CHAMBER ACTION

Senate	House

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1 Representative Andrade offered the following:

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3 **Amendment (with title amendment)**

4 Remove everything after the enacting clause and insert:

5 Section 1. Subsection (11) is added to section 110.12315,

6 Florida Statutes, to read:

7 110.12315 Prescription drug program.—The state employees'

8 prescription drug program is established. This program shall be

9 administered by the Department of Management Services, according

10 to the terms and conditions of the plan as established by the

11 relevant provisions of the annual General Appropriations Act and

12 implementing legislation, subject to the following conditions:

13 (11) The department shall contract for an annual audit of
14 any pharmacy benefit vendor contracted under the program. At a
15 minimum, the audit shall determine whether state funds are
16 expended in accordance with the terms of the vendor contract and
17 shall include an assessment of compliance with contract terms.
18 The audit shall identify any noncompliance and make
19 recommendations for corrective action by a pharmacy benefit
20 vendor. Specifically, the audit shall examine whether a pharmacy
21 benefit vendor is compliant with contract provisions related to
22 pass-through of pharmaceutical rebates and spread pricing, as
23 set forth in a contract between the department and such a
24 vendor.
25 Section 2. Subsection (16) is added to section 499.012,
26 Florida Statutes, to read:
27 499.012 Permit application requirements.—
28 (16) A permit for a prescription drug manufacturer or a
29 nonresident prescription drug manufacturer is subject to the
30 requirements of s. 499.026.
31 Section 3. Section 499.026, Florida Statutes, is created
32 to read:
33 499.026 Prescription drug price increases.—
34 (1) As used in this section, the term:
35 (a) "Drug price increase" means:
36 1. A single manufacturer price increase equal to or
37 greater than 15 percent of the price of a drug, or a single

38 manufacturer price increase that results in a cumulative price
39 increase of more than 25 percent in the preceding 12-month
40 period, for a brand-name prescription drug with a wholesale
41 acquisition cost of $50 or more for a 30-day supply; or
42 2. A single manufacturer price increase equal to or
43 greater than 25 percent of the price of a drug, or a single
44 manufacturer price increase that results in a cumulative price
45 increase of more than 35 percent in the preceding 12-month
46 period, for a generic or biosimilar prescription drug with a
47 wholesale acquisition cost of $25 or more for a 30-day supply.
48 (b) "Health insurer" means a health insurer issuing major
49 medical coverage through an individual or group policy or a
50 health maintenance organization issuing major medical coverage
51 through an individual or group contract, regulated under chapter
52 627 or chapter 641.
53 (c) "Manufacturer" means any person holding a prescription
54 drug manufacturer permit or a nonresident prescription drug
55 manufacturer permit under s. 499.01.
56 (d) "Wholesale acquisition cost" has the same meaning as
57 defined in 42 U.S.C. s. 1395w-3a.
58 (2) At least 60 days before the effective date of any drug
59 price increase, a manufacturer must provide notification of the
60 upcoming drug price increase and the amount of the drug price
61 increase to every health insurer that covers the drug. A
62 manufacturer must make the notification using the contact list

63 published by the Office of Insurance Regulation pursuant to ss.
64 627.42394 and 641.3131. Notification shall be presumed to occur
65 on the date that a manufacturer attempts to communicate with the
66 applicable point of contact published by the Office of Insurance
67 Regulation.
68 (3) By April 1 of each year, a manufacturer must submit a
69 report to the department and the Office of Insurance Regulation
70 on each drug price increase made during the previous calendar
71 year. At a minimum, the report shall include:
72 (a) A list of all drugs affected by the drug price
73 increase and both the dollar amount of each drug price increase
74 and the percentage increase of each drug price increase,
75 relative to the previous price of the drug.
76 (b) A complete description of the factors contributing to
77 the drug price increase.
78 Section 4. Section 624.491, Florida Statutes, is created
79 to read:
80 624.491 Pharmacy audits.—
81 (1) A health insurer or health maintenance organization
82 providing pharmacy benefits through a major medical individual
83 or group health policy or health maintenance contract,
84 respectively, shall comply with the requirements of this section
85 when the insurer or health maintenance organization or any
86 entity acting on behalf of the insurer or health maintenance
87 organization, including, but not limited to, a pharmacy benefit

88 manager, audits the records of a pharmacy licensed under chapter
89 465. This section does not apply to audits in which suspected
90 fraudulent activity or other intentional or willful
91 misrepresentation is evidenced by a physical review, review of
92 claims data or statements, or other investigative methods;
93 audits of claims paid for by federally funded programs; or
94 concurrent reviews or desk audits that occur within 3 business
95 days of transmission of a claim and where no chargeback or
96 recoupment is demanded. An entity that audits a pharmacy located
97 within a Health Care Fraud Prevention and Enforcement Action
98 Team (HEAT) Task Force area designated by the United States
99 Department of Health and Human Services and the United States
100 Department of Justice may dispense with the notice requirements
101 of subsection (2) if such pharmacy has been a member of a
102 credentialed provider network for less than 12 months.
103 (2) An entity conducting a pharmacy audit shall:
104 (a) Notify a pharmacy at least 7 calendar days before the
105 initial onsite audit for each audit cycle.
106 (b) Ensure the audit is not initiated during the first 3
107 calendar days of a month unless the pharmacist consents
108 otherwise.
109 (c) Limit the scope of the audit period to no more than 24
110 months after the date a claim is submitted to or adjudicated by
111 the entity.

112 (d) Ensure that an audit requiring clinical or
113 professional judgment is conducted by or in consultation with a
114 pharmacist.
115 (e) Permit a pharmacy to use the written and verifiable
116 records of a hospital, physician, or other authorized
117 practitioner, which are transmitted by any means of
118 communication, to validate the pharmacy records in accordance
119 with state and federal law.
120 (f) Ensure that a pharmacy is reimbursed for a claim that
121 was retroactively denied for a clerical error, typographical
122 error, scrivener's error, or computer error if the prescription
123 was properly and correctly dispensed, unless a pattern of such
124 errors exists, fraudulent billing is alleged, or the error
125 results in actual financial loss to the entity.
126 (g) Provide a preliminary audit report to a pharmacy
127 within 120 days after the conclusion of the audit.
128 (h) Permit a pharmacy to produce documentation to address
129 a discrepancy or audit finding within 10 business days after the
130 preliminary audit report is delivered to the pharmacy.
131 (i) Provide a final audit report to a pharmacy within 6
132 months after having provided the preliminary audit report.
133 (j) Calculate any recoupment or penalties based on actual
134 overpayments and not according to the accounting practice of
135 extrapolation.

136 (3) After receipt of the final audit report issued by a
137 health insurer or health maintenance organization, a pharmacy
138 may appeal the findings of the final audit as to whether a claim
139 payment is due or the amount of a claim payment using the
140 dispute resolution program established by s. 408.7057.
141 Section 5. Section 627.42394, Florida Statutes, is created
142 to read:
143 627.42394 Formulary changes resulting from drug price
144 increases.—
145 (1) A health insurer issuing a major medical individual or
146 group policy shall submit, and update as necessary, contact
147 information for a single point of contact for use by
148 prescription drug manufacturers to comply with s. 499.026. The
149 office shall maintain and publish a list of such points of
150 contact.
151 (2) A health insurer issuing a major medical individual or
152 group policy must provide written notice to affected insureds at
153 least 30 days in advance of making a drug formulary change
154 resulting from a drug price increase reported pursuant to s.
155 499.026.
156 (3) This section applies to policies entered into or
157 renewed on or after January 1, 2021.
158 Section 6. Section 627.64741, Florida Statutes, is amended
159 to read:
160 627.64741 Pharmacy benefit manager contracts.—

161 (1) As used in this section, the term:
162 (a) "Administrative fee" means a fee or payment under a
163 contract between a health insurer and a pharmacy benefit manager
164 associated with the pharmacy benefit manager's administration of
165 the insurer's prescription drug benefit programs that is paid by
166 the insurer to the pharmacy benefit manager.
167 (b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount
168 that a pharmacy benefit manager reimburses a pharmacist for a
169 prescription drug, excluding dispensing fees, prior to the
170 application of copayments, coinsurance, and other cost-sharing
171 charges, if any.
172 (c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity
173 doing business in this state which contracts to administer or
174 manage prescription drug benefits on behalf of a health insurer
175 to residents of this state.
176 (d) "Rebate" means all discounts and other negotiated
177 price concessions based on utilization of a prescription drug
178 and paid by the pharmaceutical manufacturer or other entity,
179 other than an insured, to the pharmacy benefit manager after the
180 claim has been adjudicated at the pharmacy.
181 (e) "Spread pricing" means any amount a pharmacy benefit
182 manager charges or receives from a health insurer for payment of
183 a prescription drug or pharmacy service that is greater than the
184 amount the pharmacy benefit manager paid to the pharmacist or

185 pharmacy that filled the prescription or provided the pharmacy
186 service.
187 (2) A contract between a health insurer and a pharmacy
188 benefit manager must require that the pharmacy benefit manager:
189 (a) Update maximum allowable cost pricing information at
190 least every 7 calendar days.
191 (b) Maintain a process that will, in a timely manner,
192 eliminate drugs from maximum allowable cost lists or modify drug
193 prices to remain consistent with changes in pricing data used in
194 formulating maximum allowable cost prices and product
195 availability.
196 (3) A contract between a health insurer and a pharmacy
197 benefit manager must prohibit the pharmacy benefit manager from
198 limiting a pharmacist's ability to disclose whether the cost-
199 sharing obligation exceeds the retail price for a covered
200 prescription drug, and the availability of a more affordable
201 alternative drug, pursuant to s. 465.0244.
202 (4) A contract between a health insurer and a pharmacy
203 benefit manager must prohibit the pharmacy benefit manager from
204 requiring an insured to make a payment for a prescription drug
205 at the point of sale in an amount that exceeds the lesser of:
206 (a) The applicable cost-sharing amount; or
207 (b) The retail price of the drug in the absence of
208 prescription drug coverage.

209 (5) A contract between a health insurer and a pharmacy
210 benefit manager must require the pharmacy benefit manager to
211 report annually the following to the insurer:
212 (a) The aggregate number of prescriptions that were
213 dispensed.
214 (b) The number and percentage of all prescriptions that
215 were provided through retail pharmacies compared to mail-order
216 pharmacies. This paragraph applies to pharmacies licensed under
217 chapter 465 which dispense drugs to the general public and which
218 were paid by the health insurer or pharmacy benefit manager
219 under the contract.
220 (c) For retail pharmacies and mail-order pharmacies
221 described in paragraph (b), the general dispensing rate, which
222 is the number and percentage of prescriptions for which a
223 generic drug was available and dispensed.
224 (d) The aggregate amount of rebates the pharmacy benefit
225 manager received in association with claims administered on
226 behalf of the insurer and the aggregate amount of such rebates
227 the pharmacy benefit manager received that were not passed
228 through to the insurer.
229 (e) The aggregate amount of administrative fees paid to
230 the pharmacy benefit manager by the insurer for the
231 administration of the insurer's prescription drug benefit
232 programs.
233 (f) The types and aggregate amounts of any fees or

234 remittances paid to the pharmacy benefit manager by pharmacies.
235 The pharmacy benefit manager shall distinguish between fees paid
236 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
237 paid by pharmacies that are not covered entities.
238 (g) The aggregate amount of revenue generated by the
239 pharmacy benefit manager through the use of spread pricing in
240 association with the administration of the insurer's pharmacy
241 benefit programs.
242 (h) The type and aggregate amount of any other fees
243 collected by the pharmacy benefit manager in association with
244 claims administered on behalf of the insurer.
245 (6) Not later than June 30, 2021, and annually thereafter,
246 a health insurer shall submit a report to the office that
247 includes the information provided by its contracted pharmacy
248 benefit managers under subsection (5). The office shall publish
249 on its website an analysis of the reported information required
250 to be provided to the insurer under subsection (5) in an
251 aggregated amount for each pharmacy benefit manager.
252 (7) The office may require a health insurer to submit to
253 the office for review any contract, or amendments to a contract,
254 for the administration or management of prescription drug
255 benefits by a pharmacy benefit manager on behalf of the insurer.
256 After review of a contract, the office may order the insurer to
257 terminate the contract in accordance with the terms of the
258 contract and applicable law if the office determines that the

259 contract does not comply with the Florida Insurance Code or the
260 pharmacy benefit manager is not registered with the office
261 pursuant to s. 624.490.
262 (8) The commission may adopt rules to administer this
263 section.
264 (9) ~~(5)~~ This section applies to contracts entered into or
265 renewed on or after July 1, 2020 ~~2018~~.
266 Section 7. Section 627.6572, Florida Statutes, is amended
267 to read:
268 627.6572 Pharmacy benefit manager contracts.—
269 (1) As used in this section, the term:
270 (a) "Administrative fee" means a fee or payment under a
271 contract between a health insurer and a pharmacy benefit manager
272 associated with the pharmacy benefit manager's administration of
273 the insurer's prescription drug benefit programs that is paid by
274 the insurer to the pharmacy benefit manager.
275 (b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount
276 that a pharmacy benefit manager reimburses a pharmacist for a
277 prescription drug, excluding dispensing fees, prior to the
278 application of copayments, coinsurance, and other cost-sharing
279 charges, if any.
280 (c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity
281 doing business in this state which contracts to administer or
282 manage prescription drug benefits on behalf of a health insurer
283 to residents of this state.

284 (d) "Rebate" means all discounts and other negotiated
285 price concessions based on utilization of a prescription drug
286 and paid by the pharmaceutical manufacturer or other entity,
287 other than an insured, to the pharmacy benefit manager after the
288 claim has been adjudicated at the pharmacy.
289 (e) "Spread pricing" means any amount a pharmacy benefit
290 manager charges or receives from a health insurer for payment of
291 a prescription drug or pharmacy service that is greater than the
292 amount the pharmacy benefit manager paid to the pharmacist or
293 pharmacy that filled the prescription or provided the pharmacy
294 service.
295 (2) A contract between a health insurer and a pharmacy
296 benefit manager must require that the pharmacy benefit manager:
297 (a) Update maximum allowable cost pricing information at
298 least every 7 calendar days.
299 (b) Maintain a process that will, in a timely manner,
300 eliminate drugs from maximum allowable cost lists or modify drug
301 prices to remain consistent with changes in pricing data used in
302 formulating maximum allowable cost prices and product
303 availability.
304 (3) A contract between a health insurer and a pharmacy
305 benefit manager must prohibit the pharmacy benefit manager from
306 limiting a pharmacist's ability to disclose whether the cost-
307 sharing obligation exceeds the retail price for a covered

308 prescription drug, and the availability of a more affordable
309 alternative drug, pursuant to s. 465.0244.
310 (4) A contract between a health insurer and a pharmacy
311 benefit manager must prohibit the pharmacy benefit manager from
312 requiring an insured to make a payment for a prescription drug
313 at the point of sale in an amount that exceeds the lesser of:
314 (a) The applicable cost-sharing amount; or
315 (b) The retail price of the drug in the absence of
316 prescription drug coverage.
317 (5) A contract between a health insurer and a pharmacy
318 benefit manager must require the pharmacy benefit manager to
319 report annually the following to the insurer:
320 (a) The aggregate number of prescriptions that were
321 dispensed.
322 (b) The number and percentage of all prescriptions that
323 were provided through retail pharmacies compared to mail-order
324 pharmacies. This paragraph applies to pharmacies licensed under
325 chapter 465 which dispense drugs to the general public and which
326 were paid by the health insurer or pharmacy benefit manager
327 under the contract.
328 (c) For retail pharmacies and mail-order pharmacies
329 described in paragraph (b), the general dispensing rate, which
330 is the number and percentage of prescriptions for which a
331 generic drug was available and dispensed.
332 (d) The aggregate amount of rebates the pharmacy benefit

333 manager received in association with claims administered on
334 behalf of the insurer and the aggregate amount of such rebates
335 the pharmacy benefit manager received that were not passed
336 through to the insurer.
337 (e) The aggregate amount of administrative fees paid to
338 the pharmacy benefit manager by the insurer for the
339 administration of the insurer's prescription drug benefit
340 programs.
341 (f) The types and aggregate amounts of any fees or
342 remittances paid to the pharmacy benefit manager by pharmacies.
343 The pharmacy benefit manager shall distinguish between fees paid
344 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
345 paid by pharmacies that are not covered entities.
346 (g) The aggregate amount of revenue generated by the
347 pharmacy benefit manager through the use of spread pricing in
348 association with the administration of the insurer's pharmacy
349 benefit programs.
350 (h) The type and aggregate amount of any other fees
351 collected by the pharmacy benefit manager in association with
352 claims administered on behalf of the insurer.
353 (6) Not later than June 30, 2021, and annually thereafter,
354 a health insurer shall submit a report to the office that
355 includes the information provided by its contracted pharmacy
356 benefit managers under subsection (5). The office shall publish
357 on its website an analysis of the reported information required

358 to be provided to the insurer under subsection (5) in an
359 aggregated amount for each pharmacy benefit manager.
360 (7) The office may require a health insurer to submit to
361 the office for review any contract, or amendments to a contract,
362 for the administration or management of prescription drug
363 benefits by a pharmacy benefit manager on behalf of the insurer.
364 After review of a contract, the office may order the insurer to
365 terminate the contract in accordance with the terms of the
366 contract and applicable law if the office determines that the
367 contract does not comply with the Florida Insurance Code or the
368 pharmacy benefit manager is not registered with the office
369 pursuant to s. 624.490.
370 (8) The commission may adopt rules to administer this
371 section.
372 (9) ~~(5)~~ This section applies to contracts entered into or
373 renewed on or after July 1, 2020 ~~2018~~.
374 Section 8. Section 641.3131, Florida Statutes, is created
375 to read:
376 641.3131 Formulary changes resulting from drug price
377 increases.—
378 (1) A health maintenance organization issuing a major
379 medical or other comprehensive coverage contract shall submit,
380 and update as necessary, contact information for a single point
381 of contact for use by prescription drug manufacturers to comply

382 with s. 499.026. The office shall maintain and publish a list of
383 such points of contact.
384 (2) A health maintenance organization issuing a major
385 medical or other comprehensive coverage contract must provide
386 written notice to affected subscribers at least 30 days in
387 advance of making a drug formulary change resulting from a drug
388 price increase reported pursuant to s. 499.026.
389 (3) This section applies to contracts entered into or
390 renewed on or after January 1, 2021.
391 Section 9. Section 641.314, Florida Statutes, is amended
392 to read:
393 641.314 Pharmacy benefit manager contracts.—
394 (1) As used in this section, the term:
395 (a) "Administrative fee" means a fee or payment under a
396 contract between a health maintenance organization and a
397 pharmacy benefit manager associated with the pharmacy benefit
398 manager's administration of the health maintenance
399 organization's prescription drug benefit programs that is paid
400 by the health maintenance organization to the pharmacy benefit
401 manager.
402 (b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount
403 that a pharmacy benefit manager reimburses a pharmacist for a
404 prescription drug, excluding dispensing fees, prior to the
405 application of copayments, coinsurance, and other cost-sharing
406 charges, if any.

407 (c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity
408 doing business in this state which contracts to administer or
409 manage prescription drug benefits on behalf of a health
410 maintenance organization to residents of this state.
411 (d) "Rebate" means all discounts and other negotiated
412 price concessions based on utilization of a prescription drug
413 and paid by the pharmaceutical manufacturer or other entity,
414 other than a subscriber, to the pharmacy benefit manager after
415 the claim has been adjudicated at the pharmacy.
416 (e) "Spread pricing" means any amount a pharmacy benefit
417 manager charges or receives from a health maintenance
418 organization for payment of a prescription drug or pharmacy
419 service that is greater than the amount the pharmacy benefit
420 manager paid to the pharmacist or pharmacy that filled the
421 prescription or provided the pharmacy service.
422 (2) A contract between a health maintenance organization
423 and a pharmacy benefit manager must require that the pharmacy
424 benefit manager:
425 (a) Update maximum allowable cost pricing information at
426 least every 7 calendar days.
427 (b) Maintain a process that will, in a timely manner,
428 eliminate drugs from maximum allowable cost lists or modify drug
429 prices to remain consistent with changes in pricing data used in
430 formulating maximum allowable cost prices and product
431 availability.

432 (3) A contract between a health maintenance organization
433 and a pharmacy benefit manager must prohibit the pharmacy
434 benefit manager from limiting a pharmacist's ability to disclose
435 whether the cost-sharing obligation exceeds the retail price for
436 a covered prescription drug, and the availability of a more
437 affordable alternative drug, pursuant to s. 465.0244.
438 (4) A contract between a health maintenance organization
439 and a pharmacy benefit manager must prohibit the pharmacy
440 benefit manager from requiring a subscriber to make a payment
441 for a prescription drug at the point of sale in an amount that
442 exceeds the lesser of:
443 (a) The applicable cost-sharing amount; or
444 (b) The retail price of the drug in the absence of
445 prescription drug coverage.
446 (5) A contract between a health maintenance organization
447 and a pharmacy benefit manager must require the pharmacy benefit
448 manager to report annually the following to the insurer:
449 (a) The aggregate number of prescriptions that were
450 dispensed.
451 (b) The number and percentage of all prescriptions that
452 were provided through retail pharmacies compared to mail-order
453 pharmacies. This paragraph applies to pharmacies licensed under
454 chapter 465 which dispense drugs to the general public and which
455 were paid by the health maintenance organization or pharmacy
456 benefit manager under the contract.

457 (c) For retail pharmacies and mail-order pharmacies
458 described in paragraph (b), the general dispensing rate, which
459 is the number and percentage of prescriptions for which a
460 generic drug was available and dispensed.
461 (d) The aggregate amount of rebates the pharmacy benefit
462 manager received in association with claims administered on
463 behalf of the health maintenance organization and the aggregate
464 amount of such rebates the pharmacy benefit manager received
465 that were not passed through to the health maintenance
466 organization.
467 (e) The aggregate amount of administrative fees paid to
468 the pharmacy benefit manager by the health maintenance
469 organization for the administration of the health maintenance
470 organization's prescription drug benefit programs.
471 (f) The types and aggregate amounts of any fees or
472 remittances paid to the pharmacy benefit manager by pharmacies.
473 The pharmacy benefit manager shall distinguish between fees paid
474 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
475 paid by pharmacies that are not covered entities.
476 (g) The aggregate amount of revenue generated by the
477 pharmacy benefit manager through the use of spread pricing in
478 association with the administration of the health maintenance
479 organization's pharmacy benefit programs.
480 (h) The type and aggregate amount of any other fees
481 collected by the pharmacy benefit manager in association with

482 claims administered on behalf of the health maintenance
483 organization.
484 (6) Not later than June 30, 2021, and annually thereafter,
485 a health maintenance organization shall submit a report to the
486 office that includes the information provided by its contracted
487 pharmacy benefit managers under subsection (5). The office shall
488 publish on its website an analysis of the reported information
489 required to be provided to the health maintenance organization
490 under subsection (5) in an aggregated amount for each pharmacy
491 benefit manager.
492 (7) The office may require a health maintenance
493 organization to submit to the office for review any contract, or
494 amendments to a contract, for the administration or management
495 of prescription drug benefits by a pharmacy benefit manager on
496 behalf of the health maintenance organization. After review of a
497 contract, the office may order the health maintenance
498 organization to terminate the contract in accordance with the
499 terms of the contract and applicable law if the office
500 determines that the contract does not comply with the Florida
501 Insurance Code or the pharmacy benefit manager is not registered
502 with the office pursuant to s. 624.490.
503 (8) The commission may adopt rules to administer this
504 section.
505 (9) ~~(5)~~ This section applies to contracts entered into or
506 renewed on or after July 1, 2020 ~~2018~~.

507 Section 10. (1) The Agency for Health Care Administration
508 shall contract for an independent analysis of pharmacy benefit
509 management practices under the Statewide Medicaid Managed Care
510 program. The analysis shall outline the types of pharmacy
511 benefit pricing contracts in place between managed care plans
512 and contracted pharmacy benefit managers and between managed
513 care plans or pharmacy benefit managers and pharmacies. At a
514 minimum, the analysis shall include:
515 (a) An examination of the fees paid to each contracted
516 pharmacy benefit manager by each managed care plan.
517 (b) An examination of the fees charged to pharmacies by
518 each managed care plan or contracted pharmacy benefit manager.
519 (c) A determination of spread pricing revenues retained by
520 each managed care plan or contracted pharmacy benefit manager.
521 (2) For purposes of this section, the term "pharmacy
522 benefit manager" means a person or entity doing business in this
523 state which contracts to administer or manage prescription drug
524 benefits on behalf of a managed care plan.
525 (3) For purposes of this section, the term "spread
526 pricing" refers to any amount a managed care plan or pharmacy
527 benefit manager received from the Medicaid program for payment
528 of a prescription drug that is greater than that paid to the
529 pharmacist or pharmacy that filled a prescription for that
530 prescription drug.

531 (4) The agency shall submit the completed analysis to the
532 Governor, the President of the Senate, and the Speaker of the
533 House of Representatives by October 1, 2020.
534 Section 11. (1) The Agency for Health Care Administration
535 shall conduct an analysis of managed care plan pharmacy networks
536 under the Statewide Medicaid Managed Care program to ensure that
537 enrollees have sufficient choice of pharmacies within
538 established geographic parameters. The agency must also analyze
539 the composition of each managed care plan pharmacy network to
540 determine the market share of large chain pharmacies, small
541 chain pharmacies, and independent pharmacies, respectively. The
542 analysis shall include:
543 (a) An examination of the pharmacy contracting patterns by
544 each managed care plan or contracted pharmacy benefit manager.
545 (b) An examination of any financial relationship between a
546 managed care provider or contracted pharmacy benefit manager and
547 its contracted pharmacies. The analysis shall examine whether a
548 managed care plan or pharmacy benefit manager establishes a
549 network that favors pharmacies in which the managed care plan or
550 pharmacy benefit manager owns a controlling or substantial
551 financial interest.
552 (2) For purposes of this section, the term "pharmacy
553 benefit manager" means a person or entity doing business in this
554 state which contracts to administer or manage prescription drug
555 benefits on behalf of a managed care plan.

556 (3) The agency shall submit the completed analysis to the
557 Governor, the President of the Senate, and the Speaker of the
558 House of Representatives by October 1, 2020.
559 Section 12. If any provision of this act or its
560 application to any person or circumstance is held invalid, the
561 invalidity does not affect other provisions or applications of
562 the act which can be given effect without the invalid provision
563 or its application, and to this end the provisions of this act
564 are severable.
565 Section 13. This act shall take effect upon becoming a
566 law.
567
568 ---
569 **T I T L E A M E N D M E N T**
570 Remove everything before the enacting clause and insert:
571 A bill to be entitled
572 An act relating to prescription drug price
573 transparency; amending s. 110.12315, F.S.; requiring
574 the Department of Management Services to contract for
575 an annual audit of any pharmacy benefit vendor
576 contracted under the state employees' prescription
577 drug program; providing requirements for such audit;
578 amending s. 499.012, F.S.; providing that permits for
579 prescription drug manufacturers and nonresident
580 prescription drug manufacturers are subject to

581 specified requirements; creating s. 499.026, F.S.;
582 providing definitions; requiring prescription drug
583 manufacturers to provide notification of drug price
584 increases to insurers; providing requirements for such
585 notification; requiring prescription drug
586 manufacturers to provide an annual report on drug
587 price increases to the Department of Business and
588 Professional Regulation and the Office of Insurance
589 Regulation; providing reporting requirements; creating
590 s. 624.491, F.S.; providing timelines and
591 documentation requirements for pharmacy audits
592 conducted by certain health insurers, health
593 maintenance organizations, or their agents; providing
594 that such requirements do not apply to audits in which
595 certain conditions are met; creating s. 627.42394,
596 F.S.; requiring certain health insurers to establish a
597 single point of contact for manufacturers to report
598 drug price increases; requiring the Office of
599 Insurance Regulation to maintain and publish a list of
600 such contacts; requiring certain health insurers to
601 provide written notice to insureds in advance of
602 formulary changes resulting from manufacturer drug
603 price increases; providing applicability; amending ss.
604 627.64741 and 627.6572, F.S.; providing definitions;
605 requiring reporting requirements in contracts between

606 health insurers and pharmacy benefit managers;
607 requiring health insurers to submit an annual report
608 to the office; requiring the office to publish such
609 reports and analyses of specified information;
610 authorizing the office to review contracts;
611 authorizing the office to order health insurers to
612 terminate contracts with pharmacy benefit managers
613 under certain circumstances; providing rulemaking
614 authority; revising applicability; creating s.
615 641.3131, F.S.; requiring certain health maintenance
616 organizations to establish a single point of contact
617 for manufacturers to report drug price increases;
618 requiring the office to maintain and publish a list of
619 such contacts; requiring certain health maintenance
620 organizations to provide written notice to subscribers
621 in advance of formulary changes resulting from
622 manufacturer drug price increases; providing
623 applicability; amending s. 641.314, F.S.; providing
624 definitions; requiring reporting requirements in
625 contracts between health maintenance organizations and
626 pharmacy benefit managers; requiring health
627 maintenance organizations to submit an annual report
628 to the office; requiring the office to publish such
629 reports and analyses of specified information;
630 authorizing the office to review contracts;

631 authorizing the office to order health maintenance
632 organizations to terminate contracts with pharmacy
633 benefit managers under certain circumstances;
634 providing rulemaking authority; revising
635 applicability; requiring the Agency for Health Care
636 Administration to contract for an independent analysis
637 of pharmacy benefit management practices under the
638 Statewide Medicaid Managed Care program; providing
639 requirements for such analysis; providing definitions;
640 requiring the agency to submit the analysis to the
641 Governor and the Legislature; requiring the agency to
642 conduct an analysis of managed care plan pharmacy
643 networks and to analyze the composition of the
644 networks under the Statewide Medicaid Managed Care
645 program; providing requirements for such analysis;
646 providing definitions; requiring the agency to submit
647 the analysis to the Governor and the Legislature;
648 providing severability; providing severability;
649 providing an effective date.