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 Appropriations

BILL:	CS/SB 1760
INTRODUCER:	Health Policy Committee and Senator Brodeur and others
SUBJECT:	Health Care Coverage
DATE:	February 27, 2026
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rainer/Johnson	Brown	HP	**Fav/CS**
2.	Barr	Sadberry	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1760 amends laws relating to state oversight of health care insurance coverage, both in commercial health insurance and Medicaid.

Effective upon the bill becoming a law, the bill establishes the Joint Legislative Committee on Medicaid Oversight (committee) to ensure the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending. The bill creates a statutory definition for the term "Joint Legislative Committee on Medicaid Oversight" to specify a committee designated by joint rule of the Legislature, by the presiding officer of either house of the Legislature, or by agreement between the presiding officers.

The bill requires the committee to identify and recommend policies and authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill also creates additional Medicaid managed care plan reporting requirements for purposes of capitation rate setting and disclosure of financial relationships with affiliated entities.

The bill requires that a contract between the Agency for Health Care Administration (AHCA) and a Medicaid managed care plan must require that any third-party administrative entity contracted by the plan must adhere to all pertinent requirements of the Medicaid program placed on the plan under the plan's contract with the AHCA.

The bill provides that payments made by a Medicaid managed care plan to affiliated entities in excess of market rates are excluded as an allowable expense when the AHCA calculates such plan's achieved savings rebate (ASR). Effective January 1, 2027, the bill revises ASR statutes to alter the amount of profit that a managed care plan may retain versus how much of such profit must be shared with the state.

The bill amends statutes relating to Medicaid managed care plan medical loss ratios (MLR) to correct a reference to federal regulations and to specify that MLRs must be calculated for each plan separately for each component of Statewide Medicaid Managed Care and for each plan in the aggregate. The AHCA must calculate such MLRs quarterly and annually and report to the Governor and the Legislature no later than six months after the end of each such period.

The bill amends the Insurance Code relating to the oversight of pharmacy benefit managers (PBMs), which are regulated by the Office of Insurance Regulation (OIR). The bill creates numerous prohibitions against PBM behavior relating to contracting with and reimbursing pharmacies. The bill also prohibits a PBM from maintaining any ownership or investment interest in, or sharing common ownership with, an affiliated manufacturer, as that term is defined by the bill.

The bill has an indeterminate, significant positive fiscal impact on state revenues and expenditures. **See Section V., Fiscal Impact Statement**.

The bill provides an effective date of July 1, 2026, with exceptions as otherwise provided.

II. Present Situation:

Joint Legislative Committees

A joint legislative committee is composed of members of the Senate and the House of Representatives, appointed by their respective presiding officers, to oversee a specified legislative function. Joint legislative committees and other joint units of the Legislature are governed by joint rules of the Senate and the House. The joint rules are adopted in the organizational session for each legislative term.[1]

For the current legislative term (2024-2026), the joint rules provide for the following standing Joint Committees:

- Administrative Procedures Committee.
- Committee on Public Counsel Oversight.
- Legislative Auditing Committee.[2]

[1] Fla. Const. Art. III, § 3. For the current Legislative term of 2024-2026, the organizational session was held, in Nov. 2024, and concurrent resolution SRC 2 - Org was adopted as the Joint Rules.
[2] Joint Rule 4.1.

The current joint rules contain the governance and membership requirements for all Joint Committees.[3] Procedures,[4] powers,[5] and administration[6] for the Joint Committees are also set out. The joint also provide for special powers and duties for each standing Joint Committee.[7]

Legislative committees are also described in ch. 11, F.S. Any standing or select committees formed by the Legislature are not executive agencies.[8] The committees are entitled to all appropriations made by the Legislature.[9] Standing and select legislative committees are granted testimony, subpoena, and document production powers.[10] All joint committees are ultimately governed by joint rules of the Senate and the House of Representatives.[11]

The Auditor General

Florida's Auditor General is a constitutional and legislative officer. Article III, s. 2 of the Florida Constitution provides that "The legislature shall appoint an auditor to serve at its pleasure who shall audit public records and perform related duties as prescribed by law or concurrent resolution." As a certified public accountant, and the state's independent auditor, the auditor general is responsible for providing unbiased, timely, and relevant information that the Legislature, citizens of the state of Florida, public entity management, and other stakeholders can use to promote government accountability and stewardship, as well as improve government operations.[12] Chapter 11, F.S., establishes the general authority and duties of the auditor general.[13]

Medicaid Managed Care

Services under the Florida Medicaid program can either be provided under Statewide Medicaid Managed Care (SMMC) or the fee-for-service (FFS) delivery systems.[14] Health care services within SMMC are managed by contracted managed care plans. A Medicaid recipient generally must enroll in the SMMC and can choose a managed care plan available in his or her area of the state.[15] If a recipient is required to choose a plan but fails to, he or she is auto-assigned to one.

Certain recipients are not required to enroll in a managed care plan but may choose to. Such recipients are those receiving prescribed pediatric extended care (PPEC) services, recipients enrolled in the iBudget waiver or in an iBudget waiver pre-enrollment category,[16] recipients with

[3] Joint Rules 4.1(3) and (4).
[4] Joint Rule 4.2.
[5] Joint Rule 4.3.
[6] Joint Rule 4.4.
[7] Joint Rules 4.5 through 4.7.
[8] Section 11.135, F.S.
[9] *Id.*
[10] Section 11.143, F.S.
[11] Section 11.147(2), F.S.
[12] Florida Auditor General, *About the Florida Auditor General,* https://flauditor.gov/pages/aboutus.html (last visited Feb. 25, 2026).
[13] Sections 11.42 through 11.47, F.S.
[14] Agency for Health Care Administration, *A Snapshot of Statewide Medicaid Managed Care 3.0,* https://ahca.myflorida.com/content/download/25049/file/SMMC_Snapshot.pdf (last visited Feb. 25, 2026).
[15] Section 409.969, F.S.
[16] *See* ss. 393.0662 and 393.0663, F.S., for statutory provisions relating to iBudget.

non-Medicare credible coverage,[17] recipients in residential treatment facilities, and persons eligible for refugee assistance.[18] Other recipients are excluded from SMMC. They are women who are eligible only for family planning services, women who are eligible only for breast and cervical cancer services, persons enrolled in the Medically Needy program, and persons who are eligible for emergency Medicaid for aliens.[19]

Florida's Medicaid program, as of January 31, 2026, had 3,945,922 enrollees.[20] The enrollment for SMMC was 2,855,096, and enrollment in FFS was 1,086,900.[21]

Under either FFS or the SMMC, a recipient is entitled to all medical benefits provided by the State Plan.[22] The SMMC has four programs for providing those service:

- Managed Medical Assistance (MMA).
- Long-Term Care Managed Care (LTCMC).
- The Prepaid Dental Program.
- The pilot program for individuals with developmental disabilities.

MMA also provides for specialty plans to be provided in MMA.[23] Specialty plans are designed for specific populations.[24] There are currently specialty products for HIV/AIDS, serious mental illness, and child welfare.[25] Furthermore, SMMC provides for specialized care coordination and expanded benefits.[26]

Florida's Medicaid program, as of December 2025, is estimated to spend approximately $37.5 billion for state Fiscal Year 2025-2026. Expenditures as of December 2025 for SMMC in state Fiscal Year 2025-2026 are estimated to be approximately $27.3 billion. Expenditures for FFS are estimated to be approximately $10.2 billion for state Fiscal Year 2025-2026.[27]

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[17] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) New Program Highlight: Managed Medical Assistance v. Fee-For-Service,* https://ahca.myflorida.com/content/download/25693/file/Managed%20Medical%20Assistance%20Plan%20vs%20Fee-for-Service.pdf (last visited Feb. 25, 2026).

[18] Section 409.972, F.S.

[19] Section 409.965, F.S.

[20] Agency for Health Care Administration, *Medicaid Monthly Enrollment Report,* available at: https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited Feb. 25, 2026).

[21] *Id*.

[22] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) New Program Highlight: Managed Medical Assistance v. Fee-For-Service*.

[23] Section 409.974(3), F.S. *Also see:* Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program,* https://ahca.myflorida.com/content/download/9126/file/SMMC_Snapshot.pdf?version=1 (last visited Feb. 25, 2026).

[24] *Id.*

[25] Agency for Health Care Administration, *A Snapshot of Statewide Medicaid Managed Care 3.0,* https://ahca.myflorida.com/content/download/25049/file/SMMC_Snapshot.pdf (last visited Feb. 25, 2026).

[26] Agency for Health Care Administration, *Statewide Medicaid Managed Care 3.0 Overview,* https://ahca.myflorida.com/content/download/25090/file/Statewide%20Medicaid%20Managed%20Care%20Full%20Deck_05212025%20.pdf (last visited Feb. 25, 2026).

[27] Social Services Estimating Conference, *December 2025 Forecast, Medicaid Distribution: Managed Care and Fee for Service* (December 22, 2025) https://edr.state.fl.us/Content/conferences/medicaid/index.cfm (last visited Feb. 25, 2026).

Encounter Data

Encounter data is recognized as essential for developing capitation rates for risk based managed care programs.[28] Pursuant to actuarial standards, encounter data is defined as "information about an interaction between a provider of health care services and a member that is documented through the submission of a claim to a managed care organization (MCO) and shared between the MCO and the state Medicaid agency."[29] Encounter data is fundamental to measuring the required activities requested of managed care programs and for helping to determine capitation rates, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development.[30]

Providing validated encounter data to the U.S. Centers for Medicare and Medicaid Services (CMS) is a basic requirement for a state's implementation of Medicaid managed care. Failure to provide accurate and complete data can result in a state's federal financial participation (FFP) being reduced or otherwise impacted.[31] Florida statutes require Medicaid managed care plans to report encounter data to the AHCA's Medicaid Encounter Data System.[32] The AHCA annually performs an Encounter Data Validation Data Validation Study.[33]

The collection of encounter data may be affected when a managed care plan compensates providers with a capitated payment or other value-based compensation, which may or may not result in a claim for payment. Another complication may result when a provider subcontracts all or a portion of the delivery of health care benefits. There are also issues on how denied claims are treated for purposes of reporting encounter data.[34] Without a built-in payment incentive for providers, encounter data completeness can be compromised.[35]

Achieved Savings Rebate

In 2011, with the implementation of SMMC, Florida Medicaid adopted an achieved savings rebate (ASR) mechanism for profit-sharing.[36] The ASR system has remained largely unchanged

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[28] Cunningham, Houchens and Lewis, *Encounter Data Standards: Implications for State Medicaid Agencies and Managed Care Entities from Final Medicaid Managed Care Rule,* Milliman (May 1, 2016) https://www.milliman.com/en/insight/encounter-data-standards-implications-for-state-medicaid-agencies-and-managed-care-entiti (last visited Feb. 25, 2026).

[29] Actuarial Standards Board, *Actuarial Standard of Practice No. 49, Medicaid Managed Care Capitation Rate Development and Certification (adopted March 2015),* p. 2, http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/ (last visited Feb. 25, 2026).

[30] *Supra* note 28.

[31] 42 C.F.R. § 438.818

[32] Section 409.967(2)(e), F.S.

[33] Agency for Health Care Administration, *Encounter Data Validation Studies,* https://ahca.myflorida.com/medicaid/medicaid-quality-activities-and-projects/encounter-data-validation-studies (last visited Feb. 25, 2026).

[34] *Supra* note 28.

[35] Manatt Health, *What's the Matter with Encounter Data? Common Issues and Actionable State Strategies for Improving a Critical Data Resource,* presentation to National Association of Health Data Organization, 35th Annual Conference, (August 17, 2020) https://www.nahdo.org/sites/default/files/2020-08/103-68%20Kevin%20McAvey%20What_s%20the%20Matter%20with%20Encounter%20Data__NAHDO%20Presentation_Aug%2016%202020.PDF (last visited Feb. 25, 2026).

[36] Chapter 2011-134, s. 8, Laws of Florida.

since then, except for a change in 2023 which recognized the need to return to the federal government a portion of the state's recoveries from the shared savings, based on the federal match percentage. There was also a change in 2025 as to the auditing requirements by which the AHCA could notify the ASR auditor of deficiencies in the report and have them corrected before the audit is finalized.[37]

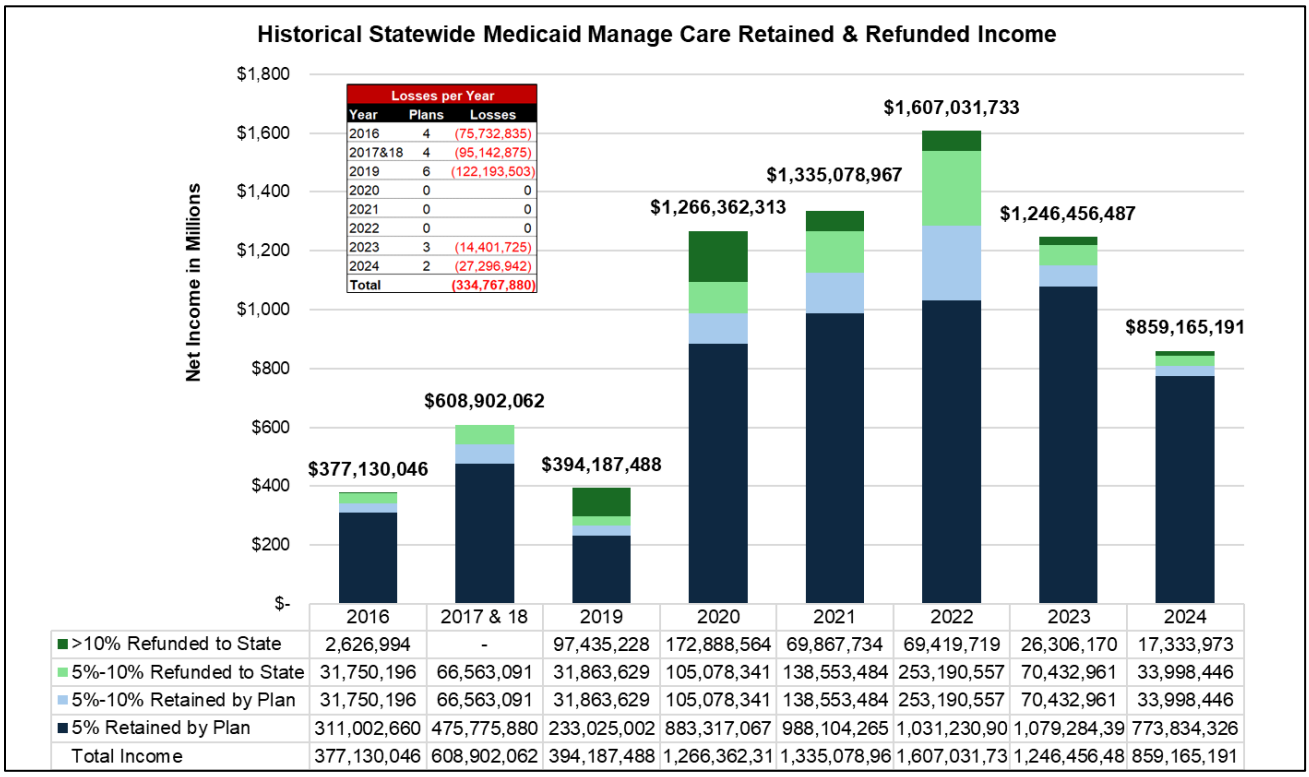
The ASR process begins with each Medicaid managed care plan submitting its audited financial statement for the preceding calendar year to the AHCA by June 1.[38] The AHCA contracts with an independent auditor who conducts a compliance audit of the various components of each plan's audited statement, which is used in calculating each calendar year's ASR for that plan.[39] Upon issuance of the compliance audit and the calculation of the ASR, the AHCA approves the report and it becomes final. A managed care plan is then required to pay any portion of its profit that must be shared with the state within 30 days of the report being final.[40]

The portion of a managed care plan's profit that must be shared with the state is calculated by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

- One hundred percent of income up to and including five percent of revenue is to be retained by the plan.
- Fifty percent of income above five percent and up to 10 percent is to be retained by the plan with the other 50 percent refunded to the state and adjusted for the federal match percentage.
- One hundred percent of income above 10 percent of revenue must be refunded to the state and adjusted for the federal match percentage.[41]

[37] Chapter 2025-204, s. 16, Laws of Florida.
[38] Section 409.967(3)(a), F.S.
[39] Section 409.967(3)(b) and (c), F.S.
[40] Section 409.967(3)(h), F.S.
[41] Section 409.967(3)(f), F.S.

The chart below illustrates the amount of ASR income retained versus refunded over the past eight years.[42]



It is possible for the plan to retain an additional one percent of profit. To achieve this additional retention, the plan must meet quality objectives developed by the AHCA. The quality objectives are focused on complex, chronic health conditions which are associated with high-cost medical treatments.[43] There is no record to date any managed care plan meeting the established quality thresholds necessary to retain the additional one percent of profit.

Medical Loss Ratios (MLR)

Medical loss ratio calculation and reporting are requirements of the federal government for Medicaid managed care programs.[44] The numerator of the ratio is all incurred claims, expenditures that improve health quality, fraud prevention activities,[45] and amounts paid to providers under state-directed payments.[46] Deducted from incurred claims are overpayment

[42] Chart data compiled from audited Achieved Savings Rebate Financial Reports obtained from the Agency for Health Care Administration (AHCA). The most recent reports are available on the AHCA website: https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-program-finance/financial-monitoring/2024-achieved-savings-rebate-asr-financial-reports-by-plan (last visited Feb. 25, 2026).

[43] Section 409.967(3)(g), F.S.
[44] MACPAC, *Medical Loss Ratios in Medicaid Managed Care, Issue Brief (*January 2022) https://www.macpac.gov/wp-content/uploads/2022/01/Medical-loss-ratio-issue-brief-January-2022.pdf (last visited Feb. 25, 2026).
[45] 42 C.F.R. § 438.8(e)
[46] 42 C.F.R. § 438.8(e)(2)(iii)(C)

recoveries from network providers and any prescription drug rebates received and accrued by a managed care plan.[47]

The denominator is adjusted premium revenue received by the plan.[48] Capitation payments for required services under the contract are the largest component of premium revenue. Revenue does not include incentive payments and pass-through payments. Federal, state, and local taxes and licensing and regulatory fees are deducted from adjusted premium revenue.[49]

Federal CMS requires that a state must have oversight of a managed care plan's MLR reporting.[50] In addition, when calculating a plan's capitation rate, there are various MLR-related standards that must be included to meet the required "actuarial soundness" standard.[51] However, states are not required to, but may, implement a minimum MLR.[52] A state can apply a required MLR in the aggregate or to different populations or a portion of the contract.[53]

Federal CMS regularly publishes MLR reports.[54] The AHCA has been collecting the required reports from the health plans and submitting them to federal CMS by its Financial Monitoring section.[55] The AHCA, in the standard contract with the health plans, requires them to prepare, deliver, and retain copies of the requisite federal MLR report for their particular plan.[56]

Section 409.967(4), F.S., authorizes the AHCA to calculate MLRs for SMMC managed care plans if required to do so as a condition of a Medicaid waiver. The statute requires that the method for calculating MLRs must classify expenditures in a manner consistent with 45 C.F.R. part 158,[57] except that:

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[47] Prescription drug rebates must be deducted if received by the health plan directly or a pharmacy benefit manager. *See* MACPAC, *Medical Loss Ratios in Medicaid Managed Care, Issue Brief* at p. 8.
[48] *Id.* at p. 3.
[49] *Id.*
[50] Centers for Medicare and Medicaid Services, *CMCS Informational Bulletin, Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio (*June 5, 2020) https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib060520_new.pdf (last visited Feb. 25, 2026).
[51] 42 C.F.R. § 438.4(b)(9) and 42 C.F.R. § 439(5)(b)(5)
[52] Centers for Medicare and Medicaid Services, *CMCS Informational Bulletin, Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio* at Q.2.
[53] 42 C.F.R. § 439.8(i)
[54] Centers for Medicare and Medicaid Services, *MLR Summary Reports,* https://data.medicaid.gov/dataset/743f9f04-4473-41e2-9da2-9a89db65ee55#data-table (last visited Feb. 25, 2026).
[55] Agency for Health Care Administration, *Financial Monitoring,* https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-program-finance/financial-monitoring (last visited Feb. 25, 2026).
[56] Agency for Health Care Administration Model Contract, FPXXX, Attachment II, Update Oct. 1, 2025(available at: https://ahca.myflorida.com/content/download/27248/file/Attachment%20II-%20-%20Core%20Contract%20Provisions%20Oct%202025.pdf). The reporting seems to be done in the context of the ASR reporting and calculation. Agency for Health Care Administration, Plan Communication, RCN 2024-03, Re: Achieved Savings Rebate (ASR) Financial Report – Medical Loss Ratio Comparison, (April 17, 2024), https://ahca.myflorida.com/content/download/27209/file/RCN%202024-03%20ASR%20Financial%20Template%20-%20MLR%20Comparison_04.17.2024.pdf (last visited Feb. 25, 2026).
[57] This portion of the Code of Federal Regulations was adopted to implement MLR requirements for health insurance issuers under the Public Health Service Act in order to address the treatment of "mini-med" and expatriate policies under these regulations for years after 2011; modify the way the regulations treat ICD-10 conversion costs; change the rules on deducting community benefit expenditures; and revise the rules governing the distribution of rebates by issuers in group markets. *See* The Federal Register, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act,*

- Funds provided by the managed care plans to graduate medical education institutions to underwrite the costs of residency positions must be classified as MLR medical expenditures, provided the funding is sufficient to sustain the positions for the number of years necessary to complete the residency requirements and the residency positions funded by the plans are active providers of care to Medicaid and uninsured patients; and
- Before final determination of the MLR for any period, a managed care plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as an MLR medical expenditure for the period.

According to the AHCA, federal CMS has not approved the two MLR exceptions listed above for Florida's waiver that authorizes SMMC. Therefore, those exceptions for MLR expenditures have never been implemented.[58]

Reporting of Administrative Subcontractors and Affiliates

As part of its contracts with Medicaid health plans, the AHCA obligates the plans to a list of reports which must be submitted electronically, either on a monthly, quarterly, or annual basis.[59] There are 28 reports on the contract list.[60] The AHCA maintains a website that contains instructions, templates, and submission directions.[61] The AHCA also regularly sends communications to the health plans as to technical details, changes, or corrections to reporting.[62]

One of the reports requires Medicaid managed care plans to disclose and file their administrative subcontractors and affiliates.[63] This report is to be filed quarterly.[64] The report is publicly available.[65] In the instructions for the report, the following definition of "affiliate" is used:

> For purposes of this report, "affiliate" or "affiliated person" means:
> (1) Any person or entity who directly or indirectly manages, controls, or oversees the operation of the Managed Care Plan, regardless of whether

https://www.federalregister.gov/documents/2011/12/07/2011-31289/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act (last visited Feb. 25, 2026).

[58] Email from staff of the Agency for Health Care Administration to staff of the Senate Committee on Health Policy, (Feb. 9, 2026), (on file with the Senate Health Policy Committee).

[59] Agency for Health Care Administration Model Contract, FPXXX, Attachment II, Update Oct. 1, 2025(available at: https://ahca.myflorida.com/content/download/27248/file/Attachment%20II-%20-%20Core%20Contract%20Provisions%20Oct%202025.pdf).

[60] *Id.* at p. 229-230.

[61] Agency for Health Care Administration, *2025-2030 Medicaid Managed Care Plan Report Guide,* https://ahca.myflorida.com/site/medicaid/statewide-medicaid-managed-care/reports-guides/2025-2030-medicaid-managed-care-plan-report-guide (last visited Feb. 25, 2026).

[62] Agency for Health Care Administration, *Agency Communications to SMMC Plans, Effective 2018-2024,* available at: https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/agency-communications-to-smmc-plans-effective-2018-2024 (last visited Feb. 25, 2026).

[63] Agency for Health Care Administration Model Contract, FPXXX, Attachment II, Update Oct. 1, 2025(available at: https://ahca.myflorida.com/content/download/27248/file/Attachment%20II-%20-%20Core%20Contract%20Provisions%20Oct%202025.pdf).

[64] *Id.* at p. 229.

[65] Agency for Health Care Administration, *Administrative Subcontractors and Affiliates Report,* 4th quarter of 2025, https://ahca.myflorida.com/content/download/28160/file/Administrative_Subcontractors_and_Affiliates_Report_Cumulative_Q4%202025%20PDF.pdf (last visited Feb. 25, 2026).

> such person or entity is a partner, shareholder, owner, officer, director, agent, or employee of the entity;
> (2) Any person or entity who has a financial relationship with the Managed Care Plan as defined by 42 CFR 438.320(1); and/or
> (3) An individual or entity who meets the definition of an affiliate as defined in 48 CFR 19.101.[66]

The report is described as informational only.[67] If a subcontractor or affiliate has been reported on the provider network file, then it is not to be included in this report.[68] The report requires the managed care plans to describe the payment methodology to such subcontractors or affiliates.[69]

Under federal regulations, there is a definition of "financial relationship" as follows:

> Financial relationship means—
> (1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or
> (2) A compensation arrangement with an entity.[70]

This definition is applicable to 42 C.F.R. part 438, which is the section of the federal regulations applicable to managed care contracting for state Medicaid programs.

Federal law requires the AHCA to obtain disclosure from any person or entity who, directly or indirectly, has a controlling interest or ownership interest in the managed care entity. Any entity that provides services under the managed care contract and who has a controlling interest or ownership interest in the managed care entity, or with which the managed care entity has a controlling interest or ownership interest, must be disclosed.[71] The relationship is traced through spouse, parent, child, or sibling.[72] The threshold for reporting an ownership interest is five percent or greater.[73] The disclosures are to be made upon:

- The entity submitting a proposal during the procurement process,
- The entity executing a contract with the state,
- Renewal or extension of the contract, and
- Within 35 days of a change of ownership.[74]

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[66] Agency for Health Care Administration, *SMMC Managed Care Report Guide Administrative Subcontractor and Affiliates Report Summary* (Feb. 1, 2025) at p. 1, note 2, https://ahca.myflorida.com/content/download/25779/file/AdministrativeSubcontractorsandAffliatesReportSummary_2.1.2025.pdf (last visited Feb. 25, 2026).
[67] *Id.*.
[68] *Id.*
[69] *Id.*at p. 3.
[70] 42 C.F.R. § 438.320
[71] 42 C.F.R. § 455.104. This section likewise applies to providers in FFS and SMMC. *See also* 42 C.F.R. § 438.608(c)(2).
[72] 42 C.F.R. § 455.104(b)(2)
[73] *Id.*
[74] 42 C.F.R. § 455.104(c)(3)

A managed care plan that fails to make such disclosures can cause the state to lose the federal financial participation paid to that health plan.[75]

Section 409.966(3)(b), F.S., provides a definition of the term "business relationship," as follows:

> "Business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.

When applying for a managed care plan contract via SMMC procurement, a plan is required to disclose all these business relationships. The AHCA may not select plans in the same region which have a business relationship with each other. Failure to disclose a business relationship can result in disqualification in the procurement.[76]

Section 409.901(1), F.S., provides a definition of "affiliate," which is:

> "Affiliate" or "affiliated person" means any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity that is a Medicaid provider, regardless of whether such person is a partner, shareholder, owner, officer, director, agent, or employee of the entity.

Medicaid providers and managed care plans are required to report within 30 days any change of any principal, officer, director, agent, or affiliated person, and when ownership changes by five percent or more.[77] There is also a requirement that such persons must have a level 2 background check.[78]

The AHCA may deny participation in the Medicaid program to an applicant or revoke any current provider agreement or contract if an affiliated person, or owner of five percent or more (or any of the others previously described) has:

- Failed to pay any outstanding overpayments;
- Makes a false representation on an application;
- Fails to disclose a controlling interest or ownership interest;
- Has been excluded , suspended, terminated, or involuntarily withdrawn from participation in the Florida Medicaid program, or any other governmental or private health insurance program; or

[75] 42 C.F.R. § 455.104(f). This section likewise applies to providers in FFS and SMMC.
[76] Section 409.966(2), F.S.
[77] Section 409.907(2)(k), F.S.
[78] Section 409.907(8)(a)2., F.S. However, if such persons are members of a unit of local government, or any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer, and the business or its controlling parent is required to file a form 10-K or other similar statement with the Securities and Exchange Commission or has a net worth of $50 million or more, they may be relieved of the obligation for background screening. *See:* s. 409.907(8)(c), F.S.

- Has been found by any licensing, certifying or professional board or agency to have violated the standards or condition of such licensure or certification.[79]

Also, the AHCA may likewise suspend or terminate a provider agreement or contract if any of the following occurs to an affiliated person or five percent or greater owner, principal, officer, director, agent, managing employee, of a provider of services to the Medicaid program:

- He or she is terminated by any state Medicaid program or Medicare, [80] or
- He or she is convicted of a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, or a criminal offense listed under ss. 408.809(4), 409.907(10), or 435.04(2), F.S.[81]

The AHCA must determine whether the entity participated or acquiesced in the reason such affiliated person, or five percent owner (or any of the others previously described), was terminated, suspended, or convicted. If the AHCA imposes any administrative sanction because of the foregoing actions of a principal, officer, director, agent, managing employee, affiliated person, or five percent owner, then it must notify the entity.[82]

Pharmacy Benefits Under Various Forms of Health Insurance or Health Coverage

Various forms of health insurance or health coverage include pharmacy benefits. Section 626.8825(1)(u), F.S., provides a definition designed to capture such various plans or programs that provide coverage and make payment for pharmacy benefits. The term "pharmacy benefits plan or program" is defined under that section of statute as follows:

> "Pharmacy benefits plan or program" means a plan or program that pays for, reimburses, covers the cost of, or provides access to discounts on pharmacist services provided by one or more pharmacies to covered persons who reside in, are employed by, or receive pharmacist services from this state. The term includes, but is not limited to, health maintenance organizations, health insurers, self-insured employer health plans, discount card programs, and government-funded health plans, including the Statewide Medicaid Managed Care program established pursuant to part IV of chapter 409 and the state group insurance program pursuant to part I of chapter 110. The term excludes such a plan or program under chapter 440.[83]

Pharmacy Benefit Managers and the Prescription Drug Supply Chain

Health insurers, health maintenance organizations (HMOs), or self-insured employers may contract with pharmacy benefit managers (PBMs) to manage their prescription drug benefits to

[79] Section 409.907(10), F.S.
[80] Section 409.907(14), F.S.
[81] Section 409.907(13), F.S.
[82] Section 409.908(24), F.S.
[83] Chapter 440, F.S., is Florida's "Workers' Compensation Law."

reduce the overall costs of prescription drugs.[84] PBMs administer drug benefits and negotiate rebates with drug manufacturers, provide mail-order pharmacy services, create drug formularies, provide disease management, conduct drug utilization management, and adjudicate claims. The PBMs, or their affiliated group purchasing organization (GPO), may negotiate rebates with pharmaceutical manufacturers, generally for brand-name and specialty drugs, in exchange for placement on a health plan's formulary.[85]

In recent years, the affordability of prescription drugs has gained national attention, resulting in PBMs and drug manufacturers coming under scrutiny as policymakers have attempted to understand their role in the drug supply chain. Many stakeholders (drug manufacturers, drug wholesalers, pharmacy services administrative organizations, pharmacies, PBMs, health plans, employers, and consumers) are involved with, and pay different prices for, prescription drugs as they move from the drug manufacturer to the ultimate consumer.

Once a prescription drug has been developed and approved for sale, drug manufacturers set their price. The prices that maximize manufacturers' revenues from brand-name drugs depend on factors such as exclusive sales rights for newly approved brand-name products, the prevalence of health insurance coverage for prescription drugs, and buyers' willingness to pay for brand-name drugs in various market segments.[86] Brand-name drugs often face competition from other drugs with similar clinical effects, which can put downward pressure on prices. The combination of exclusive sales rights and insurance coverage can give drug manufacturers considerable leverage in their price negotiations with purchasers, which may lead to higher prices.[87]

It can be difficult to determine the final price of a prescription drug. The final price of a drug may include rebates and discounts to insurers, HMOs, or PBMs or their GPOs. Market participants, such as drug wholesalers, may add their own mark-ups and fees, and drug manufacturers may offer direct consumer discounts, such as prescription drug coupons that can be redeemed when filling a particular prescription at a pharmacy.[88]

Independent community pharmacies represent about 35 percent of all retail pharmacies in the U.S.[89] Many of the independent pharmacies contract with pharmacy services administrative organizations (PSAO) to interact on their behalf with other stakeholders, such as drug wholesalers and third-party payers like large private and public health plans and their PBMs.[90] The PSAOs develop networks of pharmacies, and negotiate on their behalf with third-party

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[84] Commonwealth Fund, *Pharmacy Benefit Managers and Their Role in Drug Spending* (Apr. 22. 2019), https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending (last visited Feb. 25, 2026).
[85] *Id.*
[86] Congressional Budget Office, *Alternative Approaches to Reducing Prescription Drug Prices* (Oct. 2024) https://www.cbo.gov/publication/60812 (last visited Feb. 25, 2026).
[87] *Id.*
[88] Reynolds, Ian, et. al., *The Prescription Drug Landscape, Explored,* Mar. 2019, The Pew Charitable Trusts, https://www.pew.org/en/research-and-analysis/reports/2019/03/08/the-prescription-drug-landscape-explored (last visited Feb. 25, 2026).
[89] National Community Pharmacists Association, *NCPA Releases 2023 Digest Report* (Oct. 15, 2023), https://ncpa.org/newsroom/news-releases/2023/10/15/ncpa-releases-2023-digest-report (last visited Feb. 25, 2026).
[90] General Accounting Office, *The Number, Role, and Ownership of Pharmacy Services Administrative Organizations* (GAO-13-176) (Feb 28, 2013) https://www.gao.gov/products/GAO-13-176 (last visited Jan. 28, 2026).

payers, such as PBM's, on the pharmacy's behalf.[91] A PSAO may also provide credentialling and compliance assistance, claims reconciliation, and provide support relating to PBM audits of pharmacy.[92]

Compensation of PBMs

The PBMs receive compensation from health plans or employers for their services in a variety of ways. For example, a health plan may opt for an administrative fee contract, in which they pay the PBM directly for all of the services provided.[93] Some health plans may choose to use a spread pricing model in which the health plan pays the PBM a set price for each prescription filled, and the PBM retains the difference between the price paid by the health plan and the price paid to the pharmacy as a form of compensation.[94] In addition, PBMs may retain a portion of drug manufacturer rebates to offset the fees health plans would otherwise pay. PBMs may obtain significant rebates from manufacturers, and are reported to often pass on 90 to 95 percent of rebates to the plan sponsor.[95] An increasing number of PBMs are using "pass-through" pricing at mail order and specialty.[96] In these instances, they will charge a dispensing fee, an administrative fee and sometimes shipping charges, all of which help to offset the revenue lost by moving away from spread pricing.[97] Generally, a contract between a PBM and a health plan or an employer specifies the amount a plan or an employer will pay a PBM for brand name and generic drugs and specify certain savings guarantees.[98]

Vertical Integration Relating to PBM Ownership*[99]*

The "Big Three" PBMs – CVS Caremark, Express Scripts, and OptumRx – manage approximately 80 percent of prescription drug claims for approximately 270 million people.[100]

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[91] Pace, Scott, *The Role and Value of Pharmacy Services Administrative Organizations,* (2022), https://content.naic.org/sites/default/files/call_materials/The%20Role%20and%20Value%20of%20Pharmacy%20Services%20Administrative%20July%202022.pdf (last visited Feb. 25, 2026).
[92] *Id*.
[93] Mercer, *Understanding the Debate over PBMs* (Aug. 1, 2024) https://www.mercer.com/en-us/insights/us-health-news/understanding-the-debate-over-pbms/ (last visited Feb. 25, 2026).
[94] *Id.*
[95] Avalere Health, *The Role of PBMs in the US Healthcare System* (June 2025) https://advisory.avalerehealth.com/wp-content/uploads/2025/06/The-Role-of-PBMs-in-the-US-Healthcare-System_White-Paper.pdf (last visited Jan. 28, 2026). *See also*, Mercer, US Health News, Understanding the debate over PBMs (Aug. 1, 2024), https://www.mercer.com/en-us/insights/us-health-news/understanding-the-debate-over-pbms/ (last visited Feb. 25, 2026).
[96] *Id.*
[97] Avalere Health, *The Role of PBMs in the US Healthcare System* (June 2025) https://advisory.avalerehealth.com/wp-content/uploads/2025/06/The-Role-of-PBMs-in-the-US-Healthcare-System_White-Paper.pdf (last visited Jan. 28, 2026). *See also*, Mercer, US Health News, Understanding the debate over PBMs (Aug. 1, 2024), https://www.mercer.com/en-us/insights/us-health-news/understanding-the-debate-over-pbms/ (last visited Feb. 25, 2026).
[98] Health Affairs, *Policy Options To Help Self-Insured Employers Improve PBM Contracting Efficiency* (May 29, 2019) https://www.healthaffairs.org/content/forefront/policy-options-help-self-insured-employers-improve-pbm-contracting-efficiency (last visited Feb. 25, 2026).
[99] National Association of Insurance Commissioners, *A GUIDE TO UNDERSTANDING PHARMACY BENEFIT MANAGER AND ASSOCIATED STAKEHOLDER REGULATION* (Rev. Sep. 29, 2023) https://content.naic.org/sites/default/files/PBM%252520White%252520Paper%252520Draft%252520Adopted%252520B%252520Committee%25252011-2-23_0.pdf (last visited Feb. 25, 2026).
[100] Kaiser Family Foundation, *What to Know about Pharmacy Benefit Managers and Federal Efforts at Regulation* (Dec. 18, 2025) https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/ (last visited Feb. 25, 2026).

Coupled with the next three largest PBMs – Humana Pharmacy Solutions, MedImpact, and Prime – they represent 94 percent of prescription drug claims in the U.S. (Collectively, these six PBMs are sometimes known as the "Big Six.")

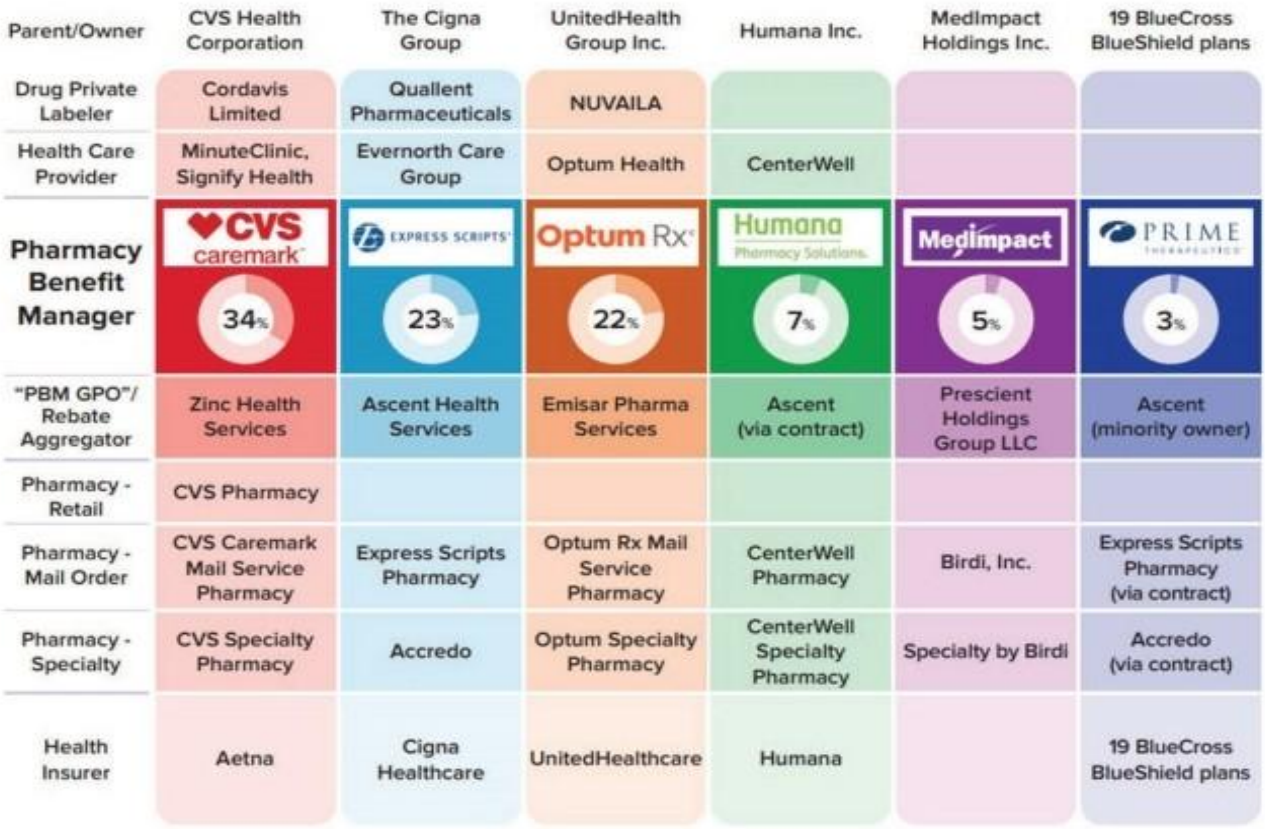
Vertical integration is the combination into one company of at least two stages of production normally performed by separate companies. The Big Six PBMs have become vertically integrated within entities that provide a broad range of services across the pharmaceutical supply chain and other segments of the health care sector, as illustrated in Figure 1.[101]

The three largest PBMs are each affiliated with a health plan and a pharmacy, so the parent company owns or controls up to three stages or more of the drug supply chain. Some PBMs are also affiliated with health care providers, such as retail clinic services. Vertical integration may allow a company to combine operations between stages of production and pass the savings from smaller transaction costs to their customers. Various PBMs are now vertically integrated with upstream suppliers of goods and services, including drug private labelers[102] and provider groups. PBMs are also vertically integrated with midstream distributors, including retail, mail order, and specialty pharmacies.

Downstream, PBMs may be vertically integrated with large health insurers which, through their health plans and plan sponsor services, provide health coverage for hundreds of millions of Americans. Due to the high degree of consolidation and vertical integration, the dominant PBMs can often exercise significant control over which drugs are available, at what price, and which pharmacies patients can use to access their prescribed medications.[103]

[101] *Id.*
[102] Freyr Blog, *Private Labeling in Pharma: Challenges and Solutions* (Apr. 20, 2023) https://www.freyrsolutions.com/blog/private-labeling-in-pharma-challenges-and-solutions (last visited Feb. 25, 2026).
[103] *Id.*

Figure 1. PBM Ownership and Vertical Integration



PBM Payment of Affiliate Pharmacies[104]

In 2022, a federal report found that commercial health plans paid affiliated pharmacies roughly 80 to 90 percent more than unaffiliated pharmacies for abiraterone acetate (generic Zytiga) and imatinib mesylate (generic Gleevec). Pharmacies affiliated with the Big Three PBMs were often paid 20 to 40 times National Average Drug Acquisition Cost (NADAC),[105] and significantly more than unaffiliated pharmacies, for the two case studies of specialty generic drugs for cancer treatment for both the commercial and Medicare Part D payer groups.[106] For example, commercial health plans reimbursed affiliated pharmacies for abiraterone acetate (generic Zytiga) in 2022 more than $5,800 per month, on average—or approximately 25 times the

[104] Federal Trade Commission, Office of Policy Planning, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies,* Interim Staff Report (July 2024) https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf (last visited Feb. 25, 2026).
[105] The NADAC is an index of drug acquisition costs based on surveys of invoices voluntarily provided primarily by small, independent pharmacies. *See Retail Price Survey,* Medicaid.gov (Jan. 5, 2026) https://www.medicaid.gov/medicaid/prescription-drugs/retail-price-survey/index.html (last visited Feb. 25, 2026).
[106] Federal Trade Commission, Office of Policy Planning, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies,* Interim Staff Report (July 2024) https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf (last visited Feb. 25, 2026).Gross reimbursement to a pharmacy is the sum of the amounts paid by the PBM, the patient, and any other payers (e.g., a secondary insurer), as applicable. NADAC is based on the maximum NADAC observed each year for the most commonly dispensed dose of the drug. NADAC was not always available for other doses of the drug. The acquisition costs for those drugs may be lower or higher than the NADAC for the most commonly dispensed dose.

$229 acquisition cost reflected by NADAC. For the second drug, imatinib mesylate (generic Gleevec), commercial health plan reimbursements to affiliated pharmacies averaged roughly $2,700 per month in 2022, more than 40 times higher than the NADAC acquisition cost of $66.

Payments to affiliated pharmacies by a PBM-affiliated fully insured health plan represent internal transfers from the PBM's vertically integrated insurer to its pharmacies. These internal transfers may have implications for medical loss ratios (MLRs), which are regulated under the federal Affordable Care Act and represent the percentage of premium revenue that health plans are required to spend on clinical care and quality improvement initiatives (80 to 85 percent) rather than administrative expenses and contributions to plan profits.[107]

Industry experts have raised concerns that vertically integrated healthcare entities can game MLR requirements by shifting funds between affiliated entities. For example, if an affiliated insurer pays an inflated price for a specialty generic to its affiliated pharmacy, the higher payment is credited as spending on clinical care and helps the affiliated insurer satisfy its MLR obligations. At the same time, the payment is credited as revenue to the affiliated pharmacy. Because the pharmacy's revenue has no bearing on the affiliated insurer's MLR calculation, this transfer payment allows the vertically integrated PBM-insurer-pharmacy entity to retain revenue and profits while formally satisfying the MLR rule—but without providing the clinical care and quality improvements that the rule is meant to promote.

Private Label Drugs

Private labeling refers to the practice of a company manufacturing a product which is then sold under another company's brand name. Private labeling is a common practice used by companies to expand their product offerings without having to invest in the research and development required to create a new drug product. Essentially, the manufacturer produces the product and allows another company to attach its own label to it.

Biosimilar drugs[108] can provide lower cost options for federally approved brand name drugs that reduce the price per prescription, on average, by 40 percent.[109] For example, Humira, characterized as the world's best-selling drug, had an average gross cost of $7,000 per month.[110] In 2023, CVS Health launched Cordavis, an international subsidiary that coproduces biosimilars with manufacturers, such as Sandoz.[111] Optum and ESI soon followed CVS Health by

[107] *Id.* at p. 31., noting MLR statutory requirement of 80 percent for individual and small group health plans and 85 percent for large group health plans. MLRs are regulated for commercial fully insured health plans.
[108] A biosimilar drug is highly similar and has no clinically meaningful differences when compared to the original FDA-approved biological product (reference product). Biosimilar drugs are made with the same types of living organism as the reference product. *See* U.S. Food and Drug Administration, *Overview of Biosimilar Products,* https://www.fda.gov/media/151058/download?attachment (last visited Feb. 25, 2026).
[109] Nelson, Nelsie, Sequoia Blog, Foreword, *How Biosimilars Can Significantly Reduce Pharmacy Costs for Employers* (Dec. 18, 2024) https://www.sequoia.com/2024/12/how-biosimilars-can-significantly-reduce-pharmacy-costs-for-employers/ (last visited Feb. 25, 2026). Many biosimilars lack interchangeability status, meaning the ability for the dispensing pharmacy to automatically substitute the biosimilar for the original, brand name product without additional approval from the prescribing provider.
[110] *Id.*
[111] Fein, Adam J., Drug Channels, *When Payers Become Producers: Inside the PBM Private-Labeling Trend* (Aug. 16, 2024) https://www.drugchannels.net/2024/08/when-payers-become-producers-inside-pbm.html (last visited Feb. 25, 2026).

announcing partnerships with third-party biosimilar procurers and private-label manufacturers to coproduce and co-label their own biosimilars to prefer on their formularies market.[112] In April 2024, Cigna Group's Evernorth Health Services announcing the production of a $0 copay Humira biosimilar via its subsidiary Quallent Pharmaceuticals, a private-label distributor.[113]

For 2025, the Big Three PBMs shifted national formularies to favor their private-label biosimilars over Humira and its many biosimilar competitors.[114] Nearly all marketed Humira biosimilars were excluded from the larger PBMs' 2025 formularies.[115] For 2025, Humira (original flavor) has or will no longer be placed on PBMs' standard formularies, and most marketed biosimilars will be excluded from the 2025 formularies.[116] Instead, each PBM's formulary will give plan sponsors the option of a high-list-price biosimilar, a lower-priced private label product, and a low-list-price unbranded biosimilar.[117]

Due to the availability of multiple biosimilars in the market for Humira, there was an 80 percent cost savings per prescription for employer plans, even without rebates.[118] The PBMs and manufacturing firms may share remaining revenues with contracted distributors, generating additional income back to the PBM. A product sold at an 80 percent discount of wholesale acquisition cost (WAC) discount leaves 20 percent left for revenue sharing with the PBM's distributor and biosimilar manufacturer.[119] This new income stream to the PBM's parent can offset potential losses to rebate revenue.[120]

The addition of a manufacturing subsidiary for a PBM is advantageous since it provides better cost control and supply chain dynamics, and allows the PBM to align an entire product distribution chain in their favor, excluding competitors and preferring their designated agents.[121] However, this may not always result in the lowest net cost drug product available for employer plans.[122]

Recent Federal Enforcement Actions Against PBMs

On February 4, 2026, the Federal Trade Commission (FTC) announced a settlement with Express Scripts, Inc., and its affiliated entities (collectively known as ESI). The settlement requires ESI to adopt fundamental changes to its business practices that increase transparency,

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[112] Fein, Adam J., Drug Channels, *When Payers Become Producers: Inside the PBM Private-Labeling Trend* (Aug. 16, 2024) https://www.drugchannels.net/2024/08/when-payers-become-producers-inside-pbm.html (last visited Feb. 25, 2026).
[113] *Id.*at *34.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] Nelson, Nelsie, Sequoia Blog, Foreword, *How Biosimilars Can Significantly Reduce Pharmacy Costs for Employers* (Dec. 18, 2024) https://www.sequoia.com/2024/12/how-biosimilars-can-significantly-reduce-pharmacy-costs-for-employers/ (last visited Feb. 25, 2026).
[119] Vogenberg, F. Randy, PhD, BR&R Biosimilars Review and Report, *Employer Plans, Private-Label Biosimilars, Little Transparency* (Feb. 19, 2025) https://biosimilarsrr.com/2025/02/19/employer-plans-private-label-biosimilars-little-transparency/ (last visited Feb. 25, 2026).
[120] *Id.*
[121] Mehr, Stanton R., *Will the emerging private-label market access channel help or hinder biosimilar market access?* (Aug. 2025) https://www.jmcp.org/doi/epdf/10.18553/jmcp.2025.31.8.824 (last visited Feb. 25, 2026).
[122] *Id.*

are expected to reduce insureds' out-of-pocket costs for drugs like insulin by up to $7 billion over 10 years and bring millions of dollars in new revenue to community pharmacies each year.

The FTC's settlement[123] resolves the FTC lawsuit[124, 125] against ESI, which alleges that ESI artificially inflated the list price of insulin drugs by using anticompetitive and unfair rebating practices, and impaired patients' access to lower list price products, ultimately shifting the cost of high insulin list prices to vulnerable patients.

The FTC's enforcement action against ESI, as well as Caremark Rx and OptumRx, alleges that the PBMs created a system that artificially drove up the list prices of drugs by preferencing rebates. The complaint alleges that this system pushed insulin manufacturers, among others, to compete for preferred formulary coverage based on the size of rebates off the list price rather than net price, which ultimately benefitted the PBMs, including ESI, which keep a portion of the inflated rebates. According to the FTC's complaint, the inflated list prices hurt patients whose out-of-pocket payments like copayments and coinsurance are tied to the list price of the drug. ESI, under the FTC's proposed consent order, has agreed to:

- Stop preferring on its standard formularies high wholesale acquisition cost versions of a drug over identical low wholesale acquisition cost versions;
- Provide a standard offering to its plan sponsors that ensures that members' out-of-pocket expenses will be based on the drug's net cost, rather than its artificially inflated list price;
- Provide covered access to TrumpRx as part of its standard offering upon relevant legal and regulatory changes;
- Provide full access to its Patient Assurance Program's insulin benefits to all members when a plan sponsor adopts a formulary that includes an insulin product covered by the Patient Assurance Program unless the plan sponsor opts out in writing;
- Provide a standard offering to all plan sponsors that allows the plan sponsor to transition off rebate guarantees and spread pricing;
- Delink drug manufacturers' compensation to ESI from list prices as part of its standard offering;
- Increase transparency for plan sponsors, including with mandatory, drug-level reporting, providing data to permit compliance with the Transparency in Coverage regulations, and disclosing payments to brokers representing plan sponsors;
- Transition its standard offering to retail community pharmacies to a more transparent and fairer model based on the actual acquisition cost for a drug product plus a dispensing fee and additional compensation for non-dispensing services;

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[123] Federal Trade Commission, *DECISION AND ORDER AS TO RESPONDENTS EXPRESS SCRIPTS, INC., EVERNORTH HEALTH, INC., MEDCO HEALTH SERVICES, INC., AND ASCENT HEALTH SERVICES LLC,* https://www.ftc.gov/system/files/ftc_gov/pdf/d09437caremarkproporder-esiresps.pdf (last visited Feb. 25, 2026).

[124] Federal Trade Commission, Press Release (Sept. 20, 2024) "*FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices | Federal Trade Commission,"* https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices (last visited Feb. 25, 2026).

[125] The FTC's administrative complaint alleges that CVS Health's Caremark, Cigna's ESI, and United Health Group's Optum, and their respective GPOs, Zinc Health Services, Ascent Health Services, and Emisar Pharma Services, have abused their economic power by rigging pharmaceutical supply chain competition in their favor, forcing patients to pay more for life-saving medication. *See In the matter of Caremark Rx, LLC, et al, FTC Docket No. 9437, Complaint,* https://www.ftc.gov/system/files/ftc_gov/pdf/612314.2024.11.26_part_3_administrative_complaint_-_revised_public_redacted_version.pdf (last visited Feb. 25, 2026).

- Promote the standard offerings to plan sponsors and retail community pharmacies; and
- Reshore its group purchasing organization Ascent from Switzerland to the United States, which will bring back to the United States more than $750 billion in purchasing activity over the duration of the order.

In a statement issued on September 20, 2024, the FTC's Bureau of Competition stated that the PBMs are not the only potentially culpable actors – the Bureau also remains deeply troubled by the role drug manufacturers like Eli Lilly, Novo Nordisk, and Sanofi play in driving up list prices of life-saving medications like insulin.[126] Further, the statement indicated that all drug manufacturers should be on notice that their participation in the type of conduct challenged here raises serious concerns, and that the Bureau of Competition may recommend suing drug manufacturers in any future enforcement actions.

Florida Regulation of Pharmacy Benefit Managers

The Office of Insurance Regulation (OIR or office)[127] 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).[128] The OIR also regulates 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.[129]

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.[130]

[126] Federal Trade Commission, Statement of FTC Bureau of Competition Deputy Director Rahul Rao on Lawsuit Against PBMs and the Role of Drug Manufacturers in Distorting Competition in the U.S Drug Distribution System (Sept. 20, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/insulin-manufacturing-statement.pdf (last visited Feb. 25, 2026).
[127] The 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 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. *See* s. 20.121(3), F.S.
[128] Section 20.121(3)(a)1., F.S.
[129] Section 626.8805(1), F.S.
[130] Section 626.88(6), F.S.

Requirements for Contracts Between a PBM and a Pharmacy Benefits Plan or Program

A contract between PBM and a pharmacy benefits plan or program must include terms that ensure compliance with the requirements of s. 626.8825(2), F.S., and, except to the extent not allowed by law, must supersede any contractual terms to the contrary. These requirements include, but are not limited to, requiring a PBM to:

- Use a pass-through pricing model, which is a payment model used by a PBM in which the payments made by the pharmacy benefits plan to the PBM for the covered outpatient drugs are:
  - Equivalent to the payments the PBM makes to a dispensing pharmacy or provider for such drugs, including any contracted professional dispensing fee between the pharmacy benefit manager and its network of pharmacies. Such dispensing fee would be paid if the pharmacy benefits plan was making the payments directly.
  - Passed through in their entirety by the pharmacy benefits plan or program or by the PBM to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation.
- Exclude terms that allow for the engagement in the practice of spread pricing unless the PBM passes along the entire amount of such difference to the pharmacy benefits plan. Spread pricing is the practice in which a PBM charges a pharmacy benefits plan or program a different amount for pharmacist services than the amount the pharmacy benefit manager reimburses a pharmacy for such pharmacist services.
- Pass 100 percent of all prescription drug manufacturer rebates received to the pharmacy benefits plan, if the contractual arrangement delegates the negotiation of rebates to the PBM, for the sole purpose of offsetting defined cost sharing and reducing premiums of covered persons. Any excess rebate revenue after the PBM and the pharmacy benefits plan have taken all actions required pursuant to this provision must be used for the sole purpose of offsetting copayments and deductibles of covered persons. This provision does not apply to contracts involving Medicaid managed care plans.
- Include network adequacy requirements that meet or exceed Medicare Part D program standards for convenient access to the network pharmacies and that:
  - Do not limit a network to solely include affiliated pharmacies;
  - Require a PBM to offer a provider contract to licensed pharmacies physically located on the physical site of providers that meet one or more of the following criteria:[131]
    - Are within the geographic service area of the pharmacy benefits plan or program and that have been specifically designated as Medicaid essential providers by the AHCA;
    - Are designated as cancer centers of excellence regardless of the geographic service area of the pharmacy benefits plan or program;
    - Are organ transplant hospitals, regardless of the geographic service area of the pharmacy benefits plan or programs;
    - Are hospitals licensed as specialty children's hospitals; or
    - Are regional perinatal intensive care centers, regardless of the geographic service area of the pharmacy benefits plan or program.

[131] Under s. 626.8825(2)(e)2., F.S., such provider contracts that a PBM must offer to licensed pharmacies physically located on the physical site of providers that meet one or more of the specified criteria "must be solely for the administration or dispensing of covered prescription drugs, including biological products, which are administered through infusions, intravenously injected, or inhaled during a surgical procedure or are covered parenteral drugs, as part of onsite outpatient care."

- Not require a covered person to receive a prescription drug by U.S. mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the pharmacy benefit manager's network for the covered person's pharmacy benefits plan or program.
- Not requiring a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs; and
- Not offering or implementing pharmacy networks that require a covered person, or provide to a covered person a promotional item or an incentive – defined as anything other than a reduced cost-sharing amount or enhanced quantity limit allowed under the benefit design for a covered drug – to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs.

Requirements for Contracts Between a PBM and a Participating Pharmacy

A contract between PBM and a participating pharmacy must include terms that ensure compliance with the requirements of s. 626.8825(3), F.S., which include, but are not limited to:

- At the time of adjudication for electronic claims or the time of reimbursement for nonelectronic claims, the PBM must provide the pharmacy with a remittance, including such detailed information as is necessary for the pharmacy or pharmacist (pharmacy) to identify the reimbursement schedule for the specific network applicable to the claim and which is the basis used by the PBM to calculate the amount of reimbursement paid.
- A prohibition of financial clawbacks, reconciliation offsets, or offsets to adjudicated claims. A PBM may not charge, withhold, or recoup direct or indirect remuneration fees, dispensing fees, brand name or generic effective rate adjustments through reconciliation, or any other monetary charge, withholding, or recoupments as related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when a fee may be recouped from a pharmacy. This prohibition does not apply to:
  - Any incentive payments provided by the PBM to a network pharmacy for meeting or exceeding predefined quality measures, recoupment due to an erroneous claim, fraud, waste, or abuse; a claim adjudicated in error; a maximum allowable cost appeal pricing adjustment; or an adjustment made as part of a pharmacy audit.
  - Any recoupment that is returned to the state for programs in ch. 409, F.S., or the state group insurance program.
- Unless otherwise prohibited by law, a PBM may not prohibit a pharmacy from:
  - Offering mail or delivery services on an opt-in basis at the sole discretion of the covered person.
  - Mailing or delivering a prescription drug to a covered person upon request.
  - Charging a shipping or handling fee to a covered person requesting a prescription drug be mailed or delivered if the pharmacy discloses to the covered person before the mailing or delivery the amount of the fee that will be charged and that the fee may not be reimbursable by the covered person's pharmacy benefits plan or program.
- The PBM must provide a reasonable administrative appeal procedure to allow a pharmacy to challenge the maximum allowable cost (MAC) pricing information and the reimbursement made under MAC for a specific drug as being below the acquisition cost available to the challenging pharmacy.

  - The pharmacy must be given at least 30 business days after an MAC update or after an adjudication for an electronic claim or reimbursement for a nonelectronic claim to file the administrative appeal. The PBM must respond to the administrative appeal within 30 business days after receipt of the appeal.
  - If the appeal is upheld, the PBM must:
    - Update the MAC information to at least the acquisition cost available to the pharmacy;
    - Permit the pharmacy to reverse and rebill the claim in question;
    - Provide to the pharmacy or pharmacist the national drug code on which the increase or change is based; and
    - Make the increase or change effective for each similarly situated pharmacy or pharmacist who is subject to the applicable MAC pricing information.
  - If the appeal is denied, the PBM must provide to the pharmacy or pharmacist the national drug code and the name of the national or regional pharmaceutical wholesalers operating in this state which have the drug currently in stock at a price below the MAC pricing information.
- Every 90 days, a PBM must report to the office the total number of appeals received and denied in the preceding 90-day period, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted.

Prohibited Acts by a PBM

Pursuant to s. 626.8827, F.S., a PBM may not engage in the following acts:
- Prohibit, restrict, or penalize in any way a pharmacy from disclosing to any person any information that the pharmacy deems appropriate, including information regarding any of the following:
  - The nature of treatment, risks, or alternatives.
  - The availability of alternate treatment, consultations, or tests.
  - The decision of utilization reviewers or similar persons to authorize or deny pharmacist services.
  - The process used to authorize or deny pharmacist services or benefits.
  - Information on financial incentives and structures used by the pharmacy benefits plan or program.
  - Information that may reduce the costs of pharmacist services.
  - Whether the cost-sharing obligation exceeds the retail price for a covered prescription drug and the availability of a more affordable alternative drug.
- Communicate at the point-of-sale, or require, a cost-sharing obligation for the covered person in an amount that exceeds the lesser of the applicable cost-sharing amount under the applicable pharmacy benefits plan or program; or the usual and customary price, as defined in s. 626.8825, F.S., of the pharmacist services.
- Fail to comply with the requirements in s. 624.491, F.S., relating to pharmacy audits. or s. 626.8825, F.S., relating to PBM transparency and accountability provisions.

The OIR Examinations and Investigations of PBMs

The OIR must examine the business and affairs of each PBM at least biennially. The scope of the examination is to determine the PBM's compliance with all provisions of part VII of ch. 626, F.S., and must include a detailed review of the PBM's compliance with

ss. 626.8825 and 626.8827, F.S. In addition to any other enforcement authority available to the OIR, the OIR must impose an administrative fine of $5,000 for each violation of ss. 626.8825 or 626.8827, F.S.

State Group Insurance Program

Pursuant to s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance (DSGI), administers the State Group Insurance Program under a cafeteria plan consistent with s. 125 Internal Revenue Code. To administer the program, the DSGI contracts with third party administrators for self-insured health plans, a fully insured HMO, and a PBM for the state employees' Self-Insured Prescription Drug Program (PDP) pursuant to s. 110.12315, F.S. The program currently provides health and pharmacy benefits to over 170,000 state employees, retirees, and their dependents. The current PBM for the state employees' prescription drug plan is OptumRx.[132] Under current law, there is no statutory minimum for the professional dispensing fee that a PBM must pay to a participating pharmacy. These fees are currently determined through contractual negotiations between the PBM and the pharmacies in its network, and between the PBM and DMS.[133]

III. Effect of Proposed Changes:

Section 1 takes effect upon the bill becoming a law and amends s. 1.01, F.S., to create a definition for the term "Joint Legislative Committee on Medicaid Oversight" to specify a committee designated by joint rule of the Legislature, by the President of the Senate or the Speaker of the House of Representatives, or by agreement between the President of the Senate and the Speaker of the House of Representatives.

Section 2 takes effect upon the bill becoming a law and creates s. 11.405, F.S., to establish the Joint Legislative Committee on Medicaid Oversight to ensure that the state Medicaid program is operating in accordance with the Legislature's intent and to promote transparency and efficiency in government spending.

The bill requires that the committee be composed of five members of the Senate appointed by the President of the Senate and five members of the House of Representatives appointed by the Speaker of the House of Representatives, with each member serving a two-year term. The chair and vice chair must be appointed for one-year terms, with the appointments alternating between the President of the Senate and the Speaker of the House of Representatives. The chair and vice chair may not be members of the same house of the Legislature, and if both the chair and the vice chair are absent at any meeting, the members present must elect a temporary chair by a majority vote.

The bill requires that members serve without compensation, but authorizes reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S. The bill authorizes the chair to establish subcommittees as needed to fulfill committee duties. The bill also requires the

[132] Department of Management Services, Division of State Group Insurance https://www.mybenefits.myflorida.com/myhealth/prescription_drug_plan (last visited Feb. 25, 2026).
[133] *Id.*

committee to convene at least twice a year, and as often as necessary to conduct its business. Meetings may be held through teleconference or other electronic means.

The bill requires the committee to evaluate all aspects of the state Medicaid program related to program financing, quality of care and health outcomes, administrative functions, and operational functions to ensure the program is providing transparency in the provision of health care plans and providers, ensuring access to quality health care services to Medicaid recipients, and providing stability to the state's budget through a health care delivery system designed to contain costs.

The bill requires the committee to identify and recommend policies that limit Medicaid spending growth while improving health care outcomes for Medicaid recipients. In developing its recommendations, the committee must do the following:

- Evaluate legislation for its long-term impact on the state Medicaid program.
- Review data submitted to the Agency for Health Care Administration (AHCA) by Medicaid managed care plans pursuant to statutory and contract requirements, including, but not limited to, timeliness of provider credentialing, timely payment of claims, rate of claim denials, prior authorization for services, and consumer complaints.
- Review the Medicaid managed care plans' encounter data, financials, and audits and the data used to calculate the plans' achieved savings rebates and medical loss ratios.
- Review data related to health outcomes of Medicaid recipients, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures for each Medicaid managed care plan, each Medicaid managed care plan's performance improvement projects, and outcome data related to all quality goals included in the Medicaid managed care organization contracts to improve quality for recipients.
- Identify any areas for improvement in statute and rule relating to the state Medicaid program.
- Develop a plan of action for the future of the state Medicaid program.

The bill authorizes the committee to submit periodic reports, including recommendations, to the Legislature on issues related to the state Medicaid program and any affiliated programs.

The bill requires the Auditor General and the AHCA to enter into and maintain a data sharing agreement by July 1, 2026, to ensure the committee has full access to all data needed to fulfill its responsibilities. The Auditor General must assist the committee in its work by providing credentialed professional staff or consulting services, including, but not limited to, an actuary not associated with the state Medicaid program or any Medicaid managed care organization who currently has a contract with the state.

The bill requires the committee to be given access to any relevant record, paper, or document in possession of a state agency, any political subdivision of the state, or any entity engaged in business or under contract with a state agency during the course of its official duties. The committee may compel the attendance and testimony of any state official or employee before the committee or secure any evidence as provided in s. 11.143, F.S. The bill provides that the committee shall also have any other powers conferred on it by joint rules of the Senate and the House of Representatives, and any joint rules of the Senate and the House of Representatives applicable to joint legislative committees apply to the proceedings of the committee.

The bill requires the AHCA to notify the committee of any change to the Medicaid managed care capitation rates and to appear before the committee to provide a report detailing the managed care capitation rates and administrative costs built into the capitation rates before implementation of any change to the capitation rates. The report must include the AHCA's historical and projected Medicaid program expenditure and utilization trend rates by Medicaid program and service category for the rate year, an explanation of how the trend rates were calculated, and the policy decisions that were included in setting the capitation rates.

If the AHCA or any division within the AHCA is required by law to report to the Legislature or to any legislative committee or subcommittee on matters relating to the state Medicaid program, the bill requires the AHCA to submit a copy of the report to the committee.

Section 3 amends Statewide Medicaid Managed Care (SMMC) law in s. 409.962, F.S., to provide the following definitions:

- "Affiliate," including the terms "affiliated with" and "affiliation," means a person, as construed in s. 1.01(3), F.S.,[134] who:
  - Directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person, including parent and subsidiary entities; or
  - Is deemed a "related party" according to the standards adopted by the Financial Accounting Standards Board.
- "Control," including the terms "controlling," "controlled by," and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership or voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

This definition of "control" applies under the bill regardless of whether such power is affirmative or negative or whether such power is actually used. Control is presumed to exist, but is not limited to, when any affiliate or person, as construed in s. 1.01(3), F.S.:[135]

- Directly or indirectly owns, controls, holds the power to vote, or holds proxies representing 10 percent or more of any class of the voting securities of any other person.
- Shares common ownership with any person, has an investor or is a holder of an ownership interest in any person, exercises control in any manner over the election of a majority of the directors or of individuals exercising similar functions of any person, has the power to exercise controlling influence over the management of any person, or serves as a working majority of the board of directors, managers, or the officers of a person, who is:
  - A provider or a member of a provider group or group practice as defined in s. 456.053, F.S., under the managed care plan; or
  - A person responsible for providing any pharmacy services, pharmaceuticals, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative services, or financial services under the managed care plan.

[134] Section 1.01(3), F.S., provides that the word "person" includes individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations.
[135] *Id.*

Additionally, the bill defines the term "market rate" to mean "the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction which is beneficial to both parties."

Section 4 amends s. 409.967, F.S., as to matters involving Medicaid managed care plan accountability.

Encounter Data Reporting and Analysis

The bill requires Medicaid managed care plans to provide encounter data on encounters for which payment was denied and encounters for which a provider was reimbursed by the plan on a capitated basis.

Under the bill, the AHCA's analysis of encounter data must be used to identify possible cases of overspending on administrative costs, payments by plans in excess of market rates, and potential managed care plan fraud, waste, and abuse. The bill requires the analysis to be used in SMMC managed care plan capitation rate-setting.

Third-Party Administrators

The bill requires that a contract between the AHCA and a Medicaid managed care plan must require that any third party administrative entity contracted by the plan must adhere to all pertinent requirements of the Medicaid program placed on the plan under the plan's contract with the AHCA.

Achieved Savings Rebates

Payments by a Medicaid managed care plan to affiliated entities in excess of market rates are excluded as an allowable expense under the bill when the AHCA calculates a plan's achieved savings rebate (ASR). (See Section 5, below, for further revisions to the ASR statute.)

Medical Loss Ratios

The bill provides that if required by federal regulations, the AHCA must calculate medical loss ratios (MLRs) for all plans contracted under the SMMC program, including managed medical assistance, long-term care managed care, and the pilot program for individuals with developmental disabilities. The bill requires MLRs to be calculated for a managed care plan separately for each SMMC component in which the plan participates and for the plan's overall participation in SMMC. The AHCA must calculate such MLRs quarterly and annually and report to the Governor and the Legislature no later than six months after the end of each such period.

The bill also corrects the current reference in s. 409.967(4)(a), F.S., to certain federal MLR regulations so that federal regulations found in 42 C.F.R. part 438 are referenced relating to federal MLR requirements for Medicaid managed care plans.

The bill deletes current law's provisions designed to allow managed care plans to donate funds to graduate medical education programs or indigent care and have those dollar amounts count as medical expenses in the MLR calculations. Those provisions were not approved by CMS in Florida's SMMC waiver.

Affiliated Entities and Related Parties; Managed Care Plan Capitations

The AHCA is directed under the bill to ensure oversight of affiliated entities and related parties paid by managed care plans, including, but not limited to, examining financial records and self-referral data of any managed care plan providing services within SMMC which uses affiliated entities and related parties. The AHCA is also directed under the bill to consider data examined under such requirement and the findings of the annual assessment required under s. 409.9675(4), F.S., (created under Section 6, below) when developing SMMC managed care plan capitation rates.

Section 5 amends s. 409.967(3), F.S., effective January 1, 2027, to revise the profit-sharing percentages for the ASR. Under the bill, the ASR will be calculated by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

- One hundred percent of income up to and including three percent of revenue (as opposed to five percent as in current law) will be retained by the plan.
- Thirty percent (as opposed to 50 percent as in current law) of income above that three percent mark and up to ten percent will be retained by the plan with the other 70 percent refunded to the state and adjusted for the federal match percentage.
- One hundred percent of income above 10 percent of revenue must be refunded to the state and adjusted for the federal match percentage, which is the same as current law.

Section 6 creates s. 409.9675, F.S., concerning affiliated entities and controlling interest reporting by Medicaid managed care plans. Each managed care plan is required under the bill to report to the AHCA and the Office of Insurance Regulation (OIR or office) the following:

- Any person controlled or affiliated with the managed care plan; and
- Any person who has an ownership interest of ten percent or greater in an affiliate or controlled entity.

The disclosure obligation concerns direct and indirect relationships. The list of affiliated or controlled entities includes any provider, group practice, pharmacy service, pharmaceutical, diagnostics, care coordination, care delivery, health care services, medical equipment, administrative or financial services to the managed care entity. The reporting is to commence March 31, 2027, and continue each year thereafter.

The contents of such annual report must contain the following information, as to any affiliations reported:

- Percentage of ownership or control of any person or entity who has any business transaction with the managed care plan in the aggregate of $25,000 or more for the preceding twelve months. The identification of such business transaction must include the specific contracts involved.
- Any significant business transaction between the managed care plan and affiliated entity, during the preceding twelve months.

If there is a change in the reported data, such change must be reported to the AHCA and the OIR within 60 days of occurrence under the bill.

Affiliation information is to be assessed and publicly reported annually by the AHCA commencing December 31, 2026. The report is to include an assessment as to how affiliate payments impact the medical benefits and administrative cost for the ASR. The initial assessment is to use years 2021, 2022, and 2023 as baseline years. The assessment report must include information which shows the amount of affiliated entity payments within the MLR, how payments for affiliated entities compare to nonaffiliated entities, and payment amounts for value-based or alternative payment arrangements.

Section 7 amends s. 626.8825, F.S., relating to pharmacy benefits manager (PBM) transparency and accountability. The bill defines the term, "affiliated manufacturer," to mean a prescription drug manufacturer permitted under part I of ch. 499, F.S., or a private label distributor as defined in 21 C.F.R. s. 207.1, which directly or indirectly through one or more intermediaries:

- Has an investment or ownership interest in a pharmacy benefit manager holding a certificate of authority issued under this part;
- Shares common ownership with a pharmacy benefit manager holding a certificate of authority issued under this part; or
- Has an investor or a holder of an ownership interest which is a pharmacy benefit manager holding a certificate of authority issued under this part.

The bill adds a definition of "covered prescription drug" to mean "any drug or biologic included in a pharmacy benefit manager's formulary which is paid for as a pharmacy benefit under the plan at any of the plan's network pharmacies."

The bill excludes organizations that participate in the Program of All-Inclusive Care for Elderly (PACE) from the current-law definition "pharmacy benefits plan or program."

The bill amends elements that are required to be included in a contract that a PBM must offer to licensed pharmacies physically located on the physical site of providers that meet one or more of five specified criteria,[136] as follows:

- The bill revises provisions relating to the types of "covered prescription drugs" that are included in such a PBM contract and the settings that are included for the administration of the drugs under such contracts.
- Under current law, such contracts must be solely for the "administration or dispensing" of covered prescription drugs. The bill changes that verbiage to "administration *and* dispensing."
- Under current law, the "covered prescription drugs" referenced above specifically include "biological products, which are administered through infusions, intravenously injected, or inhaled during a surgical procedure or are covered parenteral drugs, as part of onsite outpatient care." The bill deletes those specified elements altogether.
- Current law provides that the administration of certain prescription drugs must be covered under the offered contract as part of "onsite outpatient care." The bill changes that latter term to "outpatient care."

The bill revises requirements that a PBM may impose on specialty network participation, relating to drug safety, by removing references to provider coordination, clinical care, and monitoring

[136] The five criteria are listed in s. 626.8825(2)(e)2.a. through e., F.S.

since they are required to meet drug safety standards related to meeting Federal Drug Administration (FDA) limited distribution requirements for dispensing drugs.

The bill also clarifies that a PBM may not offset or recoup any renumeration fees, dispensing fees, brand name or generic effective rate adjustments, recoupments or other adjustments from a pharmacy if such action would reduce the amount paid to the pharmacy.

The bill revises the administrative appeal process for contesting the maximum allowable cost (MAC) pricing information and the reimbursement made for a specific drug by allowing a pharmacy or pharmacist the option to submit an electronic spreadsheet containing a consolidated administrative appeal representing multiple adjudicated claims that share the same drug and day supply and have a date of service occurring within the same calendar month.

The bill revises the MAC appeals deadline for PBMs to submit quarterly reports to the OIR to provide the deadlines are March 1 for the preceding year′s fourth quarter; May 15 for each year′s first quarter; August 15 for each year′s second quarter; and November 15 for each year′s third quarter. Currently such reports are due every 90 days for the preceding 90 days.

Section 8 amends s. 626.8827, F.S., relating to PBM prohibited practices, to provide that a breach of contractual terms required under s. 626.8825, F.S., is a prohibited practice.

The bill prohibits a PBM from restricting a pharmacy from declining to dispense a drug if the reimbursement rate for the drug is less than the actual acquisition cost to the pharmacy. The bill also prohibits a PBM from reimbursing a pharmacy less than it reimburses an affiliate pharmacy.

Lastly, the bill prohibits a PBM from maintaining an ownership interest, investment interest, or common ownership with an affiliated manufacturer, or share any investor or holder of an ownership interest with an affiliated manufacturer.

Section 9 contains a technical amendment to conform a statutory reference in s. 627.42392, F.S., to changes made elsewhere in the bill.

The bill takes effect July 1, 2026, except for Sections 1 and 2 of the bill, which are effective upon the bill becoming a law, and Section 5, which takes effect January 1, 2027.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None identified.

B. Public Records/Open Meetings Issues:

None identified.

C. Trust Funds Restrictions:

None identified.

D. State Tax or Fee Increases:

None identified.

E. Other Constitutional Issues:

Impairment of Contracts

Both the U.S. and Florida Constitutions prohibit laws that substantially impair existing contractual obligations. Florida courts apply a three-part test examining whether the law: (1) substantially impairs a contractual relationship; (2) serves a significant and legitimate public purpose; and (3) employs means reasonably necessary to achieve that purpose.

CS/SB 1760's mandate prohibiting pharmacy benefits manager (PBM) affiliations with manufacturers would materially alter the financial and structural terms of existing multi-year contracts between Department of Management Services (DMS) and PBM vendors. If applied to contracts executed before July 1, 2026, these provisions are likely to constitute a "substantial impairment," since they increase mandatory payouts and restrict corporate structure mid contract. The Florida Supreme Court held in *Dewberry v. Auto-Owners Ins. Co.,* that legislation diminishing the value of an existing contract, such as by increasing required payments may violate the Contracts Clause. Absent a clear prospective application, these provisions face an elevated risk of being found unconstitutional as applied to existing state contracts.

Equal Protection and Structural Divestiture

CS/SB 1760's prohibition on PBMs owning or investing in "affiliated manufacturers" targets a specific vertical integration model and may be challenged under the Equal Protection Clause. Similar prohibitions are being attempted in Arkansas and are being challenged as a "Bill of Attainder" because they allegedly targeted three specific national PBM's for "punishment "forced divestiture" without trial.[137] If Florida cannot demonstrate that manufacturer affiliation uniquely causes public harm, distinct from other forms of vertical integration such as PBM pharmacy or PBM insurer relationships; the provision may be vulnerable to claims that it is arbitrary and unconstitutional.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[137] On July 28, 2025, Judge Brian Miller of the U.S. District Court for the Eastern District of Arkansas granted a preliminary injunction preventing the law from taking effect because it likely violates the Commerce Clause of the U.S. Constitution and is likely preempted by TRICARE. Express Scripts Inc et al v. Richmond et al, No. 4:2025cv00520 - Document 73 (E.D. Ark. 2025), https://law.justia.com/cases/federal/district-courts/arkansas/aredce/4:2025cv00520/147864/73/ (last visited Feb. 25, 2026v).

B. Private Sector Impact:

Medicaid Managed Care Plans

The Agency for Health Care Administration (AHCA) reports that if the revisions to achieved savings rebate (ASR) profit-sharing percentages in Section 5 of the bill had been in effect in 2024 (the most recent calendar year for which ASRs have been finalized), Medicaid managed care plans would have been required to return approximately $128.3 million more in profit to the state for that year, in addition to the $51.3 million that was returned for 2024 under current law.[138]

Medicaid managed care plans may also be negatively impacted by the bill's requirements for payments made by the plans in excess of "market rates" to be considered in the capitation rate-setting process and to be excluded from ASR calculations.

Health Insurers, Health Maintenance Organizations (HMOs), Pharmacies, and Consumers of Health Coverage

The bill also allows a pharmacy to refuse to fill a prescription if the reimbursement is less than the acquisition cost of the drug, regardless of other contractual terms involved in such reimbursement. This may result in increased costs for health insurers and HMOs as they must increase reimbursement rates to maintain pharmacy participation to ensure network adequacy. Any expenditure increases will likely be passed on to individuals in the form of health insurance premium increases.

Pharmacies may see a positive fiscal impact, as they can refuse to dispense medications at a loss and still remain within a insurer's network.

C. Government Sector Impact:

The bill has a significant, positive impact on state revenues and expenditures.

The bill will have a significant, positive fiscal impact on state. An Agency for Health Care Administration (AHCA) analysis of 2024 data indicates that, in addition to the $51.3 million in profit refunded to the Florida Medicaid program for that calendar year, approximately $128.3 million in additional managed care plan profit would have been refunded in the aggregate if the bill's revisions to the Achieved Savings Rebate (ASR) had been in effect in 2024.[139] The federal share of those additional refunds would have been returned to the federal government, consistent with the applicable federal Medicaid match rate.

The chart below compares the actual historical amounts retained and refunded by the managed care plans with the amounts that would have been retained and refunded had the bill's ASR language been in effect during that period.

[138] Agency for Health Care Administration, *SB 1760 Legislative Bill Analysis* (Jan. 13, 2026) (on file with the Senate Committee on Health Policy).
[139] Agency for Health Care Administration, *supra* note 138.

Impact of Changing Achieved Savings Rebate Calculation

CURRENT		
Income as Percentage of Revenue	Retained by Plans	Refunded to State
0-5%	100%	0%
5% - 10%	50%	50%
> 10%	0%	100%

PROPOSED		
Income as Percentage of Revenue	Retained by Plans	Refunded to State
0-3%	100%	0%
3% - 10%	30%	70%
> 10%	0%	100%

ASR Year	Net Income	Crrent ASR	Current Retained	Proposed ASR	Proposed Retained	Change in ASR
2016	491,271,382	30,440,542	460,830,840	159,587,030	331,684,353	**129,146,488**
2017&18	612,106,000	12,517,103	599,588,897	147,091,429	465,014,571	**134,574,326**
2019	402,166,001	129,298,856	272,867,145	161,465,510	240,700,491	**32,166,654**
2020	1,265,477,354	271,880,304	993,597,050	539,674,641	725,802,715	**267,794,337**
2021	1,535,221,128	316,351,123	1,218,870,005	676,951,106	858,270,024	**360,599,983**
2022	1,607,031,734	322,610,276	1,284,421,458	664,076,332	942,955,403	**341,466,056**
2023	1,246,456,488	96,739,129	1,149,717,359	403,342,181	843,114,308	**306,603,052**
2024	859,169,192	51,332,419	807,836,773	179,712,060	679,457,133	**128,379,641**
9-Year Total	**8,018,899,279**	**1,231,169,752**	**6,787,729,527**	**2,931,900,289**	**5,086,998,998**	**1,700,730,537**

The AHCA is required to calculate, analyze and publish a report by December 31, 2026, and annually thereafter. Any technology costs associated with publishing the report can be absorbed within existing resources.

The Office of Insurance Regulation (OIR) indicates the actuarial review of rates will increase due to the bill, and the OIR does not currently have the capacity to address the workload. The OIR, however, has submitted a Fiscal Year 2026-2027 Legislative Budget Request to comprehensively address capacity issues within the Division of Life and Health. Should that issue be funded, no additional resources will be needed to implement the bill. [140]

VI. Technical Deficiencies:

On lines 733-736, the bill creates a new definition in s. 626.8825, F.S., of "covered prescription drug" to mean "any drug or biologic included in a pharmacy benefit manager's formulary which is paid for as a pharmacy benefit under *the plan* at any of *the plan's* network pharmacies." (Emphasis added.) The definition's reference to "the plan" is unclear. There is no definition of "plan" in that section of statute, but there *is* a definition of "pharmacy benefits plan or program" that is referenced 30 times in that section. The word "plan," apart from its inclusion or implied inclusion in "pharmacy benefits plan or program" or some other defined term, does not appear in that section of statute at all. If the definition of "covered prescription drug" intends to refer to "pharmacy benefits plan or program" instead of "plan," the bill should be amended to that effect.

[140] Email from Office of Insurance Regulation staff to Senate Appropriations Committee on Agriculture, Environment, and General Government (Feb. 25, 2026) (on file with Senate Appropriations Committee Agriculture, Environment, and General Government).

VII. Related Issues:

The bill's revisions to pharmacy benefit manager (PBM) statutes may be preempted relating to Medicare Part D plans and their PBMs under the federal "standards" clause, found in 42 U.S.C. § 1395w-26(b)(3), to the extent the bill seeks to regulate pharmacy reimbursement methodologies, or network parity already governed by U.S. Centers for Medicare and Medicaid Services (CMS) for such plans.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 1.01, 409.962, 409.967, 626.8825, and 626.8827.

This bill creates the following sections of the Florida Statutes: 11.405 and 409.9675.

IX. Additional Information:

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

CS by Health Policy on February 11, 2026:
The CS:

- Makes two sections of the bill that create the Joint Legislative Committee on Medicaid Oversight effective upon the bill becoming law instead of July 1, 2026.
- Provides a definition of "market rate" relating to payments made by Medicaid managed care plans.
- Makes the bill's revisions to Medicaid's achieved savings rebate (ASR) percentages effective January 1, 2027, instead of July 1, 2026.
- Revises the underlying bill's definition of "affiliated manufacturer" to include a "private label distributor" as defined in 21 C.F.R. s. 207.1 and deletes from the definition an "entity which contracts with a prescription drug maker for promotion and marketing of prescription drugs."
- Excludes a Program for the All-Inclusive Care for the Elderly (PACE) organization from the current-law definition of "pharmacy benefits plan or program."
- Includes a definition of "covered prescription drug."
- Amends elements that are required to be included in a contract that a pharmacy benefit manager (PBM) must offer to licensed pharmacies physically located on the physical site of specified providers, by revising provisions relating to the types of "covered prescription drugs" that are included in such a PBM contract and the settings that are included for the administration of the drugs under such contracts.
- Removes the underlying bill's revisions relating to a pharmacy's participation in a PBM specialty network, thereby maintaining current law.
- Removes the underlying bill's requirement for PBMs to pay pharmacies or pharmacists a minimum dispensing fee of $10.24 with an annual adjustment for the consumer price index for medical care.

B. Amendments:

None.