SB 1354 by **Grimsley**; (Compare to CS/H 1001) Health Care

798756	D	S		BI, Diaz de la Portilla	Delete everything after	04/07 10:09 AM
703056	AA	S		BI, Detert	Delete L.198 - 205:	04/08 08:19 AM
155310	A	S	WD	BI, Detert	Delete L.159 - 167:	04/07 10:24 AM
383102	A	S	WD	BI, Detert	Delete L.253 - 261:	04/07 10:24 AM

CS/SB 1000 by **CM, Braynon**; (Similar to CS/H 0411) Labor Pools

854214	A	S		BI, Clemens	Delete L.38:	04/07 02:44 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Simmons, Chair
Senator Clemens, Vice Chair

MEETING DATE: Tuesday, April 8, 2014
TIME: 3:00 —5:00 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Simmons, Chair; Senator Clemens, Vice Chair; Senators Benacquisto, Detert, Diaz de la Portilla, Hays, Lee, Margolis, Montford, Negron, Richter, and Ring

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1354** Grimsley (Compare CS/H 1001)	Health Care; Revising contract requirements for managed care programs; prohibiting retroactive denial of claims in certain circumstances; establishing a process for providers to override certain treatment restrictions; requiring insurers to post preferred provider information on a website, etc. HP 03/25/2014 Favorable BI 04/01/2014 Temporarily Postponed BI 04/08/2014	
2	**CS/SB 1000** Commerce and Tourism / Braynon (Similar CS/H 411)	Labor Pools; Revising methods by which a labor pool is required to compensate day laborers; requiring a labor pool to provide certain notice before a day laborer's first pay period; specifying requirements for a labor pool that selects to compensate a day laborer by payroll debit card; authorizing a labor pool to deliver a wage statement electronically upon request by the day laborer, etc. CM 03/31/2014 Fav/CS BI 04/08/2014	

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL: SB 1354

INTRODUCER: Senator Grimsley

SUBJECT: Health Care

DATE: April 7, 2014 REVISED: ___ ___ ___ ___

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.	Johnson	Knudson	BI	**Pre-meeting**

I. Summary:

SB 1354 revises the managed care accountability contract provisions for the statewide Managed Medical Assistance (MMA) contracts under the Statewide Medicaid Managed Care Program (SMMC). It requires plans that establish prescribed drug formularies to offer a range of therapeutic options with at least two products in each therapeutic class. Managed care plans under MMA must also cover any drugs newly approved by the United States Food and Drug Administration (FDA) until the Medicaid Pharmaceutical and Therapeutics Committee can review the drug for inclusion in the formulary. If a drug on a Medicaid managed care plan's formulary is removed or changed, the plan must allow an enrollee to continue that drug if the provider submits a written request that demonstrates the drug is medically necessary and the enrollee meets clinical criteria to receive the drug.

The bill requires MMA managed care plans, health insurers, managed care organizations, and health maintenance organizations and any pharmacy benefit manager under contract with these insurers, to use a standardized prior authorization form adopted by the Financial Services Commission (commission). The form is to be adopted by January 15, 2015. All prior authorization requests for medical procedures, course of treatment, and prescriptions must be submitted using the same standardized two-page form. A form submitted by a provider is deemed approved unless the issuer responds otherwise within two business days.

Managed care plans, health maintenance organizations and insurers, including Medicaid plans, that restrict medications by a step-therapy or fail-first protocol are required to have a clear and convenient process to request an override of the protocol. An override must be granted within 24 hours for certain situations where the prescribing provider believes the drug under the step-therapy or fail-first protocol has been or likely will be ineffective or will cause or will likely cause an adverse reaction. If the provider allows the patient to enter the step-therapy or fail-first protocol, the duration of the process may not exceed an amount deemed appropriate by the provider and if the provider deems it ineffective, the patient is entitled to receive the recommended course of treatment without override approval.

For insurance contracts for reduced rates of payment under s. 627.6471, F.S., the bill requires insurers to post a link on their website's homepage to a list of preferred providers. Changes to that list must be updated within 24 hours.

The bill would have a negative, significant indeterminate impact on the State Employees' Health Trust Fund. The fiscal impact on Medicaid is indeterminate at this time; it is likely to be significant.

II. Present Situation:

Medicaid

Medicaid is a joint federal and state funded program that provides healthcare for low income Floridians. The program is administered by the Agency for Healthcare Administration (AHCA). Over 3.3 million Floridians are currently enrolled in Medicaid and the program's estimated expenditures for Fiscal Year 2012-2013 were approximately $21 billion.[1] The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Statewide Medicaid Managed Care

In 2011, the Legislature passed HB 7107[2] creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The SMMC program requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits for the delivery of primary and acute care under the Managed Medical Assistance component (MMA).[3] Final approval by the federal government of the 1915(b) Medicaid waiver for the MMA component of SMMC program was received on June 14, 2013.[4] The AHCA recently begun the waiver renewal process for the period of July 1, 2014, through June 30, 2017.[5]

The AHCA is in the process of implementing the MMA component of SMMC program through which most Medicaid recipients will receive their health care services. The first regional roll-out begins May 1, 2014, and the last is scheduled for August 1, 2014. During the implementation, existing Medicaid managed care plans will continue until the region they serve transitions to the MMA program.

The AHCA's contracts with the current Medicaid managed care plans allow the plans to develop their own preferred drug list (PDL) and prior authorization processes, including step-therapy and fail-first criteria, which must be approved by the AHCA.[6] Current managed care plans also have

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[1] Agency for Health Care Administration, *Florida Medicaid*, http://ahca.myflorida.com/Medicaid/index.shtml (last visited Nov. 26, 2013).
[2] *See* ch. 2011-134, L.O.F.
[3] Health and Human Services Committee, Fla. House of Representatives, *PCS HHSC 11-01 Staff Analysis*, p.25, (Mar. 25, 2011).
[4] *See* Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/06-14-2013_Appproval_Letter.pdf (last visited Nov. 21, 2013).
[5] Agency for Health Care Administration, *Managed Medical Assistance - Federal Authorities*, http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA (last visited Nov. 21, 2013).
[6] Agency for Health Care Administration, *2014 Agency Bill Analysis - SB 1354* (Feb. 21, 2014), p. 2, on file with the Senate Health Policy Committee.

the ability to deny claims for enrollees who were later determined to be ineligible at the time of service despite having issued a prior authorization.[7]

For the first year of the MMA transition, the AHCA is requiring the MMA plans to use the Medicaid PDL. After the first year, the MMA plans may develop a plan-specific PDL for the Agency's consideration, if requested by the Agency at that time.[8]

Patient Protection and Affordable Care Act

In March 2010, the Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[9] Among its changes to the United States health care system are requirements for health insurers to make coverage available to all individuals and employers. Qualifying coverage may be obtained through an employer, the federal or state exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard. Florida did not establish its own state exchange under PPACA.

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for qualified coverage purchased through the exchange. Premium credits are set on a sliding scale based on a percentage of the federal poverty level and reduce the out of pocket costs incurred by individuals and families.[10]

Federal regulations for PPACA also govern an enrollee's coverage bought through the exchanges and for non-grandfathered plans.[11] If an enrollee's coverage bought with advance premium tax credit for a qualified health plan (QHP)[12] is terminated for non-payment of premium, for example, the regulations provide the enrollee a 3-month grace period before cancellation of coverage.[13] During the grace period, the insurer must pay claims for services rendered in the first month but may pend claims for the second and third months.[14] If coverage is ultimately terminated, the termination date is the last day of the first month of the grace period and the insurer may not recoup any claims paid during the first month of the grace period.

The federal regulations do not affect those enrollees who are not enrolled in an exchange plan or are not receiving a subsidy. The grace period for these individuals remains at the length required under s. 627.608, F.S., which varies by the length of the premium payment interval. Cancellation of coverage is effective the first day of the grace period if payment is not received.

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[7] *Id.*
[8] *Id.*
[9] P.L. 111-148. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.
[10] Centers for Medicare and Medicaid Services, *Health Insurance Marketplace - Will I Qualify for Lower Costs on Monthly Premiums?* *https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/* (last visited Mar. 22, 2014).
[11] Certain plans received "grandfather status" under PPACA. A grandfathered health plan is a plan that existed on March 23, 2010, and had at least one person continuously covered for one year. Some consumer protections elements do not apply to grandfathered plans.
[12] A "qualified health plan" is an insurance plan certified by the applicable Health Insurance Marketplace, provides the essential health benefits, established limits on cost sharing and meets other requirements. *See* *https://www.healthcare.gov/glossary/qualified-health-plan/* for more information on qualified health plans.
[13] 45 CFR 156.270 and 45 CFR 430.
[14] 45 CFR 156.270.

Step-Therapy or Fail-First Protocols

Step-therapy or fail-first protocols for prescription medication coverage require a member to try a certain drug, usually a generic alternative, before receiving coverage for another drug, usually a branded, more expensive product. Utilization management pharmacy benefit programs were first introduced in the 1980s and became popular with the implementation of tiered co-payment formularies.[15] Step therapy is usually applied to a certain drug class with the goal of encouraging generic drug use and decreasing costs without compromising the quality of care.[16] Many step-therapy programs incorporate edits into the system to recognize members through prior claims who have previously received a first step drug so claims for a second step drug are not rejected, but automatically covered.

One outcome of step-therapy programs; however, has been that enrollees who have had a claim rejected do not have a later claim for a later medication in that same class.[17] The process for notifying the patient and prescriber of a step-therapy claim rejection and the resubmission of an alternate medication varies by insurer.

Prior Authorization for Health Care Services

Insurers may require prior authorization for certain services as a cost control and quality measure. Florida has waived requirements for prior authorization for certain services and requires direct access within specified guidelines for certain services such as dermatology.[18] State law currently does not provide a specific standard form or review timeline for a prior authorization process for health care services covered by an insurer, managed care plan or health maintenance organization. Prior authorization is never required for any emergency procedure. Each insurer has established its own prior authorization process and form based on the situation and the type of authorization, such service, course of treatment, or prescription. The state has mandated a standard health claims processing form be adopted by the commission and used under s. 627.647, F.S., by all hospitals and a separate form by all physicians, dentists and pharmacists.

The National Council for Prescription Drug Programs, a non-profit, stakeholder group, proposed new uniform electronic prior authorization (ePA) standards in July 2013. The new ePA electronic prescribing standard provides for a two-way, real-time exchange of information for insurers and prescribers.[19]

Federal regulations for the Medicaid and Children's Health Insurance Program both require that managed care plans have written policies and procedures for initial and continuing authorization decisions that ensure timely access to care for enrollees with serious and chronic conditions.[20]

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[15] Patrick P. Gleason, PharmD, FCCP, BCPS, *Assessing Step-Therapy Programs: A Step in the Right Direction*, www.amcp.org, Journal of Managed Care Pharmacy, p. 274, http://www.amcp.org/data/jmcp/273-75.pdf (April 2007, Vol. 13, No. 3) (last visited Mar. 23, 2014).
[16] *Id*.
[17] Gleason, *supra*, note 15 at 273-274.
[18] *See* s. 641.31(33), F.S. Provides direct access to dermatologists for up to 5 visits and testing annually.
[19] Press Release, National Council for Prescription Drug Programs, *New Uniform Electronic Prior Authorization Standard Supplants the Need for Legislation (*March 6, 2014) on file in the Senate Health Policy Committee.
[20] *See* 42 CFR 438.210 (Medicaid) and 42 CFR 495 (Children's Health Insurance Program).

Both regulations establish that prior authorization decisions may not exceed 14 calendar days following receipt of the request, with a possible extension up to 14 additional calendar days if requested by the enrollee or provider or there is a need for additional information.

For Medicaid, an expedited authorization process is also provided that does not exceed 3 working days with the ability to extend up to 14 calendar days upon enrollee request, or if the managed care plan justifies a need for additional information and that the extension is in the enrollee's benefit.[21] Regulations governing the Children's Health Insurance Program provide a deferral to any existing state law on the authorization of health services, if applicable.[22]

Preferred Provider Listings

Individuals enrolled in plans licensed under s. 627.6471, F.S., known as a "Preferred Provider Organization" or PPO plans, incur higher out of pocket costs if the provider is out of network. These out of pocket costs can be significant to the consumer. For example, in the standard PPO Option Group Plan for state employees, the enrollee would pay a small copayment for a physician office visit with an in-network provider after the enrollee had met any calendar year deductible, but would incur 40 percent of the costs with an out of network provider for the same service.[23] The state group PPO provider, Florida Blue, provides a list of providers on its website.

Federal regulations require QHPs on the exchanges to make its provider directory available online and to potential enrollees in hard copy, upon request.[24] Further guidance from the federal Centers for Medicare and Medicaid Services (CMS) via a draft guidance letter indicates that QHPs must provide a link from the federal marketplace to their network directly where the consumer can view an up-to-date provider directory. The CMS requires the directory to include the location, contact information, specialty, medical group, any institutional affiliations for each provider and whether the provider is accepting new patients.[25]

State Group Health Insurance Program

Under the authority of s. 110.123, Florida Statutes, the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group insurance program providing employee benefits such as health, life, dental, and vision insurance products under a cafeteria plan consistent with Section 125, Internal Revenue Code.

As part of the State Group Insurance Program, the DMS contracts with third party administrators for the self-insured State Employees' PPO Plan and four self-insured HMO plans; contracts directly with two fully-insured HMOs; and contracts with a pharmacy benefits manager (PBM) for the State Employees' Prescription Drug Plan. The State Employees' Prescription Drug Plan

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[21] 42 CFR 438.210.
[22] 42 CFR 457.495(d)(2).
[23] Florida Blue, 2014 Benefits, State Employees' PPO Plan, on file with the Senate Health Policy Committee.
[24] 45 CFR 156.235(b).
[25] Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *Draft 2015 Letter to Issuers in the Federally-Facilitated Marketplace* (Feb. 4, 2014), pg. 47, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf (last visited Mar. 23, 2014).

covers all PPO and HMO plan members (excluding Medicare Advantage Plans offered exclusively to eligible retirees).

III. Effect of Proposed Changes:

Medicaid Managed Care Program (Section 1)

Section 1 revises s. 409.967, F.S., and requires a Medicaid managed care plan that establishes a prescribed drug formulary or a PDL must provide a broad range of therapeutic options for the treatment of disease consistent with the outpatient population. At least two products in each therapeutic class must be included, if feasible. The AHCA indicates it will be required to amend its existing Medicaid contracts to ensure compliance.[26]

The managed care plan must also provide coverage through prior authorization for any new drug approved by the Food and Drug Administration until the Medicaid Pharmaceutical and Therapeutics Committee (committee) can review the drug for inclusion on the formulary. The timing of the committee meeting must comply with s. 409.91195, F.S., which requires at least quarterly meetings.

If a managed care plan removes a drug from a plan's formulary, the bill requires the managed care plan to continue the enrollee's receipt of the drug if the provider submits a written request that the drug is medically necessary and meets clinical criteria.

Prior Authorization Requirements (Sections 1, 3, and 7)

Health plans, health insurers, and health maintenance organizations, including those participating under SMMC, will be required, upon adoption by the commission after January 1, 2015, to use a new, standardized prior authorization form for obtaining approval for a medical procedure, course of treatment, or prescription drug benefit. A pharmacy benefit manager under contract with a managed care plan must also comply with this requirement. The form must be available electronically from the commission and on the managed care plan's website. A prior authorization request completed on the standardized form will be deemed approved upon receipt by the managed care plan unless the managed care plan responds within two business days.

SB 1354 adds the prior authorization provisions to existing s. 409.967, F.S., and creates two new sections, ss. 627.6465 and 641.393, F.S.

Step-Therapies or Fail-First Protocols (Sections 1, 4, and 8)

If medications for the treatment of a medical condition are restricted for use through a step-therapy or fail-first protocol by a SMMC plan, an insurer, or a health maintenance organization, the prescribing provider must have access to a clear and convenient process to request an override. An override must be granted within 24 hours if the prescribing provider believes that:

- Based on sound clinical evidence, the preferred treatment required under step-therapy or fail-first protocol has been ineffective in the patient's disease or medical condition; or

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[26] *See supra,* note 6.

- Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:
  - Is expected or likely to be ineffective based on known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen; or
  - Will cause or will likely cause an adverse reaction or other physical harm to the patient.

If the patient does enroll in the step-therapy or fail-first protocol, the duration of the process may not exceed a period deemed appropriate by the provider. If the provider finds the treatment ineffective, the bill provides that the patient is entitled to receive the recommended course of treatment without requiring the provider to seek an override of the step-therapy or fail-first protocol.

To add the provisions on step-therapy and fail-first protocol for the SMMC program, s. 409.967, F.S., is amended and two new sections, ss. 627.6466 and 641.394, F.S., are created to apply the provisions to insurers and health maintenance organizations.

Payment of Claims (Sections 2 and 6)

Health insurers under s. 627.6131, F.S., and health maintenance organizations under s. 641.3155, F.S., are prohibited from retroactively denying claims because of insured ineligibility if the insurer:

- Verified the eligibility of the insured at time of treatment and provided an authorization number; or
- Provided the insured with an identification card as provided in s. 627.642(3), F.S., which at the time of service identifies the insured as eligible to receive services.

Reduced Rate Insurance Contracts - Provider Listings (Section 5)

For contracts for reduced rates of payment, s. 627.6471, F.S., is revised and insurers must post a link on their website's homepage to a list of preferred providers. Changes to the provider list must be updated within 24 hours.

The bill has an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Under Article VII, section 18(a), Fla. Const., a mandate includes a general bill requiring counties or municipalities to spend funds. Counties and municipalities are not bound by a general law to spend funds or take an action unless the Legislature has determined that such a law fulfills an important state interest and one of the specific exceptions specified in the state constitution applies. The implementation of this bill may require some counties and municipalities to spend funds or take actions regarding health insurance programs for their employees because of the step-therapy provisions, which may increase utilization of more costly brand medications. One of those mandate exceptions is that the law applies to all persons similarly situated, including the state and local governments.

This bill may apply to all similarly situated persons, including the state and local governments. Therefore, a finding by the Legislature that the bill fulfills as important state interest would remove the bill form the purview of the constitutional provision.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Consumers may see more timely authorization for certain services, course of treatment, or prescriptions ordered by their health care providers. Health care providers and their patients may also experience less of a burden receiving a brand drug under the step-therapy or fail-first guidelines because patients are provided a statutory mechanism for bypassing step one, if certain indicators are present.

The provisions of the bill would not apply to self-insured plans, which are preempted from state mandates by the federal Employee Retirement Income Security Act (ERISA). In 2011, 58.5 percent of workers with private health coverage were enrolled in self-insured plans.[27]

Individuals and employers with private insurance coverage may see an increase in premium costs related to the step-therapy or fail-first process and the prior authorization provisions. These measures are used by insurers today as utilization management and cost control tools and might impact some current policies and procedures of insurers.

Insurers under s. 627.6471, F.S., have an additional administrative impact complying with posting a list of preferred providers to their website and reflecting changes within 24 hours.

C. Government Sector Impact:

The fiscal impact to Medicaid is indeterminate at this time. The bill may increase the cost of providing a prescribed drug to Medicaid enrollees because it makes changes to the step-therapy and fail-first requirements for plan enrollees and requires that any drug prescribed or recommended by a provider be approved and reimbursed. The AHCA

[27] https://www.shrm.org/hrdisciplines/benefits/Articles/Pages/Self-Insured-Health-Plans.aspx (last visited April 4, 2014).

would also need to modify existing Medicaid managed care contracts to incorporate the revised step-therapy and formulary requirements.

This bill would have a negative, significant, indeterminate impact on the State Employees' Health Insurance Trust Fund. The Division of State Group Insurance of the Department of Management Services provided the following comments regarding the impact of the bill:[28]

Step-therapy (Fail-first Protocols): Although quantity limits are required for certain medications, the State Employees Prescription Drug Plan covers all federal legend drugs except as excluded in the Plan document. Step-therapy (fail-first protocols) and prior authorization for PPO Plan members are prohibited pursuant to footnote 1 of s. 110.12315, F.S. Although step-therapy is not prohibited for the HMO plans, it is not currently used.

Retroactive Termination of Coverage: SB 1354 would require the State Employees' PPO Plan and HMO plans to pay medical and prescription drug claims for patients whose insurance coverage has been terminated retroactively (as allowed under PPACA). Prohibiting federally allowable retro-denial of claims because of ineligibility could result in the health plan paying for services and could significantly increase the cost of health care coverage for the plan.

Prior Authorization Forms: The bill's requirement for health plans and pharmacy benefit plans to use a standardized authorization form when requesting a health plan's prior approval of a service or prescription could impede and decrease efficiency for the prior authorization process for both the doctor and the health plan. For example, the two-page form submitted may be incomplete or not have the necessary information to make an informed decision within two business days. It is unclear if there is a mechanism to request additional information to make a decision outside of the two-day window, nor does there appear to be a process for unfavorable decisions or for cases needing same-day decisions (e.g., emergency situations). The two-day turnaround is shorter than timelines set by the National Committee on Quality Assurance (NCQA).

Further, drugs and services subject to prior authorization vary greatly among health plans; it would not be possible to design a single prior authorization form that meets every medical and/or prescription drug need or use. The rules for this form are not required to be adopted on or before January 1, 2015, but this is the same day the insurance companies, HMOs, and PBMs must start using the form.

Member Identification Cards: As written, this bill appears to allow anyone holding a member ID card from a health plan to have health insurance coverage. The member ID card is intended to be a convenience for both participants and medical providers, not the final determination of eligibility. For plans that only use the policyholder's name on the card, the potential to share the card with other, noncovered persons could exist.

[28] Department of Management Services, SB 1354 Analysis (Mar. 25, 2014) on file with Senate Committee on Banking and Insurance).

Legitimately terminated participants could use the card to gain access to services. If enacted, this bill would require the plan to pay for services for ineligible persons, with the potential to greatly increase plan costs.

Online Provider Directory: Regarding the 24-hour timeframe, the bill does not address situations where the provider may end its network status retroactively.

VI. Technical Deficiencies:

On lines 299, 305, and 308 the term, “insured’s” or “insured” are used. For purposes of ch. 641, F.S., relating to health maintenance organization, the term subscriber(s) or member(s) is used.

Section 5 of the bill requires insurers to update changes in the list of preferred providers on their website within 24 hours. It is unclear whether the online list will need to be updated within 24 hours of any change in contracts with preferred providers, or may be updated by the end of the next day.

VII. Related Issues:

The bill provides a deadline of on or before January 1, 2015 for the adoption of rules and the adoption of the prior authorization form. It is unclear whether this deadline would provide adequate time for implementation of such prior authorization forms for plans that are on a calendar year.

The bill provides that the “adoption of the prior authorization form by the Financial Services Commission does not constitute a determination that affects the substantial interests of a party under chapter 120.” It is unclear what recourse would be available for affected parties.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 627.6131, 627.6471, and 641.3155.

This bill creates the following sections of the Florida Statutes: 627.6465, 627.6466, 641.393, and 641.394.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
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The Committee on Banking and Insurance (Diaz de la Portilla) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Paragraph (c) of subsection (2) of section
6 409.967, Florida Statutes, is amended to read:
7 409.967 Managed care plan accountability.—
8 (2) The agency shall establish such contract requirements
9 as are necessary for the operation of the statewide managed care
10 program. In addition to any other provisions the agency may deem

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11 necessary, the contract must require:
12 (c) *Access.*—
13 1. The agency shall establish specific standards for the
14 number, type, and regional distribution of providers in managed
15 care plan networks to ensure access to care for both adults and
16 children. Each plan must maintain a regionwide network of
17 providers in sufficient numbers to meet the access standards for
18 specific medical services for all recipients enrolled in the
19 plan. The exclusive use of mail-order pharmacies may not be
20 sufficient to meet network access standards. Consistent with the
21 standards established by the agency, provider networks may
22 include providers located outside the region. A plan may
23 contract with a new hospital facility before the date the
24 hospital becomes operational if the hospital has commenced
25 construction, will be licensed and operational by January 1,
26 2013, and a final order has issued in any civil or
27 administrative challenge. Each plan shall establish and maintain
28 an accurate and complete electronic database of contracted
29 providers, including information about licensure or
30 registration, locations and hours of operation, specialty
31 credentials and other certifications, specific performance
32 indicators, and such other information as the agency deems
33 necessary. The database must be available online to ~~both~~ the
34 agency and the public and have the capability of comparing ~~to~~
35 ~~compare~~ the availability of providers to network adequacy
36 standards and to accept and display feedback from each
37 provider’s patients. Each plan shall submit quarterly reports to
38 the agency identifying the number of enrollees assigned to each
39 primary care provider.

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40 2. If establishing a prescribed drug formulary or preferred
41 drug list, a managed care plan shall:
42 a. Provide a broad range of therapeutic options for the
43 treatment of disease states which are consistent with the
44 general needs of an outpatient population. If feasible, the
45 formulary or preferred drug list must include at least two
46 products in a therapeutic class.
47 b. Include coverage through prior authorization for each
48 new drug approved by the United States Food and Drug
49 Administration until the Medicaid Pharmaceutical and
50 Therapeutics Committee reviews such drug for inclusion on the
51 formulary. The timing of the formulary review must comply with
52 s. 409.91195.
53 c. ~~Each managed care plan must~~ Publish the ~~any~~ prescribed
54 drug formulary or preferred drug list on the plan’s website in a
55 manner that is accessible to and searchable by enrollees and
56 providers. The plan shall ~~must~~ update the list within 24 hours
57 after making a change. ~~Each plan must ensure that the prior~~
58 ~~authorization process for prescribed drugs is readily accessible~~
59 ~~to health care providers, including posting appropriate contact~~
60 ~~information on its website and providing timely responses to~~
61 ~~providers.~~
62 d. If a prescription drug on a plan’s formulary is removed
63 or changed, permit an enrollee who was receiving the drug to
64 continue to receive the drug if the prescribing provider submits
65 a written request that demonstrates that the drug is medically
66 necessary and that the enrollee meets clinical criteria to
67 receive the drug.
68 3. For enrollees ~~Medicaid recipients~~ diagnosed with

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69 hemophilia who have been prescribed anti-hemophilic-factor
70 replacement products, the agency shall provide for those
71 products and hemophilia overlay services through the agency's
72 hemophilia disease management program.
73 4. Notwithstanding any other law, in order to establish
74 uniformity in the submission of prior authorization forms, after
75 January 1, 2015, a managed care plan shall use only the
76 standardized prior authorization form adopted by the Financial
77 Services Commission pursuant to s. 627.42392 for obtaining prior
78 authorization for a medical procedure, a course of treatment, or
79 prescription drug benefits.
80 a. If a managed care plan contracts with a pharmacy
81 benefits manager to perform prior authorization services for
82 prescription drug benefits, the pharmacy benefits manager shall
83 use and accept the standardized prior authorization form. The
84 Office of Insurance Regulation and the managed care plan shall
85 make the form electronically available on their respective
86 websites.
87 b.~~3.~~ Managed care plans, and their fiscal agents or
88 intermediaries, must accept prior authorization requests for any
89 service electronically.
90 c. A completed prior authorization request submitted by a
91 health care provider using the standardized prior authorization
92 form required under this subparagraph is deemed approved upon
93 receipt by the managed care plan unless the managed care plan
94 responds otherwise within 2 business days.
95 5. If medications for the treatment of a medical condition
96 are restricted for use by a managed care plan by a step-therapy
97 or fail-first protocol, the prescribing provider must have

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98 access to a clear and convenient process to request an override
99 of the protocol from the managed care plan.
100 a. The managed care plan shall grant an override within 24
101 hours if the prescribing provider believes that:
102 (I) Based on sound clinical evidence, the preferred
103 treatment required under the step-therapy or fail-first protocol
104 has been ineffective in the treatment of the enrollee's disease
105 or medical condition; or
106 (II) Based on sound clinical evidence or medical and
107 scientific evidence, the preferred treatment required under the
108 step-therapy or fail-first protocol:
109 (A) Is expected or likely to be ineffective based on known
110 relevant physical or mental characteristics of the enrollee and
111 known characteristics of the drug regimen; or
112 (B) Will cause or will likely cause an adverse reaction or
113 other physical harm to the enrollee.
114 b. If the prescribing provider allows the enrollee to enter
115 the step-therapy or fail-first protocol recommended by the
116 managed care plan, the duration of the step-therapy or fail-
117 first protocol may not exceed a period deemed appropriate by the
118 provider. If the prescribing provider deems the treatment
119 clinically ineffective, the enrollee is entitled to receive the
120 recommended course of therapy without requiring the prescribing
121 provider to seek approval for an override of the step-therapy or
122 fail-first protocol.
123 Section 2. Section 627.42392, Florida Statutes, is created
124 to read:
125 627.42392 Prior authorization.—Notwithstanding any other
126 law, in order to establish uniformity in the submission of prior

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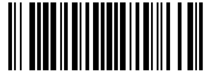
127 authorization forms, after January 1, 2015, a health insurer
128 that delivers, issues for delivery, renews, amends, or continues
129 an individual or group health insurance policy in this state,
130 including a policy issued to a small employer as defined in s.
131 627.6699, shall use only the standardized prior authorization
132 form adopted by the commission for obtaining prior authorization
133 for a medical procedure, course of treatment, or prescription
134 drug benefits.
135 (1) If a health insurer contracts with a pharmacy benefits
136 manager to perform prior authorization services for prescription
137 drug benefits, the pharmacy benefits manager shall use and
138 accept the standardized prior authorization form. The commission
139 shall adopt rules prescribing the prior authorization form on or
140 before January 1, 2015, and the office may consult with health
141 insurers or other organizations as necessary in the development
142 of the form. The form may not exceed two pages in length,
143 excluding any instructions or guiding documentation. The office
144 and the health insurer shall make the form electronically
145 available on their respective websites. The prescribing provider
146 may electronically submit the completed form to the health
147 insurer. The adoption of the form by the commission does not
148 constitute a determination that affects the substantial
149 interests of a party under chapter 120.
150 (2) A completed prior authorization request submitted by a
151 prescribing provider using the standardized prior authorization
152 form required under subsection (1) is deemed approved upon
153 receipt by the health insurer unless the health insurer responds
154 otherwise within 2 business days.
155 (3) This section does not apply to a grandfathered health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156 plan as defined in s. 627.402.
157 Section 3. Section 627.42393, Florida Statutes, is created
158 to read:
159 627.42393 Medication protocol override.—If an individual or
160 group health insurance policy, including a policy issued by a
161 small employer, as defined in s. 627.6699, restricts medications
162 for the treatment of a medical condition by a step-therapy or
163 fail-first protocol, the prescribing provider must have access
164 to a clear and convenient process to request an override of the
165 protocol from the health insurer.
166 (1) The health insurer shall authorize an override of the
167 protocol within 24 hours if the prescribing provider believes
168 that:
169 (a) Based on sound clinical evidence, the preferred
170 treatment required under the step-therapy or fail-first protocol
171 has been ineffective in the treatment of the insured's disease
172 or medical condition; or
173 (b) Based on sound clinical evidence or medical and
174 scientific evidence, the preferred treatment required under the
175 step-therapy or fail-first protocol:
176 1. Is expected or likely to be ineffective based on known
177 relevant physical or mental characteristics of the insured and
178 known characteristics of the drug regimen; or
179 2. Will cause or is likely to cause an adverse reaction or
180 other physical harm to the insured.
181 (2) If the prescribing provider allows the insured to enter
182 the step-therapy or fail-first protocol recommended by the
183 health insurer, the duration of the step-therapy or fail-first
184 protocol may not exceed a period deemed appropriate by the

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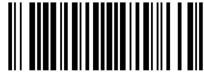
185 provider. If the prescribing provider deems the treatment
186 clinically ineffective, the insured is entitled to receive the
187 recommended course of therapy without requiring the prescribing
188 provider to seek approval for an override of the step-therapy or
189 fail-first protocol.
190 (3) This section does not apply to grandfathered health
191 plans, as defined in s. 627.402.
192 Section 4. Subsection (11) of section 627.6131, Florida
193 Statutes, is amended to read:
194 627.6131 Payment of claims.—
195 (11) A health insurer may not retroactively deny a claim
196 because of insured ineligibility:
197 (a) More than 1 year after the date of payment of the
198 claim;~~.~~
199 (b) If the health insurer verified the eligibility of the
200 insured at the time of treatment and provided an authorization
201 number; or
202 (c) If the health insurer provided the insured with an
203 identification card as provided under s. 627.642(3), which at
204 the time of service identified the insured as eligible to
205 receive services.
206 Section 5. Subsection (2) of section 627.6471, Florida
207 Statutes, is amended to read:
208 627.6471 Contracts for reduced rates of payment;
209 limitations; coinsurance and deductibles.—
210 (2) An ~~Any~~ insurer issuing a policy of health insurance in
211 this state~~,~~ which ~~insurance~~ includes coverage for the services
212 of a preferred provider~~,~~ shall ~~must~~ provide each policyholder
213 and certificateholder with a current list of preferred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214 providers, shall ~~and must~~ make the list available for public
215 inspection during regular business hours at the principal office
216 of the insurer within the state, and shall post a link to the
217 list of preferred providers on the home page of the insurer’s
218 website. Changes to the list of preferred providers must be
219 reflected on the insurer’s website within 24 hours.
220 Section 6. Paragraph (c) of subsection (2) of section
221 627.6515, Florida Statutes, is amended to read:
222 627.6515 Out-of-state groups.—
223 (2) Except as otherwise provided in this part, this part
224 does not apply to a group health insurance policy issued or
225 delivered outside this state under which a resident of this
226 state is provided coverage if:
227 (c) The policy provides the benefits specified in ss.
228 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579,
229 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675,
230 627.6691, and 627.66911, and complies with the requirements of
231 s. 627.66996.
232 Section 7. Subsection (10) of section 641.3155, Florida
233 Statutes, is amended to read:
234 641.3155 Prompt payment of claims.—
235 (10) A health maintenance organization may not
236 retroactively deny a claim because of subscriber ineligibility:
237 (a) More than 1 year after the date of payment of the
238 claim; ~~.~~
239 (b) If the health maintenance organization verified the
240 eligibility of the subscriber at the time of treatment and
241 provided an authorization number; or
242 (c) If the health maintenance organization provided the

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243 subscriber with an identification card as provided under s.
244 627.642(3), which at the time of service identified the
245 subscriber as eligible to receive services.
246 Section 8. Section 641.393, Florida Statutes, is created to
247 read:
248 641.393 Prior authorization.—Notwithstanding any other law,
249 in order to establish uniformity in the submission of prior
250 authorization forms, after January 1, 2015, a health maintenance
251 organization shall use only the standardized prior authorization
252 form adopted by the Financial Services Commission pursuant to s.
253 627.42392 for obtaining prior authorization for a medical
254 procedure, a course of treatment, or prescription drug benefits.
255 (1) If a health maintenance organization contracts with a
256 pharmacy benefits manager to perform prior authorization
257 services for prescription drug benefits, the pharmacy benefits
258 manager must use and accept the standardized prior authorization
259 form. The office and health maintenance organization shall make
260 the form electronically available on their respective websites.
261 (2) A health care provider may submit the completed form
262 electronically to the health maintenance organization.
263 (3) A completed prior authorization request submitted by a
264 health care provider using the standardized prior authorization
265 form required under this section is deemed approved upon receipt
266 by the health maintenance organization unless the health
267 maintenance organization responds otherwise within 2 business
268 days.
269 (4) This section does not apply to grandfathered health
270 plans, as defined in s. 627.402.
271 Section 9. Section 641.394, Florida Statutes, is created to

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272 read:
273 641.394 Medication protocol override.—If a health
274 maintenance organization contract restricts medications for the
275 treatment of a medical condition by a step-therapy or fail-first
276 protocol, the prescribing provider shall have access to a clear
277 and convenient process to request an override of the protocol
278 from the health maintenance organization.
279 (1) The health maintenance organization shall grant an
280 override within 24 hours if the prescribing provider believes
281 that:
282 (a) Based on sound clinical evidence, the preferred
283 treatment required under the step-therapy or fail-first protocol
284 has been ineffective in the treatment of the subscriber's
285 disease or medical condition; or
286 (b) Based on sound clinical evidence or medical and
287 scientific evidence, the preferred treatment required under the
288 step-therapy or fail-first protocol:
289 1. Is expected or likely to be ineffective based on known
290 relevant physical or mental characteristics of the subscriber
291 and known characteristics of the drug regimen; or
292 2. Will cause or is likely to cause an adverse reaction or
293 other physical harm to the subscriber.
294 (2) If the prescribing provider allows the subscriber to
295 enter the step-therapy or fail-first protocol recommended by the
296 health maintenance organization, the duration of the step-
297 therapy or fail-first protocol may not exceed a period deemed
298 appropriate by the provider. If the prescribing provider deems
299 the treatment clinically ineffective, the subscriber is entitled
300 to receive the recommended course of therapy without requiring

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301 the prescribing provider to seek approval for an override of the
302 step-therapy or fail-first protocol.
303 (3) This section does not apply to grandfathered health
304 plans, as defined in s. 627.402.
305 Section 10. This act shall take effect July 1, 2014.
306
307 ================= T I T L E A M E N D M E N T ================
308 And the title is amended as follows:
309 Delete everything before the enacting clause
310 and insert:
311 A bill to be entitled
312 An act relating to health care; amending s. 409.967,
313 F.S.; revising contract requirements for Medicaid
314 managed care programs; providing requirements for
315 plans establishing a drug formulary or preferred drug
316 list; requiring the plan to authorize an enrollee to
317 continue a drug that is removed or changed, under
318 certain circumstances; requiring the use of a
319 standardized prior authorization form; requiring a
320 pharmacy benefits manage to use and accept the form
321 under certain circumstances; providing requirements
322 for the form and for the availability and submission
323 of the form; establishing a process for providers to
324 override certain treatment restrictions; providing
325 requirements for approval of such overrides; providing
326 an exception to the override protocol in certain
327 circumstances; creating s. 627.42392, F.S.; requiring
328 health insurers to use a standardized prior
329 authorization form; requiring a pharmacy benefits

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330 manage to use and accept the form under certain
331 circumstances; providing requirements for the form and
332 for the availability and submission of the form;
333 providing an exemption; creating s. 627.42393, F.S.;
334 establishing a process for providers to override
335 certain treatment restrictions; providing requirements
336 for approval of such overrides; providing an exception
337 to the override protocol in certain circumstances;
338 providing an exemption; amending s. 627.6131, F.S.;
339 prohibiting an insurer from retroactively denying a
340 claim in certain circumstances; amending s. 627.6471,
341 F.S.; requiring insurers to post preferred provider
342 information on a website; amending s. 627.6515, F.S.;
343 applying provisions relating to prior authorization
344 and override protocols to out-of-state groups;
345 amending s. 641.3155, F.S.; prohibiting a health
346 maintenance organization from retroactively denying a
347 claim in certain circumstances; creating s. 641.393,
348 F.S.; requiring the use of a standardized prior
349 authorization form by a health maintenance
350 organization; requiring a pharmacy benefits manager to
351 use and accept the form under certain circumstances;
352 providing requirements for the availability and
353 submission of the form; providing an exemption;
354 creating s. 641.394, F.S.; establishing a process for
355 providers to override certain treatment restrictions;
356 providing requirements for approval of such overrides;
357 providing an exception to the override protocol in
358 certain circumstances; providing an exemption;

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359 providing an effective date.

703056

LEGISLATIVE ACTION

Senate	.	House
	.	
	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Detert) recommended the following:

1 **Senate Amendment to Amendment (798756)**
2
3 Delete lines 198 - 205
4 and insert:
5 claim; or
6 (b) If, under a policy compliant with the federal Patient
7 Protection and Affordable Care Act, as amended by the Health
8 Care and Education Reconciliation Act of 2010, and regulations
9 adopted pursuant to those acts, the health insurer verified the
10 eligibility of the insured at the time of treatment and provided

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11 an authorization number unless, at the time eligibility was
12 verified, the provider was notified that the insured was
13 delinquent in paying the premium.
14
15 Delete lines 238 - 245
16 and insert:
17 claim; or
18 (b) If, under a policy compliant with the federal Patient
19 Protection and Affordable Care Act, as amended by the Health
20 Care and Education Reconciliation Act of 2010, and regulations
21 adopted pursuant to those acts, the health maintenance
22 organization verified the eligibility of the subscriber at the
23 time of treatment and provided an authorization number unless,
24 at the time eligibility was verified, the provider was notified
25 that the subscriber was delinquent in paying the premium.

155310

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/07/2014	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Detert) recommended the following:

1 **Senate Amendment**

2

3 Delete lines 159 - 167

4 and insert:

5 (b) A health insurer that has verified the eligibility of
6 an insured at the time of treatment and has provided an
7 authorization number may not retroactively deny a claim because
8 of insured ineligibility under a federal Patient Protection and
9 Affordable Care Act compliant policy unless at the time
10 eligibility was verified by the insurer, the provider was

155310

11 notified that the insured was delinquent in paying the premium.

383102

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/07/2014	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Detert) recommended the following:

1 **Senate Amendment**

2

3 Delete lines 253 - 261

4 and insert:

5 (b) A health maintenance organization that has verified the

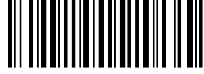
6 eligibility of a subscriber at the time of treatment and has

7 provided an authorization number may not retroactively deny a

8 claim because of subscriber ineligibility under a federal

9 Patient Protection and Affordable Care Act compliant contract

10 unless at the time eligibility was verified by the health


383102

11 maintenance organization the provider was notified that the
12 subscriber was delinquent in paying the premium.

By Senator Grimsley

21-01230-14 20141354__

1 A bill to be entitled
2 An act relating to health care; amending s. 409.967,
3 F.S.; revising contract requirements for managed care
4 programs; providing requirements for plans
5 establishing a drug formulary or list; requiring the
6 use of a standardized form; establishing a process for
7 providers to override certain treatment restrictions;
8 amending s. 627.6131, F.S.; prohibiting retroactive
9 denial of claims in certain circumstances; creating s.
10 627.6465, F.S.; requiring the use of a standardized
11 form; requiring the commission to adopt rules to
12 prescribe the form; providing requirements for the
13 form; providing requirements for the availability and
14 submission of the form; creating s. 627.6466, F.S.;
15 establishing a process for providers to override
16 certain treatment restrictions; providing requirements
17 for approval of such overrides; providing an exception
18 to the override process in certain circumstances;
19 amending s. 627.6471, F.S.; requiring insurers to post
20 preferred provider information on a website; amending
21 s. 641.3155, F.S.; prohibiting retroactive denial of
22 claims in certain circumstances; creating s. 641.393,
23 F.S.; requiring the use of a standardized form;
24 providing requirements for the availability and
25 submission of the form; creating s. 641.394, F.S.;
26 establishing a process for providers to override
27 certain treatment restrictions; providing requirements
28 for approval of such overrides; providing an exception
29 to the override process in certain circumstances;

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30 providing an effective date.
31
32 Be It Enacted by the Legislature of the State of Florida:
33
34 Section 1. Paragraph (c) of subsection (2) of section
35 409.967, Florida Statutes, is amended to read:
36 409.967 Managed care plan accountability.—
37 (2) The agency shall establish such contract requirements
38 as are necessary for the operation of the statewide managed care
39 program. In addition to any other provisions the agency may deem
40 necessary, the contract must require:
41 (c) *Access.*—
42 1. The agency shall establish specific standards for the
43 number, type, and regional distribution of providers in managed
44 care plan networks to ensure access to care for both adults and
45 children. Each plan must maintain a regionwide network of
46 providers in sufficient numbers to meet the access standards for
47 specific medical services for all recipients enrolled in the
48 plan. The exclusive use of mail-order pharmacies may not be
49 sufficient to meet network access standards. Consistent with the
50 standards established by the agency, provider networks may
51 include providers located outside the region. A plan may
52 contract with a new hospital facility before the date the
53 hospital becomes operational if the hospital has commenced
54 construction, will be licensed and operational by January 1,
55 2013, and a final order has issued in any civil or
56 administrative challenge. Each plan shall establish and maintain
57 an accurate and complete electronic database of contracted
58 providers, including information about licensure or

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registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to ~~both~~ the agency and the public and have the capability of comparing ~~to compare~~ the availability of providers to network adequacy standards and to accept and display feedback from each provider’s patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2.a. If establishing a prescribed drug formulary or preferred drug list, a managed care plan shall:

(I) Provide a broad range of therapeutic options for the treatment of disease states consistent with the general needs of an outpatient population. If feasible, the formulary or preferred drug list must include at least two products in a therapeutic class.

(II) Include coverage through prior authorization for each new drug approved by the United States Food and Drug Administration until the Medicaid Pharmaceutical and Therapeutics Committee reviews such drug for inclusion on the formulary. The timing of the formulary review must comply with s. 409.91195.

b. Each managed care plan shall ~~must~~ publish any prescribed drug formulary or preferred drug list on the plan’s website in a manner that is accessible to and searchable by enrollees and providers. The plan shall ~~must~~ update the list within 24 hours after making a change. ~~Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible~~

~~to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.~~

c. If a prescription drug on a plan’s formulary is removed or changed, the managed care plan shall permit an enrollee who was receiving the drug to continue to receive the drug if the provider submits a written request that demonstrates that the drug is medically necessary and the enrollee meets clinical criteria to receive the drug.

d. For enrollees ~~Medicaid recipients~~ diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency’s hemophilia disease management program.

3.a. Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, after January 1, 2015, a managed care plan shall use only the standardized prior authorization form adopted by the Financial Services Commission pursuant to s. 627.6465 for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefits. If a managed care plan contracts with a pharmacy benefits manager to perform prior authorization services for prescription drug benefits, the pharmacy benefits manager shall use and accept the standardized prior authorization form. The form shall be made available electronically by the commission and on the managed care plan’s website. The prescribing provider may submit the completed form electronically to the managed care plan.

b. A completed prior authorization request submitted by a

117 health care provider using the standardized prior authorization
118 form required under sub-subparagraph a. is deemed approved upon
119 receipt by the managed care plan unless the managed care plan
120 responds within 2 business days.
121 c. Managed care plans, and their fiscal agents or
122 intermediaries, must accept prior authorization requests for any
123 service electronically.
124 4. If medications for the treatment of a medical condition
125 are restricted for use by a managed care plan by a step-therapy
126 or fail-first protocol, the prescribing provider must have
127 access to a clear and convenient process to request an override
128 of the protocol from the managed care plan. The managed care
129 plan shall grant an override of the protocol within 24 hours if:
130 a. The prescribing provider believes that, based on sound
131 clinical evidence, the preferred treatment required under the
132 step-therapy or fail-first protocol has been ineffective in the
133 treatment of the enrollee's disease or medical condition; or
134 b. The prescribing provider believes that, based on sound
135 clinical evidence or medical and scientific evidence, the
136 preferred treatment required under the step-therapy or fail-
137 first protocol:
138 (I) Is expected or likely to be ineffective based on known
139 relevant physical or mental characteristics of the enrollee and
140 known characteristics of the drug regimen; or
141 (II) Will cause or will likely cause an adverse reaction or
142 other physical harm to the enrollee.
143
144 If the prescribing provider allows the enrollee to enter the
145 step-therapy or fail-first protocol recommended by the managed

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146 care plan, the duration of the step-therapy or fail-first
147 protocol may not exceed a period deemed appropriate by the
148 provider. If the prescribing provider deems the treatment
149 clinically ineffective, the enrollee is entitled to receive the
150 recommended course of therapy without requiring the prescribing
151 provider to seek approval for an override of the step-therapy or
152 fail-first protocol.
153 Section 2. Subsection (11) of section 627.6131, Florida
154 Statutes, is amended to read:
155 627.6131 Payment of claims.—
156 (11)(a) A health insurer may not retroactively deny a claim
157 because of insured ineligibility more than 1 year after the date
158 of payment of the claim.
159 (b) A health insurer that has verified the eligibility of
160 an insured at the time of treatment and has provided an
161 authorization number may not retroactively deny a claim because
162 of insured ineligibility.
163 (c) A health insurer that has provided the insured with an
164 identification card as provided in s. 627.642(3) which at the
165 time of service identifies the insured as eligible to receive
166 services may not retroactively deny a claim because of insured
167 ineligibility.
168 Section 3. Section 627.6465, Florida Statutes, is created
169 to read:
170 627.6465 Prior authorization.—
171 (1) Notwithstanding any other law, in order to establish
172 uniformity in the submission of prior authorization forms, after
173 January 1, 2015, a health insurance issuer, managed care plan as
174 defined in s. 409.901, or health maintenance organization as

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175 defined in s. 641.19 shall use only the standardized prior
176 authorization form adopted by the Financial Services Commission
177 for obtaining prior authorization for a medical procedure,
178 course of treatment, or prescription drug benefits. If a health
179 insurance issuer, managed care plan, or health maintenance
180 organization contracts with a pharmacy benefits manager to
181 perform prior authorization services for prescription drug
182 benefits, the pharmacy benefits manager shall use and accept the
183 standardized prior authorization form. The commission shall
184 adopt rules prescribing the prior authorization form on or
185 before January 1, 2015, and may consult with health insurance
186 issuers or other organizations as necessary in the development
187 of the form. The form may not exceed two pages in length,
188 excluding any instructions or guiding documentation. The form
189 shall be made available electronically by the commission and on
190 the website of the health insurance issuer, managed care plan,
191 or health maintenance organization. The prescribing provider may
192 submit the completed form electronically to the health benefit
193 plan. The adoption of the form by the commission does not
194 constitute a determination that affects the substantial
195 interests of a party under chapter 120.
196 (2) A completed prior authorization request submitted by a
197 prescribing provider using the standardized prior authorization
198 form required under subsection (1) is deemed approved upon
199 receipt by the health insurance issuer unless the health
200 insurance issuer responds within 2 business days.
201 Section 4. Section 627.6466, Florida Statutes, is created
202 to read:
203 627.6466 Fail-first protocols.—If medications for the

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204 treatment of a medical condition are restricted for use by an
205 insurer by a step-therapy or fail-first protocol, the
206 prescribing provider shall have access to a clear and convenient
207 process to request an override of the protocol from the health
208 benefit plan or health insurance issuer. The plan or issuer
209 shall grant an override of the protocol within 24 hours if:
210 (1) The prescribing provider believes that, based on sound
211 clinical evidence, the preferred treatment required under the
212 step-therapy or fail-first protocol has been ineffective in the
213 treatment of the insured's disease or medical condition; or
214 (2) The prescribing provider believes that, based on sound
215 clinical evidence or medical and scientific evidence, the
216 preferred treatment required under the step-therapy or fail-
217 first protocol:
218 (a) Is expected or likely to be ineffective based on known
219 relevant physical or mental characteristics of the insured and
220 known characteristics of the drug regimen; or
221 (b) Will cause or is likely to cause an adverse reaction or
222 other physical harm to the insured.
223
224 If the prescribing provider allows the patient to enter the
225 step-therapy or fail-first protocol recommended by the insurer,
226 the duration of the step-therapy or fail-first protocol may not
227 exceed a period deemed appropriate by the provider. If the
228 prescribing provider deems the treatment clinically ineffective,
229 the patient is entitled to receive the recommended course of
230 therapy without requiring the prescribing provider to seek
231 approval for an override of the step-therapy or fail-first
232 protocol.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

233 Section 5. Subsection (2) of section 627.6471, Florida
234 Statutes, is amended to read:
235 627.6471 Contracts for reduced rates of payment;
236 limitations; coinsurance and deductibles.—
237 (2) An ~~Any~~ insurer issuing a policy of health insurance in
238 this state~~,~~ which ~~insurance~~ includes coverage for the services
239 of a preferred provider~~,~~ shall ~~must~~ provide each policyholder
240 and certificateholder with a current list of preferred
241 providers, shall ~~and must~~ make the list available for public
242 inspection during regular business hours at the principal office
243 of the insurer within the state, and shall post a link to the
244 list of preferred providers on the home page of the insurer's
245 website. Changes to the list of preferred providers must be
246 reflected on the insurer's website within 24 hours.
247 Section 6. Subsection (10) of section 641.3155, Florida
248 Statutes, is amended to read:
249 641.3155 Prompt payment of claims.—
250 (10)(a) A health maintenance organization may not
251 retroactively deny a claim because of subscriber ineligibility
252 more than 1 year after the date of payment of the claim.
253 (b) A health maintenance organization that has verified the
254 eligibility of a subscriber at the time of treatment and has
255 provided an authorization number may not retroactively deny a
256 claim because of subscriber ineligibility.
257 (c) A health maintenance organization that has provided the
258 subscriber with an identification card as provided in s.
259 627.642(3) which at the time of service identifies the
260 subscriber as eligible to receive services may not retroactively
261 deny a claim because of subscriber ineligibility.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

262 Section 7. Section 641.393, Florida Statutes, is created to
263 read:
264 641.393 Prior authorization.—
265 (1) Notwithstanding any other law, in order to establish
266 uniformity in the submission of prior authorization forms, after
267 January 1, 2015, a health maintenance organization shall use
268 only the standardized prior authorization form adopted by the
269 Financial Services Commission pursuant to s. 627.6465 for
270 obtaining prior authorization for a medical procedure, course of
271 treatment, or prescription drug benefits. If a health
272 maintenance organization contracts with a pharmacy benefits
273 manager to perform prior authorization services for prescription
274 drug benefits, the pharmacy benefits manager must use and accept
275 the standardized prior authorization form. The form shall be
276 made available electronically by the commission and on the
277 website of the health insurance issuer, managed care plan, or
278 health maintenance organization. The health care provider may
279 submit the completed form electronically to the health benefit
280 plan.
281 (2) A completed prior authorization request submitted by a
282 health care provider using the standardized prior authorization
283 form required under subsection (1) is deemed approved upon
284 receipt by the health maintenance organization unless the health
285 maintenance organization responds within 2 business days.
286 Section 8. Section 641.394, Florida Statutes, is created to
287 read:
288 641.394 Fail-first protocols.—If medications for the
289 treatment of a medical condition are restricted for use by a
290 health maintenance organization by a step-therapy or fail-first

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291 protocol, the prescribing provider shall have access to a clear
292 and convenient process to request an override of the protocol
293 from the health maintenance organization. The health maintenance
294 organization shall grant an override of the protocol within 24
295 hours if:
296 (1) The prescribing provider believes that, based on sound
297 clinical evidence, the preferred treatment required under the
298 step-therapy or fail-first protocol has been ineffective in the
299 treatment of the insured's disease or medical condition; or
300 (2) The prescribing provider believes that, based on sound
301 clinical evidence or medical and scientific evidence, the
302 preferred treatment required under the step-therapy or fail-
303 first protocol:
304 (a) Is expected or likely to be ineffective based on known
305 relevant physical or mental characteristics of the insured and
306 known characteristics of the drug regimen; or
307 (b) Will cause or is likely to cause an adverse reaction or
308 other physical harm to the insured.
309
310 If the prescribing provider allows the patient to enter the
311 step-therapy or fail-first protocol recommended by the health
312 maintenance organization, the duration of the step-therapy or
313 fail-first protocol may not exceed a period deemed appropriate
314 by the provider. If the prescribing provider deems the treatment
315 clinically ineffective, the patient is entitled to receive the
316 recommended course of therapy without requiring the prescribing
317 provider to seek approval for an override of the step-therapy or
318 fail-first protocol.
319 Section 9. This act shall take effect July 1, 2014.

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The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL: CS/SB 1000

INTRODUCER: Commerce and Tourism Committee and Senator Braynon

SUBJECT: Labor Pools

DATE: April 7, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Siples	Hrdlicka	CM	**Fav/CS**
2.	Knudson	Knudson	BI	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1000 allows labor pools to offer additional methods to compensate day laborers for services performed. These new methods include electronic fund transfer to the financial institution designated by the day laborer and payroll debit card, which does not charge a fee for withdrawal of its contents. The labor pool must notify the day laborer of the payment method it intends to use and provide the day laborer the option to be paid by another authorized method. The bill authorizes the labor pool to provide a wage statement electronically upon written request of the day laborer.

II. Present Situation:

The Labor Pool Act

Part II of ch. 448, F.S., also known as the Labor Pool Act,[1] was enacted in 1995 to protect the health, safety, and well-being of day laborers throughout Florida. The act also outlines uniform standards of conduct and practice for labor pools. A labor pool is defined as a business entity that operates a labor hall[2] by one or more of the following methods:

- Contracting with third-party users to supply day laborers to them on a temporary basis;
- Hiring, employing, recruiting, or contracting with workers to fulfill these contracts for temporary labor; or

[1] Chapter 95-332, L.O.F.

[2] Section 448.22(3), F.S., defines a "labor hall" as a central location maintained by a labor pool where day laborers assemble and are dispatched to work for a third-party user.

- Fulfilling any contracts for day labor in accordance with the act, even if the entity also conducts other business.[3]

The act limits the methods by which a day laborer may be paid cash or commonly accepted negotiable instruments that are payable in cash, on demand at a financial institution, and without discount.[4] The act prohibits a labor pool from charging a day laborer for directly or indirectly cashing the worker's check.[5]

Payment for Labor

Chapter 532, F.S., governs the issuance of payment for labor in this state. Under the law, payment for labor may be made by order, check, draft, note, memorandum, payroll debit card, or other acknowledgment of indebtedness issued in payment of wages and payable in cash, on demand, without discount, at an established place of business. It further requires the name and address of such business to appear on the payroll debit card.

Payroll Debit Cards

More companies are using payroll debit cards to compensate their employees for their labor. The number of companies using this method to pay employees is expected to reach 10.8 million within the next 5 years.[6] However, some consumer advocates warn that employees paid by these debit cards may be subjected to fees for transactions, such as withdrawals, balance inquiries, and point of sale purchases.[7] Some of the payroll debit card issuers may also charge its cardholders overdraft and inactivity fees.

However, payroll debit cards may offer an individual who has limited or no access to a financial institution a safe and convenient way to receive her or his wages.[8] The Consumers Union and the National Consumer Law Center has issued a Model State Payroll Card Law, which they feel offer a mutually beneficial payroll program for both employers and employees.[9] The model law includes such provisions as:

- Requirement of a voluntary written consent to receive payment by payroll card;
- The availability of wages without a fee at least once each pay period;

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[3] Section 448.22(1), F.S. The act also specifically excludes certain businesses from its provisions: businesses registered as farm labor contractors; employee leasing companies; temporary help services that solely provide white collar employees, secretarial employees, clerical employees, or skilled laborers; labor union hiring halls; or labor bureau or employment offices operated by a business entity for the sole purpose of employing an individual for its own use. *See* s. 448.23, F.S.

[4] Section 448.24(2)(a), F.S.

[5] Section 448.24(1)(c), F.S.

[6] Sandra Pedicini, *More Companies Opt to Give Workers Payroll Debit Cards*, ORLANDO SENTINEL, Oct. 6, 2013, *available at* http://articles.orlandosentinel.com/2013-10-06/business/os-cfb-cover-payroll-cards-20131006_1_debit-cards-payroll-cards-such-cards (last visited Mar. 26, 2014).

[7] *Id. See also* Jessica Silver-Greenberg and Stephanie Clifford, *Paid via Card, Workers Feel Sting of Fees*, NEW YORK TIMES, June 30, 2013, *available at* http://www.nytimes.com/2013/07/01/business/as-pay-cards-replace-paychecks-bank-fees-hurt-workers.html?pagewanted=all&_r=1& (last visited Mar. 26, 2014).

[8] Press Release, American Payroll Association and National Consumer Law Center, *American Payroll Association, National Consumer Law Center Agree Payroll Cards Make Sense for Unbanked If Proper Guidelines Followed*, July 31, 2013, *available at* https://www.nclc.org/images/pdf/pr-reports/pr_effective-payroll-card2013.pdf (last visited Mar. 26, 2014).

[9] *Id. See also* Consumers Union and National Consumer Law Center, *Model State Payroll Card Law* (Feb. 2011), *available at* http://consumersunion.org/wp-content/uploads/2013/02/Payroll-Model-Law.pdf (last visited Mar. 26, 2014).

- A prohibition of certain other fees, such as fees for point of sale transactions, declined transactions, balance inquiry, and account activity;
- A provision of a periodic statement and transaction history;
- Requirement to disclose available payment options to the employee;
- A provisions that allows an employee to change the wage payment method;
- A prohibition on linking the payroll card to any form of credit account or fee-based overdraft program; and
- A requirement that payroll card funds be placed in an FDIC or NCUA insured account.

III. Effect of Proposed Changes:

Section 1 amends s. 448.24, F.S., to permit labor pools to pay a day laborer by payroll debit card or electronic funds transfer, in addition to the current options of payment by cash or a negotiable instrument that is payable in cash.

The bill provides that before the first pay period, a day laborer must be advised of the method of payment the labor pool uses, and the payment options available. A day laborer must be given the opportunity to opt out of receiving his or her wages by payroll debit card or electronic fund transfer.

If a labor pool decides to pay wages by payroll debit card, the labor pool must:
- Offer to provide wages by electronic fund transfer; and
- Provide a list of businesses in close proximity of the labor pool that will allow the day laborer to withdraw the contents of the payroll debit card without a fee.

The bill authorizes a labor pool to provide an itemized statement of a day laborer's wages, along with any deductions made by the labor pool, in an electronic format upon written request by the day laborer.

Section 2 provides an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

An employee being paid by this method may be able to avoid or reduce check-cashing fees or other fees incurred for accessing wages, if the employee does not have access or has limited access to traditional banking services.

An employer may save costs associated with the issuance of a paper check.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not define “close proximity.” Although the term is used in several statutes to delineate distance,[10] only two provisions provide a definition.[11] Section 627.736(7)(a), F.S., uses the term “area of the closest proximity.” This term was reviewed by the Fifth District Court of Appeal, which found this term to mean the same or closest metropolitan area.[12]

VIII. Statutes Affected:

This bill substantially amends section 448.24 of the Florida Statutes.

IX. Additional Information:

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

CS by Commerce and Tourism Committee on March 31, 2014:

- Provides that the labor pool must inform the day laborer of the method of payment it intends to use and the options the day laborer has to elect another payment method.
- Provides that the day laborer must be allowed to decline to be paid by payroll debit card or electronic fund transfer.

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[10] *For example*, ss. 39.6012, 119.071, 163.3175, 310.101, 310.141, 341.031, 380.0552, 403.7211, 561.01, and 856.022, F.S.

[11] Sections 119.071(3)(c)5.b. and 561.01(18), F.S., include in the definition of “entertainment or resort complex” lodging, dining, and recreational facilities adjacent to, contiguous to, or in close proximity to a theme park. Close proximity is defined to include an area within a 5-mile radius of the theme park complex.

[12] *Progressive American Insurance Co. v. Belcher*, 496 So.2d 841, 843 (Fla. 5th DCA 1986).

- Provides that a labor pool that compensates a day laborer by payroll debit card must offer to pay the day laborer by electronic fund transfer and provide the day laborer with a list of businesses, in close proximity to the labor pool, that will allow the day laborer to withdraw the contents of the payroll debit card without charging a fee.
- Provides that a labor pool can electronically supply the day laborer's wage statement upon written request of the day laborer.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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LEGISLATIVE ACTION

Senate	.	House
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The Committee on Banking and Insurance (Clemens) recommended the following:

1 **Senate Amendment**
2
3 Delete line 38
4 and insert:
5 2. Before selecting payroll debit card, provide the day
6 laborer with a list, including the

By the Committee on Commerce and Tourism; and Senator Braynon

1 A bill to be entitled
2 An act relating to labor pools; amending s. 448.24,
3 F.S.; revising methods by which a labor pool is
4 required to compensate day laborers; requiring a labor
5 pool to provide certain notice before a day laborer's
6 first pay period; specifying requirements for a labor
7 pool that selects to compensate a day laborer by
8 payroll debit card; authorizing a labor pool to
9 deliver a wage statement electronically upon request
10 by the day laborer; providing an effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Subsection (2) of section 448.24, Florida
15 Statutes, is amended to read:
16 448.24 Duties and rights.—
17 (2) A labor pool shall:
18 (a) Select one of the following methods of payment to
19 compensate a day laborer ~~laborers~~ for work performed: ~~in the~~
20 ~~form of~~
21 1. Cash.~~, or~~
22 2. Commonly accepted negotiable instruments that are
23 payable in cash, on demand at a financial institution, and
24 without discount.
25 3. Payroll debit card.
26 4. Electronic fund transfer, which must be made to a
27 financial institution designated by the day laborer.
28 (b) Before a day laborer's first pay period, provide notice
29 to the day laborer of the method of payment that the labor pool

30 intends to use for payroll and the day laborer's options to
31 elect a different method of payment, and authorize the day
32 laborer to elect not to be paid by payroll debit card or
33 electronic fund transfer.
34 (c) If selecting to compensate a day laborer by payroll
35 debit card:
36 1. Offer the day laborer the option to elect payment by
37 electronic fund transfer; and
38 2. Provide the day laborer with a list, including the
39 address, of each business that is in close proximity to the
40 labor pool and that does not charge a fee to withdraw the
41 contents of the payroll debit card.
42 (d)~~(b)~~ Compensate day laborers at or above the minimum
43 wage, in conformance with ~~the provision of~~ s. 448.01. ~~In no~~
44 ~~event shall any~~ Deductions, other than those authorized
45 ~~permitted~~ by federal or state law, may not bring the worker's
46 pay below minimum wage for the hours worked.
47 (e)~~(c)~~ Comply with all requirements of chapter 440.
48 (f)~~(d)~~ Insure any motor vehicle owned or operated by the
49 labor hall and used for the transportation of workers pursuant
50 to Florida Statutes.
51 (g)~~(e)~~ At the time of each payment of wages, furnish each
52 worker a written itemized statement showing in detail each
53 deduction made from such wages. A labor pool may deliver this
54 statement electronically upon written request of the day
55 laborer.
56 (h)~~(f)~~ Provide each worker with an annual earnings summary
57 within a reasonable period of time after the end of the
58 preceding calendar year, but no later than February 1.

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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.