

1                   A bill to be entitled  
2           An act relating to pharmacies and pharmacy benefit  
3           managers; amending s. 624.3161, F.S.; requiring the  
4           Office of Insurance Regulation to examine pharmacy  
5           benefit managers under certain circumstances;  
6           specifying that certain examination costs are payable  
7           by persons examined; transferring, renumbering, and  
8           amending s. 465.1885, F.S.; revising the entities  
9           conducting pharmacy audits to which certain  
10          requirements and restrictions apply; authorizing  
11          audited pharmacies to appeal certain findings;  
12          providing that health insurers and health maintenance  
13          organizations that transfer a certain payment  
14          obligation to pharmacy benefit managers remain  
15          responsible for specified violations; amending ss.  
16          627.6131 and 641.3155, F.S.; revising the definition  
17          of the term "claim" and providing a definition for the  
18          term "pharmacy claim"; providing an exception to  
19          applicability; making technical changes; prohibiting  
20          pharmacy benefit managers from charging pharmacists  
21          and pharmacies certain fees and from retroactively  
22          denying, holding back, and reducing payments for  
23          covered claims; requiring that the Department of  
24          Financial Services be given access to certain records,  
25          data, and information; authorizing the department to

26 investigate certain violations; providing penalties;  
27 providing applicability; amending ss. 627.64741,  
28 627.6572, and 641.314, F.S.; revising the definition  
29 of the term "maximum allowable cost"; requiring  
30 contracts between pharmacy benefit managers and  
31 individual health insurers, group health insurers, and  
32 health maintenance organizations, respectively, to  
33 prohibit pharmacy benefit managers from charging  
34 pharmacists certain fees and from retroactively  
35 denying, holding back, and reducing payments for  
36 covered claims; requiring that the department be given  
37 access to certain records, data, and information;  
38 authorizing the department to investigate certain  
39 violations; providing penalties; authorizing the  
40 office to require individual health insurers, group  
41 health insurers, and health maintenance organizations,  
42 respectively, to submit to the office certain  
43 contracts or contract amendments entered into with  
44 pharmacy benefit managers; authorizing the office to  
45 order individual health insurers, group health  
46 insurers, and health maintenance organizations,  
47 respectively, to cancel such contracts under certain  
48 circumstances; authorizing the Financial Services  
49 Commission to adopt rules; revising applicability;  
50 amending s. 627.6699, F.S.; requiring certain health

51 benefit plans covering small employers to comply with  
52 specified provisions; providing an effective date.

53

54 Be It Enacted by the Legislature of the State of Florida:

55

56 Section 1. Subsections (1) and (3) of section 624.3161,  
57 Florida Statutes, are amended to read:

58 624.3161 Market conduct examinations.—

59 (1) As often as it deems necessary, the office shall  
60 examine each pharmacy benefit manager as defined in s. 624.490;  
61 each licensed rating organization;~~;~~ each advisory organization;~~;~~  
62 each group, association, carrier~~;~~ as defined in s. 440.02, or  
63 other organization of insurers which engages in joint  
64 underwriting or joint reinsurance;~~;~~ and each authorized insurer  
65 transacting in this state any class of insurance to which the  
66 provisions of chapter 627 are applicable. The examination shall  
67 be for the purpose of ascertaining compliance by the person  
68 examined with the applicable provisions of chapters 440, 624,  
69 626, 627, and 635.

70 (3) The examination may be conducted by an independent  
71 professional examiner under contract to the office, in which  
72 case payment shall be made directly to the contracted examiner  
73 by the insurer or person examined in accordance with the rates  
74 and terms agreed to by the office and the examiner.

75 Section 2. Section 465.1885, Florida Statutes, is

76 transferred, renumbered as section 624.491, Florida Statutes,  
 77 and amended to read:

78 624.491 ~~465.1885~~ Pharmacy audits; ~~rights.~~-

79 (1) A health insurer or health maintenance organization  
 80 providing pharmacy benefits through a major medical individual  
 81 or group health insurance policy or a health maintenance  
 82 contract, respectively, shall comply with the requirements of  
 83 this section when the insurer or health maintenance organization  
 84 or any person or entity acting on behalf of the insurer or  
 85 health maintenance organization, including, but not limited to,  
 86 a pharmacy benefit manager as defined in s. 624.490, audits the  
 87 records of a pharmacy licensed under chapter 465. The person or  
 88 entity conducting such audit must ~~If an audit of the records of~~  
 89 ~~a pharmacy licensed under this chapter is conducted directly or~~  
 90 ~~indirectly by a managed care company, an insurance company, a~~  
 91 ~~third-party payor, a pharmacy benefit manager, or an entity that~~  
 92 ~~represents responsible parties such as companies or groups,~~  
 93 ~~referred to as an "entity" in this section, the pharmacy has the~~  
 94 ~~following rights:~~

95 (a) Except as provided in subsection (3), notify the  
 96 pharmacy ~~To be notified~~ at least 7 calendar days before the  
 97 initial onsite audit for each audit cycle.

98 (b) Not schedule an ~~To have the~~ onsite audit during  
 99 ~~scheduled after~~ the first 3 calendar days of a month unless the  
 100 pharmacist consents otherwise.

101           (c) Limit the duration of ~~To have~~ the audit period ~~limited~~  
102 to 24 months after the date a claim is submitted to or  
103 adjudicated by the entity.

104           (d) In the case of ~~To have~~ an audit that requires clinical  
105 or professional judgment, conduct the audit in consultation  
106 with, or allow the audit to be conducted by, ~~or in consultation~~  
107 ~~with~~ a pharmacist.

108           (e) Allow the pharmacy to use the written and verifiable  
109 records of a hospital, physician, or other authorized  
110 practitioner, which are transmitted by any means of  
111 communication, to validate the pharmacy records in accordance  
112 with state and federal law.

113           (f) Reimburse the pharmacy ~~To be reimbursed~~ for a claim  
114 that was retroactively denied for a clerical error,  
115 typographical error, scrivener's error, or computer error if the  
116 prescription was properly and correctly dispensed, unless a  
117 pattern of such errors exists, fraudulent billing is alleged, or  
118 the error results in actual financial loss to the entity.

119           (g) Provide the pharmacy with a copy of ~~To receive~~ the  
120 preliminary audit report within 120 days after the conclusion of  
121 the audit.

122           (h) Allow the pharmacy to produce documentation to address  
123 a discrepancy or audit finding within 10 business days after the  
124 preliminary audit report is delivered to the pharmacy.

125           (i) Provide the pharmacy with a copy of ~~To receive~~ the

126 final audit report within 6 months after receipt of ~~receiving~~  
127 the preliminary audit report.

128 (j) Calculate any ~~To have~~ recoupment or penalties based on  
129 actual overpayments and not according to the accounting practice  
130 of extrapolation.

131 (2) ~~The rights contained in~~ This section does ~~de~~ not apply  
132 to:

133 (a) Audits in which suspected fraudulent activity or other  
134 intentional or willful misrepresentation is evidenced by a  
135 physical review, review of claims data or statements, or other  
136 investigative methods;

137 (b) Audits of claims paid for by federally funded  
138 programs; or

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

142 (3) An entity that audits a pharmacy located within a  
143 Health Care Fraud Prevention and Enforcement Action Team (HEAT)  
144 Task Force area designated by the United States Department of  
145 Health and Human Services and the United States Department of  
146 Justice may dispense with the notice requirements of paragraph  
147 (1)(a) if such pharmacy has been a member of a credentialed  
148 provider network for less than 12 months.

149 (4) Pursuant to s. 408.7057, and after receipt of the  
150 final audit report issued by the health insurer or health

151 maintenance organization, a pharmacy may appeal the findings of  
152 the final audit as to whether a claim payment is due and as to  
153 the amount of a claim payment.

154 (5) A health insurer or health maintenance organization  
155 that, under terms of a contract, transfers to a pharmacy benefit  
156 manager the obligation to pay any pharmacy licensed under  
157 chapter 465 for any pharmacy benefit claims arising from  
158 services provided to or for the benefit of any insured or  
159 subscriber remains responsible for any violations of this  
160 section, s. 627.6131, or s. 641.3155, as applicable.

161 Section 3. Subsections (18) and (19) of section 627.6131,  
162 Florida Statutes, are renumbered as subsections (19) and (20),  
163 respectively, subsections (2), (15), (16), and (17) are amended,  
164 and a new subsection (18) is added to that section, to read:

165 627.6131 Payment of claims.—

166 (2) (a) ~~(2)~~ As used in this section, the term "claim" for a  
167 noninstitutional provider means a paper or electronic billing  
168 instrument submitted to the insurer's designated location that  
169 consists of the HCFA 1500 data set, or its successor, that has  
170 all mandatory entries for a physician licensed under chapter  
171 458, chapter 459, chapter 460, chapter 461, or chapter 463, or  
172 psychologists licensed under chapter 490 or any appropriate  
173 billing instrument that has all mandatory entries for any other  
174 noninstitutional provider. For institutional providers, the term  
175 "claim" means a paper or electronic billing instrument submitted

176 to the insurer's designated location that consists of the UB-92  
 177 data set or its successor with entries stated as mandatory by  
 178 the National Uniform Billing Committee.

179 (b) However, if the context so indicates, the term "claim"  
 180 or "pharmacy claim" means a paper or electronic billing  
 181 instrument submitted to a pharmacy benefit manager acting on  
 182 behalf of a health insurer.

183 (15) Except for subsection (18), this section is  
 184 applicable only to a major medical expense health insurance  
 185 policy as defined in s. 627.643(2) (e) offered by a group or an  
 186 individual health insurer licensed pursuant to chapter 624,  
 187 including a preferred provider policy under s. 627.6471 and an  
 188 exclusive provider organization under s. 627.6472 or a group or  
 189 individual insurance contract that only provides direct payments  
 190 to dentists for enumerated dental services.

191 (16) Notwithstanding paragraph (4) (b), if ~~where~~ an  
 192 electronic pharmacy claim is submitted to a pharmacy benefit  
 193 ~~benefits~~ manager acting on behalf of a health insurer, the  
 194 pharmacy benefit ~~benefits~~ manager shall, within 30 days after ~~of~~  
 195 receipt of the claim, pay the claim or notify a provider or  
 196 designee if a claim is denied or contested. Notice of the  
 197 insurer's action on the claim and payment of the claim is  
 198 considered to be made on the date the notice or payment was  
 199 mailed or electronically transferred.

200 (17) Notwithstanding paragraph (5) (a), if effective

201 ~~November 1, 2003, where~~ a nonelectronic pharmacy claim is  
202 submitted to a pharmacy benefit ~~benefits~~ manager acting on  
203 behalf of a health insurer, the pharmacy benefit ~~benefits~~  
204 manager shall provide acknowledgment of receipt of the claim  
205 within 30 days after receipt of the claim to the provider or  
206 provide a provider within 30 days after receipt with electronic  
207 access to the status of a submitted claim.

208 (18) (a) A pharmacy benefit manager may not:

209 1. Charge a pharmacist or pharmacy a fee related to the  
210 payment of a pharmacy claim, including, but not limited to, a  
211 fee for:

212 a. The submission of the claim;

213 b. The pharmacist's or pharmacy's enrollment or  
214 participation in a retail pharmacy network; or

215 c. The processing or transmission of the claim; or

216 2. Retroactively deny, hold back, or reduce payment for a  
217 covered claim after payment for the claim.

218 (b)1. The department shall have access to all financial  
219 and utilization records in the possession of, and data and  
220 information used by, a pharmacy benefit manager in relation to  
221 the pharmacy benefit management services provided to health  
222 insurers or other providers using the pharmacy benefit  
223 management services in the state.

224 2. The department may investigate an alleged violation of  
225 this subsection, and a pharmacy benefit manager who violates

226 this subsection is liable for a civil fine of \$10,000 for each  
227 violation.

228 (c) This subsection applies to contracts entered into,  
229 amended, or renewed on or after July 1, 2021.

230 Section 4. Section 627.64741, Florida Statutes, is amended  
231 to read:

232 627.64741 Pharmacy benefit manager contracts.—

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

234 (a) "Maximum allowable cost" means the per-unit amount  
235 that a pharmacy benefit manager reimburses a pharmacist for a  
236 prescription drug which:

237 1. Is as specified at the time of claim processing and  
238 directly or indirectly reported on the initial remittance advice  
239 of an adjudicated claim for a generic drug, brand name drug,  
240 biological product, or specialty drug;

241 2. Must be based on pricing published in the Medi-Span  
242 Master Drug Database or, if the pharmacy benefit manager uses  
243 only First Databank (FDB) MedKnowledge, on pricing published in  
244 FDB MedKnowledge;

245 3. Excludes ~~excluding~~ dispensing fees; and

246 4. Is determined before ~~prior to~~ the application of  
247 copayments, coinsurance, and other cost-sharing charges, if any.

248 (b) "Pharmacy benefit manager" means a person or entity  
249 doing business in this state which contracts to administer or  
250 manage prescription drug benefits on behalf of a health insurer

251 to residents of this state.

252 (2) A health insurer may contract only with a pharmacy  
253 benefit manager that satisfies all of the following conditions A  
254 ~~contract between a health insurer and a pharmacy benefit manager~~  
255 ~~must require that the pharmacy benefit manager:~~

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

258 (b) Maintains ~~Maintain~~ a process that ~~will~~, in a timely  
259 manner, will eliminate drugs from maximum allowable cost lists  
260 or modify drug prices to remain consistent with changes in  
261 pricing data used in formulating maximum allowable cost prices  
262 and product availability.

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

269 (d) ~~(4)~~ Does not require ~~A contract between a health~~  
270 ~~insurer and a pharmacy benefit manager must prohibit the~~  
271 ~~pharmacy benefit manager from requiring~~ an insured to make a  
272 payment for a prescription drug at the point of sale in an  
273 amount that exceeds the lesser of:

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

275 2. ~~(b)~~ The retail price of the drug in the absence of

276 prescription drug coverage.

277 (3) A contract between a health insurer and a pharmacy  
278 benefit manager must prohibit the pharmacy benefit manager from:

279 (a) Charging a pharmacist a fee related to the payment of  
280 a pharmacy claim, including, but not limited to, a fee for:

281 1. The submission of the claim;

282 2. The pharmacist's enrollment or participation in a  
283 retail pharmacy network; or

284 3. The processing or transmission of the claim; or

285 (b) Retroactively denying, holding back, or reducing  
286 payment for a covered claim after payment for the claim.

287  
288 The department shall have access to all financial and  
289 utilization records in the possession of, and data and  
290 information used by, a pharmacy benefit manager in relation to  
291 the pharmacy benefit management services provided to health  
292 insurers or other providers using the pharmacy benefit  
293 management services in the state. The department may investigate  
294 an alleged violation of this subsection, and a pharmacy benefit  
295 manager who violates this subsection is liable for a civil fine  
296 of \$10,000 for each violation.

297 (4) The office may require a health insurer to submit to  
298 the office any contract or amendment to a contract for the  
299 administration or management of prescription drug benefits by a  
300 pharmacy benefit manager on behalf of the insurer.

301 (5) After review of a contract submitted under subsection  
 302 (4), the office may order the health insurer to cancel the  
 303 contract in accordance with the terms of the contract and  
 304 applicable law if the office determines that any of the  
 305 following conditions exists:

306 (a) The fees to be paid by the insurer are so unreasonably  
 307 high as compared with similar contracts entered into by  
 308 insurers, or as compared with similar contracts entered into by  
 309 other insurers in similar circumstances, that the contract is  
 310 detrimental to the policyholders of the insurer.

311 (b) The contract does not comply with this section or any  
 312 other provision of the Florida Insurance Code.

313 (c) The pharmacy benefit manager is not registered with  
 314 the office as required under s. 624.490.

315 (6) The commission may adopt rules to administer this  
 316 section.

317 (7)~~(5)~~ This section applies to contracts entered into,  
 318 amended, or renewed on or after July 1, 2021 ~~2018~~.

319 Section 5. Section 627.6572, Florida Statutes, is amended  
 320 to read:

321 627.6572 Pharmacy benefit manager contracts.—

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

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

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

330 2. Must be based on pricing published in the Medi-Span  
331 Master Drug Database or, if the pharmacy benefit manager uses  
332 only First Databank (FDB) MedKnowledge, on pricing published in  
333 FDB MedKnowledge;

334 3. Excludes ~~excluding~~ dispensing fees; and,

335 4. Is determined before ~~prior to~~ the application of  
336 copayments, coinsurance, and other cost-sharing charges, if any.

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

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

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

347 (b) Maintains ~~Maintain~~ a process that ~~will~~, in a timely  
348 manner, will eliminate drugs from maximum allowable cost lists  
349 or modify drug prices to remain consistent with changes in  
350 pricing data used in formulating maximum allowable cost prices

351 and product availability.

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

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

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

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

366 (3) A contract between a health insurer and a pharmacy  
367 benefit manager must prohibit the pharmacy benefit manager from:

368 (a) Charging a pharmacist a fee related to the payment of  
369 a pharmacy claim, including, but not limited to, a fee for:

370 1. The submission of the claim;

371 2. The pharmacist's enrollment or participation in a  
372 retail pharmacy network; or

373 3. The processing or transmission of the claim; or

374 (b) Retroactively denying, holding back, or reducing  
375 payment for a covered claim after payment for the claim.

376  
377 The department shall have access to all financial and  
378 utilization records in the possession of, and data and  
379 information used by, a pharmacy benefit manager in relation to  
380 the pharmacy benefit management services provided to health  
381 insurers or other providers using the pharmacy benefit  
382 management services in the state. The department may investigate  
383 an alleged violation of this subsection, and a pharmacy benefit  
384 manager who violates this subsection is liable for a civil fine  
385 of \$10,000 for each violation.

386 (4) The office may require a health insurer to submit to  
387 the office any contract or amendment to a contract for the  
388 administration or management of prescription drug benefits by a  
389 pharmacy benefit manager on behalf of the insurer.

390 (5) After review of a contract submitted under subsection  
391 (4), the office may order the health insurer to cancel the  
392 contract in accordance with the terms of the contract and  
393 applicable law if the office determines that any of the  
394 following conditions exists:

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

400 (b) The contract does not comply with this section or any

401 other provision of the Florida Insurance Code.

402 (c) The pharmacy benefit manager is not registered with  
 403 the office as required under s. 624.490.

404 (6) The commission may adopt rules to administer this  
 405 section.

406 (7)~~(5)~~ This section applies to contracts entered into,  
 407 amended, or renewed on or after July 1, 2021 ~~2018~~.

408 Section 6. Paragraph (h) is added to subsection (5) of  
 409 section 627.6699, Florida Statutes, to read:

410 627.6699 Employee Health Care Access Act.—

411 (5) AVAILABILITY OF COVERAGE.—

412 (h) A health benefit plan covering small employers which  
 413 is issued, amended, or renewed in this state on or after July 1,  
 414 2021, must comply with s. 627.6572.

415 Section 7. Section 641.314, Florida Statutes, is amended  
 416 to read:

417 641.314 Pharmacy benefit manager contracts.—

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

419 (a) "Maximum allowable cost" means the per-unit amount  
 420 that a pharmacy benefit manager reimburses a pharmacist for a  
 421 prescription drug which:

422 1. Is as specified at the time of claim processing and  
 423 directly or indirectly reported on the initial remittance advice  
 424 of an adjudicated claim for a generic drug, brand name drug,  
 425 biological product, or specialty drug;

426           2. Must be based on pricing published in the Medi-Span  
427 Master Drug Database or, if the pharmacy benefit manager uses  
428 only First Databank (FDB) MedKnowledge, on pricing published in  
429 FDB MedKnowledge;

430           3. Excludes ~~Excluding~~ dispensing fees; and,

431           4. Is determined before ~~prior to~~ the application of  
432 copayments, coinsurance, and other cost-sharing charges, if any.

433           (b) "Pharmacy benefit manager" means a person or entity  
434 doing business in this state which contracts to administer or  
435 manage prescription drug benefits on behalf of a health  
436 maintenance organization to residents of this state.

437           (2) A health maintenance organization may contract only  
438 with a pharmacy benefit manager that satisfies all of the  
439 following conditions ~~A contract between a health maintenance~~  
440 ~~organization and a pharmacy benefit manager must require that~~  
441 ~~the pharmacy benefit manager:~~

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

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

449           (c) ~~(3)~~ Does not limit ~~A contract between a health~~  
450 ~~maintenance organization and a pharmacy benefit manager must~~

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451 ~~prohibit the pharmacy benefit manager from limiting a~~  
452 ~~pharmacist's ability to disclose whether the cost-sharing~~  
453 ~~obligation exceeds the retail price for a covered prescription~~  
454 ~~drug, and the availability of a more affordable alternative~~  
455 ~~drug, pursuant to s. 465.0244.~~

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

461 1. (a) The applicable cost-sharing amount; or  
462 2. (b) The retail price of the drug in the absence of  
463 prescription drug coverage.

464 (3) A contract between a health maintenance organization  
465 and a pharmacy benefit manager must prohibit the pharmacy  
466 benefit manager from:

467 (a) Charging a pharmacist a fee related to the payment of  
468 a pharmacy claim, including, but not limited to, a fee for:

469 1. The submission of the claim;  
470 2. The pharmacist's enrollment or participation in a  
471 retail pharmacy network; or

472 3. The processing or transmission of the claim; or  
473 (b) Retroactively denying, holding back, or reducing  
474 payment for a covered claim after payment for the claim.  
475

476 The department shall have access to all financial and  
477 utilization records in the possession of, and data and  
478 information used by, a pharmacy benefit manager in relation to  
479 the pharmacy benefit management services provided to health  
480 maintenance organizations or other providers using the pharmacy  
481 benefit management services in the state. The department may  
482 investigate an alleged violation of this subsection, and a  
483 pharmacy benefit manager who violates this subsection is liable  
484 for a civil fine of \$10,000 for each violation.

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

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

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

501 maintenance organization.

502 (b) The contract does not comply with this section or any  
503 other provision of the Florida Insurance Code.

504 (c) The pharmacy benefit manager is not registered with  
505 the office as required under s. 624.490.

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

508 (7)~~(5)~~ This section applies to contracts entered into,  
509 amended, or renewed on or after July 1, 2021 ~~2018~~.

510 Section 8. Subsections (16) and (17) of section 641.3155,  
511 Florida Statutes, are renumbered as subsections (17) and (18),  
512 respectively, subsections (1), (14), and (15) are amended, and a  
513 new subsection (16) is added to that section, to read:

514 641.3155 Prompt payment of claims.—

515 (1)(a)~~(1)~~ As used in this section, the term "claim" for a  
516 noninstitutional provider means a paper or electronic billing  
517 instrument submitted to the health maintenance organization's  
518 designated location that consists of the HCFA 1500 data set, or  
519 its successor, that has all mandatory entries for a physician  
520 licensed under chapter 458, chapter 459, chapter 460, chapter  
521 461, or chapter 463, or psychologists licensed under chapter 490  
522 or any appropriate billing instrument that has all mandatory  
523 entries for any other noninstitutional provider. For  
524 institutional providers, the term "claim" means a paper or  
525 electronic billing instrument submitted to the health

526 maintenance organization's designated location that consists of  
527 the UB-92 data set or its successor with entries stated as  
528 mandatory by the National Uniform Billing Committee.

529 (b) However, if the context so indicates, the term "claim"  
530 or "pharmacy claim" means a paper or electronic billing  
531 instrument submitted to a pharmacy benefit manager acting on  
532 behalf of a health maintenance organization.

533 (14) Notwithstanding paragraph (3) (b), if ~~where~~ an  
534 electronic pharmacy claim is submitted to a pharmacy benefit  
535 ~~benefits~~ manager acting on behalf of a health maintenance  
536 organization, the pharmacy benefit ~~benefits~~ manager shall,  
537 within 30 days after ~~of~~ receipt of the claim, pay the claim or  
538 notify a provider or designee if a claim is denied or contested.  
539 Notice of the organization's action on the claim and payment of  
540 the claim is considered to be made on the date the notice or  
541 payment was mailed or electronically transferred.

542 (15) Notwithstanding paragraph (4) (a), if ~~effective~~  
543 ~~November 1, 2003, where~~ a nonelectronic pharmacy claim is  
544 submitted to a pharmacy benefit ~~benefits~~ manager acting on  
545 behalf of a health maintenance organization, the pharmacy  
546 benefit ~~benefits~~ manager shall provide acknowledgment of receipt  
547 of the claim within 30 days after receipt of the claim to the  
548 provider or provide a provider within 30 days after receipt with  
549 electronic access to the status of a submitted claim.

550 (16) (a) A pharmacy benefit manager may not:

551        1. Charge a pharmacist or pharmacy a fee related to the  
552 payment of a pharmacy claim, including, but not limited to, a  
553 fee for:

554            a. The submission of the claim;  
555            b. The pharmacist's or pharmacy's enrollment or  
556 participation in a retail pharmacy network; or  
557            c. The processing or transmission of the claim; or

558        2. Retroactively deny, hold back, or reduce payment for a  
559 covered claim after payment for the claim.

560            (b)1. The department shall have access to all financial  
561 and utilization records in the possession of, and data and  
562 information used by, a pharmacy benefit manager in relation to  
563 the pharmacy benefit management services provided to health  
564 maintenance organizations or other providers using the pharmacy  
565 benefit management services in the state.

566            2. The department may investigate an alleged violation of  
567 this subsection, and a pharmacy benefit manager who violates  
568 this subsection is liable for a civil fine of \$10,000 for each  
569 violation.

570            (c) This subsection applies to contracts entered into,  
571 amended, or renewed on or after July 1, 2021.

572        Section 9. This act shall take effect July 1, 2021.