

By Senator Wright

14-00934-19

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1 A bill to be entitled
2 An act relating to prescribed drug services and
3 audits; creating s. 465.1871, F.S.; prohibiting
4 attorneys from engaging in misleading advertisement
5 related to medicinal drugs; providing causes of
6 action; providing penalties; providing a timeframe for
7 actions for recovery; amending s. 465.1885, F.S.;
8 defining terms; providing applicability; providing
9 requirements for pharmacy contracts and auditing
10 entities; revising the timeframe for notice of audit;
11 revising the rights that pharmacies have if audits are
12 conducted; prohibiting audits from considering as
13 fraud any clerical and recordkeeping error; limiting
14 charge-backs and recoupments; excluding dispensing
15 fees from calculations of overpayment; requiring
16 auditing entities to be responsible for costs
17 associated with audits; prohibiting auditing entities
18 from compensating certain employees or contractors;
19 providing penalties; requiring auditing entities to
20 state the reason for the audits under certain
21 circumstances; revising the timeframes of audit
22 periods; revising the timeframe for the delivery of
23 the preliminary audit report; revising the
24 requirements for pharmacies to address discrepancies
25 or audit findings; requiring the Office of Insurance
26 Regulation to establish an appeals process; creating
27 s. 624.491, F.S.; defining terms; requiring pharmacy
28 benefit managers to provide the office with an annual
29 report; providing report requirements; prohibiting

14-00934-19

2019906__

30 publication or disclosure of certain information;
31 requiring the office to publish certain information;
32 creating s. 624.495, F.S.; defining the term "pharmacy
33 services administration organization" or "PSAO";
34 requiring registration of pharmacy services
35 administration organizations with the office;
36 providing registration and reporting requirements;
37 requiring the office to issue registration
38 certificates under certain circumstances; authorizing
39 the Financial Services Commission to adopt rules;
40 amending s. 627.42392, F.S.; defining terms; revising
41 the circumstances under which health insurers and
42 pharmacy benefit managers are required to use prior
43 authorization forms for specified purposes; requiring
44 health insurers and pharmacy benefit managers to
45 establish and offer an online prior authorization
46 process; providing requirements for the process;
47 creating s. 627.42393, F.S.; providing definitions;
48 requiring health insurers to publish and provide to
49 insureds a procedure for exemptions from fail first
50 policies; providing requirements for the procedure;
51 providing requirements for authorization or denial of
52 policy exemptions; amending ss. 627.64741, 627.6572,
53 and 641.314, F.S.; requiring pharmacy benefit managers
54 to publish a list of certain drugs on their websites;
55 providing requirements for the publication; extending
56 the applicability date; creating ss. 627.64742,
57 627.66998, and 641.3924, F.S.; defining terms;
58 requiring health insurers and health maintenance

14-00934-19

2019906__

59 organizations to disclose to enrollees and prospective
60 enrollees or to subscribers and prospective
61 subscribers, respectively, that they are subject to
62 excess cost sharing under certain circumstances;
63 providing duties for health insurers and health
64 maintenance organizations; prohibiting disclosure of
65 specified information; providing an effective date.
66

67 Be It Enacted by the Legislature of the State of Florida:
68

69 Section 1. Section 465.1871, Florida Statutes, is created
70 to read:

71 465.1871 Attorney liability for misleading advertisement.-

72 (1) An attorney may not engage in misleading legal services
73 advertisement related to medicinal drugs. A legal services
74 advertisement is misleading if the advertisement does any of the
75 following:

76 (a) Fails to disclose at the beginning of the
77 advertisement: "This is a paid advertisement for legal
78 services."

79 (b) Presents the advertisement as a "medical alert,"
80 "health alert," "consumer alert," or "public service
81 announcement," or as any similar term.

82 (c) Displays the logo of a federal or state government
83 agency in a manner that suggests an affiliation with the agency
84 or the sponsorship of that agency.

85 (d) Uses the word "recall" when referring to a product that
86 has not been recalled either by a government agency or through
87 an agreement between the manufacturer and a government agency.

14-00934-19

2019906__

88 (e) Fails to identify the sponsor of the advertisement.

89 (f) Fails to indicate the identity of the attorney who or
90 law firm that will represent the client, or how cases will be
91 referred to an attorney who or law firm that will represent the
92 client if the sponsor of the advertisement may not represent
93 persons responding to the advertisement.

94 (2) A person who ceases to follow medical advice relating
95 to medicinal drugs because of misleading legal services
96 advertising as described in subsection (1) has a cause of action
97 for double the amount of actual damages against the attorney who
98 engaged in the misleading legal services advertisement.

99 (3) A person who ceases to follow medical advice relating
100 to medicinal drugs because of legal services advertising related
101 to medicinal drugs, whether the advertisement is misleading or
102 not, has a cause of action against the attorney who engaged in
103 the legal services advertisement.

104 (4) An action under this section may be brought in any
105 court of competent jurisdiction to recover compensatory damages
106 against the attorney who engages in legal services advertising;
107 however, the plaintiff may not recover damages twice for the
108 same injury. An action for recovery under this section must
109 commence within 2 years after the time the legal services
110 advertising last occurs.

111 Section 2. Section 465.1885, Florida Statutes, is amended
112 to read:

113 (Substantial rewording of section. See
114 s. 465.1885, F.S., for present text.)
115 465.1885 Pharmacy audits.—

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

14-00934-19

2019906__

117 (a) "Health benefit plan" means any individual or group
118 plan, employee welfare benefit plan, policy, or contract for
119 health care services issued, delivered, issued for delivery, or
120 renewed in this state by a health care insurer, health
121 maintenance organization, accident and sickness insurer,
122 fraternal benefit society, nonprofit hospital service
123 corporation, nonprofit medical services corporation, health care
124 service plan, or any other person, firm, corporation, joint
125 venture, or other similar business entity that pays for insureds
126 or beneficiaries in this state.

127 (b) "Pharmacy benefit management plan" means an arrangement
128 for the delivery of pharmacy services in which a pharmacy
129 benefit manager undertakes to administer the payment or
130 reimbursement of any of the costs of pharmacy services for an
131 enrollee on a prepaid or insured basis that contains one or more
132 incentive arrangements intended to influence the cost or level
133 of pharmacy services between the plan sponsor and one or more
134 pharmacies with respect to the delivery of pharmacy services.
135 The pharmacy benefit management plan also requires or creates a
136 benefit payment differential for enrollees to use under contract
137 with the pharmacy benefit manager.

138 (c) "Pharmacy benefit manager" means a business that
139 administers the prescription drug or device portion of pharmacy
140 benefit management plans or health insurance plans on behalf of
141 plan sponsors, insurance companies, unions, and health
142 maintenance organizations. The term includes a person or entity
143 acting for a pharmacy benefit manager in a contractual or an
144 employment relationship in the performance of pharmacy benefit
145 management for a managed care company, nonprofit hospital or

14-00934-19

2019906__

146 medical services organization, insurance company, or other
147 third-party payor.

148 (d) "Pharmacy services" means the offering for sale,
149 compounding, or dispensing of drugs, chemicals, or poisons
150 pursuant to a prescription. The term also includes the sale or
151 provision of, fitting of, or counseling on medical devices,
152 including prosthetics and durable medical equipment.

153 (2) (a) This section applies to any audit of the records of
154 a pharmacy, except Medicaid-related records, which is conducted
155 by a managed care company, a nonprofit hospital or medical
156 services organization, a health benefit plan, a third-party
157 payor, a pharmacy benefit manager, a health program administered
158 by an agency of the state, or any entity that represents those
159 companies, groups, or agencies.

160 (b) A health benefit plan located or domiciled outside of
161 this state is subject to this section if it receives, processes,
162 adjudicates, pays, or denies claims for health care services
163 submitted by or on behalf of patients, insureds, or
164 beneficiaries who reside in this state.

165 (3) A pharmacy contract must identify and describe in
166 detail the audit procedures, and the entity conducting an audit
167 shall follow these procedures.

168 (4) An entity conducting an audit shall give the pharmacy
169 written notice at least 4 weeks before conducting the initial
170 audit for each audit cycle. If the auditing entity is a pharmacy
171 benefit manager and if the auditing entity does not include its
172 auditing guidelines in its provider manual, the notice must
173 include a documented checklist of all items being audited and
174 the manual, including the name, date, and edition or volume,

14-00934-19

2019906__

175 applicable to the audit and auditing guidelines. For onsite
176 audits, a pharmacy benefit manager must also provide a list of
177 materials that are copied or removed during the course of an
178 audit. The pharmacy benefit manager may document these materials
179 on a checklist or an audit acknowledgment form. The pharmacy
180 must produce any items during the course of the audit or within
181 30 days after the audit.

182 (5) An entity conducting an audit may not interfere with
183 the delivery of pharmacy services to a patient and shall use
184 every effort to minimize inconvenience and disruption to
185 pharmacy operations during the audit process.

186 (6) An audit that involves clinical or professional
187 judgment must be conducted by or in consultation with a
188 pharmacist licensed in this state.

189 (7) The audit may not consider as fraud any clerical or
190 recordkeeping error, such as a typographical error, a
191 scrivener's error, or a computer error regarding a required
192 document or record; however, such errors may be subject to
193 recoupment if the errors resulted in overpayment to the
194 pharmacy. The pharmacy has the right to submit amended claims
195 through an online submission to correct clerical or
196 recordkeeping errors in lieu of recoupment if no actual
197 financial harm to the patient or plan has occurred and if the
198 prescription was dispensed according to the prescription
199 documentation requirements set forth in the Florida Pharmacy Act
200 and within the plan limits. The pharmacy is not subject to
201 recoupment of funds by the pharmacy benefit manager unless the
202 pharmacy benefit manager can provide proof of intent to commit
203 fraud or such error results in actual financial harm to the

14-00934-19

2019906__

204 pharmacy benefit manager, a health insurance plan managed by the
205 pharmacy benefit manager, or a consumer. A person is not subject
206 to criminal penalties for errors provided for in this subsection
207 without proof of intent to commit fraud, waste, or abuse.

208 (a) Any amount to be charged back or recouped due to
209 overpayment must not exceed the amount the pharmacy was
210 overpaid.

211 (b) The auditing entity may not include the dispensing fee
212 in the calculation of an overpayment unless a prescription is a
213 misfill. As used in this paragraph, the term "misfill" means a
214 prescription that was not dispensed, a prescription in which the
215 prescriber denied the authorization request, a prescription in
216 which an additional dispensing fee was charged, or a
217 prescription error by the pharmacy.

218 (8) The auditing entity may not use extrapolation to
219 calculate penalties or amounts to be charged back or recouped
220 unless otherwise required by federal requirements or federal
221 plans.

222 (9) The auditing entity may not require any documentation
223 that is not required by state or federal law. The information is
224 considered valid if documented on the prescription, computerized
225 treatment notes, pharmacy system, or other acceptable medical
226 records.

227 (10) Unless superseded by state or federal law, auditors
228 may have access only to previous audit reports on a particular
229 pharmacy conducted by the auditing entity for the same pharmacy
230 benefit manager, health plan, or insurer. An auditing vendor
231 contracting with multiple pharmacy benefit managers or health
232 insurance plans may not use audit reports or other information

14-00934-19

2019906__

233 gained from an audit on a particular pharmacy to conduct another
234 audit for a different pharmacy benefit manager or health
235 insurance plan.

236 (11) Audit results must be disclosed to the health benefit
237 plan in a manner pursuant to contractual terms.

238 (12) A pharmacy may use the records of a hospital,
239 physician, or other authorized practitioner of the healing arts
240 for drugs or medicinal supplies written or transmitted by any
241 means of communication for the purposes of validating the
242 pharmacy record with respect to orders or refills of a legend or
243 narcotic drug.

244 (13) (a) If the pharmacy benefit manager or its
245 representative conducts an audit, the sample size must not be
246 greater than 150 prescriptions. A refill does not constitute a
247 separate prescription for the purposes of this subsection.

248 (b) The audit must be a true representation of the billing
249 of the pharmacy to the pharmacy benefit manager. The sampling
250 for the audit must be random, with the average cost per
251 prescription audited, and may not be more than the average
252 prescription billed to the pharmacy benefit manager during that
253 period. The random process of how these prescriptions were
254 selected must be provided to the pharmacy.

255 (14) Reasonable costs associated with the audit must be the
256 responsibility of the auditing entity if the claims sample
257 exceeds 100 unique prescription hard copies.

258 (15) (a) The auditing entity may not compensate an employee
259 or contractor with which the auditing entity contracts to
260 conduct the pharmacy audit based on the amount claimed or the
261 actual amount recouped by the pharmacy being audited.

14-00934-19

2019906__

262 (b) The license of any auditing entity that violates
263 paragraph (a) may be denied, suspended, or revoked upon proof of
264 such violation.

265 (16) A finding of an overpayment must not include the cost
266 of the drugs that were dispensed in accordance with the
267 prescriber's orders, if the prescription was dispensed according
268 to prescription documentation requirements set forth by the
269 Florida Pharmacy Act and within the plan limits. A finding of an
270 overpayment may not include the dispensing fee as specified in
271 paragraph (7) (b).

272 (17) For a finding of an underpayment due to package size
273 or other clerical error, the pharmacy benefit manager shall make
274 the pharmacy whole and shall allow the pharmacy to reprocess for
275 underpayment.

276 (18) (a) Each pharmacy must be audited under the same
277 standards and parameters as other similarly situated pharmacies
278 audited by the entity and must be audited under rules applicable
279 to the contractor and time period of the prescription.

280 (b) If the auditing entity is a pharmacy benefit manager,
281 the entity must state, as requested by the Office of Insurance
282 Regulation, the reason for which the audit was initiated, such
283 as random or suspected fraud.

284 (19) When not superseded by state or federal law, the
285 period covered by an audit must not exceed 6 months after the
286 date on which the claim was submitted to or adjudicated by a
287 managed care company, a nonprofit hospital or medical services
288 organization, a health benefit plan, a third-party payor, a
289 pharmacy benefit manager, a health program administered by an
290 agency of the state, or any entity that represents those

14-00934-19

2019906__

291 companies, groups, or agencies. An audit may not be conducted 6
292 months after the date on which the pharmacy benefit management
293 plan terminated its contract to adjudicate claims with a
294 pharmacy benefit manager, health plan administrator, or any
295 other entity representing those companies.

296 (20) An audit may not be initiated or scheduled during the
297 first 5 calendar days of any month.

298 (21) The auditing entity shall provide the pharmacy with a
299 written report of the audit and shall comply with all of the
300 following requirements:

301 (a) The preliminary audit report must be delivered to the
302 pharmacy within 30 days after the conclusion of the audit, with
303 a reasonable extension to be granted upon request.

304 (b) The pharmacy must be allowed at least 60 days after
305 receipt of the preliminary audit report to produce documentation
306 to address any discrepancy found during the audit, with a
307 reasonable extension to be granted upon request.

308 (c) The auditing entity shall deliver the final report to
309 the pharmacy within 30 days after sending out the preliminary
310 audit report or within 30 days after receiving a final appeal,
311 whichever is later.

312 (d) The auditor or auditors assigned to the audit shall
313 sign the audit documents. The auditor shall sign the
314 acknowledgment or receipt, and the audit report must contain
315 clear contact information of the representative of the auditing
316 organization.

317 (22) Recoupment of any disputed funds, or repayment of
318 funds to the entity by the pharmacy if permitted pursuant to
319 contractual agreement, must occur after final internal

14-00934-19

2019906__

320 disposition of the audit, including the appeals process.

321 (a) Recoupment must be billed to the pharmacy, and the
322 pharmacy must be given reasonable time to make interest-free
323 payment, not to exceed 2 years after final disposition of the
324 audit.

325 (b) If the identified discrepancy for an individual audit
326 exceeds \$25,000, future payments in excess of that amount to the
327 pharmacy may be withheld pending finalization of the audit.

328 (23) Interest must not accrue during the audit period.

329 (24) The auditing entity shall provide a copy of the final
330 audit report, after completion of any review process, to the
331 plan sponsor in a manner pursuant to a contract.

332 (25) The Office of Insurance Regulation shall establish a
333 written appeals process under which a pharmacy may appeal an
334 unfavorable preliminary audit report to the entity. Following
335 the appeal:

336 (a) If the auditing entity finds that an unfavorable audit
337 report or any portion thereof is unsubstantiated, the entity
338 shall dismiss the audit report or that portion without the
339 necessity of any further action.

340 (b) If any of the issues raised in the appeal are not
341 resolved to the satisfaction of either party, an unsatisfied
342 party may ask the Office of Insurance Regulation to enforce the
343 provisions of the insurance code and applicable rules as they
344 relate to the review of policy contracts and associated rates.
345 The cost of mediation shall be borne by agreement of the parties
346 or by the decision of the office.

347 Section 3. Section 624.491, Florida Statutes, is created to
348 read:

14-00934-19

2019906__

349 624.491 Pharmacy benefit manager disclosures.-

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

351 (a) "Administrative fee" means a fee paid or a payment made
352 by a pharmaceutical manufacturer to a pharmacy benefit manager
353 or its designee, or a fee or payment retained by a pharmacy
354 benefit manager or its designee, pursuant to a contract between
355 the pharmacy benefit manager and the pharmaceutical manufacturer
356 in connection with the pharmacy benefit manager's administering,
357 invoicing, allocating, and collecting rebates.

358 (b) "Aggregate retained-rebate percentage" means the
359 percentage of all rebates received by a pharmacy benefit manager
360 from all pharmaceutical manufacturers which is not passed on to
361 the pharmacy benefit manager's health plan or issuer clients.
362 The percentage is calculated by dividing the aggregate dollar
363 amount of rebates that the pharmacy benefit manager received
364 during the prior calendar year from all pharmaceutical
365 manufacturers which was not passed on to the pharmacy benefit
366 manager's health plan or issuer clients by the aggregate dollar
367 amount of rebates that the pharmacy benefit manager received
368 during the prior calendar year from all pharmaceutical
369 manufacturers.

370 (c) "Health plan" means a policy, contract, certification,
371 or agreement offered or issued by an issuer to provide, deliver,
372 arrange for, pay for, or reimburse any of the costs of health
373 services.

374 (d) "Issuer" means an authorized health insurer or health
375 maintenance organization that offers one or more health plans
376 delivered or issued to deliver to any person in this state.

377 (e) "Issuer administrative service fee" means a fee paid or

14-00934-19

2019906__

378 a payment made by an issuer or its designee to a pharmacy
379 benefit manager, or a fee or payment retained by a pharmacy
380 benefit manager, pursuant to a contract between the pharmacy
381 benefit manager and the issuer or the issuer's designee in
382 connection with the pharmacy benefit manager's managing or
383 administering the pharmacy benefit and administering, invoicing,
384 allocating, and collecting rebates.

385 (f) "Pharmacy benefit manager" has the same meaning as in
386 s. 624.490(1).

387 (g) "Rebate" means a rebate, discount, or price concession
388 that is based on the use or price of a prescription drug and
389 that is paid by a pharmaceutical manufacturer or an entity other
390 than the patient, directly or indirectly, to a pharmacy benefit
391 manager after the pharmacy benefit manager adjudicates the
392 claim. Rebates include price protection rebates and a reasonable
393 estimate of volume-based discounts or other discounts.

394 (2) Beginning January 1, 2020, and by January 1 of each
395 year thereafter, a pharmacy benefit manager shall provide the
396 office with a report containing all of the following information
397 from the prior calendar year:

398 (a) The aggregate dollar amount of all administrative fees
399 that the pharmacy benefit manager received.

400 (b) The aggregate dollar amount of all administrative fees
401 that the pharmacy benefit manager received and did not pass on
402 to health plans or to issuers.

403 (c) The aggregate dollar amount of all issuer
404 administrative service fees that the pharmacy benefit manager
405 received.

406 (d) The aggregate dollar amount of rebates that the

14-00934-19

2019906__

407 pharmacy benefit manager received from all pharmaceutical
408 manufacturers.

409 (e) The aggregate dollar amount of rebates that the
410 pharmacy benefit manager received from all pharmaceutical
411 manufacturers and did not pass on to health plans or issuers.

412 (f) The aggregate retained-rebate percentage.

413 (g) Across all of the pharmacy benefit manager's
414 contractual relationships or other relationships with all health
415 plans and issuers, the highest aggregate retained-rebate
416 percentage and the lowest aggregate retained-rebate percentage.

417 (3) The pharmacy benefit manager may not publish or
418 otherwise disclose any information that would reveal the
419 identity of a specific health plan, the price charged for a
420 specific drug or class of drugs, or the amount of any rebates
421 provided for a specific drug or class of drugs. Any such
422 information is protected from disclosure as confidential and
423 proprietary information and is not subject to public records
424 requirements under s. 119.07(1) or s. 24(a), Art. I of the State
425 Constitution.

426 (4) The office shall publish in a timely manner the
427 information that it receives under subsection (2) on a publicly
428 available website. However, the office may not publish or
429 disclose any information that is considered a trade secret under
430 s. 624.4213.

431 Section 4. Section 624.495, Florida Statutes, is created to
432 read:

433 624.495 Registration of pharmacy services administration
434 organizations.—

435 (1) As used in this section, the term "pharmacy services

14-00934-19

2019906__

436 administration organization” or “PSAO” means a person or entity
437 doing business in this state which contracts with independent
438 pharmacies to represent these pharmacies or to provide them with
439 a broad range of services. Services provided by PSAOs are
440 intended to achieve administrative efficiencies, including
441 contract and payment efficiencies, for both member pharmacies
442 and third-party payors, or third-party payors’ pharmacy benefit
443 managers, as defined in s. 624.490. A PSAO’s services may
444 include, but are not limited to:

445 (a) Negotiating and contracting with third-party payors on
446 behalf of member pharmacies.

447 (b) Contracting with pharmacy benefit managers that are
448 used by third-party payors.

449 (c) Communicating information to member pharmacies
450 regarding contractual and regulatory requirements.

451 (d) Providing general and claims-specific assistance to
452 member pharmacies by means of a help desk or a dedicated staff
453 person.

454 (e) Providing other services to help member pharmacies
455 interact with third-party payors or with third-party payors’
456 pharmacy benefit managers, such as managing and analyzing
457 payment and drug-dispensing data to identify claims that are
458 unpaid or incorrectly paid by third-party payors.

459 (2) Effective January 1, 2021, to conduct business in this
460 state, a PSAO must register with the office. To initially
461 register or to renew a registration, a PSAO must submit all of
462 the following:

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

14-00934-19

2019906__

465 (b) A completed registration form adopted by the commission
466 containing:

467 1. The name and address of the registrant; and

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

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

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

478 (5) A registration certificate is valid for 2 years after
479 its date of issuance.

480 (6) The commission may adopt rules to implement this
481 section.

482 Section 5. Section 627.42392, Florida Statutes, is amended
483 to read:

484 627.42392 Prior authorization.—

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

486 (a) "Electronic prior authorization process" does not
487 include transmissions through a facsimile machine.

488 (b) "Health insurer" means an authorized insurer offering
489 health insurance as defined in s. 624.603, a managed care plan
490 as defined in s. 409.962(10), or a health maintenance
491 organization as defined in s. 641.19(12).

492 (2) Notwithstanding any other provision of law, effective
493 January 1, 2017, or 6 ~~six~~ ~~(6)~~ months after the effective date of

14-00934-19

2019906__

494 the rule adopting the prior authorization form, whichever is
495 later, a health insurer, or a pharmacy benefit ~~benefits~~ manager
496 on behalf of the health insurer, ~~which does not provide an~~
497 ~~electronic prior authorization process for use by its contracted~~
498 ~~providers,~~ shall only use the prior authorization form that has
499 been approved by the Financial Services Commission for granting
500 a prior authorization for a medical procedure, course of
501 treatment, or prescription drug benefit. Such form may not
502 exceed two pages in length, excluding any instructions or
503 guiding documentation, and must include all clinical
504 documentation necessary for the health insurer to make a
505 decision. At a minimum, the form must include:

506 (a) ~~(1)~~ Sufficient patient information to identify the
507 member, date of birth, full name, and Health Plan ID number;

508 (b) ~~(2)~~ The provider's ~~provider~~ name, address, and phone
509 number;

510 (c) ~~(3)~~ The medical procedure, course of treatment, or
511 prescription drug benefit being requested, including the medical
512 reason therefor, and all services tried and failed;

513 (d) ~~(4)~~ Any laboratory documentation required; and

514 (e) ~~(5)~~ An attestation that all information provided is true
515 and accurate.

516 (3) The Financial Services Commission in consultation with
517 the Agency for Health Care Administration shall adopt by rule
518 guidelines for all prior authorization forms which ensure the
519 general uniformity of such forms.

520 (4) Electronic prior authorization approvals do not
521 preclude benefit verification or medical review by the insurer
522 under either the medical or pharmacy benefits.

14-00934-19

2019906__

523 (5) Beginning January 1, 2020, a health insurer, or a
524 pharmacy benefit manager on behalf of the health insurer, must
525 establish and offer a secure, interactive online electronic
526 prior authorization process for accepting electronic prior
527 authorization forms. The process must allow a person seeking
528 prior authorization the ability to upload documentation if such
529 documentation is required by the health insurer or pharmacy
530 benefit manager to adjudicate the prior authorization request.

531 Section 6. Section 627.42393, Florida Statutes, is created
532 to read:

533 627.42393 Fail first policies.—

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

535 (a) "Fail first policy" means a written protocol that
536 specifies the order in which a medical procedure, course of
537 treatment, or prescription drug must be used to treat an
538 insured's condition.

539 (b) "Health insurer" has the same meaning as in s.
540 627.42392(1).

541 (c) "Policy exemption" means a determination by a health
542 insurer that a fail first policy is not medically appropriate or
543 indicated for treatment for an insured's condition and that the
544 health insurer authorizes the use of another medical procedure,
545 course of treatment, or prescription prescribed or recommended
546 by the treating health care provider for the insured's
547 condition.

548 (d) "Preceding prescription drug or medical treatment"
549 means a medical procedure, course of treatment, or prescription
550 drug that must be used pursuant to a health insurer's fail first
551 policy as a condition of coverage under a health insurance

14-00934-19

2019906__

552 policy or a health maintenance contract to treat an insured's
553 condition.

554 (e) "Urgent care situation" means an injury or condition of
555 an insured which, if medical care and treatment are not provided
556 earlier than the time generally considered by the medical
557 profession to be reasonable for a nonurgent situation, in the
558 opinion of the insured's treating health care provider, would:

559 1. Seriously jeopardize the insured's life, health, or
560 ability to regain maximum function; or

561 2. Subject the insured to severe pain that cannot be
562 adequately managed.

563 (2) A health insurer must publish on its website and
564 provide to an insured in writing a procedure for an insured and
565 health care provider to request a policy exemption. The
566 procedure must include all of the following:

567 (a) A description of the manner in which the insured or
568 health care provider may request a policy exemption.

569 (b) The manner and timeframe in which the health insurer is
570 required to authorize or deny a policy exemption request or
571 respond to an appeal of the health insurer's denial of a
572 request.

573 (c) The conditions under which the policy exemption must be
574 granted.

575 (3) (a) The health insurer must authorize or deny a policy
576 exemption request or respond to an appeal of the health
577 insurer's authorization or denial of a request within:

578 1. Seventy-two hours after obtaining a completed prior
579 authorization form for a nonurgent care situation; or

580 2. Twenty-four hours after obtaining a completed prior

14-00934-19

2019906__

581 authorization form for an urgent care situation.

582 (b) An authorization of the request must specify the
583 approved medical procedure, course of treatment, or prescription
584 drug benefits. The health insurer must grant a policy exemption
585 request if the insured has previously received a preceding
586 prescription drug or medical treatment that is in the same
587 pharmacologic class or has the same mechanism of action, and
588 such drug or treatment lacked efficacy or effectiveness or
589 adversely affected the insured.

590 (c) A denial of the request must include a detailed,
591 written explanation of the reason for the denial, the clinical
592 rationale that supports the denial, and the procedure to appeal
593 the health insurer's determination.

594 (4) The health insurer may request a copy of relevant
595 documentation from the insured's medical record in support of a
596 policy exemption request.

597 Section 7. Present subsection (5) of section 627.64741,
598 Florida Statutes, is redesignated as subsection (6) and amended,
599 and a new subsection (5) is added to that section, to read:

600 627.64741 Pharmacy benefit manager contracts.—

601 (5) Beginning July 1, 2020, for all the plans it manages
602 for health insurers or health maintenance organizations, a
603 pharmacy benefit manager must publish an up-to-date, accurate,
604 and complete list of all covered drugs on the plans' formulary
605 drug lists, including any tiered structure that it has adopted
606 and any restriction on the manner in which a drug may be
607 obtained. The formulary drug list must be easily accessible to
608 the general public for viewing.

609 (a) The list must be on the pharmacy benefit manager's

14-00934-19

2019906__

610 website and must be easily accessible through a clearly
611 identifiable link or tab, without requiring an individual to
612 create or access an account or to enter a policy number.

613 (b) If the pharmacy benefit manager manages more than one
614 plan for one or more health maintenance organizations or health
615 insurers, an individual must be able to easily discern which
616 formulary drug list applies to which plan.

617 (6)~~(5)~~ This section applies to contracts entered into or
618 renewed on or after July 1, 2020 ~~July 1, 2018~~.

619 Section 8. Section 627.64742, Florida Statutes, is created
620 to read:

621 627.64742 Cost-sharing fairness.—

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

623 (a) "Enrollee" means an individual who is covered under a
624 health insurance policy.

625 (b) "Excess cost sharing" means a deductible, copayment, or
626 coinsurance amount charged to an enrollee for a covered
627 prescription drug which is greater than the amount that the
628 enrollee's health insurance policy issuer would pay absent that
629 enrollee's cost sharing, after accounting for rebates.

630 (c) "Health insurance policy" means a policy, contract,
631 certification, or agreement offered or issued by an issuer to
632 provide, deliver, arrange for, pay for, or reimburse any of the
633 costs of health services.

634 (d) "Issuer" means an authorized health insurer that offers
635 one or more health insurance policies to any person in this
636 state.

637 (e) "Rebate" means:

638 1. A negotiated price concession, including, but not

14-00934-19

2019906__

639 limited to, a base rebate and a reasonable estimate of price
640 protection rebates and performance-based rebates, which may
641 accrue directly or indirectly to the issuer during the coverage
642 year from a manufacturer, dispensing pharmacy, or other party to
643 the transaction; and

644 2. A reasonable estimate of any fee and administrative cost
645 that are passed on to the issuer and serve to reduce the
646 issuer's prescription drug liabilities for the coverage year.

647 (2) An issuer that plans to charge enrollees cost-sharing
648 amounts that could result in excess cost sharing for a covered
649 prescription drug must disclose to enrollees and prospective
650 enrollees the fact that enrollees could be subject to such
651 excess cost sharing. Such notice must be provided in health
652 insurance policy documents, including, but not limited to, in
653 evidence of coverage materials, formulary or preferred drug
654 guides, and all marketing materials.

655 (3) An issuer must strive to make available to enrollees at
656 the point of sale an amount greater than 50 percent of the
657 rebates.

658 (4) An issuer shall annually report to the office whether
659 it made more than 50 percent of the rebates available to its
660 enrollees during the prior benefit year.

661 (5) In making the required disclosures and in offering
662 certifications under this section, an issuer may not publish or
663 otherwise reveal information regarding the amount of rebates it
664 receives, including, but not limited to, information regarding
665 the amount of rebates it receives on a product-, manufacturer-,
666 or pharmacy-specific basis. Such information is protected as a
667 trade secret under applicable law, is not subject to public

14-00934-19

2019906

668 records requirements under s. 119.07(1) or s. 24(a), Art. I of
669 the State Constitution, and may not be disclosed directly or
670 indirectly. An issuer shall impose the confidentiality
671 protections of this subsection on a vendor or downstream third
672 party that performs health care or administrative services on
673 behalf of the issuer and may receive or have access to rebate
674 information.

675 Section 9. Present subsection (5) of section 627.6572,
676 Florida Statutes, is redesignated as subsection (6) and amended,
677 and a new subsection (5) is added to that section, to read:

678 627.6572 Pharmacy benefit manager contracts.—

679 (5) Beginning July 1, 2020, for all the plans it manages
680 for health insurers or health maintenance organizations, a
681 pharmacy benefit manager must publish an up-to-date, accurate,
682 and complete list of all covered drugs on the plans' formulary
683 drug lists, including any tiered structure that it has adopted
684 and any restriction on the manner in which a drug can be
685 obtained. The formulary drug list must be easily accessible to
686 the general public for viewing.

687 (a) The list must be on the pharmacy benefit manager's
688 website and must be easily accessible through a clearly
689 identifiable link or tab, without requiring an individual to
690 create or access an account or enter a policy number.

691 (b) If the pharmacy benefit manager manages more than one
692 plan for one or more health maintenance organizations or health
693 insurers, an individual must be able to easily discern which
694 formulary drug list applies to which plan.

695 (6)~~(5)~~ This section applies to contracts entered into or
696 renewed on or after July 1, 2020 ~~July 1, 2018~~.

14-00934-19

2019906__

697 Section 10. Section 627.66998, Florida Statutes, is created
698 to read:

699 627.66998 Cost-sharing fairness.-

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

701 (a) "Enrollee" means an individual who is covered under a
702 health benefit plan policy.

703 (b) "Excess cost sharing" means a deductible, copayment, or
704 coinsurance amount charged to an enrollee for a covered
705 prescription drug which is greater than the amount that the
706 enrollee's health benefit plan issuer would pay absent that
707 enrollee's cost sharing, after accounting for rebates.

708 (c) "Health benefit plan" means a policy, contract,
709 certification, or agreement offered or issued by an issuer to
710 provide, deliver, arrange for, pay for, or reimburse any of the
711 costs of health services.

712 (d) "Issuer" means an authorized health insurer that offers
713 one or more health benefit plans to any person in this state.

714 (e) "Rebate" means:

715 1. A negotiated price concession, including, but not
716 limited to, a base rebate and a reasonable estimate of price
717 protection rebates and performance-based rebates, which may
718 accrue directly or indirectly to the issuer during the coverage
719 year from a manufacturer, dispensing pharmacy, or other party to
720 the transaction; and

721 2. A reasonable estimate of any fee and administrative cost
722 that are passed on to the issuer and serve to reduce the
723 issuer's prescription drug liabilities for the coverage year.

724 (2) An issuer that plans to charge enrollees cost-sharing
725 amounts that could result in excess cost sharing for a covered

14-00934-19

2019906__

726 prescription drug must disclose to enrollees and prospective
727 enrollees the fact that enrollees could be subject to such
728 excess cost sharing. Such notice must be provided in health
729 benefit plan documents, including, but not limited to, in
730 evidence of coverage materials, formulary or preferred drug
731 guides, and all marketing materials.

732 (3) An issuer must strive to make available to enrollees at
733 the point of sale an amount greater than 50 percent of the
734 rebates.

735 (4) An issuer shall annually report to the office whether
736 it made more than 50 percent of the rebates available to the
737 enrollees during the prior benefit year.

738 (5) In making the required disclosures and in offering
739 certifications under this section, an issuer may not publish or
740 otherwise reveal information regarding the amount of rebates it
741 receives, including, but not limited to, information regarding
742 the amount of rebates it receives on a product-, manufacturer-,
743 or pharmacy-specific basis. Such information is protected as a
744 trade secret under applicable law, is not subject to public
745 records requirements under s. 119.07(1) or s. 24(a), Art. I of
746 the State Constitution, and may not be disclosed directly or
747 indirectly. An issuer shall impose the confidentiality
748 protections of this subsection on a vendor or downstream third
749 party that performs health care or administrative services on
750 behalf of the issuer and may receive or have access to rebate
751 information.

752 Section 11. Present subsection (5) of section 641.314,
753 Florida Statutes, is redesignated as subsection (6) and amended,
754 and a new subsection (5) is added to that section, to read:

14-00934-19

2019906__

755 641.314 Pharmacy benefit manager contracts.—

756 (5) Beginning July 1, 2020, for all the plans it manages
757 for health insurers or health maintenance organizations, a
758 pharmacy benefit manager must publish an up-to-date, accurate,
759 and complete list of all covered drugs on the plans' formulary
760 drug lists, including any tiered structure that it has adopted
761 and any restriction on the manner in which a drug can be
762 obtained. The formulary drug list must be easily accessible to
763 the general public for viewing.

764 (a) The list must be on the pharmacy benefit manager's
765 website and must be easily accessible through a clearly
766 identifiable link or tab, without requiring an individual to
767 create or access an account or enter a policy number.

768 (b) If the pharmacy benefit manager manages more than one
769 plan for one or more health maintenance organizations or health
770 insurers, an individual must be able to easily discern which
771 formulary drug list applies to which plan.

772 (6)~~(5)~~ This section applies to contracts entered into or
773 renewed on or after July 1, 2020 ~~July 1, 2018~~.

774 Section 12. Section 641.3924, Florida Statutes, is created
775 to read:

776 641.3924 Cost-sharing fairness.—

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

778 (a) "Excess cost sharing" means a deductible, copayment, or
779 coinsurance amount charged to a subscriber for a covered
780 prescription drug which is greater than the amount that the
781 subscriber's health benefit plan issuer would pay absent that
782 subscriber's cost sharing, after accounting for rebates.

783 (b) "Issuer" means a health maintenance organization that

14-00934-19

2019906__

784 offers one or more health benefit plans to any person in this
785 state.

786 (c) "Rebate" means:

787 1. A negotiated price concession, including, but not
788 limited to, a base rebate and a reasonable estimate of price
789 protection rebates and performance-based rebates, which may
790 accrue directly or indirectly to the issuer during the coverage
791 year from a manufacturer, dispensing pharmacy, or other party to
792 the transaction; and

793 2. A reasonable estimate of any fee and administrative cost
794 that are passed on to the issuer and serve to reduce the
795 issuer's prescription drug liabilities for the coverage year.

796 (2) An issuer that plans to charge subscribers cost-sharing
797 amounts that could result in excess cost sharing for a covered
798 prescription drug must disclose to subscribers and prospective
799 subscribers the fact that subscribers could be subject to such
800 excess cost sharing. Such notice must be provided in health
801 maintenance contract documents, including, but not limited to,
802 in evidence of coverage materials, formulary or preferred drug
803 guides, and all marketing materials.

804 (3) An issuer must strive to make available to subscribers
805 at the point of sale an amount greater than 50 percent of the
806 rebates.

807 (4) An issuer shall annually report to the office whether
808 it made more than 50 percent of the rebates available to the
809 subscribers during the prior benefit year.

810 (5) In making the required disclosures under this section,
811 an issuer may not publish or otherwise reveal information
812 regarding the amount of rebates it receives, including, but not

14-00934-19

2019906__

813 limited to, information regarding the amount of rebates it
814 receives on a product-, manufacturer-, or pharmacy-specific
815 basis. Such information is protected as a trade secret under
816 applicable law, is not subject to public records requirements
817 under s. 119.07(1) or s. 24(a), Art. I of the State
818 Constitution, and may not be disclosed directly or indirectly.
819 An issuer shall impose the confidentiality protections of this
820 subsection on a vendor or downstream third party that performs
821 health care or administrative services on behalf of the issuer
822 and may receive or have access to rebate information.

823 Section 13. This act shall take effect January 1, 2020.