of an audit that requires clinical or
1184 professional judgment, conduct the audit in consultation with,
1185 or allow the audit to be conducted by, a pharmacist.
1186 (e) Allow the pharmacy to use the written and verifiable
1187 records of a hospital, physician, or other authorized
1188 practitioner, which are transmitted by any means of
1189 communication, to validate the pharmacy records in accordance

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1190 with state and federal law.
1191 (f) Reimburse the pharmacy for a claim that was
1192 retroactively denied for a clerical error, typographical error,
1193 scrivener's error, or computer error if the prescription was
1194 properly and correctly dispensed, unless a pattern of such
1195 errors exists, fraudulent billing is alleged, or the error
1196 results in actual financial loss to the entity.
1197 (g) Provide the pharmacy with a copy of the preliminary
1198 audit report within 120 days after the conclusion of the audit.
1199 (h) Allow the pharmacy to produce documentation to address
1200 a discrepancy or audit finding within 10 business days after the
1201 preliminary audit report is delivered to the pharmacy.
1202 (i) Provide the pharmacy with a copy of the final audit
1203 report within 6 months after the pharmacy's receipt of the
1204 preliminary audit report.
1205 (j) Calculate any recoupment or penalties based on actual
1206 overpayments and not according to the accounting practice of
1207 extrapolation.
1208 Section 20. (1) This act establishes requirements for
1209 pharmacy benefit managers as defined in s. 624.490, Florida
1210 Statutes, including, without limitation, pharmacy benefit
1211 managers in their performance of services for or otherwise on
1212 behalf of a pharmacy benefits plan or program providing coverage
1213 pursuant to Titles XVIII, XIX, or XXI of the Social Security
1214 Act, 42 U.S.C. ss. 1395 et seq., 1396 et seq., and 1397aa et
1215 seq., known as Medicare, Medicaid, or any other similar coverage
1216 under a state or Federal Government funded health plan,
1217 including the Statewide Medicaid Managed Care program
1218 established pursuant to part IV of chapter 409, Florida

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1219 Statutes, and the state group insurance program pursuant to part
1220 I of chapter 110, Florida Statutes.
1221 (2) This act is not intended, nor may it be construed, to
1222 conflict with existing, relevant federal law.
1223 (3) If any provision of this act or its application to any
1224 person or circumstances is held invalid, the invalidity does not
1225 affect other provisions or applications of this act which can be
1226 given effect without the invalid provision or application, and
1227 to this end the provisions of this act are severable.
1228 Section 21. The sum of $1.5 million is hereby appropriated
1229 to the Office of Insurance Regulation to implement this act.
1230 Section 22. This act shall take effect July 1, 2023.