A bill to be entitled

An act relating to pharmacies and pharmacy benefit managers; amending s. 624.3161, F.S.; requiring the Office of Insurance Regulation to examine pharmacy benefit managers under certain circumstances; specifying that certain examination costs are payable by persons examined; transferring, renumbering, and amending s. 465.1885, F.S.; revising the entities conducting pharmacy audits to which certain requirements and restrictions apply; authorizing audited pharmacies to appeal certain findings; providing that health insurers and health maintenance organizations that transfer a certain payment obligation to pharmacy benefit managers remain responsible for specified violations; amending ss. 627.6131 and 641.3155, F.S.; revising the definition of the term "claim" and providing a definition for the term "pharmacy claim"; providing an exception to applicability; making technical changes; prohibiting pharmacy benefit managers from charging pharmacists and pharmacies certain fees and from retroactively denying, holding back, and reducing payments for covered claims; requiring that the Department of Financial Services be given access to certain records, data, and information; authorizing the department to

investigate certain violations; providing penalties; providing applicability; amending ss. 627.64741, 627.6572, and 641.314, F.S.; revising the definition of the term "maximum allowable cost"; requiring contracts between pharmacy benefit managers and individual health insurers, group health insurers, and health maintenance organizations, respectively, to prohibit pharmacy benefit managers from charging pharmacists certain fees and from retroactively denying, holding back, and reducing payments for covered claims; requiring that the department be given access to certain records, data, and information; authorizing the department to investigate certain violations; providing penalties; authorizing the office to require individual health insurers, group health insurers, and health maintenance organizations, respectively, to submit to the office certain contracts or contract amendments entered into with pharmacy benefit managers; authorizing the office to order individual health insurers, group health insurers, and health maintenance organizations, respectively, to cancel such contracts under certain circumstances; authorizing the Financial Services Commission to adopt rules; revising applicability; amending s. 627.6699, F.S.; requiring certain health

benefit plans covering small employers to comply with specified provisions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (1) and (3) of section 624.3161, Florida Statutes, are amended to read:

624.3161 Market conduct examinations.—

(1) As often as it deems necessary, the office shall examine each pharmacy benefit manager as defined in s. 624.490; each licensed rating organization; ~~,~~ each advisory organization; ~~,~~ each group, association, carrier ~~,~~ as defined in s. 440.02, or other organization of insurers which engages in joint underwriting or joint reinsurance; ~~,~~ and each authorized insurer transacting in this state any class of insurance to which the provisions of chapter 627 are applicable. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of chapters 440, 624, 626, 627, and 635.

(3) The examination may be conducted by an independent professional examiner under contract to the office, in which case payment shall be made directly to the contracted examiner by the insurer or person examined in accordance with the rates and terms agreed to by the office and the examiner.

Section 2. Section 465.1885, Florida Statutes, is

transferred, renumbered as section 624.491, Florida Statutes, and amended to read:

624.491 ~~465.1885~~ Pharmacy audits~~; rights~~.—

(1) A health insurer or health maintenance organization providing pharmacy benefits through a major medical individual or group health insurance policy or a health maintenance contract, respectively, shall comply with the requirements of this section when the insurer or health maintenance organization or any person or entity acting on behalf of the insurer or health maintenance organization, including, but not limited to, a pharmacy benefit manager as defined in s. 624.490, audits the records of a pharmacy licensed under chapter 465. The person or entity conducting such audit must ~~If an audit of the records of a pharmacy licensed under this chapter is conducted directly or indirectly by a managed care company, an insurance company, a third-party payor, a pharmacy benefit manager, or an entity that represents responsible parties such as companies or groups, referred to as an "entity" in this section, the pharmacy has the following rights~~:

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

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

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

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

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

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

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

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

(i) Provide the pharmacy with a copy of ~~To receive~~ the

final audit report within 6 months after receipt of ~~receiving~~ the preliminary audit report.

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

(2) ~~The rights contained in~~ This section does ~~do~~ not apply to:

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

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

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

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

(4) Pursuant to s. 408.7057, and after receipt of the final audit report issued by the health insurer or health

maintenance organization, a pharmacy may appeal the findings of the final audit as to whether a claim payment is due and as to the amount of a claim payment.

(5) A health insurer or health maintenance organization that, under terms of a contract, transfers to a pharmacy benefit manager the obligation to pay any pharmacy licensed under chapter 465 for any pharmacy benefit claims arising from services provided to or for the benefit of any insured or subscriber remains responsible for any violations of this section, s. 627.6131, or s. 641.3155, as applicable.

Section 3. Subsections (18) and (19) of section 627.6131, Florida Statutes, are renumbered as subsections (19) and (20), respectively, subsections (2), (15), (16), and (17) are amended, and a new subsection (18) is added to that section, to read:

627.6131 Payment of claims.—

(2)(a) ~~(2)~~ As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the insurer's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, the term "claim" means a paper or electronic billing instrument submitted

to the insurer's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

(b) However, if the context so indicates, the term "claim" or "pharmacy claim" means a paper or electronic billing instrument submitted to a pharmacy benefit manager acting on behalf of a health insurer.

(15) Except for subsection (18), this section is applicable only to a major medical expense health insurance policy as defined in s. 627.643(2)(e) offered by a group or an individual health insurer licensed pursuant to chapter 624, including a preferred provider policy under s. 627.6471 and an exclusive provider organization under s. 627.6472 or a group or individual insurance contract that only provides direct payments to dentists for enumerated dental services.

(16) Notwithstanding paragraph (4)(b), if ~~where~~ an electronic pharmacy claim is submitted to a pharmacy benefit ~~benefits~~ manager acting on behalf of a health insurer, the pharmacy benefit ~~benefits~~ manager shall, within 30 days after ~~of~~ receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(17) Notwithstanding paragraph (5)(a), if ~~effective~~

~~November 1, 2003, where~~ a nonelectronic pharmacy claim is submitted to a pharmacy benefit ~~benefits~~ manager acting on behalf of a health insurer, the pharmacy benefit ~~benefits~~ manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

(18)(a) A pharmacy benefit manager may not:

1. Charge a pharmacist or pharmacy a fee related to the payment of a pharmacy claim, including, but not limited to, a fee for:

a. The submission of the claim;

b. The pharmacist's or pharmacy's enrollment or participation in a retail pharmacy network; or

c. The processing or transmission of the claim; or

2. Retroactively deny, hold back, or reduce payment for a covered claim after payment for the claim.

(b)1. The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health insurers or other providers using the pharmacy benefit management services in the state.

2. The department may investigate an alleged violation of this subsection, and a pharmacy benefit manager who violates

this subsection is liable for a civil fine of $10,000 for each violation.

(c) This subsection applies to contracts entered into, amended, or renewed on or after July 1, 2021.

Section 4. Section 627.64741, Florida Statutes, is amended to read:

627.64741 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug which:~~,~~

1. Is as specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand name drug, biological product, or specialty drug;

2. Must be based on pricing published in the Medi-Span Master Drug Database or, if the pharmacy benefit manager uses only First Databank (FDB) MedKnowledge, on pricing published in FDB MedKnowledge;

3. Excludes ~~excluding~~ dispensing fees; and~~,~~

4. Is determined before ~~prior to~~ the application of copayments, coinsurance, and other cost-sharing charges, if any.

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

to residents of this state.

(2) A health insurer may contract only with a pharmacy benefit manager that satisfies all of the following conditions ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

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

(b) Maintains ~~Maintain~~ a process that ~~will~~, in a timely manner, will eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c) ~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1. ~~(a)~~ The applicable cost-sharing amount; or

2. ~~(b)~~ The retail price of the drug in the absence of

prescription drug coverage.

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from:

(a) Charging a pharmacist a fee related to the payment of a pharmacy claim, including, but not limited to, a fee for:

1. The submission of the claim;

2. The pharmacist's enrollment or participation in a retail pharmacy network; or

3. The processing or transmission of the claim; or

(b) Retroactively denying, holding back, or reducing payment for a covered claim after payment for the claim.

The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health insurers or other providers using the pharmacy benefit management services in the state. The department may investigate an alleged violation of this subsection, and a pharmacy benefit manager who violates this subsection is liable for a civil fine of $10,000 for each violation.

(4) The office may require a health insurer to submit to the office any contract or amendment to a contract for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(5) After review of a contract submitted under subsection (4), the office may order the health insurer to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exists:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with this section or any other provision of the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office as required under s. 624.490.

(6) The commission may adopt rules to administer this section.

(7) ~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2021 ~~2018~~.

Section 5. Section 627.6572, Florida Statutes, is amended to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug which:~~,~~

1. Is as specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand name drug, biological product, or specialty drug;

2. Must be based on pricing published in the Medi-Span Master Drug Database or, if the pharmacy benefit manager uses only First Databank (FDB) MedKnowledge, on pricing published in FDB MedKnowledge;

3. Excludes ~~excluding~~ dispensing fees; and~~,~~

4. Is determined before ~~prior to~~ the application of copayments, coinsurance, and other cost-sharing charges, if any.

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

(2) A health insurer may contract only with a pharmacy benefit manager that satisfies all of the following conditions ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

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

(b) Maintains ~~Maintain~~ a process that ~~will~~, in a timely manner, will eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices

and product availability.

(c) ~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1. ~~(a)~~ The applicable cost-sharing amount; or

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

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from:

(a) Charging a pharmacist a fee related to the payment of a pharmacy claim, including, but not limited to, a fee for:

1. The submission of the claim;

2. The pharmacist's enrollment or participation in a retail pharmacy network; or

3. The processing or transmission of the claim; or

(b) Retroactively denying, holding back, or reducing payment for a covered claim after payment for the claim.

The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health insurers or other providers using the pharmacy benefit management services in the state. The department may investigate an alleged violation of this subsection, and a pharmacy benefit manager who violates this subsection is liable for a civil fine of $10,000 for each violation.

(4) The office may require a health insurer to submit to the office any contract or amendment to a contract for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(5) After review of a contract submitted under subsection (4), the office may order the health insurer to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exists:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with this section or any

other provision of the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office as required under s. 624.490.

(6) The commission may adopt rules to administer this section.

(7) ~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2021 ~~2018~~.

Section 6. Paragraph (h) is added to subsection (5) of section 627.6699, Florida Statutes, to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(h) A health benefit plan covering small employers which is issued, amended, or renewed in this state on or after July 1, 2021, must comply with s. 627.6572.

Section 7. Section 641.314, Florida Statutes, is amended to read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug which: ~~,~~

1. Is as specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand name drug, biological product, or specialty drug;

2. Must be based on pricing published in the Medi-Span Master Drug Database or, if the pharmacy benefit manager uses only First Databank (FDB) MedKnowledge, on pricing published in FDB MedKnowledge;

3. Excludes ~~Excluding~~ dispensing fees; and~~,~~

4. Is determined before ~~prior to~~ the application of copayments, coinsurance, and other cost-sharing charges, if any.

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

(2) A health maintenance organization may contract only with a pharmacy benefit manager that satisfies all of the following conditions ~~A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

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

(b) Maintains ~~Maintain~~ a process that ~~will~~, in a timely manner, will eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c)~~(3)~~ Does not limit ~~A contract between a health maintenance organization and a pharmacy benefit manager must~~

~~prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ a subscriber to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1. ~~(a)~~ The applicable cost-sharing amount; or

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

(3) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from:

(a) Charging a pharmacist a fee related to the payment of a pharmacy claim, including, but not limited to, a fee for:

1. The submission of the claim;

2. The pharmacist's enrollment or participation in a retail pharmacy network; or

3. The processing or transmission of the claim; or

(b) Retroactively denying, holding back, or reducing payment for a covered claim after payment for the claim.

The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health maintenance organizations or other providers using the pharmacy benefit management services in the state. The department may investigate an alleged violation of this subsection, and a pharmacy benefit manager who violates this subsection is liable for a civil fine of $10,000 for each violation.

(4) The office may require a health maintenance organization to submit to the office any contract or amendment to a contract for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the health maintenance organization.

(5) After review of a contract submitted under subsection (4), the office may order the health maintenance organization to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exists:

(a) The fees to be paid by the health maintenance organization are so unreasonably high as compared with similar contracts entered into by health maintenance organizations, or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances, that the contract is detrimental to the subscribers of the health

maintenance organization.

(b) The contract does not comply with this section or any other provision of the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office as required under s. 624.490.

(6) The commission may adopt rules to administer this section.

(7) ~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2021 ~~2018~~.

Section 8. Subsections (16) and (17) of section 641.3155, Florida Statutes, are renumbered as subsections (17) and (18), respectively, subsections (1), (14), and (15) are amended, and a new subsection (16) is added to that section, to read:

641.3155 Prompt payment of claims.—

(1)(a) ~~(1)~~ As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, the term "claim" means a paper or electronic billing instrument submitted to the health

maintenance organization's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

(b) However, if the context so indicates, the term "claim" or "pharmacy claim" means a paper or electronic billing instrument submitted to a pharmacy benefit manager acting on behalf of a health maintenance organization.

(14) Notwithstanding paragraph (3)(b), if ~~where~~ an electronic pharmacy claim is submitted to a pharmacy benefit ~~benefits~~ manager acting on behalf of a health maintenance organization, the pharmacy benefit ~~benefits~~ manager shall, within 30 days after ~~of~~ receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(15) Notwithstanding paragraph (4)(a), if ~~effective November 1, 2003, where~~ a nonelectronic pharmacy claim is submitted to a pharmacy benefit ~~benefits~~ manager acting on behalf of a health maintenance organization, the pharmacy benefit ~~benefits~~ manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

(16)(a) A pharmacy benefit manager may not:

1. Charge a pharmacist or pharmacy a fee related to the payment of a pharmacy claim, including, but not limited to, a fee for:

a. The submission of the claim;

b. The pharmacist's or pharmacy's enrollment or participation in a retail pharmacy network; or

c. The processing or transmission of the claim; or

2. Retroactively deny, hold back, or reduce payment for a covered claim after payment for the claim.

(b)1. The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health maintenance organizations or other providers using the pharmacy benefit management services in the state.

2. The department may investigate an alleged violation of this subsection, and a pharmacy benefit manager who violates this subsection is liable for a civil fine of $10,000 for each violation.

(c) This subsection applies to contracts entered into, amended, or renewed on or after July 1, 2021.

Section 9. This act shall take effect July 1, 2021.