1 A bill to be entitled
2 An act relating to prescription drug price
3 transparency; amending s. 110.12315, F.S.; requiring
4 the Department of Management Services to contract for
5 an annual audit of any pharmacy benefit vendor
6 contracted under the state employees' prescription
7 drug program; providing requirements for such audit;
8 amending s. 499.012, F.S.; providing that permits for
9 prescription drug manufacturers and nonresident
10 prescription drug manufacturers are subject to
11 specified requirements; creating s. 499.026, F.S.;
12 providing definitions; requiring prescription drug
13 manufacturers to provide notification of drug price
14 increases to insurers; providing requirements for such
15 notification; requiring prescription drug
16 manufacturers to provide an annual report on drug
17 price increases to the Department of Business and
18 Professional Regulation and the Office of Insurance
19 Regulation; providing reporting requirements; creating
20 s. 624.491, F.S.; providing timelines and
21 documentation requirements for pharmacy audits
22 conducted by certain health insurers, health
23 maintenance organizations, or their agents; providing
24 that such requirements do not apply to audits in which
25 certain conditions are met; creating s. 627.42394,

26 F.S.; requiring certain health insurers to establish a
27 single point of contact for manufacturers to report
28 drug price increases; requiring the Office of
29 Insurance Regulation to maintain and publish a list of
30 such contacts; requiring certain health insurers to
31 provide written notice to insureds in advance of
32 formulary changes resulting from manufacturer drug
33 price increases; providing applicability; amending s.
34 627.64741, F.S.; providing definitions; requiring
35 reporting requirements in contracts between health
36 insurers and pharmacy benefit managers; requiring
37 health insurers to submit an annual report to the
38 office; requiring the office to publish such reports
39 and analyses of specified information; revising
40 applicability; amending s. 627.6572, F.S.; providing
41 definitions; requiring reporting requirements in
42 contracts between health insurers and pharmacy benefit
43 managers; requiring health insurers to submit an
44 annual report to the office; requiring the office to
45 publish such reports and analyses of specified
46 information; revising applicability; creating s.
47 641.3131, F.S.; requiring certain health maintenance
48 organizations to establish a single point of contact
49 for manufacturers to report drug price increases;
50 requiring the office to maintain and publish a list of

51 such contacts; requiring certain health maintenance
52 organizations to provide written notice to subscribers
53 in advance of formulary changes resulting from
54 manufacturer drug price increases; providing
55 applicability; amending s. 641.314, F.S.; providing
56 definitions; requiring reporting requirements in
57 contracts between health maintenance organizations and
58 pharmacy benefit managers; requiring health
59 maintenance organizations to submit an annual report
60 to the office; requiring the office to publish such
61 reports and analyses of specified information;
62 revising applicability; requiring the Agency for
63 Health Care Administration to contract for an
64 independent analysis of pharmacy benefit management
65 practices under the Statewide Medicaid Managed Care
66 program; providing requirements for such audit;
67 providing definitions; requiring the agency to submit
68 the analysis to the Governor and the Legislature;
69 requiring the agency to conduct an analysis and
70 analyze the composition of managed care plan pharmacy
71 networks under the program; providing requirements for
72 such analysis; providing definitions; requiring the
73 agency to submit the analysis to the Governor and the
74 Legislature; providing an effective date.
75

76 Be It Enacted by the Legislature of the State of Florida:
77
78 Section 1. Subsection (11) is added to section 110.12315,
79 Florida Statutes, to read:
80 110.12315 Prescription drug program.—The state employees'
81 prescription drug program is established. This program shall be
82 administered by the Department of Management Services, according
83 to the terms and conditions of the plan as established by the
84 relevant provisions of the annual General Appropriations Act and
85 implementing legislation, subject to the following conditions:
86 (11) The department shall contract for an annual audit of
87 any pharmacy benefit vendor contracted under the program. At a
88 minimum, the audit shall determine whether state funds are
89 expended in accordance with the terms of the vendor contract and
90 shall include an assessment of compliance with contract terms.
91 The audit shall identify any noncompliance and make
92 recommendations for corrective action by a pharmacy benefit
93 vendor. Specifically, the audit shall examine whether a pharmacy
94 benefit vendor is compliant with contract provisions related to
95 pass-through of pharmaceutical rebates and spread pricing, as
96 set forth in a contract between the department and such a
97 vendor.
98 Section 2. Subsection (16) is added to section 499.012,
99 Florida Statutes, to read:
100 499.012 Permit application requirements.—

101 (16) A permit for a prescription drug manufacturer or a
102 nonresident prescription drug manufacturer is subject to the
103 requirements of s. 499.026.
104 Section 3. Section 499.026, Florida Statutes, is created
105 to read:
106 499.026 Prescription drug price increases.—
107 (1) As used in this section, the term:
108 (a) "Drug price increase" means a manufacturer price
109 increase equal to or greater than 15 percent of the price of a
110 drug for a brand-name prescription drug with a wholesale
111 acquisition cost of $50 or more, or a manufacturer price
112 increase equal to or greater than 25 percent of the price of a
113 drug for a generic prescription drug or a biosimilar drug with a
114 wholesale acquisition cost of $25 or more, for a 30-day supply.
115 (b) "Health insurer" means a health insurer issuing major
116 medical coverage through an individual or group policy or a
117 health maintenance organization issuing major medical coverage
118 through an individual or group contract, regulated under chapter
119 627 or chapter 641.
120 (c) "Manufacturer" means any person holding a prescription
121 drug manufacturer permit or a nonresident prescription drug
122 manufacturer permit under s. 499.01.
123 (d) "Wholesale acquisition cost" has the same meaning as
124 defined in 42 U.S.C. s. 1395w-3a.
125 (2) At least 60 days before the effective date of any drug

126 price increase, a manufacturer must provide notification of the
127 upcoming drug price increase and the amount of the drug price
128 increase to every health insurer that covers the drug. A
129 manufacturer must make the notification using the contact list
130 published by the Office of Insurance Regulation pursuant to ss.
131 627.42394 and 641.3131. Notification shall be presumed to occur
132 on the date that a manufacturer attempts to communicate with the
133 applicable point of contact published by the Office of Insurance
134 Regulation.
135 (3) By April 1 of each year, a manufacturer must submit a
136 report to the department and the Office of Insurance Regulation
137 on each drug price increase made during the previous calendar
138 year. At a minimum, the report shall include:
139 (a) A list of all drugs affected by the drug price
140 increase and both the dollar amount of each drug price increase
141 and the percentage increase of each drug price increase,
142 relative to the previous price of the drug.
143 (b) A complete description of the factors contributing to
144 the drug price increase.
145 Section 4. Section 624.491, Florida Statutes, is created
146 to read:
147 624.491 Pharmacy audits.—
148 (1) A health insurer or health maintenance organization
149 providing pharmacy benefits through a major medical individual
150 or group health policy or health maintenance contract,

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151 respectively, shall comply with the requirements of this section
152 when the insurer or health maintenance organization or any
153 entity acting on behalf of the insurer or health maintenance
154 organization, including, but not limited to, a pharmacy benefit
155 manager, audits the records of a pharmacy licensed under chapter
156 465. This section does not apply to audits in which suspected
157 fraudulent activity or other intentional or willful
158 misrepresentation is evidenced by a physical review, review of
159 claims data or statements, or other investigative methods;
160 audits of claims paid for by federally funded programs; or
161 concurrent reviews or desk audits that occur within 3 business
162 days of transmission of a claim and where no chargeback or
163 recoupment is demanded. An entity that audits a pharmacy located
164 within a Health Care Fraud Prevention and Enforcement Action
165 Team (HEAT) Task Force area designated by the United States
166 Department of Health and Human Services and the United States
167 Department of Justice may dispense with the notice requirements
168 of subsection (2) if such pharmacy has been a member of a
169 credentialed provider network for less than 12 months.
170 (2) An entity conducting a pharmacy audit shall:
171 (a) Notify the pharmacy at least 7 calendar days before
172 the initial onsite audit for each audit cycle.
173 (b) Ensure the audit is not initiated during the first 3
174 calendar days of a month unless the pharmacist consents
175 otherwise.

176 (c) Limit the audit period to 24 months after the date a
177 claim is submitted to or adjudicated by the entity.
178 (d) Provide a preliminary audit report to the pharmacy
179 within 120 days after the conclusion of the audit.
180 (e) Provide a final audit report to the pharmacy within 6
181 months after having providing the preliminary audit report.
182 Section 5. Section 627.42394, Florida Statutes, is created
183 to read:
184 627.42394 Formulary changes resulting from drug price
185 increases.—
186 (1) A health insurer issuing a major medical individual or
187 group policy shall submit, and update as necessary, contact
188 information for a single point of contact for use by
189 prescription drug manufacturers to comply with s. 499.026. The
190 office shall maintain and publish a list of such points of
191 contact.
192 (2) A health insurer issuing a major medical individual or
193 group policy must provide written notice to affected insureds at
194 least 30 days in advance of making a drug formulary change
195 resulting from a drug price increase reported pursuant to s.
196 499.026.
197 (3) This section applies to policies entered into or
198 renewed on or after January 1, 2021.
199 Section 6. Section 627.64741, Florida Statutes, is amended
200 to read:

201 627.64741 Pharmacy benefit manager contracts.—
202 (1) As used in this section, the term:
203 (a) "Administrative fee" means a fee or payment under a
204 contract between a health insurer and a pharmacy benefit manager
205 associated with the pharmacy benefit manager's administration of
206 the insurer's prescription drug benefit programs that is paid by
207 the insurer to the pharmacy benefit manager.
208 (b) (a) "Maximum allowable cost" means the per-unit amount
209 that a pharmacy benefit manager reimburses a pharmacist for a
210 prescription drug, excluding dispensing fees, prior to the
211 application of copayments, coinsurance, and other cost-sharing
212 charges, if any.
213 (c) (b) "Pharmacy benefit manager" means a person or entity
214 doing business in this state which contracts to administer or
215 manage prescription drug benefits on behalf of a health insurer
216 to residents of this state.
217 (d) "Rebate" means all discounts and other negotiated
218 price concessions based on utilization of a prescription drug
219 and paid by the pharmaceutical manufacturer or other entity,
220 other than an insured, to the pharmacy benefit manager after the
221 claim has been adjudicated at the pharmacy.
222 (e) "Spread pricing" means any amount a pharmacy benefit
223 manager charges or receives from a health insurer for payment of
224 a prescription drug or pharmacy service that is greater than the
225 amount the pharmacy benefit manager paid to the pharmacist or

226 pharmacy that filled the prescription or provided the pharmacy
227 service.
228 (2) A contract between a health insurer and a pharmacy
229 benefit manager must require that the pharmacy benefit manager:
230 (a) Update maximum allowable cost pricing information at
231 least every 7 calendar days.
232 (b) Maintain a process that will, in a timely manner,
233 eliminate drugs from maximum allowable cost lists or modify drug
234 prices to remain consistent with changes in pricing data used in
235 formulating maximum allowable cost prices and product
236 availability.
237 (3) A contract between a health insurer and a pharmacy
238 benefit manager must prohibit the pharmacy benefit manager from
239 limiting a pharmacist's ability to disclose whether the cost-
240 sharing obligation exceeds the retail price for a covered
241 prescription drug, and the availability of a more affordable
242 alternative drug, pursuant to s. 465.0244.
243 (4) A contract between a health insurer and a pharmacy
244 benefit manager must prohibit the pharmacy benefit manager from
245 requiring an insured to make a payment for a prescription drug
246 at the point of sale in an amount that exceeds the lesser of:
247 (a) The applicable cost-sharing amount; or
248 (b) The retail price of the drug in the absence of
249 prescription drug coverage.
250 (5) A contract between a health insurer and a pharmacy

251 benefit manager must require the pharmacy benefit manager to
252 report annually the following to the insurer:
253 (a) The aggregate amount of rebates the pharmacy benefit
254 manager received in association with claims administered on
255 behalf of the insurer and the aggregate amount of such rebates
256 the pharmacy benefit manager received that were not passed
257 through to the insurer.
258 (b) The aggregate amount of administrative fees paid to
259 the pharmacy benefit manager by the insurer for the
260 administration of the insurer's prescription drug benefit
261 programs.
262 (c) The types and aggregate amounts of any fees or
263 remittances paid to the pharmacy benefit manager by pharmacies.
264 The pharmacy benefit manager shall distinguish between fees paid
265 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
266 paid by pharmacies that are not covered entities.
267 (d) The aggregate amount of revenue generated by the
268 pharmacy benefit manager through the use of spread pricing in
269 association with the administration of the insurer's pharmacy
270 benefit programs.
271 (e) The type and aggregate amount of any other fees
272 collected by the pharmacy benefit manager in association with
273 claims administered on behalf of the insurer.
274 (6) Not later than June 30, 2021, and annually thereafter,
275 a health insurer shall submit a report to the office that

276 includes the information provided by its contracted pharmacy
277 benefit managers under subsection (5). The office shall publish
278 on its website an analysis of the reported information required
279 to be provided to the insurer under subsection (5) in an
280 aggregated amount for each pharmacy benefit manager.
281 (7) ~~(5)~~ This section applies to contracts entered into or
282 renewed on or after July 1, 2020 ~~2018~~.
283 Section 7. Section 627.6572, Florida Statutes, is amended
284 to read:
285 627.6572 Pharmacy benefit manager contracts.—
286 (1) As used in this section, the term:
287 (a) "Administrative fee" means a fee or payment under a
288 contract between a health insurer and a pharmacy benefit manager
289 associated with the pharmacy benefit manager's administration of
290 the insurer's prescription drug benefit programs that is paid by
291 the insurer to the pharmacy benefit manager.
292 (b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount
293 that a pharmacy benefit manager reimburses a pharmacist for a
294 prescription drug, excluding dispensing fees, prior to the
295 application of copayments, coinsurance, and other cost-sharing
296 charges, if any.
297 (c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity
298 doing business in this state which contracts to administer or
299 manage prescription drug benefits on behalf of a health insurer
300 to residents of this state.

301 (d) "Rebate" means all discounts and other negotiated
302 price concessions based on utilization of a prescription drug
303 and paid by the pharmaceutical manufacturer or other entity,
304 other than an insured, to the pharmacy benefit manager after the
305 claim has been adjudicated at the pharmacy.
306 (e) "Spread pricing" means any amount a pharmacy benefit
307 manager charges or receives from a health insurer for payment of
308 a prescription drug or pharmacy service that is greater than the
309 amount the pharmacy benefit manager paid to the pharmacist or
310 pharmacy that filled the prescription or provided the pharmacy
311 service.
312 (2) A contract between a health insurer and a pharmacy
313 benefit manager must require that the pharmacy benefit manager:
314 (a) Update maximum allowable cost pricing information at
315 least every 7 calendar days.
316 (b) Maintain a process that will, in a timely manner,
317 eliminate drugs from maximum allowable cost lists or modify drug
318 prices to remain consistent with changes in pricing data used in
319 formulating maximum allowable cost prices and product
320 availability.
321 (3) A contract between a health insurer and a pharmacy
322 benefit manager must prohibit the pharmacy benefit manager from
323 limiting a pharmacist's ability to disclose whether the cost-
324 sharing obligation exceeds the retail price for a covered
325 prescription drug, and the availability of a more affordable

326 alternative drug, pursuant to s. 465.0244.
327 (4) A contract between a health insurer and a pharmacy
328 benefit manager must prohibit the pharmacy benefit manager from
329 requiring an insured to make a payment for a prescription drug
330 at the point of sale in an amount that exceeds the lesser of:
331 (a) The applicable cost-sharing amount; or
332 (b) The retail price of the drug in the absence of
333 prescription drug coverage.
334 (5) A contract between a health insurer and a pharmacy
335 benefit manager must require the pharmacy benefit manager to
336 report annually the following to the insurer:
337 (a) The aggregate amount of rebates the pharmacy benefit
338 manager received in association with claims administered on
339 behalf of the insurer and the aggregate amount of such rebates
340 the pharmacy benefit manager received that were not passed
341 through to the insurer.
342 (b) The aggregate amount of administrative fees paid to
343 the pharmacy benefit manager by the insurer for the
344 administration of the insurer's prescription drug benefit
345 programs.
346 (c) The types and aggregate amounts of any fees or
347 remittances paid to the pharmacy benefit manager by pharmacies.
348 The pharmacy benefit manager shall distinguish between fees paid
349 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
350 paid by pharmacies that are not covered entities.

351 (d) The aggregate amount of revenue generated by the
352 pharmacy benefit manager through the use of spread pricing in
353 association with the administration of the insurer's pharmacy
354 benefit programs.
355 (e) The type and aggregate amount of any other fees
356 collected by the pharmacy benefit manager in association with
357 claims administered on behalf of the insurer.
358 (6) Not later than June 30, 2021, and annually thereafter,
359 a health insurer shall submit a report to the office that
360 includes the information provided by its contracted pharmacy
361 benefit managers under subsection (5). The office shall publish
362 on its website an analysis of the reported information required
363 to be provided under subsection (5) in an aggregated amount for
364 each pharmacy benefit manager.
365 (7) ~~(5)~~ This section applies to contracts entered into or
366 renewed on or after July 1, 2020 ~~2018~~.
367 Section 8. Section 641.3131, Florida Statutes, is created
368 to read:
369 641.3131 Formulary changes resulting from drug price
370 increases.—
371 (1) A health maintenance organization issuing a major
372 medical or other comprehensive coverage contract shall submit,
373 and update as necessary, contact information for a single point
374 of contact for use by prescription drug manufacturers to comply
375 with s. 499.026. The office shall maintain and publish a list of

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

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

426 and a pharmacy benefit manager must prohibit the pharmacy
427 benefit manager from limiting a pharmacist's ability to disclose
428 whether the cost-sharing obligation exceeds the retail price for
429 a covered prescription drug, and the availability of a more
430 affordable alternative drug, pursuant to s. 465.0244.
431 (4) A contract between a health maintenance organization
432 and a pharmacy benefit manager must prohibit the pharmacy
433 benefit manager from requiring a subscriber to make a payment
434 for a prescription drug at the point of sale in an amount that
435 exceeds the lesser of:
436 (a) The applicable cost-sharing amount; or
437 (b) The retail price of the drug in the absence of
438 prescription drug coverage.
439 (5) A contract between a health maintenance organization
440 and a pharmacy benefit manager must require the pharmacy benefit
441 manager to report annually the following to the health
442 maintenance organization:
443 (a) The aggregate amount of rebates the pharmacy benefit
444 manager received in association with claims administered on
445 behalf of the health maintenance organization and the aggregate
446 amount of such rebates the pharmacy benefit manager received
447 that were not passed through to the health maintenance
448 organization.
449 (b) The aggregate amount of administrative fees paid to
450 the pharmacy benefit manager by the health maintenance

451 organization for the administration of the health maintenance
452 organization's prescription drug benefit programs.
453 (c) The types and aggregate amounts of any fees or
454 remittances paid to the pharmacy benefit manager by pharmacies.
455 The pharmacy benefit manager shall distinguish between fees paid
456 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
457 paid by pharmacies that are not covered entities.
458 (d) The aggregate amount of revenue generated by the
459 pharmacy benefit manager through the use of spread pricing in
460 association with the administration of the health maintenance
461 organization's pharmacy benefit programs.
462 (e) The type and aggregate amount of any other fees
463 collected by the pharmacy benefit manager in association with
464 claims administered on behalf of the health maintenance
465 organization.
466 (6) Not later than June 30, 2021, and annually thereafter,
467 a health maintenance organization shall submit a report to the
468 office that includes the information provided by its contracted
469 pharmacy benefit managers under subsection (5). The office shall
470 publish on its website an analysis of the reported information
471 required to be provided to the health maintenance organization
472 under subsection (5) in an aggregated amount for each pharmacy
473 benefit manager.
474 (7)~~(5)~~ This section applies to contracts entered into or
475 renewed on or after July 1, 2020 ~~2018~~.

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476 Section 10. (1) The Agency for Health Care Administration
477 shall contract for an independent analysis of pharmacy benefit
478 management practices under the Statewide Medicaid Managed Care
479 program. The analysis shall outline the types of pharmacy
480 benefit pricing contracts in place between managed care plans
481 and contracted pharmacy benefit managers and between managed
482 care plans or pharmacy benefit managers and pharmacies. At a
483 minimum, the analysis shall include:
484 (a) An examination of the fees paid to each contracted
485 pharmacy benefit manager by each managed care plan.
486 (b) An examination of the fees charged to pharmacies by
487 each managed care plan or contracted pharmacy benefit manager.
488 (c) A determination of spread pricing revenues retained by
489 each managed care plan or contracted pharmacy benefit manager.
490 (2) For purposes of this section, the term "pharmacy
491 benefit manager" means a person or entity doing business in this
492 state which contracts to administer or manage prescription drug
493 benefits on behalf of a managed care plan.
494 (3) For purposes of this section, the term "spread
495 pricing" refers to any amount a managed care plan or pharmacy
496 benefit manager received from the Medicaid program for payment
497 of a prescription drug that is greater than that paid to the
498 pharmacist or pharmacy that filled a prescription for that
499 prescription drug.
500 (4) The agency shall submit the completed analysis to the

501 Governor, the President of the Senate, and the Speaker of the
502 House of Representatives by June 30, 2020.
503 Section 11. (1) The Agency for Health Care Administration
504 shall conduct an analysis of managed care plan pharmacy networks
505 under the Statewide Medicaid Managed Care program to ensure that
506 enrollees have sufficient choice of pharmacies within
507 established geographic parameters. The agency must also analyze
508 the composition of each managed care plan pharmacy network to
509 determine the market share of large chain pharmacies, small
510 chain pharmacies, and independent pharmacies, respectively. The
511 analysis shall include:
512 (a) An examination of the pharmacy contracting patterns by
513 each managed care plan or contracted pharmacy benefit manager.
514 (b) An examination of any financial relationship between a
515 managed care provider or contracted pharmacy benefit manager and
516 its contracted pharmacies. The analysis shall examine whether a
517 managed care plan or pharmacy benefit manager establishes a
518 network that favors pharmacies in which the managed care plan or
519 pharmacy benefit manager owns a controlling or substantial
520 financial interest.
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) The agency shall submit the completed analysis to the

526 Governor, the President of the Senate, and the Speaker of the
527 House of Representatives by June 30, 2020.
528 Section 12. This act shall take effect upon becoming a
529 law.