

By Senator Wright

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1 A bill to be entitled
2 An act relating to prescription drug coverage;
3 amending s. 624.3161, F.S.; authorizing the Office of
4 Insurance Regulation to examine pharmacy benefit
5 managers; specifying that certain examination costs
6 are payable by persons examined; transferring,
7 renumbering, and amending s. 465.1885, F.S.; revising
8 entities conducting pharmacy audits to which certain
9 requirements and restrictions apply; authorizing
10 audited pharmacies to appeal certain findings;
11 providing that health insurers and health maintenance
12 organizations that transfer a certain payment
13 obligation to pharmacy benefit managers remain
14 responsible for certain violations; creating s.
15 624.491, F.S.; providing applicability; requiring
16 health insurers and health maintenance organizations,
17 or pharmacy benefit managers on behalf of health
18 insurers and health maintenance organizations, to
19 annually report specified information to the office;
20 requiring reporting pharmacy benefit managers to also
21 provide the information to health insurers and health
22 maintenance organizations they contract with;
23 authorizing the Financial Services Commission to adopt
24 rules; amending ss. 627.64741, 627.6572, and 641.314,
25 F.S.; defining and redefining terms; specifying
26 requirements relating to brand-name and generic drugs
27 in contracts between pharmacy benefit managers and
28 pharmacies or pharmacy services administration
29 organizations; requiring an agreement for pharmacy

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30 benefit managers to pass through certain financial
31 benefits to the individual or group health insurer or
32 health maintenance organization, respectively;
33 authorizing the office to require health insurers or
34 health maintenance organizations to submit certain
35 contracts or contract amendments to the office;
36 authorizing the office to order insurers or health
37 maintenance organizations to cancel such contracts
38 under certain circumstances; authorizing the
39 commission to adopt rules; revising applicability;
40 providing an effective date.

41
42 Be It Enacted by the Legislature of the State of Florida:

43
44 Section 1. Subsections (1) and (3) of section 624.3161,
45 Florida Statutes, are amended to read:

46 624.3161 Market conduct examinations.—

47 (1) As often as it deems necessary, the office shall
48 examine each pharmacy benefit manager, each licensed rating
49 organization, each advisory organization, each group,
50 association, carrier, as defined in s. 440.02, or other
51 organization of insurers which engages in joint underwriting or
52 joint reinsurance, and each authorized insurer transacting in
53 this state any class of insurance to which the provisions of
54 chapter 627 are applicable. The examination shall be for the
55 purpose of ascertaining compliance by the person examined with
56 the applicable provisions of chapters 440, 624, 626, 627, and
57 635.

58 (3) The examination may be conducted by an independent

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59 professional examiner under contract to the office, in which
 60 case payment shall be made directly to the contracted examiner
 61 by the insurer or person examined in accordance with the rates
 62 and terms agreed to by the office and the examiner.

63 Section 2. Section 465.1885, Florida Statutes, is
 64 transferred, renumbered as s. 624.491, Florida Statutes, and
 65 amended to read:

66 624.491 ~~465.1885~~ Pharmacy audits; rights.—

67 (1) A health insurer or health maintenance organization
 68 providing pharmacy benefits through a major medical individual
 69 or group health insurance policy or health maintenance contract,
 70 respectively, shall comply with the requirements of this section
 71 when the insurer or health maintenance organization or any
 72 entity acting on behalf of the insurer or health maintenance
 73 organization, including, but not limited to, a pharmacy benefit
 74 manager, audits the records of a pharmacy licensed under chapter
 75 465. Such audit must comply with the following requirements ~~if~~
 76 an audit of the records of a pharmacy licensed under this
 77 chapter is conducted directly or indirectly by a managed care
 78 company, an insurance company, a third-party payor, a pharmacy
 79 benefit manager, or an entity that represents responsible
 80 parties such as companies or groups, referred to as an "entity"
 81 in this section, the pharmacy has the following rights:

82 (a) The pharmacy must ~~To~~ be notified at least 7 calendar
 83 days before the initial onsite audit for each audit cycle.

84 (b) An ~~To have the~~ onsite audit may not be scheduled during
 85 after the first 3 calendar days of a month unless the pharmacist
 86 consents otherwise.

87 (c) The scope of ~~To have~~ the audit period must be limited

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88 to 24 months after the date a claim is submitted to or
89 adjudicated by the entity.

90 (d) ~~To have~~ An audit that requires clinical or professional
91 judgment must be conducted by or in consultation with a
92 pharmacist.

93 (e) A pharmacy may ~~To~~ use the written and verifiable
94 records of a hospital, physician, or other authorized
95 practitioner, which are transmitted by any means of
96 communication, to validate the pharmacy records in accordance
97 with state and federal law.

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

104 (g) A copy of ~~To receive~~ the preliminary audit report must
105 be provided to the pharmacy within 120 days after the conclusion
106 of the audit.

107 (h) A pharmacy may ~~To~~ produce documentation to address a
108 discrepancy or audit finding within 10 business days after the
109 preliminary audit report is delivered to the pharmacy.

110 (i) A copy of ~~To receive~~ the final audit report must be
111 provided to the pharmacy within 6 months after receipt of
112 ~~receiving~~ the preliminary audit report.

113 (j) Any ~~To have~~ recoupment or penalties must be calculated
114 based on actual overpayments and not according to the accounting
115 practice of extrapolation.

116 (2) ~~The rights contained in~~ This section does ~~de~~ not apply

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117 to:

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

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

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

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

134 (4) Pursuant to s. 408.7057 and after receipt of the final
135 audit report issued by the health insurer or health maintenance
136 organization, a pharmacy may appeal the findings of the final
137 audit as to whether a claim payment is due or the amount of a
138 claim payment.

139 (5) If a health insurer or health maintenance organization
140 transfers to a pharmacy benefit manager through a contract the
141 obligation to pay any pharmacy licensed under chapter 465 for
142 any pharmacy benefit claims arising from services provided to or
143 for the benefit of any insured or subscriber, the health insurer
144 or health maintenance organization remains responsible for any
145 violations of this section, s. 627.6131, or s. 641.3155.

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146 Section 3. Section 624.491, Florida Statutes, is created to
147 read:

148 624.491 Health insurer, health maintenance organization,
149 and pharmacy benefit manager reporting requirements.-

150 (1) This section applies to:

151 (a) A health insurer or health maintenance organization
152 issuing, delivering, or issuing for delivery comprehensive major
153 medical individual or group insurance policies or health
154 maintenance contracts, respectively, in this state; and

155 (b) A pharmacy benefit manager providing pharmacy benefit
156 management services on behalf of a health insurer or health
157 maintenance organization described in paragraph (a) and managing
158 prescription drug coverage under a contract with the health
159 insurer or health maintenance organization.

160 (2) By March 1 annually, a health insurer or health
161 maintenance organization, or a pharmacy benefit manager on
162 behalf of a health insurer or health maintenance organization,
163 shall report, in a form and manner as prescribed by the
164 commission, the following information to the office with respect
165 to services provided by the health insurer or health maintenance
166 organization, or the pharmacy benefit manager on behalf of the
167 insurer or health maintenance organization, for the immediately
168 preceding policy or contract year:

169 (a) The total number of prescriptions that were dispensed.

170 (b) The number and percentage of all prescriptions that
171 were provided through retail pharmacies compared to mail-order
172 pharmacies. This paragraph applies to pharmacies licensed under
173 chapter 465 which dispense drugs to the general public and which
174 were paid by the health insurer, health maintenance

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175 organization, or pharmacy benefit manager under the contract.

176 (c) For retail pharmacies and mail-order pharmacies
177 described in paragraph (b), the general dispensing rate, which
178 is the number and percentage of prescriptions for which a
179 generic drug was available and dispensed.

180 (d) The aggregate amount and types of rebates, discounts,
181 price concessions, or other earned revenues that the health
182 insurer, health maintenance organization, or pharmacy benefit
183 manager negotiated for and are attributable to patient
184 utilization under the plan, excluding bona fide service fees
185 that include, but are not limited to, distribution service fees,
186 inventory management fees, product stocking allowances, and fees
187 associated with administrative services agreements and patient
188 care programs.

189 (e) If negotiated by the pharmacy benefit manager, the
190 aggregate amount of the rebates, discounts, or price concessions
191 under paragraph (d) which were passed through to the health
192 insurer or health maintenance organization.

193 (f) If the health insurer or health maintenance
194 organization contracted with a pharmacy benefit manager, the
195 aggregate amount of the difference between the amount the health
196 insurer or health maintenance organization paid the pharmacy
197 benefit manager and the amount the pharmacy benefit manager paid
198 retail pharmacies and mail order pharmacies.

199 (3) A pharmacy benefit manager that reports the information
200 under subsection (2) to the office shall also provide the
201 information to the health insurer or health maintenance
202 organization with which the pharmacy benefit manager is under
203 contract.

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204 (4) The commission may adopt rules to administer this
 205 section.

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

208 627.64741 Pharmacy benefit manager contracts.—

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

210 (a) "Brand-name drug" means a drug that:

211 1. Is a brand drug described by Medi-Span and has a
 212 multisource code field containing an "M" (cobranded product), an
 213 "O" (originator brand), or an "N" (single-source brand), except
 214 for a drug with a multisource code of "O" and a Dispense as
 215 Written code of 3, 4, 5, 6, or 9; or

216 2. Has an equivalent brand drug designation in the First
 217 Databank FDB MedKnowledge database.

218 (b) "Generic drug" means a drug that:

219 1. Is a generic drug described by Medi-Span and has a
 220 multisource code field containing a "Y" (generic), or an "O" and
 221 a Dispense as Written code of 3, 4, 5, 6, or 9; or

222 2. Has an equivalent generic drug designation in the First
 223 Databank FDB MedKnowledge database.

224 (c) "Maximum allowable cost" means the per-unit amount that
 225 a pharmacy benefit manager reimburses a pharmacist for a
 226 prescription drug;

227 1. As specified at the time of claim processing and
 228 directly or indirectly reported on the initial remittance advice
 229 of an adjudicated claim for a generic drug, brand-name drug,
 230 biological product, or specialty drug;

231 2. Which amount must be based on pricing published in the
 232 Medi-Span Master Drug Database, or, if the pharmacy benefit

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233 manager uses only First Databank FDB MedKnowledge, must be based
234 on pricing published in First Databank FDB MedKnowledge; and

235 3. ~~7~~ Excluding dispensing fees, prior to the application of
236 copayments, coinsurance, and other cost-sharing charges, if any.

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

241 (2) A health insurer may contract only with a pharmacy
242 benefit manager that ~~A contract between a health insurer and a~~
243 ~~pharmacy benefit manager must require that the pharmacy benefit~~
244 ~~manager:~~

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

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

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

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

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262 exceeds the lesser of:

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

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

266 (3) A drug identified as a brand-name drug must be
267 considered a brand-name drug for all purposes under an
268 agreement, contract, or amendment to a contract between a
269 pharmacy benefit manager and a pharmacy, or a pharmacy services
270 administration organization on behalf of the pharmacy. A single-
271 source generic drug with only one manufacturer must be
272 reimbursed as if it were a brand-name drug.

273 (4) A drug identified as a generic drug must be considered
274 a generic drug for all purposes under an agreement, contract, or
275 amendment to a contract between a pharmacy benefit manager and a
276 pharmacy, or a pharmacy services administrative organization
277 acting on behalf of the pharmacy. The pharmacy benefit manager
278 and the pharmacy, or a pharmacy services administrative
279 organization on behalf of the pharmacy, shall agree that if the
280 pharmacy benefit manager is provided any rebate or other
281 financial benefit for any drug identified as a generic drug, the
282 pharmacy benefit manager must pass through all such rebates or
283 other financial benefits to the health insurer.

284 (5) The office may require a health insurer to submit to
285 the office any contract, or amendments to a contract, for the
286 administration or management of prescription drug benefits by a
287 pharmacy benefit manager on behalf of the insurer.

288 (6) After review of a contract under subsection (5), the
289 office may order the insurer to cancel the contract in
290 accordance with the terms of the contract and applicable law if

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291 the office determines that any of the following conditions
292 exist:

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

298 (b) The contract does not comply with the Florida Insurance
299 Code.

300 (c) The pharmacy benefit manager is not registered with the
301 office pursuant to s. 624.490.

302 (7) The commission may adopt rules to administer this
303 section.

304 (8)~~(5)~~ This section applies to contracts entered into,
305 amended, or renewed on or after July 1, 2020 ~~2018~~.

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

308 627.6572 Pharmacy benefit manager contracts.—

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

310 (a) "Brand-name drug" means a drug that:

311 1. Is a brand drug described by Medi-Span and has a
312 multisource code field containing an "M" (cobranded product), an
313 "O" (originator brand), or an "N" (single-source brand), except
314 for a drug with a multisource code of "O" and a Dispense as
315 Written code of 3, 4, 5, 6, or 9; or

316 2. Has an equivalent brand drug designation in the First
317 Databank FDB MedKnowledge database.

318 (b) "Generic drug" means a drug that:

319 1. Is a generic drug described by Medi-Span and has a

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320 multisource code field containing a "Y" (generic), or an "O" and
321 a Dispense as Written code of 3, 4, 5, 6, or 9; or

322 2. Has an equivalent generic drug designation in the First
323 Databank FDB MedKnowledge database.

324 (c) "Maximum allowable cost" means the per-unit amount that
325 a pharmacy benefit manager reimburses a pharmacist for a
326 prescription drug;

327 1. As specified at the time of claim processing and
328 directly or indirectly reported on the initial remittance advice
329 of an adjudicated claim for a generic drug, brand-name drug,
330 biological product, or specialty drug;

331 2. Which amount must be based on pricing published in the
332 Medi-Span Master Drug Database, or, if the pharmacy benefit
333 manager uses only First Databank FDB MedKnowledge, must be based
334 on pricing published in First Databank FDB MedKnowledge; and

335 3. ~~7~~ Excluding dispensing fees, prior to the application of
336 copayments, coinsurance, and other cost-sharing charges, if any.

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

341 (2) A health insurer may contract only with a pharmacy
342 benefit manager that ~~A contract between a health insurer and a~~
343 ~~pharmacy benefit manager must require that the pharmacy benefit~~
344 ~~manager:~~

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

347 (b) ~~Maintains~~ Maintain a process that will, in a timely
348 manner, eliminate drugs from maximum allowable cost lists or

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349 modify drug prices to remain consistent with changes in pricing
350 data used in formulating maximum allowable cost prices and
351 product availability.

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

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

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

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

366 (3) A drug identified as a brand-name drug must be
367 considered a brand-name drug for all purposes under an
368 agreement, contract, or amendment to a contract between a
369 pharmacy benefit manager and pharmacy, or a pharmacy services
370 administration organization on behalf of the pharmacy. A single-
371 source generic drug with only one manufacturer must be
372 reimbursed as if it were a brand-name drug.

373 (4) A drug identified as a generic drug must be considered
374 a generic drug for all purposes under an agreement, contract, or
375 amendment to a contract between a pharmacy benefit manager and a
376 pharmacy, or a pharmacy services administrative organization
377 acting on behalf of the pharmacy. The pharmacy benefit manager

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378 and the pharmacy, or a pharmacy services administrative
379 organization on behalf of the pharmacy, shall agree that if the
380 pharmacy benefit manager is provided any rebate or other
381 financial benefit for any drug identified as a generic drug, the
382 pharmacy benefit manager must pass through all such rebates or
383 other financial benefits to the health insurer.

384 (5) The office may require a health insurer to submit to
385 the office any contract, or amendments to a contract, for the
386 administration or management of prescription drug benefits by a
387 pharmacy benefit manager on behalf of the insurer.

388 (6) After review of a contract under subsection (5), the
389 office may order the insurer to cancel the contract in
390 accordance with the terms of the contract and applicable law if
391 the office determines that any of the following conditions
392 exist:

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

398 (b) The contract does not comply with the Florida Insurance
399 Code.

400 (c) The pharmacy benefit manager is not registered with the
401 office pursuant to s. 624.490.

402 (7) The commission may adopt rules to administer this
403 section.

404 (8)~~(5)~~ This section applies to contracts entered into,
405 amended, or renewed on or after July 1, 2020 ~~2018~~.

406 Section 6. Section 641.314, Florida Statutes, is amended to

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407 read:

408 641.314 Pharmacy benefit manager contracts.-

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

410 (a) "Brand-name drug" means a drug that:411 1. Is a brand drug described by Medi-Span and has a
412 multisource code field containing an "M" (cobranded product), an
413 "O" (originator brand), or an "N" (single-source brand), except
414 for a drug with a multisource code of "O" and a Dispense as
415 Written code of 3, 4, 5, 6, or 9; or416 2. Has an equivalent brand drug designation in the First
417 Databank FDB MedKnowledge database.418 (b) "Generic drug" means a drug that:419 1. Is a generic drug described by Medi-Span and has a
420 multisource code field containing a "Y" (generic), or an "O" and
421 a Dispense as Written code of 3, 4, 5, 6, or 9; or422 2. Has an equivalent generic drug designation in the First
423 Databank FDB MedKnowledge database.424 (c) "Maximum allowable cost" means the per-unit amount that
425 a pharmacy benefit manager reimburses a pharmacist for a
426 prescription drug:427 1. As specified at the time of claim processing and
428 directly or indirectly reported on the initial remittance advice
429 of an adjudicated claim for a generic drug, brand-name drug,
430 biological product, or specialty drug;431 2. Which amount must be based on pricing published in the
432 Medi-Span Master Drug Database, or, if the pharmacy benefit
433 manager uses only First Databank FDB MedKnowledge, must be based
434 on pricing published in First Databank FDB MedKnowledge; and435 3. ~~7~~ Excluding dispensing fees, prior to the application of

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436 copayments, coinsurance, and other cost-sharing charges, if any.

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

441 (2) A health maintenance organization may contract only
442 with a pharmacy benefit manager that ~~A contract between a health~~
443 ~~maintenance organization and a pharmacy benefit manager must~~
444 ~~require that the pharmacy benefit manager:~~

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

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

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

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

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

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

467 (3) A drug identified as a brand-name drug must be
468 considered a brand-name drug for all purposes under an
469 agreement, contract, or amendment to a contract between a
470 pharmacy benefit manager and a pharmacy, or a pharmacy services
471 administration organization on behalf of the pharmacy. A single-
472 source generic drug with only one manufacturer must be
473 reimbursed as if it were a brand-name drug.

474 (4) A drug identified as a generic drug must be considered
475 a generic drug for all purposes under an agreement, contract, or
476 amendment to a contract between a pharmacy benefit manager and a
477 pharmacy, or a pharmacy services administrative organization
478 acting on behalf of the pharmacy. The pharmacy benefit manager
479 and the pharmacy, or a pharmacy services administrative
480 organization on behalf of the pharmacy, shall agree that if the
481 pharmacy benefit manager is provided any rebate or other
482 financial benefit for any drug identified as a generic drug, the
483 pharmacy benefit manager must pass through all such rebates or
484 other financial benefits to the health maintenance organization.

485 (5) The office may require a health maintenance
486 organization to submit to the office any contract, or amendments
487 to a contract, for the administration or management of
488 prescription drug benefits by a pharmacy benefit manager on
489 behalf of the health maintenance organization.

490 (6) After review of a contract under subsection (5), the
491 office may order the health maintenance organization to cancel
492 the contract in accordance with the terms of the contract and
493 applicable law if the office determines that any of the

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494 following conditions exist:

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

502 (b) The contract does not comply with the Florida Insurance
503 Code.

504 (c) The pharmacy benefit manager is not registered with the
505 office pursuant to s. 624.490.

506 (7) The commission may adopt rules to administer this
507 section.

508 (8)(5) This section applies to pharmacy benefit manager
509 contracts entered into, amended, or renewed on or after July 1,
510 2020 ~~2018~~.

511 Section 7. This act shall take effect July 1, 2020.