

By Senator Grimsley

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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;

21-01230-14

20141354__

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

21-01230-14

20141354__

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

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

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

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

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

21-01230-14

20141354__

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

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

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

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

116 b. A completed prior authorization request submitted by a

21-01230-14

20141354__

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

21-01230-14

20141354__

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

21-01230-14

20141354__

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

21-01230-14

20141354__

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.

21-01230-14

20141354__

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.

21-01230-14

20141354__

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

21-01230-14

20141354__

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.