By the Committee on Health Policy; and Senators Brodeur, Rodriguez, Wright, and Perry

588-03161-23 20231550c1

1 A bill to be entitled
2 An act relating to prescription drugs; providing a
3 short title; amending s. 499.005, F.S.; specifying
4 additional prohibited acts related to the Florida Drug
5 and Cosmetic Act; amending s. 499.012, F.S.; providing
6 that prescription drug manufacturer and nonresident
7 prescription drug manufacturer permitholders are
8 subject to specified requirements; creating s.
9 499.026, F.S.; defining terms; requiring certain drug
10 manufacturers to notify the Department of Business and
11 Professional Regulation of reportable drug price
12 increases on a specified form on the effective date of
13 such increase; providing requirements for the form;
14 providing construction; requiring such manufacturers
15 to submit certain reports to the department by a
16 specified date each year; providing requirements for
17 the reports; authorizing the department to request
18 certain additional information from the manufacturer
19 before approving the report; requiring the department
20 to submit the forms and reports to the Agency for
21 Health Care Administration to be posted on the
22 agency's website; prohibiting the agency from posting
23 on its website certain submitted information that is
24 marked as a trade secret; requiring the agency to
25 compile all information from the submitted forms and
26 reports and make it available to the Governor and the
27 Legislature upon request; prohibiting manufacturers
28 from claiming a public records exemption for trade
29 secrets for certain information provided in such forms

30 or reports; providing that department employees remain
31 protected from liability for releasing the forms and
32 reports as public records; authorizing the department,
33 in consultation with the agency, to adopt rules;
34 providing for emergency rulemaking; amending s.
35 624.307, F.S.; requiring the Division of Consumer
36 Services of the Department of Financial Services to
37 designate an employee as the primary contact for
38 consumer complaints involving pharmacy benefit
39 managers; requiring the division to refer certain
40 complaints to the Office of Insurance Regulation;
41 amending s. 624.490, F.S.; revising the definition of
42 the term "pharmacy benefit manager"; amending s.
43 624.491, F.S.; revising provisions related to pharmacy
44 audits; amending s. 626.88, F.S.; revising the
45 definition of the term "administrator"; defining the
46 term "pharmacy benefit manager"; amending s. 626.8805,
47 F.S.; providing a grandfathering provision for certain
48 pharmacy benefit managers operating as administrators;
49 providing a penalty for certain persons who do not
50 hold a certificate of authority to act as an
51 administrator on or after a specified date; providing
52 additional requirements for pharmacy benefit managers
53 applying for a certificate of authority to act as an
54 administrator; exempting pharmacy benefit managers
55 from certain fees; amending s. 626.8814, F.S.;
56 requiring pharmacy benefit managers to identify
57 certain ownership affiliations to the office;
58 requiring pharmacy benefit managers to report any

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59 change in such information to the office within a
60 specified timeframe; creating s. 626.8825, F.S.;
61 defining terms; providing requirements for certain
62 contracts between a pharmacy benefit manager and a
63 pharmacy benefits plan or program or a participating
64 pharmacy; specifying requirements for certain
65 administrative appeal procedures that such contracts
66 with participating pharmacies must include; requiring
67 pharmacy benefit managers to submit reports on
68 submitted appeals to the office every 90 days;
69 creating s. 626.8827, F.S.; specifying prohibited
70 practices for pharmacy benefit managers; creating s.
71 626.8828, F.S.; authorizing the office to investigate
72 administrators that are pharmacy benefit managers and
73 certain applicants; requiring the office to review
74 certain referrals and investigate them under certain
75 circumstances; providing for biennial reviews of
76 pharmacy benefit managers; authorizing the office to
77 conduct additional examinations; requiring the office
78 to conduct an examination under certain circumstances;
79 providing procedures and requirements for such
80 examinations; defining the terms “contracts” and
81 “knowing and willful”; providing that independent
82 professional examiners under contract with the office
83 may conduct examinations of pharmacy benefit managers;
84 requiring the Financial Services Commission to adopt
85 specified rules; specifying provisions that apply to
86 such investigations and examinations; providing
87 recordkeeping requirements for pharmacy benefit

88 managers; authorizing the office to order the
89 production of such records and other specified
90 information; authorizing the office to take statements
91 under oath; requiring pharmacy benefit managers and
92 applicants subjected to an investigation or
93 examination to pay the associated expenses; specifying
94 covered expenses; providing for collection of such
95 expenses; providing for the deposit of certain moneys
96 into the Insurance Regulatory Trust Fund; authorizing
97 the office to pay examiners, investigators, and other
98 persons from such fund; providing administrative
99 penalties; providing grounds for administrative action
100 against a certificate of authority; amending s.
101 626.89, F.S.; requiring pharmacy benefit managers to
102 notify the office of specified complaints,
103 settlements, or discipline within a specified
104 timeframe; requiring pharmacy benefit managers to
105 annually submit a certain attestation statement to the
106 office; amending s. 627.42393, F.S.; providing that
107 certain step-therapy protocol requirements apply to a
108 pharmacy benefit manager acting on behalf of a health
109 insurer; amending ss. 627.64741 and 627.6572, F.S.;
110 conforming provisions to changes made by the act;
111 amending s. 641.31, F.S.; providing that certain step-
112 therapy protocol requirements apply to a pharmacy
113 benefit manager acting on behalf of a health
114 maintenance organization; amending s. 641.314, F.S.;
115 conforming a provision to changes made by the act;
116 providing legislative intent, construction, and

117 severability; providing appropriations and authorizing
118 positions; providing an effective date.
119
120 Be It Enacted by the Legislature of the State of Florida:
121
122 Section 1. This act may be cited as the "Prescription Drug
123 Reform Act."
124 Section 2. Subsection (29) is added to section 499.005,
125 Florida Statutes, to read:
126 499.005 Prohibited acts.—It is unlawful for a person to
127 perform or cause the performance of any of the following acts in
128 this state:
129 (29) Failure to accurately complete and timely submit
130 reportable drug price increase forms and reports as required
131 under this part and rules adopted thereunder.
132 Section 3. Subsection (16) is added to section 499.012,
133 Florida Statutes, to read:
134 499.012 Permit application requirements.—
135 (16) A permit for a prescription drug manufacturer or a
136 nonresident prescription drug manufacturer is subject to the
137 requirements of s. 499.026.
138 Section 4. Section 499.026, Florida Statutes, is created to
139 read:
140 499.026 Notification of manufacturer prescription drug
141 price increases.—
142 (1) As used in this section, the term:
143 (a) "Course of therapy" means the recommended daily dose
144 units of a prescription drug pursuant to its prescribing label
145 for 30 days or the recommended daily dose units of a

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146 prescription drug pursuant to its prescribing label for a normal
147 course of treatment which is less than 30 days.
148 (b) “Manufacturer” means a person holding a prescription
149 drug manufacturer permit or a nonresident prescription drug
150 manufacturer permit under s. 499.01.
151 (c) “Prescription drug” has the same meaning as in s.
152 499.003 and includes biological products but is limited to those
153 prescription drugs and biological products intended for human
154 use.
155 (d) “Reportable drug price increase” means, for a
156 prescription drug with a wholesale acquisition cost of at least
157 $100 for a course of therapy before the effective date of an
158 increase:
159 1. Any increase of 15 percent or more of the wholesale
160 acquisition cost during the preceding 12-month period; or
161 2. Any increase of 40 percent or more of the wholesale
162 acquisition cost during the preceding 3 calendar years.
163 (e) “Wholesale acquisition cost” means, with respect to a
164 prescription drug or biological product, the manufacturer’s list
165 price for the prescription drug or biological product to
166 wholesalers or direct purchasers in the United States, not
167 including prompt pay or other discounts, rebates, or reductions
168 in price, for the most recent month for which the information is
169 available, as reported in wholesale price guides or other
170 publications of drug or biological product pricing data.
171 (2) On the effective date of a manufacturer’s reportable
172 drug price increase, the manufacturer must provide notification
173 of each reportable drug price increase to the department on a
174 form prescribed by the department. The form must require the

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175 manufacturer to specify all of the following:
176 (a) The proprietary and nonproprietary names of the
177 prescription drug, as applicable.
178 (b) The wholesale acquisition cost before the reportable
179 drug price increase.
180 (c) The dollar amount of the reportable drug price
181 increase.
182 (d) The percentage amount of the reportable drug price
183 increase from the wholesale acquisition cost before the
184 reportable drug price increase.
185 (e) A statement regarding whether a change or improvement
186 in the prescription drug necessitates the reportable drug price
187 increase. If so, the manufacturer must describe the change or
188 improvement.
189 (f) The intended uses of the prescription drug.
190
191 This subsection does not prohibit a manufacturer from notifying
192 other parties, such as pharmacy benefit managers, of a drug
193 price increase before the effective date of the drug price
194 increase.
195 (3) By April 1 of each year, each manufacturer shall submit
196 a report to the department on a form prescribed by the
197 department. A report is not deemed to be submitted until
198 approved by the department. The report must include all of the
199 following:
200 (a) A list of all prescription drugs affected by a
201 reportable drug price increase during the previous calendar year
202 and both the dollar amount of each reportable drug price
203 increase and the percentage increase of each reportable drug

204 price increase relative to the previous wholesale acquisition
205 cost of the prescription drug. The prescription drugs must be
206 identified using their proprietary names and nonproprietary
207 names, as applicable.
208 (b) If more than one form has been filed under this section
209 for previous reportable drug price increases, the percentage
210 increase of the prescription drug from the earliest form filed
211 to the most recent form filed.
212 (c) The intended uses of each prescription drug listed in
213 the report and whether the prescription drug manufacturer
214 benefits from market exclusivity for such drug.
215 (d) The length of time the prescription drug has been
216 available for purchase.
217 (e) A complete description of the factors contributing to
218 each reportable drug price increase. The factors must be
219 provided with such specificity as to explain the need or
220 justification for each reportable drug price increase. The
221 department may request additional information from a
222 manufacturer relating to the need or justification of any
223 reportable drug price increase before approving the
224 manufacturer's report.
225 (f) Any action that the manufacturer has filed to extend a
226 patent report after the first extension has been granted.
227 (4)(a) The department shall submit all forms and reports
228 submitted by manufacturers to the Agency for Health Care
229 Administration, to be posted on the agency's website pursuant to
230 s. 408.062. The agency may not post on its website any of the
231 information provided pursuant to paragraph (2)(e), paragraph
232 (3)(e), or paragraph (3)(f) which is marked as a trade secret.

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233 The agency shall compile all information on the forms and
234 reports submitted by manufacturers and make it available upon
235 request to the Governor, the President of the Senate, and the
236 Speaker of the House of Representatives.
237 (b) Except for information provided pursuant to paragraph
238 (2)(e), paragraph (3)(e), or paragraph (3)(f), a manufacturer
239 may not claim a public records exemption for a trade secret
240 under s. 119.0715 for any information required by the department
241 under this section. Department employees remain protected from
242 liability for release of forms and reports pursuant to s.
243 119.0715(4).
244 (5) The department, in consultation with the Agency for
245 Health Care Administration, shall adopt rules to implement this
246 section.
247 (a) The department shall adopt necessary emergency rules
248 pursuant to s. 120.54(4) to implement this section. If an
249 emergency rule adopted under this section is held to be
250 unconstitutional or an invalid exercise of delegated legislative
251 authority and becomes void, the department may adopt an
252 emergency rule pursuant to this section to replace the rule that
253 has become void. If the emergency rule adopted to replace the
254 void emergency rule is also held to be unconstitutional or an
255 invalid exercise of delegated legislative authority and becomes
256 void, the department must follow the nonemergency rulemaking
257 procedures of the Administrative Procedure Act to replace the
258 rule that has become void.
259 (b) For emergency rules adopted under this section, the
260 department need not make the findings required under s.
261 120.54(4)(a). Emergency rules adopted under this section are

262 also exempt from:
263 1. Sections 120.54(3)(b) and 120.541. Challenges to
264 emergency rules adopted under this section are subject to the
265 time schedules provided in s. 120.56(5).
266 2. Section 120.54(4)(c) and remain in effect until replaced
267 by rules adopted under the nonemergency rulemaking procedures of
268 the Administrative Procedure Act.
269 Section 5. Paragraph (a) of subsection (10) of section
270 624.307, Florida Statutes, is amended, and paragraph (b) of that
271 subsection is republished, to read:
272 624.307 General powers; duties.—
273 (10)(a) The Division of Consumer Services shall perform the
274 following functions concerning products or services regulated by
275 the department or office:
276 1. Receive inquiries and complaints from consumers.
277 2. Prepare and disseminate information that the department
278 deems appropriate to inform or assist consumers.
279 3. Provide direct assistance to and advocacy for consumers
280 who request such assistance or advocacy.
281 4. With respect to apparent or potential violations of law
282 or applicable rules committed by a person or entity licensed by
283 the department or office, report apparent or potential
284 violations to the office or to the appropriate division of the
285 department, which may take any additional action it deems
286 appropriate.
287 5. Designate an employee of the division as the primary
288 contact for consumers on issues relating to sinkholes.
289 6. Designate an employee of the division as the primary
290 contact for consumers and pharmacies on issues relating to

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291 pharmacy benefit managers. The division must refer to the office
292 any consumer complaint that alleges conduct that may constitute
293 a violation of part VII of chapter 626 or for which a pharmacy
294 benefit manager does not respond in accordance with paragraph
295 (b).
296 (b) Any person licensed or issued a certificate of
297 authority by the department or the office shall respond, in
298 writing, to the division within 20 days after receipt of a
299 written request for documents and information from the division
300 concerning a consumer complaint. The response must address the
301 issues and allegations raised in the complaint and include any
302 requested documents concerning the consumer complaint not
303 subject to attorney-client or work-product privilege. The
304 division may impose an administrative penalty for failure to
305 comply with this paragraph of up to $2,500 per violation upon
306 any entity licensed by the department or the office and $250 for
307 the first violation, $500 for the second violation, and up to
308 $1,000 for the third or subsequent violation upon any individual
309 licensed by the department or the office.
310 Section 6. Subsection (1) of section 624.490, Florida
311 Statutes, is amended to read:
312 624.490 Registration of pharmacy benefit managers.—
313 (1) As used in this section, the term “pharmacy benefit
314 manager” has the same meaning as in s. 626.88 ~~means a person or~~
315 ~~entity doing business in this state which contracts to~~
316 ~~administer prescription drug benefits on behalf of a health~~
317 ~~insurer or a health maintenance organization to residents of~~
318 ~~this state~~.
319 Section 7. Subsections (1) and (5) of section 624.491,

Florida Statutes, are amended to read:

624.491 Pharmacy audits.—

(1) A pharmacy benefits plan or program as defined in s. 626.8825 ~~health insurer or health maintenance organization~~ providing pharmacy benefits ~~through a major medical individual or group health insurance policy or a health maintenance contract, respectively,~~ must comply with the requirements of this section when the pharmacy benefits plan or program ~~health insurer or health maintenance organization~~ or any person or entity acting on behalf of the pharmacy benefits plan or program ~~health insurer or health maintenance organization~~, including, but not limited to, a pharmacy benefit manager as defined in s. 626.88 ~~s. 624.490(1)~~, audits the records of a pharmacy licensed under chapter 465. The person or entity conducting such audit must:

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

(b) Not schedule an onsite audit during the first 3 calendar days of a month unless the pharmacist consents otherwise.

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

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

(e) Allow the pharmacy to use the written and verifiable records of a hospital, physician, or other authorized

349 practitioner, which are transmitted by any means of
350 communication, to validate the pharmacy records in accordance
351 with state and federal law.
352 (f) Reimburse the pharmacy for a claim that was
353 retroactively denied for a clerical error, typographical error,
354 scrivener's error, or computer error if the prescription was
355 properly and correctly dispensed, unless a pattern of such
356 errors exists, fraudulent billing is alleged, or the error
357 results in actual financial loss to the entity.
358 (g) Provide the pharmacy with a copy of the preliminary
359 audit report within 120 days after the conclusion of the audit.
360 (h) Allow the pharmacy to produce documentation to address
361 a discrepancy or audit finding within 10 business days after the
362 preliminary audit report is delivered to the pharmacy.
363 (i) Provide the pharmacy with a copy of the final audit
364 report within 6 months after the pharmacy's receipt of the
365 preliminary audit report.
366 (j) Calculate any recoupment or penalties based on actual
367 overpayments and not according to the accounting practice of
368 extrapolation.
369 (5) A <u>pharmacy benefits plan or program</u> ~~health insurer or~~
370 ~~health maintenance organization~~ that, under terms of a contract,
371 transfers to a pharmacy benefit manager the obligation to pay a
372 pharmacy licensed under chapter 465 for any pharmacy benefit
373 claims arising from services provided to or for the benefit of
374 an insured or subscriber remains responsible for a violation of
375 this section.
376 Section 8. Subsection (1) of section 626.88, Florida
377 Statutes, is amended, and subsection (6) is added to that

378 section, to read:
379 626.88 Definitions.—For the purposes of this part, the
380 term:
381 (1) "Administrator" means ~~is~~ any person who directly or
382 indirectly solicits or effects coverage of, collects charges or
383 premiums from, or adjusts or settles claims on residents of this
384 state in connection with authorized commercial self-insurance
385 funds or with insured or self-insured programs which provide
386 life or health insurance coverage or coverage of any other
387 expenses described in s. 624.33(1); ~~or~~ any person who, through a
388 health care risk contract as defined in s. 641.234 with an
389 insurer or health maintenance organization, provides billing and
390 collection services to health insurers and health maintenance
391 organizations on behalf of health care providers; or a pharmacy
392 benefit manager. The term does not include~~, other than~~ any of
393 the following ~~persons~~:
394 (a) An employer or wholly owned direct or indirect
395 subsidiary of an employer, on behalf of such employer's
396 employees or the employees of one or more subsidiary or
397 affiliated corporations of such employer.
398 (b) A union on behalf of its members.
399 (c) An insurance company which is either authorized to
400 transact insurance in this state or is acting as an insurer with
401 respect to a policy lawfully issued and delivered by such
402 company in and pursuant to the laws of a state in which the
403 insurer was authorized to transact an insurance business.
404 (d) A health care services plan, health maintenance
405 organization, professional service plan corporation, or person
406 in the business of providing continuing care, possessing a valid

407 certificate of authority issued by the office, and the sales
408 representatives thereof, if the activities of such entity are
409 limited to the activities permitted under the certificate of
410 authority.
411 (e) An entity that is affiliated with an insurer and that
412 only performs the contractual duties, between the administrator
413 and the insurer, of an administrator for the direct and assumed
414 insurance business of the affiliated insurer. The insurer is
415 responsible for the acts of the administrator and is responsible
416 for providing all of the administrator's books and records to
417 the insurance commissioner, upon a request from the insurance
418 commissioner. For purposes of this paragraph, the term "insurer"
419 means a licensed insurance company, health maintenance
420 organization, prepaid limited health service organization, or
421 prepaid health clinic.
422 (f) A nonresident entity licensed in its state of domicile
423 as an administrator if its duties in this state are limited to
424 the administration of a group policy or plan of insurance and no
425 more than a total of 100 lives for all plans reside in this
426 state.
427 (g) An insurance agent licensed in this state whose
428 activities are limited exclusively to the sale of insurance.
429 (h) A person appointed as a managing general agent in this
430 state, whose activities are limited exclusively to the scope of
431 activities conveyed under such appointment.
432 (i) An adjuster licensed in this state whose activities are
433 limited to the adjustment of claims.
434 (j) A creditor on behalf of such creditor's debtors with
435 respect to insurance covering a debt between the creditor and

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436 its debtors.
437 (k) A trust and its trustees, agents, and employees acting
438 pursuant to such trust established in conformity with 29 U.S.C.
439 s. 186.
440 (l) A trust exempt from taxation under s. 501(a) of the
441 Internal Revenue Code, a trust satisfying the requirements of
442 ss. 624.438 and 624.439, or any governmental trust as defined in
443 s. 624.33(3), and the trustees and employees acting pursuant to
444 such trust, or a custodian and its agents and employees,
445 including individuals representing the trustees in overseeing
446 the activities of a service company or administrator, acting
447 pursuant to a custodial account which meets the requirements of
448 s. 401(f) of the Internal Revenue Code.
449 (m) A financial institution which is subject to supervision
450 or examination by federal or state authorities or a mortgage
451 lender licensed under chapter 494 who collects and remits
452 premiums to licensed insurance agents or authorized insurers
453 concurrently or in connection with mortgage loan payments.
454 (n) A credit card issuing company which advances for and
455 collects premiums or charges from its credit card holders who
456 have authorized such collection if such company does not adjust
457 or settle claims.
458 (o) A person who adjusts or settles claims in the normal
459 course of such person's practice or employment as an attorney at
460 law and who does not collect charges or premiums in connection
461 with life or health insurance coverage.
462 (p) A person approved by the department who administers
463 only self-insured workers' compensation plans.
464 (q) A service company or service agent and its employees,

465 authorized in accordance with ss. 626.895-626.899, serving only
466 a single employer plan, multiple-employer welfare arrangements,
467 or a combination thereof.
468 (r) Any provider or group practice, as defined in s.
469 456.053, providing services under the scope of the license of
470 the provider or the member of the group practice.
471 (s) Any hospital providing billing, claims, and collection
472 services solely on its own and its physicians’ behalf and
473 providing services under the scope of its license.
474 (t) A corporation not for profit whose membership consists
475 entirely of local governmental units authorized to enter into
476 risk management consortiums under s. 112.08.
477
478 A person who provides billing and collection services to health
479 insurers and health maintenance organizations on behalf of
480 health care providers shall comply with the provisions of ss.
481 627.6131, 641.3155, and 641.51(4).
482 (6) “Pharmacy benefit manager” means a person or an entity
483 doing business in this state which contracts to administer
484 prescription drug benefits on behalf of a pharmacy benefits plan
485 or program as defined in s. 626.8825. The term includes, but is
486 not limited to, a person or an entity that performs one or more
487 of the following services:
488 (a) Pharmacy claims processing.
489 (b) Administration or management of pharmacy discount card
490 programs.
491 (c) Managing pharmacy networks or pharmacy reimbursement.
492 (d) Paying or managing claims for pharmacist services
493 provided to covered persons.

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494 (e) Developing or managing a clinical formulary, including
495 utilization management or quality assurance programs.
496 (f) Pharmacy rebate administration.
497 (g) Managing patient compliance, therapeutic intervention,
498 or generic substitution programs.
499 (h) Administration or management of a mail-order pharmacy
500 program.
501 Section 9. Present subsections (3) through (6) of section
502 626.8805, Florida Statutes, are redesignated as subsections (4)
503 through (7), respectively, a new subsection (3) and subsection
504 (8) are added to that section, and subsection (1) and present
505 subsection (3) of that section are amended, to read:
506 626.8805 Certificate of authority to act as administrator.—
507 (1) It is unlawful for any person to act as or hold himself
508 or herself out to be an administrator in this state without a
509 valid certificate of authority issued by the office pursuant to
510 ss. 626.88-626.894. A pharmacy benefit manager that is
511 registered with the office under s. 624.490 as of June 30, 2023,
512 may continue to operate until January 1, 2024, as an
513 administrator without a certificate of authority and is not in
514 violation of the requirement to possess a valid certificate of
515 authority as an administrator during that timeframe. To qualify
516 for and hold authority to act as an administrator in this state,
517 an administrator must otherwise be in compliance with this code
518 and with its organizational agreement. The failure of any
519 person, excluding a pharmacy benefit manager, to hold such a
520 certificate while acting as an administrator shall subject such
521 person to a fine of not less than $5,000 or more than $10,000
522 for each violation. A person who, on or after January 1, 2024,

523 does not hold a certificate of authority to act as an
524 administrator while operating as a pharmacy benefit manager is
525 subject to a fine of $10,000 per violation per day.
526 (3) An applicant that is a pharmacy benefit manager must
527 also submit all of the following:
528 (a) A complete biographical statement on forms prescribed
529 by the commission, an independent investigation report, and
530 fingerprints obtained pursuant to chapter 624 of all of the
531 individuals referred to in paragraph (2)(c).
532 (b) A self-disclosure of any administrative, civil, or
533 criminal complaints, settlements, or discipline of the
534 applicant, or any of the applicant’s affiliates, which relate to
535 a violation of the insurance laws, including pharmacy benefit
536 manager laws, in any state.
537 (c) A statement attesting to compliance with the network
538 requirements in s. 626.8825 beginning January 1, 2024.
539 (4)(a) ~~(3)~~ The applicant shall make available for inspection
540 by the office copies of all contracts relating to services
541 provided by the administrator to insurers or other persons using
542 the services of the administrator.
543 (b) An applicant that is a pharmacy benefit manager shall
544 also make available for inspection by the office:
545 1. Copies of all contract templates with any pharmacy as
546 defined in s. 465.003; and
547 2. Copies of all subcontracts to support its operations.
548 (8) A pharmacy benefit manager is exempt from fees
549 associated with the initial application and the annual filing
550 fees in s. 626.89.
551 Section 10. Section 626.8814, Florida Statutes, is amended

552 to read:

553 626.8814 Disclosure of ownership or affiliation.—

554 (1) Each administrator shall identify to the office any
555 ownership interest or affiliation of any kind with any insurance
556 company responsible for providing benefits directly or through
557 reinsurance to any plan for which the administrator provides
558 administrative services.

559 (2) Pharmacy benefit managers shall also identify to the
560 office any ownership affiliation of any kind with any pharmacy
561 which, either directly or indirectly, through one or more
562 intermediaries:

563 (a) Has an investment or ownership interest in a pharmacy
564 benefit manager holding a certificate of authority issued under
565 this part;

566 (b) Shares common ownership with a pharmacy benefit manager
567 holding a certificate of authority issued under this part; or

568 (c) Has an investor or a holder of an ownership interest
569 which is a pharmacy benefit manager holding a certificate of
570 authority issued under this part.

571 (3) A pharmacy benefit manager shall report any change in
572 information required by subsection (2) to the office in writing
573 within 60 days after the change occurs.

574 Section 11. Section 626.8825, Florida Statutes, is created
575 to read:

576 626.8825 Pharmacy benefit manager transparency and
577 accountability.—

578 (1) DEFINITIONS.—As used in this section, the term:

579 (a) “Adjudication transaction fee” means a fee charged by
580 the pharmacy benefit manager to the pharmacy for electronic

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581 claim submissions.
582 (b) “Affiliated pharmacy” means a pharmacy that, either
583 directly or indirectly through one or more intermediaries:
584 1. Has an investment or ownership interest in a pharmacy
585 benefit manager holding a certificate of authority issued under
586 this part;
587 2. Shares common ownership with a pharmacy benefit manager
588 holding a certificate of authority issued under this part; or
589 3. Has an investor or a holder of an ownership interest
590 which is a pharmacy benefit manager holding a certificate of
591 authority issued under this part.
592 (c) “Brand name or generic effective rate” means the
593 contractual rate set forth by a pharmacy benefit manager for the
594 reimbursement of covered brand name or generic drugs, calculated
595 using the total payments in the aggregate, by drug type, during
596 the performance period. The effective rates are typically
597 calculated as a discount from industry benchmarks, such as
598 average wholesale price or wholesale acquisition cost.
599 (d) “Covered person” means a person covered by,
600 participating in, or receiving the benefit of a pharmacy
601 benefits plan or program.
602 (e) “Direct and indirect remuneration fees” means price
603 concessions that are paid to the pharmacy benefit manager by the
604 pharmacy retrospectively and that cannot be calculated at the
605 point of sale. The term may also include discounts, chargebacks
606 or rebates, cash discounts, free goods contingent on a purchase
607 agreement, upfront payments, coupons, goods in kind, free or
608 reduced-price services, grants, or other price concessions or
609 similar benefits from manufacturers, pharmacies, or similar

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610 entities.

611 (f) “Dispensing fee” means a fee intended to cover
612 reasonable costs associated with providing the drug to a covered
613 person. This cost includes the pharmacist’s services and the
614 overhead associated with maintaining the facility and equipment
615 necessary to operate the pharmacy.

616 (g) “Effective rate guarantee” means the minimum ingredient
617 cost reimbursement a pharmacy benefit manager guarantees it will
618 pay for pharmacist services during the applicable measurement
619 period.

620 (h) “Erroneous claims” means pharmacy claims submitted in
621 error, including, but not limited to, unintended, incorrect,
622 fraudulent, or test claims.

623 (i) “Incentive payment” means a retrospective monetary
624 payment made as a reward or recognition by the pharmacy benefits
625 plan or program or pharmacy benefit manager to a pharmacy for
626 meeting or exceeding predefined pharmacy performance metrics as
627 related to quality measures, such as Healthcare Effectiveness
628 Data and Information Set measures.

629 (j) “Maximum allowable cost appeal pricing adjustment”
630 means a retrospective positive payment adjustment made to a
631 pharmacy by the pharmacy benefits plan or program or by the
632 pharmacy benefit manager pursuant to an approved maximum
633 allowable cost appeal request submitted by the same pharmacy to
634 dispute the amount reimbursed for a drug based on the pharmacy
635 benefit manager’s listed maximum allowable cost price.

636 (k) “Monetary recoupments” means rescinded or recouped
637 payments from a pharmacy or provider by the pharmacy benefits
638 plan or program or by the pharmacy benefit manager.

639 (l) “Network” means a group of pharmacies that agree to
640 provide pharmacist services to covered persons on behalf of a
641 pharmacy benefits plan or program or a group of pharmacy
642 benefits plans or programs in exchange for payment for such
643 services. The term includes a pharmacy that generally dispenses
644 outpatient prescription drugs to covered persons.
645 (m) “Network reconciliation offsets” means a process during
646 annual payment reconciliation between a pharmacy benefit manager
647 and a pharmacy which allows the pharmacy benefit manager to
648 offset an amount for overperformance or underperformance of
649 contractual guarantees across guaranteed line items, channels,
650 networks, or payors, as applicable.
651 (n) “Participation contract” means any agreement between a
652 pharmacy benefit manager and pharmacy for the provision and
653 reimbursement of pharmacist services and any exhibits,
654 attachments, amendments, or addendums to such agreement.
655 (o) “Pass-through pricing model” means a payment model used
656 by a pharmacy benefit manager in which the payments made by the
657 pharmacy benefits plan or program to the pharmacy benefit
658 manager for the covered outpatient drugs are:
659 1. Equivalent to the payments the pharmacy benefit manager
660 makes to a dispensing pharmacy or provider for such drugs,
661 including any contracted professional dispensing fee between the
662 pharmacy benefit manager and its network of pharmacies. Such
663 dispensing fee would be paid if the pharmacy benefits plan or
664 program was making the payments directly.
665 2. Passed through in their entirety by the pharmacy
666 benefits plan or program or by the pharmacy benefit manager to
667 the pharmacy or provider that dispenses the drugs, and the

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668 payments are made in a manner that is not offset by any
669 reconciliation.
670 (p) “Pharmacist” has the same meaning as in s. 465.003.
671 (q) “Pharmacist services” means products, goods, and
672 services or any combination of products, goods, and services
673 provided as part of the practice of the profession of pharmacy
674 as defined in s. 465.003 or otherwise covered by a pharmacy
675 benefits plan or program.
676 (r) “Pharmacy” has the same meaning as in s. 465.003.
677 (s) “Pharmacy benefit manager” has the same meaning as in
678 s. 626.88.
679 (t) “Pharmacy benefits plan or program” means a plan or
680 program that pays for, reimburses, covers the cost of, or
681 provides access to discounts on pharmacist services provided by
682 one or more pharmacies to covered persons who reside in, are
683 employed by, or receive pharmacist services from this state. The
684 term includes, but is not limited to, health maintenance
685 organizations, health insurers, self-insured employer health
686 plans, discount card programs, and government-funded health
687 plans, including the Statewide Medicaid Managed Care program
688 established pursuant to part IV of chapter 409 and the state
689 group insurance program pursuant to part I of chapter 110.
690 (u) “Rebate” means all payments that accrue to a pharmacy
691 benefit manager or its pharmacy benefits plan or program client,
692 directly or indirectly, from a pharmaceutical manufacturer,
693 including, but not limited to, discounts, administration fees,
694 credits, incentives, or penalties associated directly or
695 indirectly in any way with claims administered on behalf of a
696 pharmacy benefits plan or program client.

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697 (v) "Spread pricing" is the practice in which a pharmacy
698 benefit manager charges a pharmacy benefits plan or program a
699 different amount for pharmacist services than the amount the
700 pharmacy benefit manager reimburses a pharmacy for such
701 pharmacist services.
702 (w) "Usual and customary price" means the amount charged to
703 cash customers for a pharmacist service exclusive of sales tax
704 or other amounts claimed.
705 (2) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A
706 PHARMACY BENEFITS PLAN OR PROGRAM.—In addition to any other
707 requirements in the Florida Insurance Code, all contractual
708 arrangements executed, amended, adjusted, or renewed on or after
709 July 1, 2023, which are applicable to pharmacy benefits covered
710 on or after January 1, 2024, between a pharmacy benefit manager
711 and a pharmacy benefits plan or program must:
712 (a) Use a pass-through pricing model, remaining consistent
713 with the prohibition in paragraph (3)(c).
714 (b) Exclude terms that allow for the direct or indirect
715 engagement in the practice of spread pricing unless the pharmacy
716 benefit manager passes along the entire amount of such
717 difference to the pharmacy benefits plan or program as allowable
718 under paragraph (a).
719 (c) Ensure that funds received in relation to providing
720 services for a pharmacy benefits plan or program or a pharmacy
721 are received by the pharmacy benefit manager in trust for the
722 pharmacy benefits plan or program or pharmacy, as applicable,
723 and are used or distributed only pursuant to the pharmacy
724 benefit manager's contract with the pharmacy benefits plan or
725 program or with the pharmacy or as otherwise required by

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726 applicable law.
727 (d) Require the pharmacy benefit manager to pass 100
728 percent of all prescription drug manufacturer rebates, including
729 nonresident manufacturer rebates, received to the pharmacy
730 benefits plan or program, if the contractual arrangement
731 delegates the negotiation of rebates to the pharmacy benefit
732 manager, for the sole purpose of offsetting defined cost sharing
733 and reducing premiums of covered persons. Any excess rebate
734 revenue after the pharmacy benefit manager and the pharmacy
735 benefits plan or program have taken all actions required under
736 this paragraph must be used for the sole purpose of offsetting
737 copayments and deductibles of covered persons. This paragraph
738 does not apply to contracts involving Medicaid managed care
739 plans.
740 (e) Include network adequacy requirements that meet or
741 exceed the Medicare Part D program standards for convenient
742 access to network pharmacies set forth in 42 C.F.R. s. 423.120,
743 and that:
744 1. Do not limit a network to solely include affiliated
745 pharmacies;
746 2. Require a pharmacy benefit manager to offer a provider
747 contract to licensed pharmacies physically located on the
748 physical site of providers that are:
749 a. Within the pharmacy benefits plan's or program's
750 geographic service area and that have been specifically
751 designated as essential providers by the Agency for Health Care
752 Administration pursuant to s. 409.975(1)(a);
753 b. Designated as a Cancer Center of Excellence under s.
754 381.925, regardless of the pharmacy benefits plan's or program's

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755 geographic service area;
756 c. Organ transplant hospitals, regardless of the pharmacy
757 benefits plan's or program's geographic service area;
758 d. Hospitals licensed as specialty children's hospitals as
759 defined in s. 395.002; or
760 e. Regional perinatal intensive care centers as defined in
761 s. 383.16(2), regardless of the pharmacy benefits plan's or
762 program's geographic service area.
763
764 Such provider contracts must be solely for the administration or
765 dispensing of covered prescription drugs, including biological
766 products, that are administered through infusions, intravenously
767 injected, inhaled during a surgical procedure, or a covered
768 parenteral drug, as part of onsite outpatient care;
769 3. Do not require a covered person to receive a
770 prescription drug by United States mail, common carrier, local
771 courier, third-party company or delivery service, or pharmacy
772 direct delivery. This subparagraph does not prohibit a pharmacy
773 benefit manager from operating mail order or delivery programs
774 on an opt-in basis at the sole discretion of a covered person;
775 4. Prohibit a requirement for a covered person to receive
776 pharmacist services from an affiliated pharmacy or an affiliated
777 health care provider for the in-person administration of covered
778 prescription drugs; offering or implementing pharmacy networks
779 that require or provide a promotional item or an incentive,
780 defined as anything other than a reduced copay or premium of a
781 covered drug, to a covered person to use an affiliated pharmacy
782 or an affiliated health care provider for the in-person
783 administration of covered prescription drugs; or advertising,

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784 marketing, or promoting an affiliated pharmacy to covered
785 persons. Subject to the foregoing, a pharmacy benefit manager
786 may include an affiliated pharmacy in communications to covered
787 persons regarding network pharmacies and prices, provided that
788 the pharmacy benefit manager includes information, such as links
789 to all nonaffiliated network pharmacies, in such communications
790 and that the information provided is accurate and of equal
791 prominence. This paragraph may not be construed to prohibit a
792 pharmacy benefit manager from entering into an agreement with an
793 affiliated pharmacy to provide pharmacist services to covered
794 persons.
795 (f) Prohibit the ability of a pharmacy benefit manager to
796 condition participation in one pharmacy network on participation
797 in any other pharmacy network or penalize a pharmacy for
798 exercising its prerogative not to participate in a specific
799 pharmacy network.
800 (g) Prohibit a pharmacy benefit manager from instituting a
801 network that requires a pharmacy to meet accreditation standards
802 inconsistent with or more stringent than applicable federal and
803 state requirements for licensure and operation as a pharmacy in
804 this state.
805 (3) CONTRACTS BETWEEN A PHARMACY BENEFIT MANAGER AND A
806 PARTICIPATING PHARMACY.—In addition to other requirements in the
807 Florida Insurance Code, a participation contract executed,
808 amended, adjusted, or renewed on or after July 1, 2023, that
809 applies to pharmacist services on or after January 1, 2024,
810 between a pharmacy benefit manager and one or more pharmacies or
811 pharmacists, must include, in substantial form, terms that
812 ensure compliance with all of the following requirements, and

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813 that, except to the extent not allowed by law, shall supersede
814 any contractual terms in the participation contract to the
815 contrary:
816 (a) At the time of adjudication for electronic claims or
817 the time of reimbursement for nonelectronic claims, the pharmacy
818 benefit manager shall provide the pharmacy with a remittance,
819 including such detailed information as is necessary for the
820 pharmacy or pharmacist to identify the reimbursement schedule
821 for the specific network applicable to the claim and which is
822 the basis used by the pharmacy benefit manager to calculate the
823 amount of reimbursement paid. This information must include, but
824 is not limited to, the applicable network reimbursement ID or
825 plan ID as defined in the most current version of the National
826 Council for Prescription Drug Programs (NCPDP) Telecommunication
827 Standard Implementation Guide, or its nationally recognized
828 successor industry guide. The commission shall adopt rules to
829 implement this paragraph.
830 (b) The pharmacy benefit manager must ensure that any basis
831 of reimbursement information is communicated to a pharmacy in
832 accordance with the NCPDP Telecommunication Standard
833 Implementation Guide, or its nationally recognized successor
834 industry guide, when performing reconciliation for any effective
835 rate guarantee, and that such basis of reimbursement information
836 communicated is accurate, corresponds with the applicable
837 network rate, and may be relied upon by the pharmacy.
838 (c) A prohibition of financial clawbacks or reconciliation
839 offsets. A pharmacy benefit manager may not recoup direct or
840 indirect remuneration fees, dispensing fees, brand name or
841 generic effective rate adjustments through reconciliation, or

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842 any other monetary recoupments as related to discounts, multiple
843 network reconciliation offsets, adjudication transaction fees,
844 and any other instance when a fee may be recouped from a
845 pharmacy. For purposes of this section, the terms "financial
846 clawbacks" or "reconciliation offsets" do not include:
847 1. Any incentive payments provided by the pharmacy benefit
848 manager to a network pharmacy for meeting or exceeding
849 predefined quality measures, such as Healthcare Effectiveness
850 Data and Information Set measures; recoupment due to an
851 erroneous claim, fraud, waste, or abuse; a claim adjudicated in
852 error; a maximum allowable cost appeal pricing adjustment; or an
853 adjustment made as part of a pharmacy audit pursuant to s.
854 624.491.
855 2. Any recoupment that is returned to the state for
856 programs in chapter 409 or the state group insurance program in
857 s. 110.123.
858 (d) A pharmacy benefit manager may not unilaterally change
859 the terms of any participation contract.
860 (e) Unless otherwise prohibited by law, a pharmacy benefit
861 manager may not prohibit a pharmacy or pharmacist from:
862 1. Offering mail or delivery services on an opt-in basis at
863 the sole discretion of the covered person.
864 2. Mailing or delivering a prescription drug to a covered
865 person upon his or her request.
866 3. Charging a shipping or handling fee to a covered person
867 requesting a prescription drug be mailed or delivered if the
868 pharmacy or pharmacist discloses to the covered person before
869 the mailing or delivery the amount of the fee that will be
870 charged and that the fee may not be reimbursable by the covered

871 person’s pharmacy benefits plan or program.
872 (f) The pharmacy benefit manager must provide a pharmacy,
873 upon its request, a list of pharmacy benefits plans or programs
874 in which the pharmacy is a part of the network. Updates to the
875 list must be communicated to the pharmacy within 7 days. The
876 pharmacy benefit manager may not restrict the pharmacy or
877 pharmacist from disclosing this information to the public.
878 (g) The pharmacy benefit manager must ensure that the
879 Electronic Remittance Advice contains claim level payment
880 adjustments in accordance with the American National Standards
881 Institute Accredited Standards Committee, X12 format, and
882 includes or is accompanied by the appropriate level of detail
883 for the pharmacy to reconcile any debits or credits, including,
884 but not limited to, pharmacy NCPDP or NPI identifier, date of
885 service, prescription number, refill number, adjustment code, if
886 applicable, and transaction amount.
887 (h) The pharmacy benefit manager shall provide a reasonable
888 administrative appeal procedure to allow a pharmacy or
889 pharmacist to challenge the maximum allowable cost pricing
890 information and the reimbursement made under the maximum
891 allowable cost as defined in s. 627.64741 for a specific drug as
892 being below the acquisition cost available to the challenging
893 pharmacy or pharmacist.
894 1. The administrative appeal procedure must include a
895 telephone number and e-mail address, or a website, for the
896 purpose of submitting the administrative appeal. The appeal may
897 be submitted by the pharmacy or an agent of the pharmacy
898 directly to the pharmacy benefit manager or through a pharmacy
899 service administration organization. The pharmacy or pharmacist

900 must be given at least 30 business days after a maximum
901 allowable cost update or after an adjudication for an electronic
902 claim or reimbursement for a nonelectronic claim to file the
903 administrative appeal.
904 2. The pharmacy benefit manager must respond to the
905 administrative appeal within 30 business days after receipt of
906 the appeal.
907 3. If the appeal is upheld, the pharmacy benefit manager
908 must:
909 a. Update the maximum allowable cost pricing information to
910 at least the acquisition cost available to the pharmacy;
911 b. Permit the pharmacy or pharmacist to reverse and rebill
912 the claim in question;
913 c. Provide to the pharmacy or pharmacist the national drug
914 code on which the increase or change is based; and
915 d. Make the increase or change effective for each similarly
916 situated pharmacy or pharmacist who is subject to the applicable
917 maximum allowable cost pricing information.
918 4. If the appeal is denied, the pharmacy benefit manager
919 must provide to the pharmacy or pharmacist the national drug
920 code and the name of the national or regional pharmaceutical
921 wholesalers operating in this state which have the drug
922 currently in stock at a price below the maximum allowable cost
923 pricing information.
924 5. Every 90 days, a pharmacy benefit manager shall report
925 to the office the total number of appeals received and denied in
926 the preceding 90-day period for each specific drug for which an
927 appeal was submitted pursuant to this paragraph.
928 Section 12. Section 626.8827, Florida Statutes, is created

929 to read:

930 626.8827 Pharmacy benefit manager prohibited practices.—In
931 addition to other prohibitions in this part, a pharmacy benefit
932 manager may not do any of the following:

933 (1) Prohibit, restrict, or penalize in any way a pharmacy
934 or pharmacist from disclosing to any person any information that
935 the pharmacy or pharmacist deems appropriate, including, but not
936 limited to, information regarding any of the following:

937 (a) The nature of treatment, risks, or alternatives
938 thereto.

939 (b) The availability of alternate treatment, consultations,
940 or tests.

941 (c) The decision of utilization reviewers or similar
942 persons to authorize or deny pharmacist services.

943 (d) The process used to authorize or deny pharmacist
944 services or benefits.

945 (e) Information on financial incentives and structures used
946 by the pharmacy benefits plan or program.

947 (f) Information that may reduce the costs of pharmacist
948 services.

949 (g) Whether the cost-sharing obligation exceeds the retail
950 price for a covered prescription drug and the availability of a
951 more affordable alternative drug, pursuant to s. 465.0244.

952 (2) Prohibit, restrict, or penalize in any way a pharmacy
953 or pharmacist from disclosing information to the office, the
954 Agency for Health Care Administration, Department of Management
955 Services, law enforcement, or state and federal governmental
956 officials, provided that the recipient of the information
957 represents it has the authority, to the extent provided by state

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958 or federal law, to maintain proprietary information as
959 confidential; and before disclosure of information designated as
960 confidential, the pharmacist or pharmacy marks as confidential
961 any document in which the information appears or requests
962 confidential treatment for any oral communication of the
963 information.
964 (3) Communicate at the point-of-sale, or otherwise require,
965 a cost-sharing obligation for the covered person in an amount
966 that exceeds the lesser of:
967 (a) The applicable cost-sharing amount under the applicable
968 pharmacy benefits plan or program; or
969 (b) The usual and customary price, as defined in s.
970 626.8825, of the pharmacist services.
971 (4) Transfer or share records relative to prescription
972 information containing patient-identifiable or prescriber-
973 identifiable data to an affiliated pharmacy for any commercial
974 purpose other than the limited purposes of facilitating pharmacy
975 reimbursement, formulary compliance, or utilization review on
976 behalf of the applicable pharmacy benefits plan or program.
977 (5) Fail to make any payment due to a pharmacy for an
978 adjudicated claim with a date of service before the effective
979 date of a pharmacy’s termination from a pharmacy benefit network
980 unless payments are withheld because of actual fraud on the part
981 of the pharmacy or except as otherwise required by law.
982 (6) Terminate the contract of, penalize, or disadvantage a
983 pharmacist or pharmacy due to a pharmacist or pharmacy:
984 (a) Disclosing information about pharmacy benefit manager
985 practices in accordance with this act;
986 (b) Exercising any of its prerogatives under this part; or

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987 (c) Sharing any portion, or all, of the pharmacy benefit
988 manager contract with the office pursuant to a complaint or a
989 query regarding whether the contract is in compliance with this
990 act.
991 (7) Fail to comply with the requirements in s. 626.8825 or
992 s. 624.491.
993 Section 13. Section 626.8828, Florida Statutes, is created
994 to read:
995 626.8828 Investigations and examinations of pharmacy
996 benefit managers; expenses; penalties.—
997 (1) The office may investigate administrators who are
998 pharmacy benefit managers and applicants for authorization as
999 provided in ss. 624.307 and 624.317. The office shall review any
1000 referral made pursuant to s. 624.307(10) and shall investigate
1001 any referral that, as determined by the Commissioner of
1002 Insurance Regulation or his or her designee, reasonably
1003 indicates a possible violation of this part.
1004 (2)(a) The office shall examine the business and affairs of
1005 each pharmacy benefit manager at least biennially. The biennial
1006 examination of each pharmacy benefit manager must be a
1007 systematic review for the purpose of determining the pharmacy
1008 benefit manager's compliance with all provisions of this part
1009 and all other laws or rules applicable to pharmacy benefit
1010 managers and must include a detailed review of the pharmacy
1011 benefit manager's compliance with ss. 626.8825 and 626.8827. The
1012 first 2-year cycle for conducting biennial reviews begins July
1013 1, 2023. By January 1 of the year following a 2-year cycle, the
1014 office must deliver to the Governor, the President of the
1015 Senate, and the Speaker of the House of Representatives a report

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1016 summarizing the results of the biennial examinations during the
1017 most recent 2-year cycle which includes detailed descriptions of
1018 any violations committed by each pharmacy benefit manager and
1019 detailed reporting of actions taken by the office against each
1020 pharmacy benefit manager for such violations.
1021 (b) The office also may conduct additional examinations as
1022 often as it deems advisable or necessary for the purpose of
1023 ascertaining compliance with this part and any other laws or
1024 rules applicable to pharmacy benefit managers or applicants for
1025 authorization.
1026 (c) If a referral made pursuant to s. 624.307(10)
1027 reasonably indicates a pattern or practice of violations of this
1028 part by a pharmacy benefit manager, the office must begin an
1029 examination of the pharmacy benefit manager or include findings
1030 related to such referral within an ongoing examination.
1031 (d) Based on the findings of an examination that a pharmacy
1032 benefit manager or an applicant for authorization has exhibited
1033 a pattern or practice of knowing and willful violations of s.
1034 626.8825 or s. 626.8827, the office may, pursuant to chapter
1035 120, order a pharmacy benefit manager to file all contracts
1036 between the pharmacy benefit manager and pharmacies or pharmacy
1037 benefits plans or programs and any policies, guidelines, rules,
1038 protocols, standard operating procedures, instructions, or
1039 directives that govern or guide the manner in which the pharmacy
1040 benefit manager or applicant conducts business related to such
1041 knowing and willful violations for review and inspection for the
1042 following 36-month period. Such documents are public records and
1043 are not trade secrets or otherwise exempt from s. 119.07(1). As
1044 used in this section, the term:

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1045 1. “Contracts” means any contract to which s. 626.8825 is
1046 applicable.
1047 2. “Knowing and willful” means any act of commission or
1048 omission which is committed intentionally, as opposed to
1049 accidentally, and which is committed with knowledge of the act’s
1050 unlawfulness or with reckless disregard as to the unlawfulness
1051 of the act.
1052 (e) Examinations may be conducted by an independent
1053 professional examiner under contract to the office, in which
1054 case payment must be made directly to the contracted examiner by
1055 the pharmacy benefit manager examined in accordance with the
1056 rates and terms agreed to by the office and the examiner. The
1057 commission shall adopt rules providing for the types of
1058 independent professional examiners who may conduct examinations
1059 under this section, which types must include, but need not be
1060 limited to, independent certified public accountants, actuaries,
1061 investment specialists, information technology specialists, or
1062 others meeting criteria specified by commission rule. The rules
1063 must also require that:
1064 1. The rates charged to the pharmacy benefit manager being
1065 examined are consistent with rates charged by other firms in a
1066 similar profession and are comparable with the rates charged for
1067 comparable examinations.
1068 2. The firm selected by the office to perform the
1069 examination has no conflicts of interest which might affect its
1070 ability to independently perform its responsibilities for the
1071 examination.
1072 (3) In making investigations and examinations of pharmacy
1073 benefit managers and applicants for authorization, the office

1074 and such pharmacy benefit manager are subject to all of the
1075 following provisions:
1076 (a) Section 624.318, as to the conduct of examinations.
1077 (b) Section 624.319, as to examination and investigation
1078 reports.
1079 (c) Section 624.321, as to witnesses and evidence.
1080 (d) Section 624.322, as to compelled testimony.
1081 (e) Section 624.324, as to hearings.
1082 (f) Section 624.34, as to fingerprinting.
1083 (g) Any other provision of chapter 624 applicable to the
1084 investigation or examination of a licensee under this part.
1085 (4)(a) A pharmacy benefit manager must maintain an accurate
1086 record of all contracts and records with all pharmacies and
1087 pharmacy benefits plans or programs for the duration of the
1088 contract, and for 5 years thereafter. Such contracts must be
1089 made available to the office and kept in a form accessible to
1090 the office.
1091 (b) The office may order any pharmacy benefit manager or
1092 applicant to produce any records, books, files, contracts,
1093 advertising and solicitation materials, or other information and
1094 may take statements under oath to determine whether the pharmacy
1095 benefit manager or applicant is in violation of the law or is
1096 acting contrary to the public interest.
1097 (5)(a) Notwithstanding s. 624.307(3), each pharmacy benefit
1098 manager and applicant for authorization must pay to the office
1099 the expenses of the examination or investigation. Such expenses
1100 include actual travel expenses, a reasonable living expense
1101 allowance, compensation of the examiner, investigator, or other
1102 person making the examination or investigation, and necessary

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1103 costs of the office directly related to the examination or
1104 investigation. Such travel expenses and living expense
1105 allowances are limited to those expenses necessarily incurred on
1106 account of the examination or investigation and shall be paid by
1107 the examined pharmacy benefit manager or applicant together with
1108 compensation upon presentation by the office to such pharmacy
1109 benefit manager or applicant of such charges and expenses after
1110 a detailed statement has been filed by the examiner and approved
1111 by the office.
1112 (b) All moneys collected from pharmacy benefit managers and
1113 applicants for authorization pursuant to this subsection shall
1114 be deposited into the Insurance Regulatory Trust Fund, and the
1115 office may make deposits from time to time into such fund from
1116 moneys appropriated for the operation of the office.
1117 (c) Notwithstanding s. 112.061, the office may pay to the
1118 examiner, investigator, or person making such examination or
1119 investigation out of such trust fund the actual travel expenses,
1120 reasonable living expense allowance, and compensation in
1121 accordance with the statement filed with the office by the
1122 examiner, investigator, or other person, as provided in
1123 paragraph (a).
1124 (6) In addition to any other enforcement authority
1125 available to the office, the office shall impose an
1126 administrative fine of $5,000 for each violation of s. 626.8825
1127 or s. 626.8827. Each instance of a violation of such sections by
1128 a pharmacy benefit manager against each individual pharmacy or
1129 prescription benefits plan or program constitutes a separate
1130 violation. Notwithstanding any other provision of law, there is
1131 no limitation on aggregate fines issued pursuant to this

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1132 section. The proceeds from any administrative fine shall be
1133 deposited into the General Revenue Fund.
1134 (7) Failure by a pharmacy benefit manager to pay expenses
1135 incurred or administrative fines imposed under this section is
1136 grounds for the denial, suspension, or revocation of its
1137 certificate of authority.
1138 Section 14. Section 626.89, Florida Statutes, is amended to
1139 read:
1140 626.89 Annual financial statement and filing fee; notice of
1141 change of ownership; pharmacy benefit manager filings.—
1142 (1) Each authorized administrator shall annually file with
1143 the office a full and true statement of its financial condition,
1144 transactions, and affairs within 3 months after the end of the
1145 administrator’s fiscal year or within such extension of time as
1146 the office for good cause may have granted. The statement must
1147 be for the preceding fiscal year and must be in such form and
1148 contain such matters as the commission prescribes and must be
1149 verified by at least two officers of the administrator.
1150 (2) Each authorized administrator shall also file an
1151 audited financial statement performed by an independent
1152 certified public accountant. The audited financial statement
1153 must ~~shall~~ be filed with the office within 5 months after the
1154 end of the administrator’s fiscal year and be for the preceding
1155 fiscal year. An audited financial statement prepared on a
1156 consolidated basis must include a columnar consolidating or
1157 combining worksheet that must be filed with the statement and
1158 must comply with the following:
1159 (a) Amounts shown on the consolidated audited financial
1160 statement must be shown on the worksheet;

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1161 (b) Amounts for each entity must be stated separately; and
1162 (c) Explanations of consolidating and eliminating entries
1163 must be included.
1164 (3) At the time of filing its annual statement, the
1165 administrator shall pay a filing fee in the amount specified in
1166 s. 624.501 for the filing of an annual statement by an insurer.
1167 (4) In addition, the administrator shall immediately notify
1168 the office of any material change in its ownership.
1169 (5) A pharmacy benefit manager shall also notify the office
1170 within 30 days after any administrative, civil, or criminal
1171 complaints, settlements, or discipline of the pharmacy benefit
1172 manager or any of its affiliates which relate to a violation of
1173 the insurance laws, including pharmacy benefit laws in any
1174 state.
1175 (6) A pharmacy benefit manager shall also annually submit
1176 to the office a statement attesting to its compliance with the
1177 network requirements of s. 626.8825.
1178 (7) The commission may by rule require all or part of the
1179 statements or filings required under this section to be
1180 submitted by electronic means in a computer-readable form
1181 compatible with the electronic data format specified by the
1182 commission.
1183 Section 15. Subsection (5) is added to section 627.42393,
1184 Florida Statutes, to read:
1185 627.42393 Step-therapy protocol.—
1186 (5) This section applies to a pharmacy benefit manager
1187 acting on behalf of a health insurer.
1188 Section 16. Subsections (2), (3), and (4) of section
1189 627.64741, Florida Statutes, are amended to read:

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1190 627.64741 Pharmacy benefit manager contracts.—
1191 (2) In addition to the requirements of part VII of chapter
1192 626, a contract between a health insurer and a pharmacy benefit
1193 manager must require that the pharmacy benefit manager:
1194 (a) Update maximum allowable cost pricing information at
1195 least every 7 calendar days.
1196 (b) Maintain a process that will, in a timely manner,
1197 eliminate drugs from maximum allowable cost lists or modify drug
1198 prices to remain consistent with changes in pricing data used in
1199 formulating maximum allowable cost prices and product
1200 availability.
1201 ~~(3) A contract between a health insurer and a pharmacy~~
1202 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1203 ~~limiting a pharmacist's ability to disclose whether the cost-~~
1204 ~~sharing obligation exceeds the retail price for a covered~~
1205 ~~prescription drug, and the availability of a more affordable~~
1206 ~~alternative drug, pursuant to s. 465.0244.~~
1207 ~~(4) A contract between a health insurer and a pharmacy~~
1208 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1209 ~~requiring an insured to make a payment for a prescription drug~~
1210 ~~at the point of sale in an amount that exceeds the lesser of:~~
1211 ~~(a) The applicable cost-sharing amount; or~~
1212 ~~(b) The retail price of the drug in the absence of~~
1213 ~~prescription drug coverage.~~
1214 Section 17. Subsections (2), (3), and (4) of section
1215 627.6572, Florida Statutes, are amended to read:
1216 627.6572 Pharmacy benefit manager contracts.—
1217 (2) In addition to the requirements of part VII of chapter
1218 626, a contract between a health insurer and a pharmacy benefit

1219 manager must require that the pharmacy benefit manager:
1220 (a) Update maximum allowable cost pricing information at
1221 least every 7 calendar days.
1222 (b) Maintain a process that will, in a timely manner,
1223 eliminate drugs from maximum allowable cost lists or modify drug
1224 prices to remain consistent with changes in pricing data used in
1225 formulating maximum allowable cost prices and product
1226 availability.
1227 ~~(3) A contract between a health insurer and a pharmacy~~
1228 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1229 ~~limiting a pharmacist's ability to disclose whether the cost-~~
1230 ~~sharing obligation exceeds the retail price for a covered~~
1231 ~~prescription drug, and the availability of a more affordable~~
1232 ~~alternative drug, pursuant to s. 465.0244.~~
1233 ~~(4) A contract between a health insurer and a pharmacy~~
1234 ~~benefit manager must prohibit the pharmacy benefit manager from~~
1235 ~~requiring an insured to make a payment for a prescription drug~~
1236 ~~at the point of sale in an amount that exceeds the lesser of:~~
1237 ~~(a) The applicable cost-sharing amount; or~~
1238 ~~(b) The retail price of the drug in the absence of~~
1239 ~~prescription drug coverage.~~
1240 Section 18. Paragraph (e) is added to subsection (46) of
1241 section 641.31, Florida Statutes, to read:
1242 641.31 Health maintenance contracts.—
1243 (46)
1244 (e) This subsection applies to a pharmacy benefit manager
1245 acting on behalf of a health maintenance organization.
1246 Section 19. Subsections (2), (3), and (4) of section
1247 641.314, Florida Statutes, are amended to read:

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1248 641.314 Pharmacy benefit manager contracts.—
1249 (2) In addition to the requirements of part VII of chapter
1250 626, a contract between a health maintenance organization and a
1251 pharmacy benefit manager must require that the pharmacy benefit
1252 manager:
1253 (a) Update maximum allowable cost pricing information at
1254 least every 7 calendar days.
1255 (b) Maintain a process that will, in a timely manner,
1256 eliminate drugs from maximum allowable cost lists or modify drug
1257 prices to remain consistent with changes in pricing data used in
1258 formulating maximum allowable cost prices and product
1259 availability.
1260 (3) A contract between a health maintenance organization
1261 and a pharmacy benefit manager must prohibit the pharmacy
1262 benefit manager from limiting a pharmacist's ability to disclose
1263 whether the cost-sharing obligation exceeds the retail price for
1264 a covered prescription drug, and the availability of a more
1265 affordable alternative drug, pursuant to s. 465.0244.
1266 (4) A contract between a health maintenance organization
1267 and a pharmacy benefit manager must prohibit the pharmacy
1268 benefit manager from requiring a subscriber to make a payment
1269 for a prescription drug at the point of sale in an amount that
1270 exceeds the lesser of:
1271 (a) The applicable cost-sharing amount; or
1272 (b) The retail price of the drug in the absence of
1273 prescription drug coverage.
1274 Section 20. (1) This act establishes requirements for
1275 pharmacy benefit managers as defined in s. 626.88, Florida
1276 Statutes, including, without limitation, pharmacy benefit

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1277 managers in their performance of services for or otherwise on
1278 behalf of a pharmacy benefits plan or program as defined in s.
1279 626.8825, Florida Statutes, which includes coverage pursuant to
1280 Titles XVIII, XIX, or XXI of the Social Security Act, 42 U.S.C.
1281 ss. 1395 et seq., 1396 et seq., and 1397aa et seq., known as
1282 Medicare, Medicaid, or any other similar coverage under a state
1283 or Federal Government funded health plan, including the
1284 Statewide Medicaid Managed Care program established pursuant to
1285 part IV of chapter 409, Florida Statutes, and the state group
1286 insurance program pursuant to part I of chapter 110, Florida
1287 Statutes.
1288 (2) This act is not intended, nor may it be construed, to
1289 conflict with existing, relevant federal law.
1290 (3) If any provision of this act or its application to any
1291 person or circumstances is held invalid, the invalidity does not
1292 affect other provisions or applications of this act which can be
1293 given effect without the invalid provision or application, and
1294 to this end the provisions of this act are severable.
1295 Section 21. For the 2023-2024 fiscal year, the sum of
1296 $980,705 in recurring funds and $146,820 in nonrecurring funds
1297 from the Insurance Regulatory Trust Fund are appropriated to the
1298 Office of Insurance Regulation, and 10 full-time equivalent
1299 positions with associated salary rate of 644,877 are authorized,
1300 for the purpose of implementing this act.
1301 Section 22. This act shall take effect July 1, 2023.

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