A bill to be entitled

An act relating to prescription drug price transparency; amending s. 110.12315, F.S.; requiring the Department of Management Services to contract for an annual audit of any pharmacy benefit vendor contracted under the state employees' prescription drug program; providing requirements for such audit; amending s. 499.012, F.S.; providing that permits for prescription drug manufacturers and nonresident prescription drug manufacturers are subject to specified requirements; creating s. 499.026, F.S.; providing definitions; requiring prescription drug manufacturers to provide notification of drug price increases to insurers; providing requirements for such notification; requiring prescription drug manufacturers to provide an annual report on drug price increases to the Department of Business and Professional Regulation and the Office of Insurance Regulation; providing reporting requirements; creating s. 624.491, F.S.; providing timelines and documentation requirements for pharmacy audits conducted by certain health insurers, health maintenance organizations, or their agents; providing that such requirements do not apply to audits in which certain conditions are met; creating s. 627.42394,

F.S.; requiring certain health insurers to establish a single point of contact for manufacturers to report drug price increases; requiring the Office of Insurance Regulation to maintain and publish a list of such contacts; requiring certain health insurers to provide written notice to insureds in advance of formulary changes resulting from manufacturer drug price increases; providing applicability; amending ss. 627.64741 and 627.6572, F.S.; providing definitions; requiring reporting requirements in contracts between health insurers and pharmacy benefit managers; requiring health insurers to submit an annual report to the office; requiring the office to publish such reports and analyses of specified information; authorizing the office to review contracts; authorizing the office to order health insurers to terminate contracts with pharmacy benefit managers under certain circumstances; providing rulemaking authority; revising applicability; creating s. 641.3131, F.S.; requiring certain health maintenance organizations to establish a single point of contact for manufacturers to report drug price increases; requiring the office to maintain and publish a list of such contacts; requiring certain health maintenance organizations to provide written notice to subscribers

in advance of formulary changes resulting from manufacturer drug price increases; providing applicability; amending s. 641.314, F.S.; providing definitions; requiring reporting requirements in contracts between health maintenance organizations and pharmacy benefit managers; requiring health maintenance organizations to submit an annual report to the office; requiring the office to publish such reports and analyses of specified information; authorizing the office to review contracts; authorizing the office to order health maintenance organizations to terminate contracts with pharmacy benefit managers under certain circumstances; providing rulemaking authority; revising applicability; requiring the Agency for Health Care Administration to contract for an independent analysis of pharmacy benefit management practices under the Statewide Medicaid Managed Care program; providing requirements for such analysis; providing definitions; requiring the agency to submit the analysis to the Governor and the Legislature; requiring the agency to conduct an analysis of managed care plan pharmacy networks and to analyze the composition of the networks under the Statewide Medicaid Managed Care program; providing requirements for such analysis;

providing definitions; requiring the agency to submit the analysis to the Governor and the Legislature; providing severability; providing severability; providing an effective date.

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

Section 1. Subsection (11) is added to section 110.12315, Florida Statutes, to read:

110.12315 Prescription drug program.—The state employees' prescription drug program is established. This program shall be administered by the Department of Management Services, according to the terms and conditions of the plan as established by the relevant provisions of the annual General Appropriations Act and implementing legislation, subject to the following conditions:

(11) The department shall contract for an annual audit of any pharmacy benefit vendor contracted under the program. At a minimum, the audit shall determine whether state funds are expended in accordance with the terms of the vendor contract and shall include an assessment of compliance with contract terms. The audit shall identify any noncompliance and make recommendations for corrective action by a pharmacy benefit vendor. Specifically, the audit shall examine whether a pharmacy benefit vendor is compliant with contract provisions related to pass-through of pharmaceutical rebates and spread pricing, as

set forth in a contract between the department and such a vendor.

Section 2. Subsection (16) is added to section 499.012, Florida Statutes, to read:

499.012 Permit application requirements.—

(16) A permit for a prescription drug manufacturer or a nonresident prescription drug manufacturer is subject to the requirements of s. 499.026.

Section 3. Section 499.026, Florida Statutes, is created to read:

499.026 Prescription drug price increases.—

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

(a) "Drug price increase" means:

1. A single manufacturer price increase equal to or greater than 15 percent of the price of a drug, or a single manufacturer price increase that results in a cumulative price increase of more than 25 percent in the preceding 12-month period, for a brand-name prescription drug with a wholesale acquisition cost of $50 or more for a 30-day supply; or

2. A single manufacturer price increase equal to or greater than 25 percent of the price of a drug, or a single manufacturer price increase that results in a cumulative price increase of more than 35 percent in the preceding 12-month period, for a generic or biosimilar prescription drug with a wholesale acquisition cost of $25 or more for a 30-day supply.

(b) "Health insurer" means a health insurer issuing major medical coverage through an individual or group policy or a health maintenance organization issuing major medical coverage through an individual or group contract, regulated under chapter 627 or chapter 641.

(c) "Manufacturer" means any person holding a prescription drug manufacturer permit or a nonresident prescription drug manufacturer permit under s. 499.01.

(d) "Wholesale acquisition cost" has the same meaning as defined in 42 U.S.C. s. 1395w-3a.

(2) At least 60 days before the effective date of any drug price increase, a manufacturer must provide notification of the upcoming drug price increase and the amount of the drug price increase to every health insurer that covers the drug. A manufacturer must make the notification using the contact list published by the Office of Insurance Regulation pursuant to ss. 627.42394 and 641.3131. Notification shall be presumed to occur on the date that a manufacturer attempts to communicate with the applicable point of contact published by the Office of Insurance Regulation.

(3) By April 1 of each year, a manufacturer must submit a report to the department and the Office of Insurance Regulation on each drug price increase made during the previous calendar year. At a minimum, the report shall include:

(a) A list of all drugs affected by the drug price

increase and both the dollar amount of each drug price increase and the percentage increase of each drug price increase, relative to the previous price of the drug.

(b) A complete description of the factors contributing to the drug price increase.

Section 4. Section 624.491, Florida Statutes, is created to read:

624.491 Pharmacy audits.—

(1) A health insurer or health maintenance organization providing pharmacy benefits through a major medical individual or group health policy or health maintenance contract, respectively, shall comply with the requirements of this section when the insurer or health maintenance organization or any entity acting on behalf of the insurer or health maintenance organization, including, but not limited to, a pharmacy benefit manager, audits the records of a pharmacy licensed under chapter 465. This section does not apply to audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods; audits of claims paid for by federally funded programs; or concurrent reviews or desk audits that occur within 3 business days of transmission of a claim and where no chargeback or recoupment is demanded. An entity that audits a pharmacy located within a Health Care Fraud Prevention and Enforcement Action

Team (HEAT) Task Force area designated by the United States Department of Health and Human Services and the United States Department of Justice may dispense with the notice requirements of subsection (2) if such pharmacy has been a member of a credentialed provider network for less than 12 months.

(2) An entity conducting a pharmacy audit shall:

(a) Notify a pharmacy at least 7 calendar days before the initial onsite audit for each audit cycle.

(b) Ensure the audit is not initiated during the first 3 calendar days of a month unless the pharmacist consents otherwise.

(c) Limit the scope of the audit period to no more than 24 months after the date a claim is submitted to or adjudicated by the entity.

(d) Ensure that an audit requiring clinical or professional judgment is conducted by or in consultation with a pharmacist.

(e) Permit a pharmacy to use the written and verifiable records of a hospital, physician, or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law.

(f) Ensure that a pharmacy is reimbursed for a claim that was retroactively denied for a clerical error, typographical error, scrivener's error, or computer error if the prescription

was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged, or the error results in actual financial loss to the entity.

(g) Provide a preliminary audit report to a pharmacy within 120 days after the conclusion of the audit.

(h) Permit a pharmacy to produce documentation to address a discrepancy or audit finding within 10 business days after the preliminary audit report is delivered to the pharmacy.

(i) Provide a final audit report to a pharmacy within 6 months after having provided the preliminary audit report.

(j) Calculate any recoupment or penalties based on actual overpayments and not according to the accounting practice of extrapolation.

(3) After receipt of the final audit report issued by a health insurer or health maintenance organization, a pharmacy may appeal the findings of the final audit as to whether a claim payment is due or the amount of a claim payment using the dispute resolution program established by s. 408.7057.

Section 5. Section 627.42394, Florida Statutes, is created to read:

627.42394 Formulary changes resulting from drug price increases.—

(1) A health insurer issuing a major medical individual or group policy shall submit, and update as necessary, contact information for a single point of contact for use by

prescription drug manufacturers to comply with s. 499.026. The office shall maintain and publish a list of such points of contact.

(2) A health insurer issuing a major medical individual or group policy must provide written notice to affected insureds at least 30 days in advance of making a drug formulary change resulting from a drug price increase reported pursuant to s. 499.026.

(3) This section applies to policies entered into or renewed on or after January 1, 2021.

Section 6. Section 627.64741, Florida Statutes, is amended to read:

627.64741 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health insurer and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of the insurer's prescription drug benefit programs that is paid by the insurer to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity

doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than an insured, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health insurer for payment of a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from

limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health insurer and a pharmacy benefit manager must require the pharmacy benefit manager to report annually the following to the insurer:

(a) The aggregate number of prescriptions that were dispensed.

(b) The number and percentage of all prescriptions that were provided through retail pharmacies compared to mail-order pharmacies. This paragraph applies to pharmacies licensed under chapter 465 which dispense drugs to the general public and which were paid by the health insurer or pharmacy benefit manager under the contract.

(c) For retail pharmacies and mail-order pharmacies described in paragraph (b), the general dispensing rate, which is the number and percentage of prescriptions for which a

generic drug was available and dispensed.

(d) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the insurer and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the insurer.

(e) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the insurer for the administration of the insurer's prescription drug benefit programs.

(f) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies. The pharmacy benefit manager shall distinguish between fees paid by covered entities, as defined in 42 U.S.C. s. 256b, and fees paid by pharmacies that are not covered entities.

(g) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the insurer's pharmacy benefit programs.

(h) The type and aggregate amount of any other fees collected by the pharmacy benefit manager in association with claims administered on behalf of the insurer.

(6) Not later than June 30, 2021, and annually thereafter, a health insurer shall submit a report to the office that includes the information provided by its contracted pharmacy

benefit managers under subsection (5). The office shall publish on its website an analysis of the reported information required to be provided to the insurer under subsection (5) in an aggregated amount for each pharmacy benefit manager.

(7) The office may require a health insurer to submit to the office for review any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer. After review of a contract, the office may order the insurer to terminate the contract in accordance with the terms of the contract and applicable law if the office determines that the contract does not comply with the Florida Insurance Code or the pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(8) The commission may adopt rules to administer this section.

(9) ~~(5)~~ This section applies to contracts entered into or renewed on or after July 1, 2020 ~~2018~~.

Section 7. Section 627.6572, Florida Statutes, is amended to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health insurer and a pharmacy benefit manager associated with the pharmacy benefit manager's administration of

the insurer's prescription drug benefit programs that is paid by the insurer to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than an insured, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health insurer for payment of a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at

least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health insurer and a pharmacy benefit manager must require the pharmacy benefit manager to report annually the following to the insurer:

(a) The aggregate number of prescriptions that were dispensed.

(b) The number and percentage of all prescriptions that

were provided through retail pharmacies compared to mail-order pharmacies. This paragraph applies to pharmacies licensed under chapter 465 which dispense drugs to the general public and which were paid by the health insurer or pharmacy benefit manager under the contract.

(c) For retail pharmacies and mail-order pharmacies described in paragraph (b), the general dispensing rate, which is the number and percentage of prescriptions for which a generic drug was available and dispensed.

(d) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the insurer and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the insurer.

(e) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the insurer for the administration of the insurer's prescription drug benefit programs.

(f) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies. The pharmacy benefit manager shall distinguish between fees paid by covered entities, as defined in 42 U.S.C. s. 256b, and fees paid by pharmacies that are not covered entities.

(g) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in

association with the administration of the insurer's pharmacy benefit programs.

(h) The type and aggregate amount of any other fees collected by the pharmacy benefit manager in association with claims administered on behalf of the insurer.

(6) Not later than June 30, 2021, and annually thereafter, a health insurer shall submit a report to the office that includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish on its website an analysis of the reported information required to be provided to the insurer under subsection (5) in an aggregated amount for each pharmacy benefit manager.

(7) The office may require a health insurer to submit to the office for review any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer. After review of a contract, the office may order the insurer to terminate the contract in accordance with the terms of the contract and applicable law if the office determines that the contract does not comply with the Florida Insurance Code or the pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(8) The commission may adopt rules to administer this section.

(9) ~~(5)~~ This section applies to contracts entered into or

renewed on or after July 1, 2020 ~~2018~~.

Section 8. Section 641.3131, Florida Statutes, is created to read:

641.3131 Formulary changes resulting from drug price increases.—

(1) A health maintenance organization issuing a major medical or other comprehensive coverage contract shall submit, and update as necessary, contact information for a single point of contact for use by prescription drug manufacturers to comply with s. 499.026. The office shall maintain and publish a list of such points of contact.

(2) A health maintenance organization issuing a major medical or other comprehensive coverage contract must provide written notice to affected subscribers at least 30 days in advance of making a drug formulary change resulting from a drug price increase reported pursuant to s. 499.026.

(3) This section applies to contracts entered into or renewed on or after January 1, 2021.

Section 9. Section 641.314, Florida Statutes, is amended to read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Administrative fee" means a fee or payment under a contract between a health maintenance organization and a pharmacy benefit manager associated with the pharmacy benefit

manager's administration of the health maintenance organization's prescription drug benefit programs that is paid by the health maintenance organization to the pharmacy benefit manager.

(b) ~~(a)~~ "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(c) ~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(d) "Rebate" means all discounts and other negotiated price concessions based on utilization of a prescription drug and paid by the pharmaceutical manufacturer or other entity, other than a subscriber, to the pharmacy benefit manager after the claim has been adjudicated at the pharmacy.

(e) "Spread pricing" means any amount a pharmacy benefit manager charges or receives from a health maintenance organization for payment of a prescription drug or pharmacy service that is greater than the amount the pharmacy benefit manager paid to the pharmacist or pharmacy that filled the prescription or provided the pharmacy service.

(2) A contract between a health maintenance organization

and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring a subscriber to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5) A contract between a health maintenance organization and a pharmacy benefit manager must require the pharmacy benefit

manager to report annually the following to the insurer:

(a) The aggregate number of prescriptions that were dispensed.

(b) The number and percentage of all prescriptions that were provided through retail pharmacies compared to mail-order pharmacies. This paragraph applies to pharmacies licensed under chapter 465 which dispense drugs to the general public and which were paid by the health maintenance organization or pharmacy benefit manager under the contract.

(c) For retail pharmacies and mail-order pharmacies described in paragraph (b), the general dispensing rate, which is the number and percentage of prescriptions for which a generic drug was available and dispensed.

(d) The aggregate amount of rebates the pharmacy benefit manager received in association with claims administered on behalf of the health maintenance organization and the aggregate amount of such rebates the pharmacy benefit manager received that were not passed through to the health maintenance organization.

(e) The aggregate amount of administrative fees paid to the pharmacy benefit manager by the health maintenance organization for the administration of the health maintenance organization's prescription drug benefit programs.

(f) The types and aggregate amounts of any fees or remittances paid to the pharmacy benefit manager by pharmacies.

The pharmacy benefit manager shall distinguish between fees paid by covered entities, as defined in 42 U.S.C. s. 256b, and fees paid by pharmacies that are not covered entities.

(g) The aggregate amount of revenue generated by the pharmacy benefit manager through the use of spread pricing in association with the administration of the health maintenance organization's pharmacy benefit programs.

(h) The type and aggregate amount of any other fees collected by the pharmacy benefit manager in association with claims administered on behalf of the health maintenance organization.

(6) Not later than June 30, 2021, and annually thereafter, a health maintenance organization shall submit a report to the office that includes the information provided by its contracted pharmacy benefit managers under subsection (5). The office shall publish on its website an analysis of the reported information required to be provided to the health maintenance organization under subsection (5) in an aggregated amount for each pharmacy benefit manager.

(7) The office may require a health maintenance organization to submit to the office for review any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the health maintenance organization. After review of a contract, the office may order the health maintenance

organization to terminate the contract in accordance with the terms of the contract and applicable law if the office determines that the contract does not comply with the Florida Insurance Code or the pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(8) The commission may adopt rules to administer this section.

(9) ~~(5)~~ This section applies to contracts entered into or renewed on or after July 1, 2020 ~~2018~~.

Section 10. (1) The Agency for Health Care Administration shall contract for an independent analysis of pharmacy benefit management practices under the Statewide Medicaid Managed Care program. The analysis shall outline the types of pharmacy benefit pricing contracts in place between managed care plans and contracted pharmacy benefit managers and between managed care plans or pharmacy benefit managers and pharmacies. At a minimum, the analysis shall include:

(a) An examination of the fees paid to each contracted pharmacy benefit manager by each managed care plan.

(b) An examination of the fees charged to pharmacies by each managed care plan or contracted pharmacy benefit manager.

(c) A determination of spread pricing revenues retained by each managed care plan or contracted pharmacy benefit manager.

(2) For purposes of this section, the term "pharmacy benefit manager" means a person or entity doing business in this

state which contracts to administer or manage prescription drug benefits on behalf of a managed care plan.

(3) For purposes of this section, the term "spread pricing" refers to any amount a managed care plan or pharmacy benefit manager received from the Medicaid program for payment of a prescription drug that is greater than that paid to the pharmacist or pharmacy that filled a prescription for that prescription drug.

(4) The agency shall submit the completed analysis to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2020.

Section 11. (1) The Agency for Health Care Administration shall conduct an analysis of managed care plan pharmacy networks under the Statewide Medicaid Managed Care program to ensure that enrollees have sufficient choice of pharmacies within established geographic parameters. The agency must also analyze the composition of each managed care plan pharmacy network to determine the market share of large chain pharmacies, small chain pharmacies, and independent pharmacies, respectively. The analysis shall include:

(a) An examination of the pharmacy contracting patterns by each managed care plan or contracted pharmacy benefit manager.

(b) An examination of any financial relationship between a managed care provider or contracted pharmacy benefit manager and its contracted pharmacies. The analysis shall examine whether a

managed care plan or pharmacy benefit manager establishes a network that favors pharmacies in which the managed care plan or pharmacy benefit manager owns a controlling or substantial financial interest.

(2) For purposes of this section, the term "pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a managed care plan.

(3) The agency shall submit the completed analysis to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2020.

Section 12. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or its application, and to this end the provisions of this act are severable.

Section 13. This act shall take effect upon becoming a law.