FLORIDA HOU.S.E OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 697	**COMPANION BILL:** SB 1158 (Grall)
TITLE: Drug Prices and Coverage	**LINKED BILLS:** None
SPONSOR(S): Kincart Jonsson	**RELATED BILLS:** None

Committee References

Health Care Facilities & Systems	➤	Budget	➤	Health & Human Services
15 Y, 1 N		27 Y, 2 N		25 Y, 0 N, As CS

SUMMARY

Effect of the Bill:
CS/HB 697 makes it unlawful for a PBM to force a pharmacy to take a loss when dispensing a drug or to reimburse a nonaffiliated pharmacy less than an affiliated pharmacy. The bill requires PBMs to allow in-network pharmacies to submit consolidated appeals comprised of multiple adjudicated claims featuring identical drugs, day supplies, and dates of service.

The bill excludes a PBM which only serves beneficiaries of a Program of All-Inclusive Care for the Elderly (PACE) organization from current PBM law governing the terms and conditions of contracts between health plan sponsors and PBMs.

Fiscal or Economic Impact:
None.

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ANALYSIS

EFFECT OF THE BILL:

Pharmacy Benefit Managers

CS/HB 697 creates new regulatory requirements for pharmacy benefit managers (PBMs) concerning business practices and pharmacy contracts.

Unlawful Activity

The bill makes it unlawful for a PBM to prohibit or restrict a pharmacy from declining to dispense a prescription drug or biological product for less than the pharmacy's actual acquisition cost. (Section 2). This provision prevents a PBM from forcing a pharmacy to take a loss when dispensing a drug.

The bill also makes it unlawful for a PBM to reimburse a nonaffiliated pharmacy less than the PBM reimburses an affiliated pharmacy. (Section 2). This provision prevents a PBM from leveraging the market power of its parent healthcare conglomerate over non-affiliated pharmacies.

Contracts

The bill requires contracts between a PBM and an in-network pharmacy to include terms which establish an administrative appeal procedure such that a pharmacy may submit a consolidated appeal comprised of multiple adjudicated claims featuring identical drugs and day supplies, provided they also share dates of service occurring within the same calendar month. (Section 1). This provision is specific to contracts between PBMs and pharmacies

and does not involve the state executive branch's Division of Administrative Hearings; consolidated appeals will promote administrative efficiencies for all parties involved in an internal maximum allowable cost appeal.

The bill excludes a PBM which only serves beneficiaries of a Program of All-Inclusive Care for the Elderly (PACE) organization from current PBM law governing the terms and conditions of contracts between health plan sponsors and PBMs. (Section 1). PACE organizations, which serve certain elderly adults at risk of nursing home care, are already subject to oversight and regular audits by the federal government. Under the bill, this exemption eliminates current redundancies of effort and expense concerning PBM oversight and auditing activities by the Office of Insurance Regulation because the Centers for Medicare and Medicaid Services, in cooperation with the Agency for Health Care Administration, already perform oversight and auditing activities over PACE organizations.

The bill provides an effective date of July 1, 2026. (Section 3).

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Health Care Coverage in Florida

Government Sponsors

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid Program, licensing and regulating health facilities, and providing health care quality and price information to Floridians.[1] The Department of Children and Families makes Medicaid eligibility determinations.[2] For January 2026, Florida Medicaid recorded a monthly enrollment total of 3,945,922 people, with 72.3% enrolled in managed care plans, 27.5% enrolled in the fee-for-service program, and 0.1% enrolled in the Program of All-Inclusive Care for the Elderly (PACE).[3, 4]

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[5] The federal government also sets the minimum mandatory benefits to be covered in every state's Medicaid program.[6] Under federal Medicaid law, prescription drug coverage is an optional benefit states may choose to cover; Florida Medicaid covers prescription drugs.[7]

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[1] Office of Program Policy Analysis and Government Accountability, *Agency for Health Care Administration*, https://oppaga.fl.gov/ProgramSummary/ProgramDetail?programNumber=5048 (last visited Feb. 23, 2026).
[2] S. 409.902, F.S.
[3] The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. Medicaid, PACE, https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE (last visited Feb. 23, 2026).
[4] Florida Agency for Health Care Administration, Current Comprehensive Medicaid Managed Care Enrollment Reports, (Jan. 2026) https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited Feb. 23, 2026). Select the "Medicaid" tab on the lower toolbar of the Excel Spreadsheet.
[5] Title 42 U.S.C. §§ 1396-1396w -5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725).
[6] S. 409.905, F.S. Florida Medicaid Managed Care sets a minimum benefit package that build on top of the federal minimum benefits package. S. 409.973, F.S.
[7] S. 409.973(1)(x), F.S.

Manufacturer Rebates

The Medicaid Drug Rebate Program (MDRP) is a federally negotiated rebate program that helps State Medicaid agencies obtain rebates from drug manufacturers in return for outpatient coverage of the manufacturer's brand-name drugs. The rebate amount is the sum of a basic rebate[8] plus an inflation rebate.[9]

In addition to federally negotiated rebates, Florida Medicaid also negotiates for state-only manufacturer rebates, also known as state supplemental rebates. Current law specifies the threshold amount of supplemental rebates at 14% of the average manufacturer's price on the last day of the quarter. In addition, current law authorizes Florida Medicaid to require generic drug manufacturers to provide a minimum rebate of 15.1% of the average manufacturer price for the generic drug. There is no upper limit on the supplemental rebate amount.[10]

Prescription Drug Coverage and Utilization Management

AHCA administers a prescription-drug spending-control program for Florida Medicaid which includes the use of a preferred drug list (PDL) and various utilization management techniques. The PDL is recommended by gubernatorially appointed Pharmaceutical and Therapeutics (P&T) Committee, which considers which drugs are medically appropriate, cost-effective therapeutic drugs for Medicaid enrollees. The P&T Committee also makes recommendations regarding the use of prior authorization. Current law requires the PDL to include at least two drugs in each therapeutic class, if feasible. AHCA requires prior authorization for Medicaid-covered prescription drugs not on the PDL.[11]

Medicaid managed care plans must follow the AHCA prescription drug coverage and utilization management requirements and use the preferred drug list, and may not establish their own preferred drug list. The plans establish the pharmacy networks, and may limit the size of pharmacy networks based on need, competitive bidding, price negotiations, credentialing, or similar criteria.[12]

Program of All-Inclusive Care for the Elderly

Under federal law, PACE provides pre-paid, capitated, comprehensive health care services to adults aged 55 years or older who need a nursing home level of care but can live safely in their communities for as long as it is medically and socially feasible.[13] PACE organizations, which are entities with agreements with the Centers for Medicare & Medicaid Services (CMS) and the state administering agency (i.e., AHCA in Florida), must provide a benefits package to PACE participants that includes all Medicare-covered services, all Medicaid-covered services specified in the state plan, and other services determined necessary to improve and maintain the participants overall health; this includes prescription drugs.[14] PACE organizations must only operate within their designated service areas, and there are currently eight designated service areas in Florida (Regions A-H). Through December 2025, AHCA

[8] The basic rebate is the greater of 23.1% of the average manufacturer price or the average manufacturer price minus the Medicaid best price. The Medicaid best price is the manufacturer's net price for a drug and is inclusive of all applicable discounts, rebates, or other transactions that adjust prices.
[9] The inflation rebate is an amount that offsets the increase in a manufacturer's gross price for a drug above inflation.
[10] S. 409.912(5)(a), F.S. AHCA may negotiate an amount lower than 14% of the average manufacturer price if the federal and/or supplemental rebate equal or exceeds 29%.
[11] Ss. 409.912; 409.912(5)(a); 409.91195; 409.91196, F.S.
[12] *Id*.
[13] 42 C.F.R. § 460.2. "Florida Medicaid's Covered Services and HCBS Waivers: Program of All-Inclusive Care for the Elderly," *Agency for Health Care Administration*, https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/program-of-all-inclusive-care-for-the-elderly (last visited Feb. 26, 2026).
[14] 42 C.F.R. §§ 460.6. 460.92. The benefit limitations under Medicare and Medicaid and the conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, and other cost-sharing do not apply to PACE participants, who must receive such benefits solely through the PACE organization. 42 C.F.R. §§ 460.90. "Florida Medicaid's Covered Services and HCBS Waivers: Program of All-Inclusive Care for the Elderly," *Agency for Health Care Administration*, https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/program-of-all-inclusive-care-for-the-elderly (last visited Feb. 26, 2026).

reports there are 16 operational PACE organizations, 10 applicants seeking approval for PACE organization status, and 3,858 total participants receiving benefits through PACE organizations.[15]

Oversight and Audits

Under federal law, CMS audits the operations of PACE organizations. For the first three years of a PACE organization's trial period, CMS audits its operations, which includes analyzing fiscal soundness, service capacity, substantial compliance with federal law, and other factors. Beyond the first three years, CMS audits the PACE organization as appropriate, taking into account the performance levels and substantial compliance. For each audit, CMS must work in cooperation with the state administering agency (i.e., AHCA in Florida).[16] CMS may take corrective action for violations revealed by an audit, including sanctions and termination of an organization's PACE status.[17]

Commercial Plan Sponsors

Commercial Health Insurers

The Office of Insurance Regulation (OIR) reports that the individual health insurance market in Florida covers about 4.4 million people, and another 2.1 million receive coverage through the group health insurance market. Total premiums for the commercial market exceeded $45.9 billion in 2024 with approximately $31.4 billion in the individual market and $14.4 billion in the group market.[18]

The Florida Health Insurance Advisory Board (FHIAB) advises OIR, AHCA, the Department of Financial Services, other executive departments, and the Legislature on health insurance issues. As of year-end 2024, FHIAB reports that health insurance coverage by market segment consisted of:

- Individual Coverage – 4,444,258 covered lives, an increase of 22.4% from 2023.
- Small Group (1-50 members) – 355,416 covered lives, a decrease of 11.2% from 2023.
- Large Group (51+ members) – 1,731,416 covered lives, a decrease of 3.2% from 2023.
- Total Market – 6,531,543 covered lives, an increase of 12.2% from 2023.[19]

Health Maintenance Organizations

A health maintenance organization (HMO) offers cost-sensitive health insurance plans geared towards preventative health care and characterized by strict in-network, referral-based care coordination, with exceptions for emergencies, managed by the plan beneficiary's designated primary care physician.[20] HMOs must have an OIR-issued certificate of authority and an AHCA-issued Health Care Provider Certificate to operate in Florida.[21] Once an HMO is issued a certificate, the HMO may enter into contracts in Florida to provide an agreed-upon set of

[15] "Program of All-Inclusive Care for the Elderly, Monthly Report: December 2025," *Agency for Health Care Administration*, (Feb. 4, 2026) https://ahca.myflorida.com/content/download/28203/file/December%202025%20PACE%20Report.pdf (last visited Feb. 26, 2026).
[16] 42 U.S.C. §§ 1395eee(e)(4), 1396u-4(e)(4).
[17] 42 C.F.R. § 460.194
[18] Florida Health Insurance Advisory Board, *2025 Florida Health Insurance Market Report*, Florida Office of Insurance Regulation (adopted Dec. 19, 2025) https://floir.gov/docs-sf/default-source/fhiab/florida-health-insurance-market-reports/fhiab-2025-market-report---final-as-approved-2.pdf (last visited Feb, 23, 2026).
[19] *Id*.
[20] *See* Chief Financial Officer, "Health Insurance and Health Maintenance Organizations: a guide for consumers" Department of Financial Services, (Jul. 2025) https://myfloridacfo.com/docs-sf/consumer-services-libraries/consumerservices-documents/understanding-coverage/consumer-guides/health-insurance-guide.pdf?sfvrsn=5546b2b_4 (last visited Feb. 23, 2026).
[21] S. 641.21(1), F.S.

comprehensive health care services, including drugs, to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum.[22] As of February 23, 2026, OIR reports there are 56 HMOs.[23]

State Employee Group Insurance Program

The State Employee Group Insurance Program (SGI Program) is governed by ch. 110, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS). The SGI Program is an optional benefit for all state employees, and includes health, life, dental, vision, disability, and other supplemental insurance benefits. The SGI program covers over 360,000 state employees, dependents, and retirees. The SGI Program typically makes benefits changes on a plan year basis, January 1 through December 31.

As part of the SGI Program, DMS is required to maintain the State Employee Prescription Drug Program (Prescription Drug Plan).[24] DMS contracts with Optum Rx, a pharmacy benefit manager, to administer the Prescription Drug Plan.[25] For Fiscal Year 2024-2025, DSGI estimates that the State Employee Group Insurance Program spent $1.22 billion on prescription drug claims for covered beneficiaries and an additional $5.1 million on pharmacy benefit manager claims administration.[26]

Pharmacy Benefit Managers

To manage drug costs, a health plan sponsor typically contracts a pharmacy benefit manager (PBM) to build their prescription drug benefit package. As a contracted professional service, the PBM develops the health plan's prescription drug formulary and organizes a network of pharmacies where plan beneficiaries can pick up their prescriptions at reduced prices. A PBM who contracts to administer prescription drug benefits in Florida on behalf of a health plan sponsor must be licensed as an insurance administrator by obtaining a certificate of authority from OIR.[27] A certificate of authority issued to a PBM remains valid, unless OIR suspends or revokes the certificate, so long as the PBM conducts business in Florida.[28] As of February 23, 2026, OIR regulates 71 PBMs.[29]

As an insurance administrator, a PBM acts in a fiduciary capacity[30] on behalf of the health plan sponsor,[31] and negotiates directly with drug manufacturers and pharmacies interested in selling their drugs and pharmacist services, respectively, to the health plan's beneficiaries. PBMs can manage utilization of a prescription drug and its overall cost by making the drug's out-of-pocket cost higher or lower. As a result, the placement of prescription drugs on a formulary can affect utilization of a drug. Through negotiations, PBMs secure reduced drug prices or arrange rebate deals with drug manufacturers and drug manufacturers receive a steady volume of beneficiary demand for their drugs. The inclusion of a pharmacy within a health plan's pharmacy network can increase

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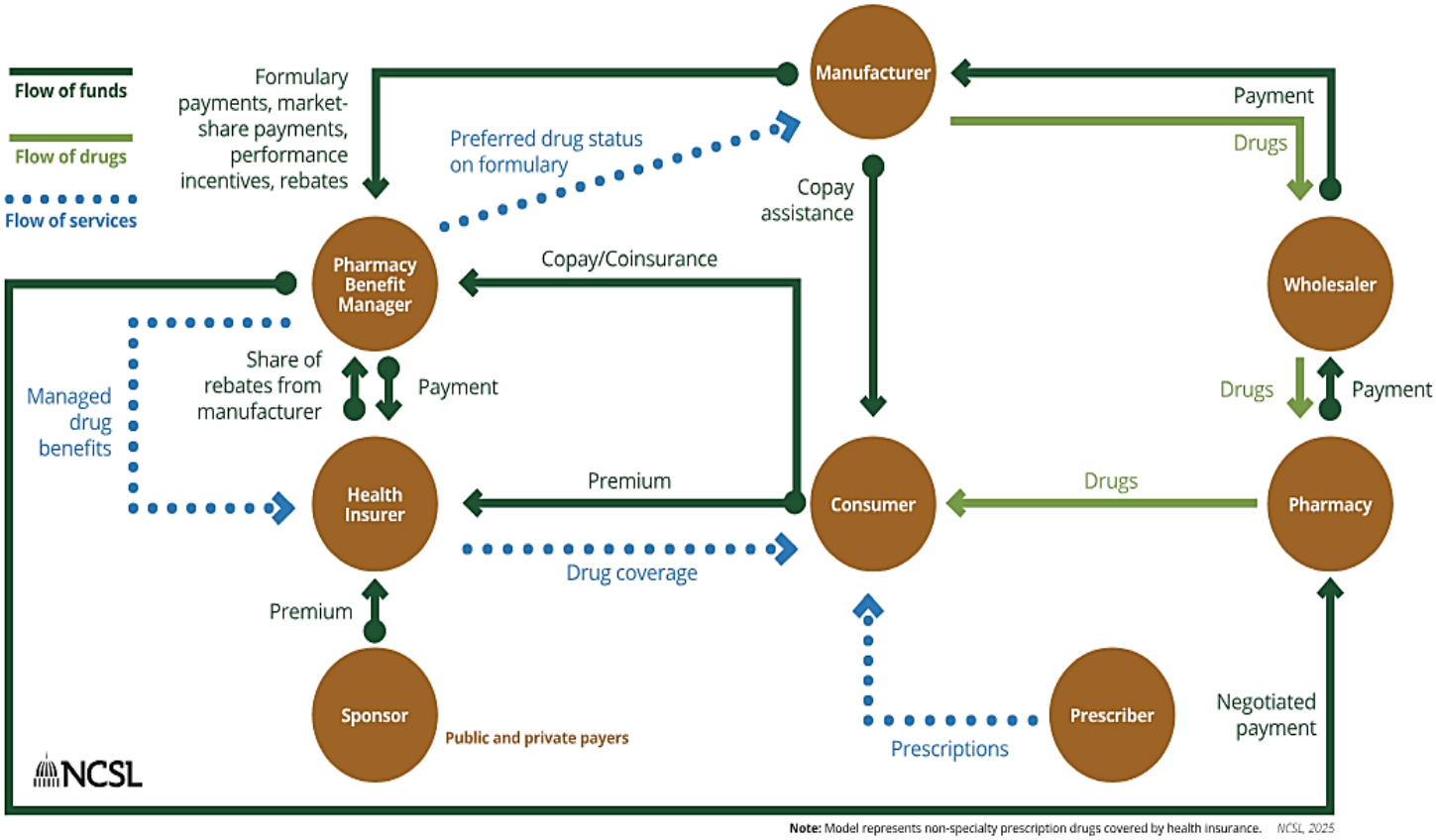
[22] Ss. 641.19(4), 641.31(1), F.S.
[23] Office of Insurance Regulation, "Active Company Search," https://companysearch.floir.gov/ (last visited Feb. 23, 2026). For the "Company Type" row, select "Health Maintenance Organization (HMO)" and click "Search" for inquiry results.
[24] S. 110.12315, F.S.
[25] Department of Management Services, *myFlorida, Prescription Drug Plan*, https://www.mybenefits.myflorida.com/myhealth/prescription_drug_plan (last visited Feb. 23, 2026).
[26] DSGI estimates that the state preferred provider organization plans spent $644.3 million on prescription drug claims plus another $2.7 million on PBM administration, the state health maintenance plans spent $570.7 million on prescription drug claims plus another $2.4 million on PBM administration, and the Medicare Advantage prescription drug plans spent $9.6 million. Division of State Group Insurance, "State Employees' Group Health Self-Insurance Trust Fund: Report on Financial Outlook for the Fiscal Years Ending June 30, 2025 through June 30, 2030," Department of Management Services, Ex. III: Financial Outlook by Fiscal Year, pp. 9 (Aug. 11, 2025) https://www.edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf (last visited Feb. 23, 2026).
[27] S. 626.8805(1), F.S. If a PBM lacks a valid certificate of authority to act as an administrator, the PBM is subject to a fine of $10,000 per violation per day.
[28] S. 626.8805(6), F.S.
[29] Office of Insurance Regulation, "Active Company Search," https://companysearch.floir.gov/ (last visited Feb. 23, 2026). For the "Company Type" row, select "Pharmacy Benefit Manager" and click "Search" for inquiry results.
[30] Fiduciary representation contemplates a legally cognizable relationship of trust where an intermediary figure advances the interests of a principal for the primary and direct benefit of the principal's designated beneficiary.
[31] S. 626.883, F.S.

customer volume for that pharmacy. Through negotiations, PBMs gain favorable reimbursement rates with pharmacies. In return, in-network pharmacies enjoy a steady volume of beneficiary demand for their services.

The prescription drug supply chain is a complex machine where PBMs directly or indirectly influence most individualized transactions amongst industry participants, as the infographic below illustrates.[32]



In recent years, state governments have focused on PBMs for several reasons, including their business practices, market consolidation, and lack of transparency, all of which factor into concerns that PBMs themselves have played a role in increasing drug prices, even as they work to manage pharmacy benefits and costs for insurers.[33]

Unlawful Activity

OIR also takes enforcement action against PBMs that commit the following unlawful business activities, pursuant to s. 626.8827, F.S.:

- Prohibiting, restricting, or penalizing a pharmacy from disclosing to any person:
  - The nature of treatment, risks, or alternatives.
  - The availability of alternate treatment, consultations, or tests.
  - The decision of, or the process used by, utilization reviewers to authorize or deny pharmacist services or benefits.
  - Information on financial incentives and structures used by the health plan sponsor.

[32] "Prescription Drug Supply Chain," *National Conference of State Legislatures* (updated Feb. 23, 2026) https://www.ncsl.org/health/prescription-drug-supply-chain (last visited Jan. 22, 2026).
[33] Meredith Freed, Julliette Cubanski, and Elizabeth Williams, "What to Know About Pharmacy Benefit Managers (PBMs) and Federal Efforts at Regulation," *KFF* (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. 23, 2026).

  - 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.
  - Other information the pharmacy deems appropriate to disclose.
- Prohibiting, restricting, or penalizing a pharmacy from disclosing confidential proprietary information to certain state agencies,[34] provided that the pharmacy marks such information as confidential or requests confidential treatment for any oral communication of such information.
- Communicating at the point-of-sale, or otherwise require, a cost-sharing obligation for the plan beneficiary 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[35] of the pharmacist services.
- Transferring or sharing records relative to prescription information containing patient-identifiable or prescriber-identifiable data to an affiliated pharmacy for any commercial purpose other than the limited purposes of facilitating pharmacy reimbursement, formulary compliance, or utilization review on behalf of the applicable pharmacy benefits plan or program.
- Failing to make any payment due to a pharmacy for an adjudicated claim with a date of service before the effective date of a pharmacy's termination from a pharmacy benefit network.[36]
- Terminating the contract of, penalize, or disadvantage a pharmacy that lawfully discloses information about PBM practices, exercises statutorily reserved prerogatives, or shares its contractual agreement with OIR pursuant to a compliant or query.
- Failing to pay a pharmacy for any pharmacy benefit claim, provided that the health plan sponsor delegates the obligation of payment to the PBM.
- Failing to comply with contractual requirements as specified in 626.8825(2), F.S.

As an OIR-regulated entity, PBMs must cooperate with biennial examinations and ad hoc investigations, make available certain documents and records, and comply with recordkeeping requirements. OIR must impose an administrative fine of $5,000 for each contractual violation and, or each unlawful activity discovered; a PBM's failure to pay is grounds for the denial, suspension, or revocation of its certificate of authority.[37] OIR has approximately 38 ongoing PBM investigations, as of September 2025.[38]

Contracts

Current law sets many parameters on PBM contracts with health plan sponsors and pharmacies, including requiring or prohibiting certain terms and conditions.

With respect to its contractual agreements with health plan sponsors, PBMs must incorporate the following terms and conditions, pursuant to s. 626.8825(2), F.S.:

- Use a pass-through pricing model[39] without applying financial clawbacks, reconciliation offsets, or offsets to adjudicated claims.

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[34] These state agencies include OIR, AHCA, the Department of Management Services, law enforcement, or state and federal governmental officials.
[35] The usual and customary price means the amount charged to cash customers for a pharmacist service exclusive of sales tax or other amounts claimed. s. 626.8825, F.S.
[36] However, a PBM may withhold payment because of fraud on the part of the pharmacy or when other law requires.
[37] S. 626.8828, F.S.
[38] Email from Seth Stubbs, Director of Legislative & Cabinet Affairs, Office of Insurance Regulation, on September 19, 2025. On file with the Health & Human Services Committee.
[39] A pass-through pricing model is where the health plan sponsor pays the PBM for covered outpatient drugs which are 1) equivalent to the payments the PBM makes to a dispensing pharmacy or provider for such drugs, including any contracted professional dispensing fee between the PBM and in-network pharmacies, and which are 2) passed through in their entirety by the health plan sponsor or by the PBM

- Prohibit spread pricing.[40]
- Use accounting measures to ensure a health plan sponsor's payment for services rendered to the PBM is allocated pursuant to the terms of the contract.
- Pass 100% of manufacturer rebates to offset plan beneficiary cost-sharing obligations and premium amounts, provided the contract delegates rebate negotiation to the PBM.[41]
- Include federally complaint pharmacy network adequacy requirements.
- Prohibit conditioning a pharmacy's participation in one pharmacy network upon its participation in another pharmacy network.
- Prohibit penalizing a pharmacy from exercising its prerogative not to participate in a specific pharmacy network.
- Prohibit requiring that in-network pharmacies meet accreditation standards inconsistent with or more stringent than federal and state requirements for licensure as a pharmacy (except specialty networks).
- Provide a 60-day continuity-of-care period concerning drug formulary changes, during which plan beneficiaries may access covered drugs on the formulary at the current price.

With respect to its contractual agreements with pharmacies, PBMs must incorporate the following terms and conditions, pursuant to s. 626.8825(3), F.S.

- Provide detailed remittance information that helps pharmacies identify the appropriate reimbursement schedule at the time of claim adjudication and ensure that claim level payment adjustments comply with nationally standardized protocols.
- Use nationally standardized reconciliation protocol for any effective rate guarantee.
- Prohibit financial clawbacks, reconciliations offsets, or offsets to adjudicated claims.
- Prohibit PBM from charging, withholding, or recouping direct or indirect remuneration fees, dispensing fees, or brand name or generic rate adjustments through reconciliation.[42]
- Prohibit PBM from charging, withholding, or recouping amounts related to discounts, multiple network reconciliation offsets, adjudication transaction fees, and any other instance when a free may be recouped from a pharmacy.[43]
- Prohibit PBM from unilaterally changing the terms of any participation contract.
- Allow pharmacy to offer mail or delivery services if plan beneficiary generally opts in to such services or specifically requests such services.
- Allow pharmacy to charge a shipping and handling fee if pharmacy discloses the amount to the plan beneficiary as well as the possibility of not being reimbursed for those fees.
- Provide upon a pharmacy's request a list of health plan sponsors in which the pharmacy is part of the network.[44]

As of February 24, 2026, 10,890 pharmacies have active permits issued by the Department of Health (DOH).[45]

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to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation. S. 626.8825(1)(p), F.S.

[40] Spread pricing occurs when a PBM charges a health plan sponsor a different amount for pharmacist services than the amount the PBM reimburses a pharmacy for the same pharmacist services. s. 626.8825(1)(w), F.S.

[41] The manufacturer rebate pass-through payment does not apply to PBM contracts involving Medicaid managed care plans.

[42] This prohibition does not apply to recoupments returned to Medicaid or the State Group Insurance Program. This prohibition also does not apply to PBM incentive payments to network pharmacies for meeting or exceeding quality metrics. This prohibition also does not apply to recoupment due to erroneous claims, fraud, waste, or abuse. This prohibition also does not apply to a claim adjudicated in error, a maximum allowable cost appeal pricing adjustment, or an adjustment made as part of a pharmacy audit.

[43] *Id*.

[44] The PBM must communicate list updates to the pharmacy within 7 days, and the PBM cannot restrict the pharmacy from publicly disclosing the list.

[45] Division of Medical Quality Assurance, "License Verification," Department of Health, https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited Feb. 24, 2026). In the "Profession" row, select "Pharmacy" and in the "License Status" row, select "Practicing statuses only", and click "Search" for inquiry results.

Maximum Allowable Cost and Reimbursement Appeals

Current law requires a PBM's contractual agreement with a pharmacy to provide a reasonable administrative appeal procedure that allows a pharmacy to appeal the PBM's maximum allowable cost pricing information and the corresponding reimbursement for a specific drug that the pharmacy argues is below its acquisition cost. Every 90 days, OIR-regulated PBMs must report to OIR the total number of appeals received and denied for each specific drug in the preceding 90-day period and supply its explanations or reasonings for each denial.[46]

Vertical Integration

Vertical integration describes a form of marketplace consolidation where different lines of business affiliate under a parent conglomerate to maximize administrative efficiencies, bring emerging markets to scale, and streamline the customer's user experience. A noteworthy example of vertical integration in the technology sector is Amazon's expansion into the grocery business (Whole Foods), primary care (One Medical), entertainment (Metro-Goldwyn-Mayer), home automation (Ring), and pharmacy (PillPack), amongst other lines of business. In contrast to vertical integration, horizontal integration occurs when business rivals within the same line of business acquire or merge with each other to exercise greater market share over remaining competitors. A timely example of horizontal integration is the present merger & acquisition fight in the entertainment sector between Netflix and Paramount for Warner Bros. Discovery.

Vertical integration of the healthcare sector reflects a recent shift towards risk-based contracting amongst payers and providers, where a parent healthcare conglomerate builds a vertically integrated network of different lines of business (e.g., insurance, PBM, primary care, pharmacy, etc.) to distribute acute financial risks for individual business segments across the entire healthcare delivery supply chain. While vertical mergers may create pro-competitive administrative efficiencies, they also create anticompetitive effects.[47]

Current law requires PBMs to disclose to OIR any ownership interests or affiliations of any kind with:

- Any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the PBM provides administrative services; and
- Any pharmacy which, either directly or indirectly, through one or more intermediaries:
    - Has an investment or ownership interest in an OIR-regulated PBM;
    - Share common ownership with an OIR-regulated PBM; or
    - Has an investor or a holder of an ownership interest which is an OIR-regulated PBM.[48]

Any such ownership interest or affiliation with an insurance company or pharmacy means the PBM is vertically integrated with a parent healthcare conglomerate, alongside its affiliated insurance company and affiliated pharmacies. As the below infographic illustrates, a handful of parent healthcare conglomerates control the prescription drug supply chain in the United States, which includes manufacturing, distribution, prescription drug coverage and reimbursement, PBMs, prescribing providers, and pharmacy fulfillment.[49]

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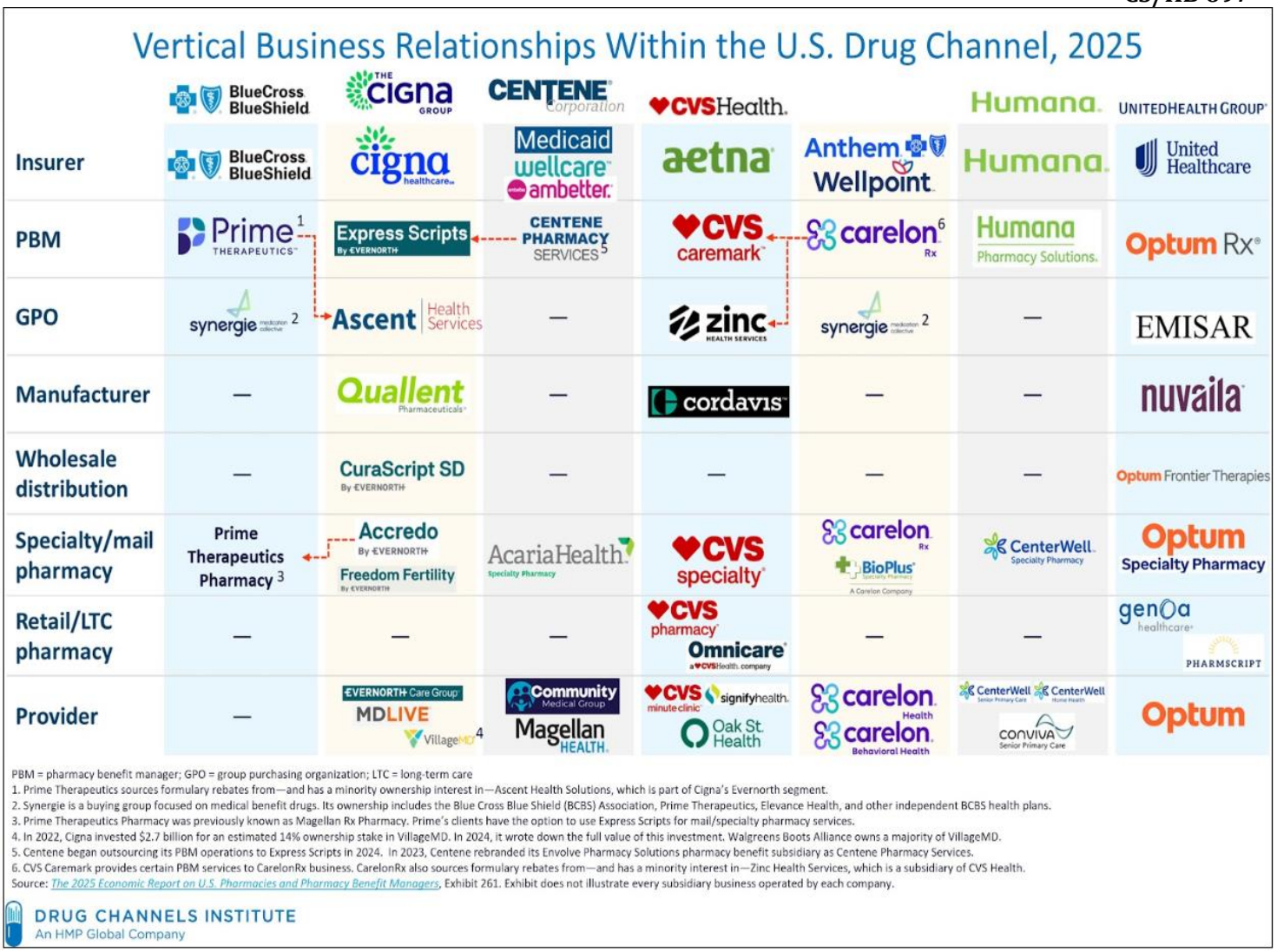
[46] S. 626.8825(3)(h), F.S.

[47] *See* Kevin Hahm and Brian Miller, "A Framework for Evaluating Vertical Integration Among Payers and Providers," *American Bar Association*, 39 Fall Antitrust 45 (Fall 2024) https://www.americanbar.org/content/dam/aba/publications/antitrust/magazine/2024/vol-39-issue-1/framework-evaluating-vertical-integration.pdf (last visited Feb. 23, 2026).

[48] S. 626.8814, F.S. A PBM must also formally report any change ownership interests or affiliations to OIR within 60 days after the change occurs.

[49] Drug Channels Institute, "Drug Channels: Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers" (Apr. 2025) https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html (last visited Feb. 23, 2026).



For 2024, nearly 80% of all equivalent prescription claims were processed by three PBMs: the CVS Caremark business of CVS Health, the Express Scripts business of Cigna, and the Optum Rx business of UnitedHealth Group. Five of the six largest PBMs are now owned by organizations that also own a health insurer.[50]

In 2025, the FTC analyzed 51 specialty generic drugs[51] dispensed from 2017 to 2022 for members of commercial health plans and Medicare Part D prescription drug plans managed by CVS Caremark, Express Scripts, and Optum Rx as a part of its ongoing study of the PBM industry. The FTC found that these three PBMs marked up numerous specialty generic drugs by hundreds and thousands of precent, with the majority of the most highly marked up drugs dispensed by the PBM's own affiliated pharmacies. The FTC believes this dispensing pattern indicates that these PBMs may be steering highly profitable prescriptions to their own affiliated pharmacies. The FTC also found that CVS Caremark, Express Scripts, and Optum Rx reimbursed their affiliated pharmacies at a higher rate than they paid unaffiliated pharmacies on nearly every specialty generic drug examined. Collectively, these companies

[50] Adam Fein, "The Top Pharmacy Benefit Mangers of 2024: Market Share and Key Industry Developments," *The Drug Channels Institute* (Mar. 31, 2025) https://www.drugchannels.net/2025/03/the-top-pharmacy-benefit-managers-of.html (last visited Feb. 23, 2026).
[51] Historically, specialty drugs necessitated special handing and administration. The FTC asserts this is not necessarily the case anymore and that there is no standard definition. Instead, the FTC states specialty drugs are characterized by a variety of factors, including their high cost.

generated more than $7.3 billion in revenue from dispensing drugs in excess of the drugs' estimated acquisition costs plus an additional $1.4 billion from spread pricing. [52]

In the same analysis, the FTC observed that these specialty generic drug dispensing practices account for 12% of aggregated operating income in 2021 as reported by the parent healthcare conglomerates' business segments.[53]

RECENT LEGISLATION:

YEAR	BILL #/SUBJECT	HOU.S.E/*SENATE* SPONSOR(S)	OTHER INFORMATION
2023	CS/CS/SB 1550 - Prescription Drugs	Chaney/ *Brodeur*	Became law July 1, 2023.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Care Facilities & Systems Subcommittee	15 Y, 1 N	1/21/2026	Lloyd	DesRochers
Budget Committee	27 Y, 2 N	1/27/2026	Pridgeon	Smith
Health & Human Services Committee	25 Y, 0 N, As CS	2/26/2026	Calamas	DesRochers

THE CHANGES ADOPTED BY THE COMMITTEE:	• Deleted the proposed prohibition on:
	  ○ Insurers and pharmacy benefit managers (PBMs) adversely changing their drug coverage formularies during the plan year.
	  ○ Contracts between a PBM and a pharmacy benefit plan that force the pharmacy to dispense an affiliated manufacturer's drug or biological product when a generic or biosimilar is available.
	• Removed the proposed most-favored-nation upper payment limits.
	• Specified that claim cost disputes may be consolidated for appeal if they involve the same drug, day supply, and the date of service, rather than merely being "substantially similar."
	• Excluded a PBM which only serves beneficiaries of a Program of All-Inclusive Care for the Elderly from current PBM law.
	• Retained all other PBM-related proposals			

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.

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[52] Federal Trade Commission, "FTC Releases Second Interim Staff Report on Prescription Drug Middlemen," (Jan. 14, 2025) https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen (last visited Feb. 23, 2026).

[53] *Id.*