

By the Committees on Appropriations; and Banking and Insurance;
and Senator Grimsley

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1 A bill to be entitled
2 An act relating to health care; amending s. 409.967,
3 F.S.; revising contract requirements for Medicaid
4 managed care programs; providing requirements for
5 plans establishing a drug formulary or preferred drug
6 list; requiring the use of a standardized prior
7 authorization form; providing requirements for the
8 form and for the availability and submission of the
9 form; requiring a pharmacy benefits manager to use and
10 accept the form under certain circumstances;
11 establishing a process for providers to override
12 certain treatment restrictions; providing requirements
13 for approval of such overrides; providing an exception
14 to the override protocol in certain circumstances;
15 creating s. 627.42392, F.S.; requiring health insurers
16 to use a standardized prior authorization form;
17 providing requirements for the form and for the
18 availability and submission of the form; requiring a
19 pharmacy benefits manager to use and accept the form
20 under certain circumstances; providing an exemption;
21 creating s. 627.42393, F.S.; establishing a process
22 for providers to override certain treatment
23 restrictions; providing requirements for approval of
24 such overrides; providing an exception to the override
25 protocol in certain circumstances; providing an
26 exemption; amending s. 627.6131, F.S.; prohibiting an
27 insurer from retroactively denying a claim in certain
28 circumstances; amending s. 627.6471, F.S.; requiring
29 insurers to post preferred provider information on a

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30 website; specifying that changes to such a website
31 must be made within a certain time; amending s.
32 627.6515, F.S.; applying provisions relating to prior
33 authorization and override protocols to out-of-state
34 groups; amending s. 641.3155, F.S.; prohibiting a
35 health maintenance organization from retroactively
36 denying a claim in certain circumstances; creating s.
37 641.393, F.S.; requiring the use of a standardized
38 prior authorization form by a health maintenance
39 organization; providing requirements for the
40 availability and submission of the form; requiring a
41 pharmacy benefits manager to use and accept the form
42 under certain circumstances; providing an exemption;
43 creating s. 641.394, F.S.; establishing a process for
44 providers to override certain treatment restrictions;
45 providing requirements for approval of such overrides;
46 providing an exception to the override protocol in
47 certain circumstances; providing an exemption;
48 providing an effective date.

49
50 Be It Enacted by the Legislature of the State of Florida:

51
52 Section 1. Paragraph (c) of subsection (2) of section
53 409.967, Florida Statutes, is amended to read:

54 409.967 Managed care plan accountability.—

55 (2) The agency shall establish such contract requirements
56 as are necessary for the operation of the statewide managed care
57 program. In addition to any other provisions the agency may deem
58 necessary, the contract must require:

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59 (c) Access.—

60 1. The agency shall establish specific standards for the
61 number, type, and regional distribution of providers in managed
62 care plan networks to ensure access to care for both adults and
63 children. Each plan must maintain a regionwide network of
64 providers in sufficient numbers to meet the access standards for
65 specific medical services for all recipients enrolled in the
66 plan. The exclusive use of mail-order pharmacies may not be
67 sufficient to meet network access standards. Consistent with the
68 standards established by the agency, provider networks may
69 include providers located outside the region. A plan may
70 contract with a new hospital facility before the date the
71 hospital becomes operational if the hospital has commenced
72 construction, will be licensed and operational by January 1,
73 2013, and a final order has issued in any civil or
74 administrative challenge. Each plan shall establish and maintain
75 an accurate and complete electronic database of contracted
76 providers, including information about licensure or
77 registration, locations and hours of operation, specialty
78 credentials and other certifications, specific performance
79 indicators, and such other information as the agency deems
80 necessary. The database must be available online to ~~both~~ the
81 agency and the public and have the capability of comparing ~~to~~
82 ~~compare~~ the availability of providers to network adequacy
83 standards and to accept and display feedback from each
84 provider's patients. Each plan shall submit quarterly reports to
85 the agency identifying the number of enrollees assigned to each
86 primary care provider.

87 2. If establishing a prescribed drug formulary or preferred

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88 drug list, a managed care plan shall:

89 a. Provide a broad range of therapeutic options for the
90 treatment of disease states which are consistent with the
91 general needs of an outpatient population. If feasible, the
92 formulary or preferred drug list must include at least two
93 products in a therapeutic class.

94 b. Each managed care plan must Publish the any prescribed
95 drug formulary or preferred drug list on the plan's website in a
96 manner that is accessible to and searchable by enrollees and
97 providers. The plan shall must update the list within 24 hours
98 after making a change. Each plan must ensure that the prior
99 authorization process for prescribed drugs is readily accessible
100 to health care providers, including posting appropriate contact
101 information on its website and providing timely responses to
102 providers.

103 3. For enrollees Medicaid recipients diagnosed with
104 hemophilia who have been prescribed anti-hemophilic-factor
105 replacement products, the agency shall provide for those
106 products and hemophilia overlay services through the agency's
107 hemophilia disease management program.

108 3. Managed care plans, and their fiscal agents or
109 intermediaries, must accept prior authorization requests for any
110 service electronically.

111 4. Notwithstanding any other law, in order to establish
112 uniformity in the submission of prior authorization forms,
113 effective January 1, 2015, a managed care plan shall use a
114 single standardized form for obtaining prior authorization for a
115 medical procedure, course of treatment, or prescription drug
116 benefit. The form may not exceed two pages in length, excluding

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117 any instructions or guiding documentation.

118 a. The managed care plan shall make the form available
119 electronically and online to practitioners. The prescribing
120 provider may electronically submit the completed prior
121 authorization form to the managed care plan.

122 b. If the managed care plan contracts with a pharmacy
123 benefits manager to perform prior authorization services for a
124 medical procedure, course of treatment, or prescription drug
125 benefit, the pharmacy benefits manager must use and accept the
126 standardized prior authorization form.

127 c. A completed prior authorization request submitted by a
128 health care provider using the standardized prior authorization
129 form is deemed approved upon receipt by the managed care plan
130 unless the managed care plan responds otherwise within 3
131 business days.

132 5. If medications for the treatment of a medical condition
133 are restricted for use by a managed care plan by a step-therapy
134 or fail-first protocol, the prescribing provider must have
135 access to a clear and convenient process to request an override
136 of the protocol from the managed care plan.

137 a. The managed care plan shall grant an override within 72
138 hours if the prescribing provider documents that:

139 (I) Based on sound clinical evidence, the preferred
140 treatment required under the step-therapy or fail-first protocol
141 has been ineffective in the treatment of the enrollee's disease
142 or medical condition; or

143 (II) Based on sound clinical evidence or medical and
144 scientific evidence, the preferred treatment required under the
145 step-therapy or fail-first protocol:

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146 (A) Is expected or is likely to be ineffective based on
147 known relevant physical or mental characteristics of the
148 enrollee and known characteristics of the drug regimen; or

149 (B) Will cause or will likely cause an adverse reaction or
150 other physical harm to the enrollee.

151 b. If the prescribing provider allows the enrollee to enter
152 the step-therapy or fail-first protocol recommended by the
153 managed care plan, the duration of the step-therapy or fail-
154 first protocol may not exceed the customary period for use of
155 the medication if the prescribing provider demonstrates such
156 treatment to be clinically ineffective. If the managed care plan
157 can, through sound clinical evidence, demonstrate that the
158 originally prescribed medication is likely to require more than
159 the customary period to provide any relief or amelioration to
160 the enrollee, the step-therapy or fail-first protocol may be
161 extended for an additional period, but no longer than the
162 original customary period for use of the medication.

163 Notwithstanding this provision, a step-therapy or fail-first
164 protocol shall be terminated if the prescribing provider
165 determines that the enrollee is having an adverse reaction or is
166 suffering from other physical harm resulting from the use of the
167 medication.

168 Section 2. Section 627.42392, Florida Statutes, is created
169 to read:

170 627.42392 Prior authorization.—

171 (1) Notwithstanding any other law, in order to establish
172 uniformity in the submission of prior authorization forms,
173 effective January 1, 2015, a health insurer that delivers,
174 issues for delivery, renews, amends, or continues an individual

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175 or group health insurance policy in this state, including a
176 policy issued to a small employer as defined in s. 627.6699,
177 shall use a single standardized form for obtaining prior
178 authorization for a medical procedure, course of treatment, or
179 prescription drug benefit. The form may not exceed two pages in
180 length, excluding any instructions or guiding documentation.

181 (a) The health insurer shall make the form available
182 electronically and online to practitioners. The prescribing
183 provider may submit the completed prior authorization form
184 electronically to the health insurer.

185 (b) If the health insurer contracts with a pharmacy
186 benefits manager to perform prior authorization services for a
187 medical procedure, course of treatment, or prescription drug
188 benefit, the pharmacy benefits manager must use and accept the
189 standardized prior authorization form.

190 (c) A completed prior authorization request submitted by a
191 health care provider using the standardized prior authorization
192 form is deemed approved upon receipt by the health insurer
193 unless the health insurer responds otherwise within 3 business
194 days.

195 (2) This section does not apply to a grandfathered health
196 plan as defined in s. 627.402.

197 Section 3. Section 627.42393, Florida Statutes, is created
198 to read:

199 627.42393 Medication protocol override.—If an individual or
200 group health insurance policy, including a policy issued by a
201 small employer as defined in s. 627.6699, restricts medications
202 for the treatment of a medical condition by a step-therapy or
203 fail-first protocol, the prescribing provider must have access

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204 to a clear and convenient process to request an override of the
205 protocol from the health insurer.

206 (1) The health insurer shall authorize an override of the
207 protocol within 72 hours if the prescribing provider documents
208 that:

209 (a) Based on sound clinical evidence, the preferred
210 treatment required under the step-therapy or fail-first protocol
211 has been ineffective in the treatment of the insured's disease
212 or medical condition; or

213 (b) Based on sound clinical evidence or medical and
214 scientific evidence, the preferred treatment required under the
215 step-therapy or fail-first protocol:

216 1. Is expected or is likely to be ineffective based on
217 known relevant physical or mental characteristics of the insured
218 and known characteristics of the drug regimen; or

219 2. Will cause or is likely to cause an adverse reaction or
220 other physical harm to the insured.

221 (2) If the prescribing provider allows the insured to enter
222 the step-therapy or fail-first protocol recommended by the
223 health insurer, the duration of the step-therapy or fail-first
224 protocol may not exceed the customary period for use of the
225 medication if the prescribing provider demonstrates such
226 treatment to be clinically ineffective. If the health insurer
227 can, through sound clinical evidence, demonstrate that the
228 originally prescribed medication is likely to require more than
229 the customary period for such medication to provide any relief
230 or amelioration to the insured, the step-therapy or fail-first
231 protocol may be extended for an additional period of time, but
232 no longer than the original customary period for the medication.

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233 Notwithstanding this provision, a step-therapy or fail-first
234 protocol shall be terminated if the prescribing provider
235 determines that the insured is having an adverse reaction or is
236 suffering from other physical harm resulting from the use of the
237 medication.

238 (3) This section does not apply to grandfathered health
239 plans, as defined in s. 627.402.

240 Section 4. Subsection (11) of section 627.6131, Florida
241 Statutes, is amended to read:

242 627.6131 Payment of claims.—

243 (11) A health insurer may not retroactively deny a claim
244 because of insured ineligibility:

245 (a) More than 1 year after the date of payment of the
246 claim; or

247 (b) If, under a policy compliant with the federal Patient
248 Protection and Affordable Care Act, as amended by the Health
249 Care and Education Reconciliation Act of 2010, and the
250 regulations adopted pursuant to those acts, the health insurer
251 verified the eligibility of the insured at the time of treatment
252 and provided an authorization number, unless, at the time
253 eligibility was verified, the provider was notified that the
254 insured was delinquent in paying the premium.

255 Section 5. Subsection (2) of section 627.6471, Florida
256 Statutes, is amended to read:

257 627.6471 Contracts for reduced rates of payment;
258 limitations; coinsurance and deductibles.—

259 (2) An ~~Any~~ insurer issuing a policy of health insurance in
260 this state, ~~which insurance~~ includes coverage for the services
261 of a preferred provider shall, ~~must~~ provide each policyholder

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262 and certificateholder with a current list of preferred
263 providers, shall ~~and must~~ make the list available for public
264 inspection during regular business hours at the principal office
265 of the insurer within the state, and shall post a link to the
266 list of preferred providers on the home page of the insurer's
267 website. Changes to the list of preferred providers must be
268 reflected on the insurer's website within 24 hours.

269 Section 6. Paragraph (c) of subsection (2) of section
270 627.6515, Florida Statutes, is amended to read:

271 627.6515 Out-of-state groups.—

272 (2) Except as otherwise provided in this part, this part
273 does not apply to a group health insurance policy issued or
274 delivered outside this state under which a resident of this
275 state is provided coverage if:

276 (c) The policy provides the benefits specified in ss.
277 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579,
278 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675,
279 627.6691, and 627.66911, and complies with the requirements of
280 s. 627.66996.

281 Section 7. Subsection (10) of section 641.3155, Florida
282 Statutes, is amended to read:

283 641.3155 Prompt payment of claims.—

284 (10) A health maintenance organization may not
285 retroactively deny a claim because of subscriber ineligibility:

286 (a) More than 1 year after the date of payment of the
287 claim; or

288 (b) If, under a policy in compliance with the federal
289 Patient Protection and Affordable Care Act, as amended by the
290 Health Care and Education Reconciliation Act of 2010, and the

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291 regulations adopted pursuant to those acts, the health
292 maintenance organization verified the eligibility of the
293 subscriber at the time of treatment and provided an
294 authorization number, unless, at the time eligibility was
295 verified, the provider was notified that the subscriber was
296 delinquent in paying the premium.

297 Section 8. Section 641.393, Florida Statutes, is created to
298 read:

299 641.393 Prior authorization.—Notwithstanding any other law,
300 in order to establish uniformity in the submission of prior
301 authorization forms, effective January 1, 2015, a health
302 maintenance organization shall use a single standardized form
303 for obtaining prior authorization for prescription drug
304 benefits. The form may not exceed two pages in length, excluding
305 any instructions or guiding documentation.

306 (1) A health maintenance organization shall make the form
307 available electronically and online to practitioners. A health
308 care provider may electronically submit the completed form to
309 the health maintenance organization.

310 (2) If a health maintenance organization contracts with a
311 pharmacy benefits manager to perform prior authorization
312 services for prescription drug benefits, the pharmacy benefits
313 manager must use and accept the standardized prior authorization
314 form.

315 (3) A completed prior authorization request submitted by a
316 health care provider using the standardized prior authorization
317 form required under this section is deemed approved upon receipt
318 by the health maintenance organization unless the health
319 maintenance organization responds otherwise within 3 business

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320 days.

321 (4) This section does not apply to grandfathered health
322 plans, as defined in s. 627.402.

323 Section 9. Section 641.394, Florida Statutes, is created to
324 read:

325 641.394 Medication protocol override.—If a health
326 maintenance organization contract restricts medications for the
327 treatment of a medical condition by a step-therapy or fail-first
328 protocol, the prescribing provider shall have access to a clear
329 and convenient process to request an override of the protocol
330 from the health maintenance organization.

331 (1) The health maintenance organization shall grant an
332 override within 72 hours if the prescribing provider documents
333 that:

334 (a) Based on sound clinical evidence, the preferred
335 treatment required under the step-therapy or fail-first protocol
336 has been ineffective in the treatment of the subscriber's
337 disease or medical condition; or

338 (b) Based on sound clinical evidence or medical and
339 scientific evidence, the preferred treatment required under the
340 step-therapy or fail-first protocol:

341 1. Is expected or is likely to be ineffective based on
342 known relevant physical or mental characteristics of the
343 subscriber and known characteristics of the drug regimen; or

344 2. Will cause or is likely to cause an adverse reaction or
345 other physical harm to the subscriber.

346 (2) If the prescribing provider allows the subscriber to
347 enter the step-therapy or fail-first protocol recommended by the
348 health maintenance organization, the duration of the step-

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349 therapy or fail-first protocol may not exceed the customary
350 period for use of the medication if the prescribing provider
351 demonstrates such treatment to be clinically ineffective. If the
352 health maintenance organization can, through sound clinical
353 evidence, demonstrate that the originally prescribed medication
354 is likely to require more than the customary period to provide
355 any relief or amelioration to the subscriber, the step-therapy
356 or fail-first protocol may be extended for an additional period,
357 but no longer than the original customary period for use of the
358 medication. Notwithstanding this provision, a step-therapy or
359 fail-first protocol shall be terminated if the prescribing
360 provider determines that the subscriber is having an adverse
361 reaction or is suffering from other physical harm resulting from
362 the use of the medication.

363 (3) This section does not apply to grandfathered health
364 plans, as defined in s. 627.402.

365 Section 10. This act shall take effect July 1, 2014.