

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 ss.
34 627.64741 and 627.6572, F.S.; providing definitions;
35 requiring reporting requirements in contracts between
36 health insurers and pharmacy benefit managers;
37 requiring health insurers to submit an annual report
38 to the office; requiring the office to publish such
39 reports and analyses of specified information;
40 authorizing the office to review contracts;
41 authorizing the office to order health insurers to
42 terminate contracts with pharmacy benefit managers
43 under certain circumstances; providing rulemaking
44 authority; revising applicability; creating s.
45 641.3131, F.S.; requiring certain health maintenance
46 organizations to establish a single point of contact
47 for manufacturers to report drug price increases;
48 requiring the office to maintain and publish a list of
49 such contacts; requiring certain health maintenance
50 organizations to provide written notice to subscribers

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

76 providing definitions; requiring the agency to submit
 77 the analysis to the Governor and the Legislature;
 78 providing severability; providing severability;
 79 providing an effective date.
 80

81 Be It Enacted by the Legislature of the State of Florida:
 82

83 Section 1. Subsection (11) is added to section 110.12315,
 84 Florida Statutes, to read:

85 110.12315 Prescription drug program.—The state employees'
 86 prescription drug program is established. This program shall be
 87 administered by the Department of Management Services, according
 88 to the terms and conditions of the plan as established by the
 89 relevant provisions of the annual General Appropriations Act and
 90 implementing legislation, subject to the following conditions:

91 (11) The department shall contract for an annual audit of
 92 any pharmacy benefit vendor contracted under the program. At a
 93 minimum, the audit shall determine whether state funds are
 94 expended in accordance with the terms of the vendor contract and
 95 shall include an assessment of compliance with contract terms.
 96 The audit shall identify any noncompliance and make
 97 recommendations for corrective action by a pharmacy benefit
 98 vendor. Specifically, the audit shall examine whether a pharmacy
 99 benefit vendor is compliant with contract provisions related to
 100 pass-through of pharmaceutical rebates and spread pricing, as

101 set forth in a contract between the department and such a
102 vendor.

103 Section 2. Subsection (16) is added to section 499.012,
104 Florida Statutes, to read:

105 499.012 Permit application requirements.—

106 (16) A permit for a prescription drug manufacturer or a
107 nonresident prescription drug manufacturer is subject to the
108 requirements of s. 499.026.

109 Section 3. Section 499.026, Florida Statutes, is created
110 to read:

111 499.026 Prescription drug price increases.—

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

113 (a) "Drug price increase" means:

114 1. A single manufacturer price increase equal to or
115 greater than 15 percent of the price of a drug, or a single
116 manufacturer price increase that results in a cumulative price
117 increase of more than 25 percent in the preceding 12-month
118 period, for a brand-name prescription drug with a wholesale
119 acquisition cost of \$50 or more for a 30-day supply; or

120 2. A single manufacturer price increase equal to or
121 greater than 25 percent of the price of a drug, or a single
122 manufacturer price increase that results in a cumulative price
123 increase of more than 35 percent in the preceding 12-month
124 period, for a generic or biosimilar prescription drug with a
125 wholesale acquisition cost of \$25 or more for a 30-day supply.

126 (b) "Health insurer" means a health insurer issuing major
 127 medical coverage through an individual or group policy or a
 128 health maintenance organization issuing major medical coverage
 129 through an individual or group contract, regulated under chapter
 130 627 or chapter 641.

131 (c) "Manufacturer" means any person holding a prescription
 132 drug manufacturer permit or a nonresident prescription drug
 133 manufacturer permit under s. 499.01.

134 (d) "Wholesale acquisition cost" has the same meaning as
 135 defined in 42 U.S.C. s. 1395w-3a.

136 (2) At least 60 days before the effective date of any drug
 137 price increase, a manufacturer must provide notification of the
 138 upcoming drug price increase and the amount of the drug price
 139 increase to every health insurer that covers the drug. A
 140 manufacturer must make the notification using the contact list
 141 published by the Office of Insurance Regulation pursuant to ss.
 142 627.42394 and 641.3131. Notification shall be presumed to occur
 143 on the date that a manufacturer attempts to communicate with the
 144 applicable point of contact published by the Office of Insurance
 145 Regulation.

146 (3) By April 1 of each year, a manufacturer must submit a
 147 report to the department and the Office of Insurance Regulation
 148 on each drug price increase made during the previous calendar
 149 year. At a minimum, the report shall include:

150 (a) A list of all drugs affected by the drug price

151 increase and both the dollar amount of each drug price increase
152 and the percentage increase of each drug price increase,
153 relative to the previous price of the drug.

154 (b) A complete description of the factors contributing to
155 the drug price increase.

156 Section 4. Section 624.491, Florida Statutes, is created
157 to read:

158 624.491 Pharmacy audits.—

159 (1) A health insurer or health maintenance organization
160 providing pharmacy benefits through a major medical individual
161 or group health policy or health maintenance contract,
162 respectively, shall comply with the requirements of this section
163 when the insurer or health maintenance organization or any
164 entity acting on behalf of the insurer or health maintenance
165 organization, including, but not limited to, a pharmacy benefit
166 manager, audits the records of a pharmacy licensed under chapter
167 465. This section does not apply to audits in which suspected
168 fraudulent activity or other intentional or willful
169 misrepresentation is evidenced by a physical review, review of
170 claims data or statements, or other investigative methods;
171 audits of claims paid for by federally funded programs; or
172 concurrent reviews or desk audits that occur within 3 business
173 days of transmission of a claim and where no chargeback or
174 recoupment is demanded. An entity that audits a pharmacy located
175 within a Health Care Fraud Prevention and Enforcement Action

176 Team (HEAT) Task Force area designated by the United States
177 Department of Health and Human Services and the United States
178 Department of Justice may dispense with the notice requirements
179 of subsection (2) if such pharmacy has been a member of a
180 credentialed provider network for less than 12 months.

181 (2) An entity conducting a pharmacy audit shall:

182 (a) Notify a pharmacy at least 7 calendar days before the
183 initial onsite audit for each audit cycle.

184 (b) Ensure the audit is not initiated during the first 3
185 calendar days of a month unless the pharmacist consents
186 otherwise.

187 (c) Limit the scope of the audit period to no more than 24
188 months after the date a claim is submitted to or adjudicated by
189 the entity.

190 (d) Ensure that an audit requiring clinical or
191 professional judgment is conducted by or in consultation with a
192 pharmacist.

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

198 (f) Ensure that a pharmacy is reimbursed for a claim that
199 was retroactively denied for a clerical error, typographical
200 error, scrivener's error, or computer error if the prescription

201 was properly and correctly dispensed, unless a pattern of such
 202 errors exists, fraudulent billing is alleged, or the error
 203 results in actual financial loss to the entity.

204 (g) Provide a preliminary audit report to a pharmacy
 205 within 120 days after the conclusion of the audit.

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

209 (i) Provide a final audit report to a pharmacy within 6
 210 months after having provided the preliminary audit report.

211 (j) Calculate any recoupment or penalties based on actual
 212 overpayments and not according to the accounting practice of
 213 extrapolation.

214 (3) After receipt of the final audit report issued by a
 215 health insurer or health maintenance organization, a pharmacy
 216 may appeal the findings of the final audit as to whether a claim
 217 payment is due or the amount of a claim payment using the
 218 dispute resolution program established by s. 408.7057.

219 Section 5. Section 627.42394, Florida Statutes, is created
 220 to read:

221 627.42394 Formulary changes resulting from drug price
 222 increases.—

223 (1) A health insurer issuing a major medical individual or
 224 group policy shall submit, and update as necessary, contact
 225 information for a single point of contact for use by

226 prescription drug manufacturers to comply with s. 499.026. The
227 office shall maintain and publish a list of such points of
228 contact.

229 (2) A health insurer issuing a major medical individual or
230 group policy must provide written notice to affected insureds at
231 least 30 days in advance of making a drug formulary change
232 resulting from a drug price increase reported pursuant to s.
233 499.026.

234 (3) This section applies to policies entered into or
235 renewed on or after January 1, 2021.

236 Section 6. Section 627.64741, Florida Statutes, is amended
237 to read:

238 627.64741 Pharmacy benefit manager contracts.—

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

240 (a) "Administrative fee" means a fee or payment under a
241 contract between a health insurer and a pharmacy benefit manager
242 associated with the pharmacy benefit manager's administration of
243 the insurer's prescription drug benefit programs that is paid by
244 the insurer to the pharmacy benefit manager.

245 (b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount
246 that a pharmacy benefit manager reimburses a pharmacist for a
247 prescription drug, excluding dispensing fees, prior to the
248 application of copayments, coinsurance, and other cost-sharing
249 charges, if any.

250 (c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity

251 | doing business in this state which contracts to administer or
252 | manage prescription drug benefits on behalf of a health insurer
253 | to residents of this state.

254 | (d) "Rebate" means all discounts and other negotiated
255 | price concessions based on utilization of a prescription drug
256 | and paid by the pharmaceutical manufacturer or other entity,
257 | other than an insured, to the pharmacy benefit manager after the
258 | claim has been adjudicated at the pharmacy.

259 | (e) "Spread pricing" means any amount a pharmacy benefit
260 | manager charges or receives from a health insurer for payment of
261 | a prescription drug or pharmacy service that is greater than the
262 | amount the pharmacy benefit manager paid to the pharmacist or
263 | pharmacy that filled the prescription or provided the pharmacy
264 | service.

265 | (2) A contract between a health insurer and a pharmacy
266 | benefit manager must require that the pharmacy benefit manager:

267 | (a) Update maximum allowable cost pricing information at
268 | least every 7 calendar days.

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

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

276 limiting a pharmacist's ability to disclose whether the cost-
277 sharing obligation exceeds the retail price for a covered
278 prescription drug, and the availability of a more affordable
279 alternative drug, pursuant to s. 465.0244.

280 (4) A contract between a health insurer and a pharmacy
281 benefit manager must prohibit the pharmacy benefit manager from
282 requiring an insured to make a payment for a prescription drug
283 at the point of sale in an amount that exceeds the lesser of:

284 (a) The applicable cost-sharing amount; or

285 (b) The retail price of the drug in the absence of
286 prescription drug coverage.

287 (5) A contract between a health insurer and a pharmacy
288 benefit manager must require the pharmacy benefit manager to
289 report annually the following to the insurer:

290 (a) The aggregate number of prescriptions that were
291 dispensed.

292 (b) The number and percentage of all prescriptions that
293 were provided through retail pharmacies compared to mail-order
294 pharmacies. This paragraph applies to pharmacies licensed under
295 chapter 465 which dispense drugs to the general public and which
296 were paid by the health insurer or pharmacy benefit manager
297 under the contract.

298 (c) For retail pharmacies and mail-order pharmacies
299 described in paragraph (b), the general dispensing rate, which
300 is the number and percentage of prescriptions for which a

301 generic drug was available and dispensed.

302 (d) The aggregate amount of rebates the pharmacy benefit
303 manager received in association with claims administered on
304 behalf of the insurer and the aggregate amount of such rebates
305 the pharmacy benefit manager received that were not passed
306 through to the insurer.

307 (e) The aggregate amount of administrative fees paid to
308 the pharmacy benefit manager by the insurer for the
309 administration of the insurer's prescription drug benefit
310 programs.

311 (f) The types and aggregate amounts of any fees or
312 remittances paid to the pharmacy benefit manager by pharmacies.
313 The pharmacy benefit manager shall distinguish between fees paid
314 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
315 paid by pharmacies that are not covered entities.

316 (g) The aggregate amount of revenue generated by the
317 pharmacy benefit manager through the use of spread pricing in
318 association with the administration of the insurer's pharmacy
319 benefit programs.

320 (h) The type and aggregate amount of any other fees
321 collected by the pharmacy benefit manager in association with
322 claims administered on behalf of the insurer.

323 (6) Not later than June 30, 2021, and annually thereafter,
324 a health insurer shall submit a report to the office that
325 includes the information provided by its contracted pharmacy

326 benefit managers under subsection (5). The office shall publish
327 on its website an analysis of the reported information required
328 to be provided to the insurer under subsection (5) in an
329 aggregated amount for each pharmacy benefit manager.

330 (7) The office may require a health insurer to submit to
331 the office for review any contract, or amendments to a contract,
332 for the administration or management of prescription drug
333 benefits by a pharmacy benefit manager on behalf of the insurer.
334 After review of a contract, the office may order the insurer to
335 terminate the contract in accordance with the terms of the
336 contract and applicable law if the office determines that the
337 contract does not comply with the Florida Insurance Code or the
338 pharmacy benefit manager is not registered with the office
339 pursuant to s. 624.490.

340 (8) The commission may adopt rules to administer this
341 section.

342 (9)~~(5)~~ This section applies to contracts entered into or
343 renewed on or after July 1, 2020 ~~2018~~.

344 Section 7. Section 627.6572, Florida Statutes, is amended
345 to read:

346 627.6572 Pharmacy benefit manager contracts.—

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

348 (a) "Administrative fee" means a fee or payment under a
349 contract between a health insurer and a pharmacy benefit manager
350 associated with the pharmacy benefit manager's administration of

351 the insurer's prescription drug benefit programs that is paid by
352 the insurer to the pharmacy benefit manager.

353 (b)-(a) "Maximum allowable cost" means the per-unit amount
354 that a pharmacy benefit manager reimburses a pharmacist for a
355 prescription drug, excluding dispensing fees, prior to the
356 application of copayments, coinsurance, and other cost-sharing
357 charges, if any.

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

362 (d) "Rebate" means all discounts and other negotiated
363 price concessions based on utilization of a prescription drug
364 and paid by the pharmaceutical manufacturer or other entity,
365 other than an insured, to the pharmacy benefit manager after the
366 claim has been adjudicated at the pharmacy.

367 (e) "Spread pricing" means any amount a pharmacy benefit
368 manager charges or receives from a health insurer for payment of
369 a prescription drug or pharmacy service that is greater than the
370 amount the pharmacy benefit manager paid to the pharmacist or
371 pharmacy that filled the prescription or provided the pharmacy
372 service.

373 (2) A contract between a health insurer and a pharmacy
374 benefit manager must require that the pharmacy benefit manager:

375 (a) Update maximum allowable cost pricing information at

376 | least every 7 calendar days.

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

382 | (3) A contract between a health insurer and a pharmacy
 383 | benefit manager must prohibit the pharmacy benefit manager from
 384 | limiting a pharmacist's ability to disclose whether the cost-
 385 | sharing obligation exceeds the retail price for a covered
 386 | prescription drug, and the availability of a more affordable
 387 | alternative drug, pursuant to s. 465.0244.

388 | (4) A contract between a health insurer and a pharmacy
 389 | benefit manager must prohibit the pharmacy benefit manager from
 390 | requiring an insured to make a payment for a prescription drug
 391 | at the point of sale in an amount that exceeds the lesser of:

392 | (a) The applicable cost-sharing amount; or

393 | (b) The retail price of the drug in the absence of
 394 | prescription drug coverage.

395 | (5) A contract between a health insurer and a pharmacy
 396 | benefit manager must require the pharmacy benefit manager to
 397 | report annually the following to the insurer:

398 | (a) The aggregate number of prescriptions that were
 399 | dispensed.

400 | (b) The number and percentage of all prescriptions that

401 were provided through retail pharmacies compared to mail-order
402 pharmacies. This paragraph applies to pharmacies licensed under
403 chapter 465 which dispense drugs to the general public and which
404 were paid by the health insurer or pharmacy benefit manager
405 under the contract.

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

410 (d) The aggregate amount of rebates the pharmacy benefit
411 manager received in association with claims administered on
412 behalf of the insurer and the aggregate amount of such rebates
413 the pharmacy benefit manager received that were not passed
414 through to the insurer.

415 (e) The aggregate amount of administrative fees paid to
416 the pharmacy benefit manager by the insurer for the
417 administration of the insurer's prescription drug benefit
418 programs.

419 (f) The types and aggregate amounts of any fees or
420 remittances paid to the pharmacy benefit manager by pharmacies.
421 The pharmacy benefit manager shall distinguish between fees paid
422 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
423 paid by pharmacies that are not covered entities.

424 (g) The aggregate amount of revenue generated by the
425 pharmacy benefit manager through the use of spread pricing in

426 association with the administration of the insurer's pharmacy
427 benefit programs.

428 (h) The type and aggregate amount of any other fees
429 collected by the pharmacy benefit manager in association with
430 claims administered on behalf of the insurer.

431 (6) Not later than June 30, 2021, and annually thereafter,
432 a health insurer shall submit a report to the office that
433 includes the information provided by its contracted pharmacy
434 benefit managers under subsection (5). The office shall publish
435 on its website an analysis of the reported information required
436 to be provided to the insurer under subsection (5) in an
437 aggregated amount for each pharmacy benefit manager.

438 (7) The office may require a health insurer to submit to
439 the office for review any contract, or amendments to a contract,
440 for the administration or management of prescription drug
441 benefits by a pharmacy benefit manager on behalf of the insurer.
442 After review of a contract, the office may order the insurer to
443 terminate the contract in accordance with the terms of the
444 contract and applicable law if the office determines that the
445 contract does not comply with the Florida Insurance Code or the
446 pharmacy benefit manager is not registered with the office
447 pursuant to s. 624.490.

448 (8) The commission may adopt rules to administer this
449 section.

450 (9)(5) This section applies to contracts entered into or

451 renewed on or after July 1, 2020 ~~2018~~.

452 Section 8. Section 641.3131, Florida Statutes, is created
453 to read:

454 641.3131 Formulary changes resulting from drug price
455 increases.—

456 (1) A health maintenance organization issuing a major
457 medical or other comprehensive coverage contract shall submit,
458 and update as necessary, contact information for a single point
459 of contact for use by prescription drug manufacturers to comply
460 with s. 499.026. The office shall maintain and publish a list of
461 such points of contact.

462 (2) A health maintenance organization issuing a major
463 medical or other comprehensive coverage contract must provide
464 written notice to affected subscribers at least 30 days in
465 advance of making a drug formulary change resulting from a drug
466 price increase reported pursuant to s. 499.026.

467 (3) This section applies to contracts entered into or
468 renewed on or after January 1, 2021.

469 Section 9. Section 641.314, Florida Statutes, is amended
470 to read:

471 641.314 Pharmacy benefit manager contracts.—

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

473 (a) "Administrative fee" means a fee or payment under a
474 contract between a health maintenance organization and a
475 pharmacy benefit manager associated with the pharmacy benefit

476 manager's administration of the health maintenance
477 organization's prescription drug benefit programs that is paid
478 by the health maintenance organization to the pharmacy benefit
479 manager.

480 (b)(a) "Maximum allowable cost" means the per-unit amount
481 that a pharmacy benefit manager reimburses a pharmacist for a
482 prescription drug, excluding dispensing fees, prior to the
483 application of copayments, coinsurance, and other cost-sharing
484 charges, if any.

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

489 (d) "Rebate" means all discounts and other negotiated
490 price concessions based on utilization of a prescription drug
491 and paid by the pharmaceutical manufacturer or other entity,
492 other than a subscriber, to the pharmacy benefit manager after
493 the claim has been adjudicated at the pharmacy.

494 (e) "Spread pricing" means any amount a pharmacy benefit
495 manager charges or receives from a health maintenance
496 organization for payment of a prescription drug or pharmacy
497 service that is greater than the amount the pharmacy benefit
498 manager paid to the pharmacist or pharmacy that filled the
499 prescription or provided the pharmacy service.

500 (2) A contract between a health maintenance organization

501 and a pharmacy benefit manager must require that the pharmacy
 502 benefit manager:

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

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

510 (3) A contract between a health maintenance organization
 511 and a pharmacy benefit manager must prohibit the pharmacy
 512 benefit manager from limiting a pharmacist's ability to disclose
 513 whether the cost-sharing obligation exceeds the retail price for
 514 a covered prescription drug, and the availability of a more
 515 affordable alternative drug, pursuant to s. 465.0244.

516 (4) A contract between a health maintenance organization
 517 and a pharmacy benefit manager must prohibit the pharmacy
 518 benefit manager from requiring a subscriber to make a payment
 519 for a prescription drug at the point of sale in an amount that
 520 exceeds the lesser of:

521 (a) The applicable cost-sharing amount; or

522 (b) The retail price of the drug in the absence of
 523 prescription drug coverage.

524 (5) A contract between a health maintenance organization
 525 and a pharmacy benefit manager must require the pharmacy benefit

526 manager to report annually the following to the insurer:

527 (a) The aggregate number of prescriptions that were
528 dispensed.

529 (b) The number and percentage of all prescriptions that
530 were provided through retail pharmacies compared to mail-order
531 pharmacies. This paragraph applies to pharmacies licensed under
532 chapter 465 which dispense drugs to the general public and which
533 were paid by the health maintenance organization or pharmacy
534 benefit manager under the contract.

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

539 (d) The aggregate amount of rebates the pharmacy benefit
540 manager received in association with claims administered on
541 behalf of the health maintenance organization and the aggregate
542 amount of such rebates the pharmacy benefit manager received
543 that were not passed through to the health maintenance
544 organization.

545 (e) The aggregate amount of administrative fees paid to
546 the pharmacy benefit manager by the health maintenance
547 organization for the administration of the health maintenance
548 organization's prescription drug benefit programs.

549 (f) The types and aggregate amounts of any fees or
550 remittances paid to the pharmacy benefit manager by pharmacies.

551 The pharmacy benefit manager shall distinguish between fees paid
552 by covered entities, as defined in 42 U.S.C. s. 256b, and fees
553 paid by pharmacies that are not covered entities.

554 (g) The aggregate amount of revenue generated by the
555 pharmacy benefit manager through the use of spread pricing in
556 association with the administration of the health maintenance
557 organization's pharmacy benefit programs.

558 (h) The type and aggregate amount of any other fees
559 collected by the pharmacy benefit manager in association with
560 claims administered on behalf of the health maintenance
561 organization.

562 (6) Not later than June 30, 2021, and annually thereafter,
563 a health maintenance organization shall submit a report to the
564 office that includes the information provided by its contracted
565 pharmacy benefit managers under subsection (5). The office shall
566 publish on its website an analysis of the reported information
567 required to be provided to the health maintenance organization
568 under subsection (5) in an aggregated amount for each pharmacy
569 benefit manager.

570 (7) The office may require a health maintenance
571 organization to submit to the office for review any contract, or
572 amendments to a contract, for the administration or management
573 of prescription drug benefits by a pharmacy benefit manager on
574 behalf of the health maintenance organization. After review of a
575 contract, the office may order the health maintenance

576 organization to terminate the contract in accordance with the
577 terms of the contract and applicable law if the office
578 determines that the contract does not comply with the Florida
579 Insurance Code or the pharmacy benefit manager is not registered
580 with the office pursuant to s. 624.490.

581 (8) The commission may adopt rules to administer this
582 section.

583 (9)~~(5)~~ This section applies to contracts entered into or
584 renewed on or after July 1, 2020 ~~2018~~.

585 Section 10. (1) The Agency for Health Care Administration
586 shall contract for an independent analysis of pharmacy benefit
587 management practices under the Statewide Medicaid Managed Care
588 program. The analysis shall outline the types of pharmacy
589 benefit pricing contracts in place between managed care plans
590 and contracted pharmacy benefit managers and between managed
591 care plans or pharmacy benefit managers and pharmacies. At a
592 minimum, the analysis shall include:

593 (a) An examination of the fees paid to each contracted
594 pharmacy benefit manager by each managed care plan.

595 (b) An examination of the fees charged to pharmacies by
596 each managed care plan or contracted pharmacy benefit manager.

597 (c) A determination of spread pricing revenues retained by
598 each managed care plan or contracted pharmacy benefit manager.

599 (2) For purposes of this section, the term "pharmacy
600 benefit manager" means a person or entity doing business in this

601 state which contracts to administer or manage prescription drug
602 benefits on behalf of a managed care plan.

603 (3) For purposes of this section, the term "spread
604 pricing" refers to any amount a managed care plan or pharmacy
605 benefit manager received from the Medicaid program for payment
606 of a prescription drug that is greater than that paid to the
607 pharmacist or pharmacy that filled a prescription for that
608 prescription drug.

609 (4) The agency shall submit the completed analysis to the
610 Governor, the President of the Senate, and the Speaker of the
611 House of Representatives by October 1, 2020.

612 Section 11. (1) The Agency for Health Care Administration
613 shall conduct an analysis of managed care plan pharmacy networks
614 under the Statewide Medicaid Managed Care program to ensure that
615 enrollees have sufficient choice of pharmacies within
616 established geographic parameters. The agency must also analyze
617 the composition of each managed care plan pharmacy network to
618 determine the market share of large chain pharmacies, small
619 chain pharmacies, and independent pharmacies, respectively. The
620 analysis shall include:

621 (a) An examination of the pharmacy contracting patterns by
622 each managed care plan or contracted pharmacy benefit manager.

623 (b) An examination of any financial relationship between a
624 managed care provider or contracted pharmacy benefit manager and
625 its contracted pharmacies. The analysis shall examine whether a

626 managed care plan or pharmacy benefit manager establishes a
627 network that favors pharmacies in which the managed care plan or
628 pharmacy benefit manager owns a controlling or substantial
629 financial interest.

630 (2) For purposes of this section, the term "pharmacy
631 benefit manager" means a person or entity doing business in this
632 state which contracts to administer or manage prescription drug
633 benefits on behalf of a managed care plan.

634 (3) The agency shall submit the completed analysis to the
635 Governor, the President of the Senate, and the Speaker of the
636 House of Representatives by October 1, 2020.

637 Section 12. If any provision of this act or its
638 application to any person or circumstance is held invalid, the
639 invalidity does not affect other provisions or applications of
640 the act which can be given effect without the invalid provision
641 or its application, and to this end the provisions of this act
642 are severable.

643 Section 13. This act shall take effect upon becoming a
644 law.