A bill to be entitled

An act relating to pharmacy benefit managers; creating s. 465.1862, F.S.; defining terms; specifying contract terms that must be included in a contract between a pharmacy benefit manager and a pharmacy; providing restrictions on the inclusion of prescriptions drugs on a list that specifies the maximum allowable cost for such drugs; requiring the pharmacy benefit manager to disclose certain information to a plan sponsor; requiring a contract between a pharmacy benefit manager and a pharmacy to include an appeal process; requiring a pharmacy benefit manager to contractually commit to providing a certain reimbursement rate for generic drugs; providing an effective date.

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

Section 1. Section 465.1862, Florida Statutes, is created to read:

465.1862 Pharmacy benefit managers.—

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

(a) "Average wholesale price" (AWP) means the published or suggested cost of pharmaceuticals charged to a pharmacy by a large group of pharmaceutical wholesalers.

(b) "AWP discount," also known as the generic effective rate, means the negotiated amount a plan sponsor pays to

pharmacies for the ingredient cost of a prescription and is commonly expressed as a percentage of AWP.

(c) "Maximum allowable cost" (MAC) means the upper limit or maximum amount that an insurance or managed care plan will pay for generic or brand-name drugs that have generic versions available, which are included on a PBM-generated list of products.

(d) "Pharmacy benefit manager" (PBM) means a person, business, or other entity that provides administrative services related to processing and paying prescription claims for pharmacy benefit and coverage programs. Such services may include contracting with a pharmacy or network of pharmacies; establishing payment levels for provider pharmacies; negotiating discounts and rebate arrangements with drug manufacturers; developing and managing prescription formularies, preferred drug lists, and prior authorization programs; ensuring audit compliance; and providing management reports.

(e) "Plan sponsor" means an employer, insurer, managed care organization, prepaid limited health service organization, third-party administration, or other entity contracting for pharmacy benefit manager services.

(2) A pharmacy benefit manager who contracts with a pharmacy in this state shall annually contract with the pharmacy on or before January 1 of the contract year. Such contract must:

(a) Include the basis of the methodology and sources used to determine the MAC pricing administered by the pharmacy

benefit manager, update the pricing information on such a list at least every 7 calendar days, and establish a reasonable process for the prompt notification of such pricing updates to network pharmacies.

(b) Maintain a procedure to eliminate products from the list or modify the MAC pricing in a timely fashion in order to remain consistent with pricing changes in the marketplace.

(3) In order to place a particular prescription drug on a MAC list, the pharmacy benefit manager must, at a minimum, ensure that:

(a) The drug has at least three or more nationally available, therapeutically equivalent, multiple-source generic drugs that have a significant cost difference.

(b) The products are listed as therapeutically and pharmaceutically equivalent or "A" rated in the United States Food and Drug Administration's most recent version of the Orange Book.

(c) The product is available for purchase, without limitation, by all pharmacies in the state from national or regional wholesalers and may not be obsolete or temporarily unavailable.

(4) The pharmacy benefit manager must disclose the following to the plan sponsor:

(a) The basis of the methodology and sources used to establish applicable MAC pricing in the contract between the pharmacy benefit manager and the plan sponsor. Applicable MAC

lists must be updated and provided to the plan sponsor when there is a change.

(b) Whether the pharmacy benefit manager uses a MAC list for drugs dispensed at retail but does not use a MAC list for drugs dispensed by mail order in the contract between the pharmacy benefit manager and the plan sponsor or within 21 business days after implementation of the practice.

(c) Whether the pharmacy benefit manager is using the identical MAC list with respect to billing the plan sponsor as it does when reimbursing all network pharmacies. If multiple MAC lists are used, the pharmacy benefit manager must disclose any difference between the amount paid to a pharmacy and the amount charged to the plan sponsor.

(5) All contracts between a pharmacy benefit manager and a contracted pharmacy must include:

(a) A process for appealing, investigating, and resolving disputes regarding MAC pricing. The process must:

1. Limit the right to appeal to 90 calendar days after the initial claim.

2. Investigate and resolve the dispute within 7 days.

3. Provide a telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals.

(b) If the appeal is denied, the pharmacy benefit manager shall provide the reason for the denial and identify the national drug code of a drug product that may be purchased by a

contracted pharmacy at a price at or below the MAC.

(c) If an appeal is upheld, the pharmacy benefit manager shall make an adjustment retroactive to the date of adjudication. The pharmacy benefit manager shall make the adjustment effective for all similarly situated pharmacies in this state which are within the network.

(6) A pharmacy benefit manager shall contractually commit to providing a particular aggregate average reimbursement rate for generics or a maximum average AWP discount on multisource generics as a whole. For purposes of the AWP discount amount, a pharmacy benefit manager must use an AWP published by a nationally available compendia. The aggregate average rate for reimbursement shall be calculated using the actual amount paid to the pharmacy, excluding the dispensing fee. The reimbursement rate may not be calculated solely according to the amount allowed by the plan and must include all generics dispensed, regardless of whether they are subject to MAC pricing.

Section 2. This act shall take effect July 1, 2014.