By Senator Rodriguez

39-00799A-22 2022742__

A bill to be entitled

An act relating to pharmacies and pharmacy benefit managers; amending s. 409.967, F.S.; requiring that certain pharmacies be included in managed care plan pharmacy networks; requiring managed care plans to publish the Agency for Health Care Administration's preferred drug list, rather than any prescribed drug formulary; requiring plans to update the list within a certain timeframe after the agency makes a change; amending s. 409.973, F.S.; providing requirements for managed care plans using pharmacy benefit managers; requiring the agency to seek a plan amendment or federal waiver by a specified date; amending s. 409.975, F.S.; conforming a provision to changes made by the act; amending s. 624.3161, F.S.; requiring the Office of Insurance Regulation to examine pharmacy benefit managers under certain circumstances; specifying that certain examination costs are payable by persons examined; amending 624.490, F.S.; authorizing the Office of Insurance Regulation to suspend or revoke a pharmacy benefit manager's registration or impose a fine for specified violations; defining the terms "spread pricing" and "affiliate"; transferring, renumbering, and amending s. 465.1885, F.S.; revising the entities conducting pharmacy audits to which certain requirements and restrictions apply; authorizing audited pharmacies to appeal certain findings; providing that health insurers and health maintenance organizations that

transfer a certain payment obligation to pharmacy benefit managers remain responsible for specified violations; amending s. 627.6131, F.S.; revising the definition of the term "claim" and defining the term "pharmacy claim"; providing an exception to applicability; making technical changes; prohibiting pharmacy benefit managers from charging pharmacists and pharmacies certain fees and from retroactively denying, holding back, or reducing payments for covered claims; requiring that the Department of Financial Services have access to certain records, data, and information; providing applicability; amending ss. 627.64741, 627.6572, and 641.314, F.S.; revising the definition of the term "maximum allowable cost"; requiring that the department have access to certain records, data, and information; providing that pharmacy benefit managers that violate certain provisions are subject to administrative penalties; authorizing the Financial Services Commission to adopt rules; revising applicability; amending s. 627.6699, F.S.; requiring certain health benefit plans covering small employers to comply with specified provisions; amending s. 641.3155, F.S.; revising the definition of the term "claim" and providing a definition for the term "pharmacy claim"; making technical changes; prohibiting pharmacy benefit managers from charging pharmacists and pharmacies certain fees and from retroactively denying, holding back, or reducing payments for covered claims; requiring that the

department have access to certain records, data, and information; providing applicability; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. Any pharmacy willing to accept reasonable terms and conditions established by the agency shall be included in a managed care plan's pharmacy network. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by

January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish the agency's ~~any prescribed drug formulary or~~ preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after the agency makes ~~making~~ a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide

for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 2. Subsection (7) is added to section 409.973, Florida Statutes, to read:

409.973 Benefits.—

(7) PRESCRIPTION DRUG BENEFITS.—

(a) Each plan operating in the managed medical assistance program using a pharmacy benefit manager shall:

1. Ensure the pharmacy benefit manager complies with the requirements of s. 624.490.

2. Require the pharmacy benefit manager to reimburse Medicaid pharmacy providers and providers enrolled as dispensing practitioners for drugs dispensed in an amount equal to the National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee of $10.60. If the NADAC is unavailable, the pharmacy benefit manager must reimburse the providers in an amount equal to the wholesale acquisition cost plus a professional dispensing fee of $10.60.

3. Require the pharmacy benefit manager to use preferred drug lists established by the agency.

(b) The agency shall seek any state plan amendment or federal waiver necessary to implement this subsection no later than December 31, 2022.

Section 3. Subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section and in s. 409.967(2)(c), managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are

classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(46).

3. Hospitals that are trauma centers as defined in s. 395.4001(15).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate

as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the

following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

(c) After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion. For purposes of this paragraph, the term "essential provider" includes providers determined by the agency to be essential Medicaid providers under paragraph (a) and the statewide essential providers specified in paragraph (b).

(d) The applicable Medicaid rates for emergency services paid by a plan under this section to a provider with which the

plan does not have an active contract shall be determined according to s. 409.967(2)(b).

(e) Each managed care plan may offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

Section 4. Subsections (1) and (3) of section 624.3161, Florida Statutes, are amended to read:

624.3161 Market conduct examinations.—

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

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

Section 5. Present subsection (6) of section 624.490, Florida Statutes, is redesignated as subsection (7), and a new

subsection (6) is added to that section, to read:

624.490 Registration of pharmacy benefit managers.—

(6) The office may suspend or revoke a pharmacy benefit manager's registration or impose a fine if it finds the pharmacy benefit manager:

(a) Breached its fiduciary duty to the health insurer or health maintenance organization.

(b) Used spread pricing. For purposes of this subsection, "spread pricing" means any technique by which a pharmacy benefit manager charges or claims an amount from a health insurer or health maintenance organization for pharmacy or pharmacist services, including payment for a prescription drug, which is different than the amount the pharmacy benefit manager pays to the pharmacy or pharmacist that provided the services.

(c) Reduced payment for pharmacy or pharmacist services, directly or indirectly, by creating, imposing, or establishing direct or indirect remuneration fees, generic effective rates, dispensing effective rates, brand effective rates, any other effective rates, in-network fees, performance fees, pre-adjudication fees, post-adjudication fees, or any other mechanism that reduces, or aggregately reduces, payment for pharmacy or pharmacist services.

(d) Required or influenced an insured or enrollee to use an affiliate. For purposes of this subsection, "affiliate" means a pharmacy in which a pharmacy benefit manager, directly or indirectly, has an investment, financial, or ownership interest; a pharmacy that, directly or indirectly, has an investment, financial, or ownership interest in the pharmacy benefit manager; or a pharmacy that is under common ownership, directly

or indirectly, as the pharmacy benefit manager.

(e) Required or influenced an insured or enrollee to use a mail-order pharmacy.

(f) Excluded a pharmacy that was willing to accept the plan's terms and reimbursement, and that met the plan's credentialing requirements and quality standards, from participating in the plan.

(g) Violated s. 624.491, s. 627.6131, s. 627.64741, s. 627.6572, s. 641.314, or s. 641.3155.

Section 6. Section 465.1885, Florida Statutes, is transferred, renumbered as section 624.491, Florida Statutes, and amended to read:

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

(1) Health insurers, health maintenance organizations, and pharmacy benefit managers shall comply with the requirements of this section when auditing the records of a pharmacy licensed under chapter 465. The person or entity conducting such audit must ~~If an audit of the records of a pharmacy licensed under this chapter is conducted directly or indirectly by a managed care company, an insurance company, a third-party payor, a pharmacy benefit manager, or an entity that represents responsible parties such as companies or groups, referred to as an "entity" in this section, the pharmacy has the following rights~~:

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

(b) Not schedule an ~~To have the~~ onsite audit during ~~scheduled after~~ the first 3 calendar days of a month unless the

pharmacist consents otherwise.

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

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

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

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

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

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

(i) Provide the pharmacy with a copy of ~~To receive~~ the final audit report within 6 months after receipt of ~~receiving~~ the preliminary audit report.

(j) Calculate any ~~To have~~ recoupment or penalties based on

actual overpayments and not according to the accounting practice of extrapolation.

(2) ~~The rights contained in~~ This section does ~~do~~ not apply to:

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

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

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

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

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

(5) A health insurer or health maintenance organization that, under terms of a contract, transfers to a pharmacy benefit manager the obligation to pay any pharmacy licensed under chapter 465 for any pharmacy benefit claims arising from

services provided to or for the benefit of any insured or subscriber remains responsible for any violations of this section, s. 627.6131, or s. 641.3155, as applicable.

Section 7. Present subsections (18) and (19) of section 627.6131, Florida Statutes, are redesignated as subsections (19) and (20), respectively, a new subsection (18) is added to that section, and subsections (2), (15), (16), and (17) of that section are amended, to read:

627.6131 Payment of claims.—

(2)(a) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the insurer's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, the term "claim" means a paper or electronic billing instrument submitted to the insurer's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

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

(15) Except for subsection (18), this section is applicable only to a major medical expense health insurance policy as defined in s. 627.643(2)(e) offered by a group or an individual

health insurer licensed pursuant to chapter 624, including a preferred provider policy under s. 627.6471 and an exclusive provider organization under s. 627.6472 or a group or individual insurance contract that only provides direct payments to dentists for enumerated dental services.

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

(17) Notwithstanding paragraph (5)(a), if ~~effective November 1, 2003, where~~ a nonelectronic pharmacy claim is submitted to a pharmacy benefit ~~benefits~~ manager acting on behalf of a health insurer, the pharmacy benefit ~~benefits~~ manager must ~~shall~~ provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

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

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

a. The submission of the claim;

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

c. The processing or transmission of the claim; or

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

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

(c) This subsection applies to contracts entered into, amended, or renewed on or after January 1, 2023.

Section 8. Present subsection (5) of section 627.64741, Florida Statutes, is redesignated as subsection (8) and amended, a new subsection (5) and subsections (6) and (7) are added to that section, and subsection (1) of that section is amended, to read:

627.64741 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug and that:~~,~~

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

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

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

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

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

(5) The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health insurers or other providers using the pharmacy benefit management services in this state.

(6) A pharmacy benefit manager that violates the contract provisions required by this section is subject to the penalties provided in s. 624.490(6).

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

(8)~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after January 1, 2023 ~~July 1, 2018~~.

Section 9. Present subsection (5) of section 627.6572, Florida Statutes, is redesignated as subsection (8) and amended, a new subsection (5) and subsections (6) and (7) are added to that section, and subsection (1) of that section is amended, to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a

prescription drug and that:~~,~~

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

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

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

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

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

(5) The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health insurers or other providers using the pharmacy benefit management services in this state.

(6) A pharmacy benefit manager that violates the contract provisions required by this section is subject to the penalties provided in s. 624.490(6).

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

(8)~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after January 1, 2023 ~~July 1, 2018~~.

Section 10. Paragraph (h) is added to subsection (5) of section 627.6699, Florida Statutes, to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(h) A health benefit plan covering small employers which is delivered, issued, amended, or renewed in this state on or after January 1, 2023, must comply with s. 627.6572.

Section 11. Present subsection (5) of section 641.314, Florida Statutes, is redesignated as subsection (8) and amended, a new subsection (5) and subsections(6) and (7) are added to that section, and subsection (1) of that section is amended, to read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug and that:~~,~~

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

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

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

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

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

doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(5) The department shall have access to all financial and utilization records in the possession of, and data and information used by, a pharmacy benefit manager in relation to the pharmacy benefit management services provided to health insurers or other providers using the pharmacy benefit management services in this state.

(6) A pharmacy benefit manager that violates the contract provisions required by this section is subject to the penalties provided in s. 624.490(6).

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

(8) ~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after January 1, 2023 ~~July 1, 2018~~.

Section 12. Present subsections (16) and (17) of section 641.3155, Florida Statutes, are redesignated as subsections (17) and (18), respectively, a new subsection (16) is added to that section, and subsections (1), (14), and (15) of that section are amended, to read:

641.3155 Prompt payment of claims.—

(1)(a) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490

or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, the term "claim" means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

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

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

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

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

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

a. The submission of the claim;

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

c. The processing or transmission of the claim; or

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

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

(c) This subsection applies to contracts entered into, amended, or renewed on or after January 1, 2023.

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