

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 Appropriations

BILL: CS/CS/SB 1354

INTRODUCER: Appropriations Committee; Banking and Insurance Committee; and Senator Grimsley

SUBJECT: Health Care

DATE: April 24, 2014

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Lloyd</u>	<u>Stovall</u>	<u>HP</u>	Favorable
2.	<u>Johnson</u>	<u>Knudson</u>	<u>BI</u>	Fav/CS
3.	<u>Brown</u>	<u>Kynoch</u>	<u>AP</u>	Fav/CS

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1354 revises the managed care accountability contract requirements for the Managed Medical Assistance (MMA) contracts under the Statewide Medicaid Managed Care Program (SMMC). MMA managed care plans that establish a prescribed drug formulary or preferred drug list must provide a broad range of therapeutic options, and, if feasible, the formulary or drug list must include at least two products in a therapeutic class.

Beginning January 1, 2015, each health insurer, managed care organization, health maintenance organization (HMO) and MMA managed care plan must use a single standardized form for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefit.

Under the bill, a prior authorization request submitted for prescription drugs is deemed approved unless an insurer responds otherwise within three business days. Health insurers, managed care organizations, HMOs, and MMA managed care plans that restrict medications by a step-therapy or fail-first protocol are required to have a clear and convenient process for providers to request an override of the protocol, among other requirements in the bill. An override must be granted within 72 hours for certain situations where the prescribing provider documents that 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. The bill also provides circumstances for the customary period for use of the medication under the step therapy or fail-first protocol to be extended by the

MMA plan, insurer or HMO or terminated by the prescribing provider under certain circumstances.

The bill is likely to have a significant negative, but indeterminate, impact on the Medicaid program and on the State Employees' Group Health Self-Insurance Trust Fund.

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). As of March 31, 2014, 3,539,441 Floridians were enrolled in Medicaid. The program's estimated expenditures for Fiscal Year 2013-2014 are approximately \$22.2 billion.¹ The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Statewide Medicaid Managed Care

Part IV of chapter 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The program, authorized under two federal Medicaid waivers, is designed for the AHCA to issue invitations to negotiate² and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and was scheduled to complete its statewide roll-out in March 2014.³ The MMA component is scheduled to begin enrolling Medicaid recipients in May 2014 and finish its roll-out in August 2014.⁴

The AHCA's current contracts with non-SMMC 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.⁵ Non-SMMC managed care plans also have 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.⁶

¹ Social Services Estimating Conference, *Medicaid Services Expenditures*, February 26, 2014, available at <http://edr.state.fl.us/Content/conferences/mc/index.shtml#LTCMC> (last visited April 17, 2014).

² An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.

³ *See* < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#LTCMC >, last visited March 20, 2014.

⁴ *See* < http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMA >, last visited March 20, 2014.

⁵ Agency for Health Care Administration, *2014 Agency Bill Analysis - SB 1354* (Feb. 21, 2014), p. 2, on file with the Senate Committee on Health Policy.

⁶ *Id.*

For the first year of the MMA transition, the AHCA is requiring the MMA plans to use the Medicaid PDL. After the first year, MMA plans may develop a plan-specific PDL for the AHCA's consideration, if requested by the AHCA at that time.⁷

The Patient Protection and Affordable Care Act

In March 2010, the Congress passed and President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA).⁸ Among its changes to the U.S. 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 U.S. 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.⁹

Federal regulations for PPACA also govern an enrollee's coverage bought through the exchanges and for non-grandfathered plans.¹⁰ If an enrollee's coverage bought with advance premium tax credit for a qualified health plan (QHP)¹¹ is terminated for non-payment of premium, for example, the regulations provide the enrollee a 3-month grace period before cancellation of coverage.¹² 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.¹³ 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 do not receive 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.

⁷ *Id.*

⁸ 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.

⁹ 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).

¹⁰ 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 1 year. Some consumer protections elements do not apply to grandfathered plans.

¹¹ 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.

¹² 45 CFR 156.270 and 45 CFR 430.

¹³ 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.¹⁴ Typically, step-therapy is applied to a certain drug class with the goal of encouraging generic drug use and decreasing costs without compromising the quality of care.¹⁵ 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.

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.¹⁶ 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 law prohibits requirements for prior authorization for certain services and requires direct access within specified guidelines for certain services such as dermatology.¹⁷ 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 HMO. 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, service, course of treatment, or prescription. The state has mandated a standard health claims processing form be adopted and used under s. 627.647, F.S., by all hospitals and a separate form for all physicians, dentists and pharmacists.

Federal regulations for Medicaid and the Children's Health Insurance Program (or CHIP, which, in Florida, is known as Kidcare) 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.¹⁸ Under these federal regulations, 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 three working days with the ability to extend up to 14 calendar days upon enrollee request, or if

¹⁴ 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).

¹⁵ *Id.*

¹⁶ Gleason, *supra*, note 15 at 273-274.

¹⁷ See s. 641.31(33), F.S. Provides direct access to dermatologists for up to five visits and testing annually.

¹⁸ See 42 CFR 438.210 (Medicaid) and 42 CFR 495 (Children's Health Insurance Program).

the managed care plan justifies a need for additional information and the extension is in the enrollee's benefit.¹⁹ Regulations governing the CHIP provide a deferral to any existing state law on the authorization of health services, if applicable.²⁰

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.²¹ The state group PPO provider, Florida Blue, provides a list of in-network providers on its website.

Federal regulations require a QHP on a PPACA exchange to make its provider directory available online and to potential enrollees in hard copy, upon request.²² Further guidance from the federal Centers for Medicare and Medicaid Services (CMS) indicates that QHPs must provide a link from the federal exchange to their networks 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.²³

State Group Health Insurance Program

Under the authority of s. 110.123, F.S., 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 s. 125 of the 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 covers all PPO and HMO plan members (excluding Medicare Advantage Plans offered exclusively to eligible retirees).

¹⁹ 42 CFR 438.210.

²⁰ 42 CFR 457.495(d)(2).

²¹ Florida Blue, 2014 Benefits, State Employees' PPO Plan, on file with the Senate Health Policy Committee.

²² 45 CFR 156.235(b).

²³ 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).

III. Effect of Proposed Changes:

Statewide Medicaid Managed Care Program (Section 1)

Section 1 revises s. 409.967, F.S., and requires a Medicaid managed care plan in Statewide Medicaid Managed Care (SMMC) that establishes a prescribed drug formulary or a PDL to 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.²⁴

Prior Authorization Requirements (Sections 1, 2, and 8)

Health plans, health insurers, and health maintenance organizations (HMOs), including those participating under SMMC, will be required, after January 1, 2015, to use a single, 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 on the Medicaid managed care plan, insurer, or HMO'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 otherwise within three business days. The bill adds the prior authorization provisions to existing s. 409.967, F.S., and creates two new sections, ss. 627.42392 and 641.393, F.S.

The prior authorization requirements in ss. 627.42392 and 641.393, F.S., do not apply to grandfathered health plans.

Medication Protocol Overrides (Sections 1, 3, and 9)

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 HMO, the prescribing provider must have access to a clear and convenient process to request an override. An override must be granted within 72 hours if the prescribing provider documents 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
- 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 the customary period for use of the medication if the prescriber demonstrates such treatment to be clinically ineffective. If the SMMC plan, an insurer or an HMO can demonstrate that the originally prescribed medication is likely to require more than the customary period to

²⁴ See *supra*, note 6.

provide any relief or amelioration to the enrollee, the step therapy or fail-first protocol may be extended for an additional time period, but no longer than the customary period for the medication. Notwithstanding these provisions, if the prescribing provider determines the enrollee is having an adverse reaction or suffering physical harm from the use of the medication, the step-therapy or fail first therapy shall be terminated.

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. 627.42393 and 641.394, F.S., are created to apply the provisions to insurers and HMOs. The medication protocol overrides do not apply to grandfathered health plans.

Payment of Claims (Sections 4 and 7)

Currently, health insurers under s. 627.6131, F.S., and HMOs under s. 641.3155, F.S., are prohibited from retroactively denying claims because of insured ineligibility more than 1 year after the date of the payment of the claim. The bill requires a health insurer or HMO to notify a provider that an insured or subscriber of a PPACA-compliant policy or contract is delinquent in their premium payments at the time of eligibility verification for the treatment in order to deny a claim for that treatment because of patient ineligibility. This provision would not apply to grandfathered plans.

Reduced Rate Insurance Contracts - Provider Listings (Section 5)

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

Out of State Groups (Section 6)

For any group health insurance policy issued or delivered outside this state to a resident of this state, s. 627.6515, F.S., is updated to incorporate cross references to the newly created sections under ss. 627.42392 and 627.42393, F.S. These sections relating to prior authorization and the medication protocol override process would be applicable to out of state group health insurance policies sold under s. 627.6515, F.S.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Under Article VII, section 18(a) of the State Constitution, 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 an important state interest would remove the bill from 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.²⁵

Insurers, managed care organizations, and health maintenance organizations are likely to experience an indeterminate but significant increase in costs to cover prescription drugs under the bill. Those cost increases are likely to flow through to the purchasers of health insurance coverage, such as individuals and employers.

Individuals and employers with private insurance coverage may see an increase in out-of-pocket costs or premiums for health coverage related to the implementation of the bill's step-therapy and prior authorization provisions. Insurers use these measures as utilization management and cost control tools and will affect some current policies and procedures of insurers.

²⁵ <https://www.shrm.org/hrdisciplines/benefits/Articles/Pages/Self-Insured-Health-Plans.aspx> (last visited April 4, 2014).

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:

Medicaid

The bill has a negative indeterminate fiscal impact to Medicaid. This negative impact is likely to be significant given that Statewide Medicaid Managed Care is scheduled to fully complete its phase-in by August 2014. According to an actuarial analysis conducted by the Wakely Consulting Group for the Florida Association of Health Plans on April 3, 2014, Medicaid managed care plans were able to reduce the costs of providing prescription drugs to Medicaid recipients by 37 percent in calendar year 2012 when compared to those same costs in Medicaid's MediPass (fee-for-service) program during Fiscal Year 2011-2012, due, in part, to the plans' use of step-edit and prior authorization protocols authorized under current law.²⁶ 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 provides a mechanism for prescribers to seek an override of that process with documentation. The AHCA would also need to modify existing Medicaid managed care plan contracts to incorporate the revised step-therapy and formulary requirements.

Division of State Group Insurance

According to the Department of Management Services, the bill would have a negative, significant, indeterminate impact on the State Employees' Group Health Self-Insurance Trust Fund. Excerpts of the fiscal analysis provided by the Division of State Group Insurance of the Department of Management Services are provided below:²⁷

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 three business days. It is unclear if there is a mechanism to request additional information to make a decision outside the three -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 three-day turnaround is shorter than timelines set by the National Committee on Quality Assurance for non-urgent service decisions.

Further, drugs and services subject to prior authorization vary greatly among health plans; it may not be possible to design a single prior authorization form that meets every medical and/or prescription drug need or use.

²⁶ Wakely Consulting Group analysis on file with staff of the Committee on Appropriations.

²⁷ Department of Management Services, *Senate Bill 1354 Analysis* (Mar. 25, 2014) (on file with Senate Committee on Banking and Insurance).

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:

None.

VII. Related Issues:

In several instances, the bill requires an insurer or managed care plan to provide an override process for a prescriber that permits an enrollee to “receive” a certain drug based on the premise that the “use” of medication might be restricted by an insurer or managed care plan. However, insurers and managed care plans cannot prohibit an enrollee or subscriber from receiving or using prescription drugs or medications. Insurers and managed care plans may utilize certain protocols regarding the *payment* for prescription drugs and medications received or used by enrollees or subscribers, but they cannot prohibit any person from receiving or using drugs or medications. The bill’s language along these lines creates uncertainty as to the effect of those provisions and how those provisions will be interpreted by state regulatory agencies.

The bill provides a deadline of January 1, 2015, for using a single, standardized prior authorization form. It is unclear whether this deadline would provide adequate time for implementation.

Section 1311(d)(3)(B) of the PPACA requires states to defray the costs of state-mandated benefits in excess of essential health benefits for individuals enrolled in any qualified health plan either in the individual market or in the small group market. The bill requires health insurers and HMOs to grant step-therapy overrides within 72 hours to providers who document that step-therapy protocols could be ineffective or harmful. The bill does not address whether the medication must be a covered benefit under the plan. It is unclear whether a plan would be required to pay for an exclusion, such as an experimental or investigational drug because the provider overrides the step-therapy protocol.

In Section 1 of the bill, a conflict exists in the prior authorization timeframes. For health care providers, the time standard for approval of a prior authorization form is three business days. In the next paragraph for prescribing providers, the time standard for approval is two business days. It is not clear which standard should apply for the prior authorization process for providers.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 627.6131, 627.6471, 627.6515, and 641.3155.

This bill creates the following sections of the Florida Statutes: 627.42392, 627.42393, 641.393, and 641.394.

IX. Additional Information:

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

CS/CS by Appropriations on April 22, 2014:

The CS makes the following substantive changes:

- Eliminates the provision requiring coverage through prior authorization by an MMA plan of any 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;
- Removes the provision permitting a Medicaid enrollee to continue receiving a drug after its removal from the formulary upon written request from the prescribing provider and demonstration that the drug is medically necessary;
- Revises the requirements for standardized prior authorization forms for an MMA plan, insurer and a health maintenance organization (HMO) to require a single, standardized form by January 1, 2015, that is accessible to providers electronically and online;
- Modifies the time standard for approval of a medication protocol override request by an MMA plan, insurer, and an HMO from 24 hours to 72 hours;
- Revises the time standard for approval of prior authorization requests by an MMA plan, insurer, and an HMO from one business day to 3 business days;
- Requires prescribing providers under a step therapy or fail first protocol process for an MMA plan, insurer and an HMO to document ineffectiveness of treatment or adverse reaction for an override; and
- Modifies the conditions under which an enrollee may be terminated from a step-therapy or fail first protocol as the customary period for the medication and adds a process for the MMA plan, insurer, or an HMO to extend the customary period under certain circumstances.

CS by Banking and Insurance on April 8, 2014:

The CS provides technical, conforming changes and the following substantive changes:

- Eliminates provision that would have prohibited health insurers and health maintenance organizations from retroactively denying claims because of insured ineligibility if the insurer or health maintenance organization provided the insured/subscriber with an identification card, which at the time of service identifies the insured/subscriber as eligible to receive services.
- Requires health insurers and health maintenance organizations to notify a provider that an insured/subscriber is delinquent in their payment of premiums at the time of eligibility verification for services in order to be able to deny a claim if the insured/subscriber does not pay their premium for a PPACA compliant policy or contract.
- Exempts grandfathered plans from the step-therapy and prior authorization provisions.

B. Amendments:

None.

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