A bill to be entitled

An act relating to health care; amending s. 409.967, F.S.; revising contract requirements for managed care programs; providing requirements for plans establishing a drug formulary or list; establishing a process for providers to override certain treatment restrictions; repealing s. 627.608, F.S., relating to health insurer grace periods; amending s. 627.6131, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 627.6466, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override process in certain circumstances; amending s. 627.6471, F.S.; requiring insurers to post provider information on a website; amending s. 641.31, F.S.; deleting provisions relating to health maintenance contract grace periods; amending s. 641.3155, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 641.394, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override process in certain circumstances; amending ss. 383.145, 641.2018, and 641.3922, F.S.; conforming cross-references; providing an effective

date.

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

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

409.967 Managed care plan accountability.—

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

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or

administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or 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 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. Whenever feasible, the formulary or preferred drug list shall include at least two products in a therapeutic class.

(II) Include coverage through prior authorization for each drug newly 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 shall ~~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. Managed care plans, and their fiscal agents or intermediaries, shall ~~must~~ accept prior authorization requests for any service electronically.

4. When medications for the treatment of a medical condition are restricted for use by a managed care plan by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request

an override of the protocol from the managed care plan. The managed care plan shall grant an override of the protocol within 24 hours under the following circumstances:

a. The prescribing provider recommends, based on sound clinical evidence, that the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the enrollee's disease or medical condition; or

b. Based on sound clinical evidence or medical and scientific evidence:

(I) The prescribing provider believes that 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

(II) The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the enrollee.

If the prescribing provider allows the enrollee to enter the step-therapy or fail-first protocol recommended by the managed care plan, the duration of the step-therapy or fail-first protocol may not exceed a period deemed appropriate by the provider. If the prescribing provider deems the treatment clinically ineffective, the enrollee is entitled to receive the recommended course of therapy without requiring the prescribing

provider to seek approval for an override of the step-therapy or fail-first protocol.

Section 2. Section 627.608, Florida Statutes, is repealed.

Section 3. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

(11) A health insurer may not retroactively deny a claim because of insured ineligibility more than 1 year after the date of payment of the claim. A health insurer that has verified the eligibility of an insured at the time of treatment and has provided an authorization number may not retroactively deny a claim because of insured ineligibility.

Section 4. Section 627.6466, Florida Statutes, is created to read:

627.6466 Fail-first protocols.—When medications for the treatment of a medical condition are restricted for use by an insurer by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the health benefit plan or health insurance issuer. The plan or issuer shall grant an override of the protocol within 24 hours under the following circumstances:

(a) The prescribing provider recommends, based on sound clinical evidence, that the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence:

1. The prescribing provider believes that 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 insured and known characteristics of the drug regimen; or

2. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol will cause or is likely to cause an adverse reaction or other physical harm to the insured.

If the prescribing provider allows the patient to enter the step-therapy or fail-first protocol recommended by the insurer, the duration of the step-therapy or fail-first protocol may not exceed a period deemed appropriate by the provider. If the prescribing provider deems the treatment clinically ineffective, the patient is entitled to receive the recommended course of therapy without requiring the prescribing provider to seek approval for an override of the step-therapy or fail-first protocol.

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

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

(2) Any insurer issuing a policy of health insurance in

this state, which insurance includes coverage for the services of a preferred provider, shall ~~must~~ provide each policyholder and certificateholder with a current list of preferred providers, shall ~~and must~~ make the list available for public inspection during regular business hours at the principal office of the insurer within the state, and shall post a link to the list of preferred providers on the home page of the insurer's website. Changes to the list of preferred providers shall be reflected on the insurer's website within 24 hours.

Section 6. Subsection (15) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

~~(15)(a) All health maintenance contracts, certificates, and member handbooks shall contain the following provision:~~

~~"Grace Period: This contract has a (insert a number not less than 10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the contract will stay in force."~~

~~(b) The required provision of paragraph (a) shall not apply to certificates or member handbooks delivered to individual subscribers under a group health maintenance contract when the employer or other person who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscribers. However, such required provision shall apply to the group health maintenance contract.~~

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

641.3155 Prompt payment of claims.—

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of the claim. A health maintenance organization that has verified the eligibility of a subscriber at the time of treatment and has provided an authorization number may not retroactively deny a claim because of subscriber ineligibility.

Section 8. Section 641.394, Florida Statutes, is created to read:

641.394 Fail-first protocols.—When medications for the treatment of a medical condition are restricted for use by a health maintenance organization by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the health maintenance organization. The health maintenance organization shall grant an override of the protocol within 24 hours under the following circumstances:

(a) The prescribing provider recommends, based on sound clinical evidence, that the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence:

1. The prescribing provider believes that 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 insured and known characteristics of the drug regimen; or

2. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol will cause or is likely to cause an adverse reaction or other physical harm to the insured.

If the prescribing provider allows the patient to enter the step-therapy or fail-first protocol recommended by the health maintenance organization, the duration of the step-therapy or fail-first protocol may not exceed a period deemed appropriate by the provider. If the prescribing provider deems the treatment clinically ineffective, the patient is entitled to receive the recommended course of therapy without requiring the prescribing provider to seek approval for an override of the step-therapy or fail-first protocol.

Section 9. Paragraph (j) of subsection (3) of section 383.145, Florida Statutes, is amended to read:

383.145 Newborn and infant hearing screening.—

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.—

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup

reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled in MediPass or Medicaid patients covered by a fee for service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(29) ~~641.31(30)~~, except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental polices, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers shall be eligible to bill Medicaid for the professional and technical component of each procedure code.

Section 10. Subsection (1) of section 641.2018, Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.—

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits

other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive health care services as provided in ss. 641.19(4), (11), and (12), and 641.31(1), except ss. 641.31(9), (12), (16), (17), (18), (19), (20), and (23) ~~(17), (18), (19), (20), (21), and (24)~~ and 641.31095.

Section 11. Paragraph (a) of subsection (7) of section 641.3922, Florida Statutes, is amended to read:

641.3922 Conversion contracts; conditions.—Issuance of a converted contract shall be subject to the following conditions:

(7) REASONS FOR CANCELLATION; TERMINATION.—The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

(a) Fraud or intentional misrepresentation, subject to the limitations of s. 641.31(22) ~~641.31(23)~~, in applying for any benefits under the converted health maintenance contract.~~;~~

Section 12. This act shall take effect July 1, 2014.