The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1256
INTRODUCER:	Senator Grall
SUBJECT:	Pharmacy Audits
DATE:	February 10, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Favorable**
2.			AEG	
3.			RC	

I. Summary:

SB 1256 revises the pharmacy audit requirements that a pharmacy benefit manager or their auditor must follow. The bill:

- Establishes uniform audit standards for pharmacy benefit manager (PBM) affiliated pharmacies and nonaffiliated pharmacies;
- Extends the amount of prior notice of an audit that a PBM must provide to a pharmacy from 7 days to 30 days;
- Limits each audit to random sampling of no more than 0.1 percent of prescriptions; prohibits targeted selection by drug class, cost, or category unless fraud is suspected; and provides that additional claims can only be audited if fraud, waste, or abuse is reasonably suspected and stated in writing;
- Establishes protocols and notice for the designation of a pharmacy audit as a fraud, waste, and abuse audit; requires written notice to the pharmacy before commencement of such audit, including a clear statement that the audit is designated as a fraud, waste, or abuse audit, the specific claims or classes of claims to which the fraud, waste, or abuse designation applies, and a list of the specific facts, data, or allegations forming the basis for the fraud, waste, abuse designation;
- Prohibits PBM auditors from being compensated based on contingency based on recovery amounts;
- Creates inventory reconciliation protections to ensure that pharmacy-to-pharmacy transfers cannot be rejected; and limits documentation to the Federal Supply Chain Act requirements;
- Delays PBM recoupment until any appeals are resolved; the pharmacy has responded to any appeal; and the final audit report is issued;
- Limits recoupment to dispensing fee unless the pharmacy failed to dispense the drug or committed fraud; and prohibits ingredient cost recoupment for clerical or documentation errors; and

- Authorizes the Office of Insurance (OIR) to investigate audit complaints, issue fines based on the severity of the violation, order restitution for improper recoupments; and suspend or revoke a PBM registration for willful violations.

II. Present Situation:

The Office of Insurance Regulation[1]

The Office of Insurance Regulation (OIR) is an office under the Financial Services Commission (commission), which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. The commission is the agency head for purposes of rulemaking for OIR. The commission is not subject to control, supervision, or direction by the Department of Financial Services in any manner, including purchasing, transactions involving real or personal property, personnel, or budgetary matters. OIR is responsible for the regulation of all activities of insurers and other risk-bearing entities, including licensure, rates, policy forms, market conduct, claims, solvency, administrative supervision, pursuant to the Florida Insurance Code (code).

Pharmacy Benefit Managers

The OIR also regulates pharmacy benefit managers (PBMs). A PBM operating in Florida must be registered with OIR, pursuant to s. 624.490, F.S., and hold a valid certificate of authority (COA) as an insurance administrator. A PBM is a person or an entity doing business in this state which contracts to administer prescription drug benefits on behalf of a pharmacy benefits plan or program. The term includes, but is not limited to, a person or an entity that performs one or more of the following services on behalf of such plan or program:

- Pharmacy claims processing.
- Administration or management of a pharmacy discount card program.
- Managing pharmacy networks or pharmacy reimbursement.
- Paying or managing claims for pharmacist services provided to covered persons.
- Developing or managing a clinical formulary, including utilization management or quality assurance programs.
- Pharmacy rebate administration.
- Managing patient compliance, therapeutic intervention, or generic substitution programs.
- Administration or management of a mail-order pharmacy program.[2]

A pharmacy benefit plan or program[3] includes, but is not limited to, health maintenance organizations (HMOs), health insurers, self-insured employer health plans, discount card programs, and government-funded health plans, including the Statewide Medicaid Managed Care (SMMC) program established pursuant to part IV of ch. 409, F.S., and the state group insurance program pursuant to part I of ch. 110, F.S. The term excludes such a plan or program under ch. 440, F.S. the workers' compensation law.

[1] Section 20.121(3), F.S.
[2] Section 626.88(6), F.S.
[3] Section 626.8825(1)(u), F.S.

Section 624.491, F.S., prescribes the terms and conditions for an audit of a pharmacy licensed under ch. 465, F.S., by an entity, such as a pharmacy benefit plan or a pharmacy benefit manager, or their representative auditor. Pursuant to s. 408.7057, F.S., and after the receipt of the final audit report, a pharmacy may appeal the findings of the final audit report as to whether a claim payment is due and as to the amount of the claim payment.

Statewide Provider and Health Plan Claim Dispute[4]

Section 408.7057, F.S., creates the Statewide Provider and Health Plan Claim Dispute Resolution Program (program) within the Agency for Health Care Administration (agency). The program assist health care providers and health insurance plans resolve health care claims disputes. Capitol Bridge is the agency's contracted independent dispute resolution organization who serves as the arbitrator of claims disputes between the health care providers and health insurance plans. The program provides a lower cost dispute resolution option to formal litigation.

The program is not mandatory but provides a path to dispute resolution in lieu of formal litigation. However, once a provider requests arbitration services related to a SMMC claim dispute, the SMMC contracted plan must participate in the arbitration process. Once both parties agree to participate, the decision is binding.

The resolution organization has 60 days to make a recommendation to the agency after receipt of the appropriate forms and documentation. The resolution organization has the right to request additional documentation from both parties. The total review time may not exceed 90 days following receipt of the initial claim dispute request. The agency has 30 days to issue a final order based upon the date of receipt of the recommendation made by the resolution organization. The final order is subject to judicial review pursuant to s. 120.68, F.S.

Pharmacist Licensure

The Board of Pharmacy (Board), in conjunction with the Department of Health (Department), regulate the practice of pharmacists pursuant to ch. 465, F.S. To be licensed as a pharmacist, a person must:

- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Hold a degree from an accredited and approved school or college of pharmacy;
- Have completed a Board-approved internship; and
- Successfully complete the Board-approved examination.

A pharmacist must complete at least 30 hours of Board-approved continuing education during each biennial renewal period. Section 465.003(22), F.S. outlines a pharmacist's authority within the scope of practice of the profession of pharmacy. According to the Department of Health's Division of Medical Quality Assurance 2024-2025 Annual Report, there are 41,245 licensed pharmacists in Florida.

[4] Agency for Health Care Administration, Statewide Provider and Health Plan Claim Dispute Resolution Program Statewide Provider and Health Plan Claim Dispute Resolution Program FAQ | Florida Agency for Health Care Administration (last visited Feb. 2, 2026).

Audits of Pharmacies

Audits of pharmacy claims serve two main purposes, namely, detecting fraud, waste and abuse within the prescription drug benefit, and validating data entry and documentation to ensure that pharmacies meet regulatory and contractual requirements. Auditors review a sample of the total population of claims to determine compliance with the PBM contract.

Audit sampling is the application of an audit procedure to less than 100 percent of the items within an account balance or class of transactions for the purpose of evaluating some characteristic of the balance or class.[5] Generally, the sample size is based on statistically valid rational and risk assessments.[6] The sample must be representative of the population. Further, the sample must be large enough to reflect the population, typically requiring a lower margin of error (e.g., +/- 3 percent) and higher confidence level (e.g., 95 percent).[7]

III. Effect of Proposed Changes:

Section 1 amends s. 624.491, F.S., relating to pharmacy audits, to:

- Require the person conducting a pharmacy audit (auditor) on behalf of a pharmacy benefit plan or program to apply uniform audit standards, scope, frequency, and penalty practices to all pharmacies within the pharmacy benefit plan's network, including the pharmacy benefit managers owned or affiliated and non-affiliated pharmacies;
- Prohibits the auditor from imposing stricter audit methodologies, higher error thresholds, expanded documentation requirements or more frequent audits on nonaffiliated pharmacies than on pharmacy benefit manager owned or affiliated pharmacies.
- Requires the auditor to provide documentation demonstrating compliance with applying uniform audit standards, penalty practices to all pharmacies within the pharmacy benefit's plan network, upon request by the Office of Insurance Regulation (OIR) or a network pharmacy subject to audit.
- Requires auditor to provide at 30 instead of 7 days advance notice before any initial onsite or remote audit for each audit cycle.
- Prohibits an auditor from scheduling an audit during the first seven instead of three calendar days of the month unless the pharmacy consents in writing.
- Limits the scope of each audit to a random sampling of no more than 0.1 percent of prescriptions. Any additional claims may be audited only if fraud, waste, or abuse is reasonably suspected and stated in writing.
- Requires the auditor to use a random selection process for conducting audits. Targeting selection based on drug class, cost, or therapeutic category is prohibited unless fraud, waste, or abuse is suspected and stated in writing.
- Requires that if an audit requires clinical or professional judgement, any pharmacist used must be licensed in Florida.

[5] Public Company Accounting Oversight Board, AS 2315: Audit Sampling | PCAOB (Dec. 15, 2026).
[6] Packaging Digest, How to determine a valid sample size for testing medical device packaging (Oct. 19, 2018) (last visited Feb. 2, 2026).
[7] *Id.*

- Authorizes the pharmacy to use the written and verifiable records of a prescriber to validate the pharmacy records. The bill also provides that electronic records and scanned prescriptions are valid.
- Requires that a pharmacy must be reimbursed for an omission or discrepancy in documentation which does not affect the identity of the patient, the identity of the prescriber, the drug dispensed, the quantity dispensed, the date of service, or the accuracy of the amount paid under the claim, 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. The bill provides that such errors are not considered fraud unless there is clear and convincing evidence of intent to defraud.
- Requires the auditor to provide the pharmacy with a copy of the preliminary audit report within 30 instead of 120 days after the conclusion of the audit.
- Authorizes the pharmacy to initiate an appeal within 30 instead of 10 days after the preliminary audit is delivered to the pharmacy. A written appeals process is required.
- Provides that recoupment may not be calculated according to the accounting practice of extrapolation unless agreed upon in writing as part of a settlement. Recoupment is limited to the dispensing fee unless the pharmacy failed to dispense the drug or acted with willful intent to defraud. Ingredient cost recoupment is prohibited unless fraud or willful misrepresentation is proven. All recouped funds must be returned in full to the plan sponsor.
- Provides that recoupment may not occur until:
    - The pharmacy has had at least 30 days to respond;
    - All appeals are resolved; and
    - A final audit report is issued.
- Prohibits compensation of the auditor based on recovery amounts.

The bill provides that the person conducting the pharmacy audit may not:

- Disregard valid inventory acquired in accordance with state and federal law and legitimate business practices. All legally sourced products held by the pharmacy at the time of dispensing must count toward inventory reconciliation.
- Impose additional notification or approval requirements for routine pharmacy business decisions.
- Require sourcing from a narrower list of distributors than what is permitted under state or federal licensure standards.
- Impose manufacturer-driven restrictions on the source of drug products used in audit reconciliation.
- Reject purchases from pharmacy-to-pharmacy transfers conducted in accordance with state and federal law and accompanied by appropriate transaction documentation.
- Require bank statements, deposit records, including copies of the front or back of checks, and point-of-sale transaction records, or a combination of such records if any one or more of these records sufficiently demonstrates copay collection consistent with industry norms. Reasonable proof of copay collection must be limited to standard pharmacy records, including signature logs, point-of-sale transaction records, and accounting records.
- Require subsequent attestations from the patient. Lack of subsequent attestation may not be used to justify claim reversal or recoupment if a pharmacy possesses valid

documentation that medication was dispensed to the patient or his or her authorized representative, including, but not limited to, signature logs, electronic dispensing records, point-of-sale transaction records, or an in-person pharmacist acknowledgement of dispensing.

- Initiate subsequent attestations more than 180 days after the date of service.
- Require duplicate or extraordinary documentation beyond what is required under state and federal law in invoice audits. The following is deemed sufficient proof of lawful acquisition of products for audit reconciliation purposes:
  - Invoices from licensed wholesalers or distributors.
  - Valid documentation of pharmacy-to-pharmacy transfers conducted in accordance with state or federal law.
  - Records consistent with the Drug Supply Chain Security Act, 21 U.S.C. ss. 351 et seq., and Board of Pharmacy requirements.

The bill provides that an audit designated as a fraud, waste, or abuse audit must be based on specific, documented evidence or a credible allegation of fraud, waste, or abuse involving the pharmacy or a specific claim or set of claims under review. The person or entity conducting a fraud, waste, or abuse audit must provide the pharmacy with, in writing, before commencement of such audit:

- A clear statement that the audit is designated as a fraud, waste, or abuse audit.
- A list of the specific facts, data, or allegations forming the basis for the fraud, waste, abuse designation.
- Identification of the specific claims or classes of claims to which the fraud, waste, or abuse designation applies.

The bill provides that person or entity auditing the records of a pharmacy licensed under chapter 465, F.S., may not use a fraud, waste, or abuse audit designation to circumvent any provision of s. 624.491, F.S., unless the audit complies fully with the fraud, waste, or abuse audit provisions.

The bill provides that the provisions of s. 624.491, F.S., do not apply to audits conducted by the Medicaid Fraud Control Unit or initiated under a criminal investigation supported by probable cause.

Authorizes OIR to:

- Investigate complaints of violations of s. 624.491, F.S.
- Issue cease and desist orders.
- Impose administrative fines as follows:
  - For misuse of the fraud, waste, or abuse designation in violation of subsection (3), a fine not to exceed $100,000 per violation.
  - For a violation of paragraph (1)(a), paragraph (1)(b), or paragraph (1)(c), a fine not to exceed $50,000 per violation.
  - For any other violation of this section, a fine not to exceed $25,000 per violation.
- Order restitution for improper recoupments.
- Prohibit any person or entity from conducting audits under s. 624.491, F.S. for up to 2 years upon a finding that such person or entity has committed willful abuse of the fraud, waste, or abuse designation in violation of s. 624.491(3), F.S.

- Suspend or revoke a pharmacy benefit manager's registration under s. 624.490 for repeated or willful violations.

The Financial Services Commission is authorized to adopt rules necessary to implement the bill.

Section 2 provides the bill takes effect July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The amendments to the pharmacy audit requirements and recoupment practices by PBMs may reduce the number and amount of recoupments collected by PBMs from pharmacies.

C. Government Sector Impact:

The bill provides the Office of Insurance Regulation with more enforcement authority to investigate complaints relating to pharmacy audits, as well as fines for noncompliance.

VI. Technical Deficiencies:

Typically, a sample size is based on statistically valid rationale and risk assessments of the entity being audited.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends section 624.491 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.