By Senator Grimsley

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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; requiring the use of a standardized form; establishing a process for providers to override certain treatment restrictions; amending s. 627.6131, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 627.6465, F.S.; requiring the use of a standardized form; requiring the commission to adopt rules to prescribe the form; providing requirements for the form; providing requirements for the availability and submission of the form; 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 preferred provider information on a website; amending s. 641.3155, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 641.393, F.S.; requiring the use of a standardized form; providing requirements for the availability and submission of the form; 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;

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 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

health care provider using the standardized prior authorization form required under sub-subparagraph a. is deemed approved upon receipt by the managed care plan unless the managed care plan responds within 2 business days.

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

4. If 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 must 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 if:

a. The prescribing provider believes that, based on sound clinical evidence, 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. The prescribing provider believes that, based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

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

627.6131 Payment of claims.—

(11)(a) 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.

(b) 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.

(c) A health insurer that has provided the insured with an identification card as provided in s. 627.642(3) which at the time of service identifies the insured as eligible to receive services may not retroactively deny a claim because of insured ineligibility.

Section 3. Section 627.6465, Florida Statutes, is created to read:

627.6465 Prior authorization.—

(1) Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, after January 1, 2015, a health insurance issuer, managed care plan as defined in s. 409.901, or health maintenance organization as

defined in s. 641.19 shall use only the standardized prior authorization form adopted by the Financial Services Commission for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefits. If a health insurance issuer, managed care plan, or health maintenance organization 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 commission shall adopt rules prescribing the prior authorization form on or before January 1, 2015, and may consult with health insurance issuers or other organizations as necessary in the development of the form. The form may not exceed two pages in length, excluding any instructions or guiding documentation. The form shall be made available electronically by the commission and on the website of the health insurance issuer, managed care plan, or health maintenance organization. The prescribing provider may submit the completed form electronically to the health benefit plan. The adoption of the form by the commission does not constitute a determination that affects the substantial interests of a party under chapter 120.

(2) A completed prior authorization request submitted by a prescribing provider using the standardized prior authorization form required under subsection (1) is deemed approved upon receipt by the health insurance issuer unless the health insurance issuer responds within 2 business days.

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

627.6466 Fail-first protocols.—If 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 if:

(1) The prescribing provider believes that, based on sound clinical evidence, 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

(2) The prescribing provider believes that, based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

(a) 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

(b) 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) An ~~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 must be reflected on the insurer's website within 24 hours.

Section 6. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10)(a) 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.

(b) 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.

(c) A health maintenance organization that has provided the subscriber with an identification card as provided in s. 627.642(3) which at the time of service identifies the subscriber as eligible to receive services may not retroactively deny a claim because of subscriber ineligibility.

Section 7. Section 641.393, Florida Statutes, is created to read:

641.393 Prior authorization.—

(1) Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, after January 1, 2015, a health maintenance organization 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 health maintenance organization contracts with a pharmacy benefits manager to perform prior authorization services for prescription drug benefits, the pharmacy benefits manager must use and accept the standardized prior authorization form. The form shall be made available electronically by the commission and on the website of the health insurance issuer, managed care plan, or health maintenance organization. The health care provider may submit the completed form electronically to the health benefit plan.

(2) A completed prior authorization request submitted by a health care provider using the standardized prior authorization form required under subsection (1) is deemed approved upon receipt by the health maintenance organization unless the health maintenance organization responds within 2 business days.

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

641.394 Fail-first protocols.—If 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 if:

(1) The prescribing provider believes that, based on sound clinical evidence, 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

(2) The prescribing provider believes that, based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

(a) 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

(b) 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. This act shall take effect July 1, 2014.