

By the Committee on Banking and Insurance; and Senator Grimsley

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1 A bill to be entitled
2 An act relating to health care; amending s. 409.967,
3 F.S.; revising contract requirements for Medicaid
4 managed care programs; providing requirements for
5 plans establishing a drug formulary or preferred drug
6 list; requiring the plan to authorize an enrollee to
7 continue a drug that is removed or changed, under
8 certain circumstances; requiring the use of a
9 standardized prior authorization form; requiring a
10 pharmacy benefits manager to use and accept the form
11 under certain circumstances; providing requirements
12 for the form and for the availability and submission
13 of the form; establishing a process for providers to
14 override certain treatment restrictions; providing
15 requirements for approval of such overrides; providing
16 an exception to the override protocol in certain
17 circumstances; creating s. 627.42392, F.S.; requiring
18 health insurers to use a standardized prior
19 authorization form; requiring a pharmacy benefits
20 manager to use and accept the form under certain
21 circumstances; providing requirements for the form and
22 for the availability and submission of the form;
23 providing an exemption; creating s. 627.42393, F.S.;
24 establishing a process for providers to override
25 certain treatment restrictions; providing requirements
26 for approval of such overrides; providing an exception
27 to the override protocol in certain circumstances;
28 providing an exemption; amending s. 627.6131, F.S.;
29 prohibiting an insurer from retroactively denying a

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30 claim in certain circumstances; amending s. 627.6471,
31 F.S.; requiring insurers to post preferred provider
32 information on a website; amending s. 627.6515, F.S.;
33 applying provisions relating to prior authorization
34 and override protocols to out-of-state groups;
35 amending s. 641.3155, F.S.; prohibiting a health
36 maintenance organization from retroactively denying a
37 claim in certain circumstances; creating s. 641.393,
38 F.S.; requiring the use of a standardized prior
39 authorization form by a health maintenance
40 organization; requiring a pharmacy benefits manager to
41 use and accept the form under certain circumstances;
42 providing requirements for the availability and
43 submission of the form; providing an exemption;
44 creating s. 641.394, F.S.; establishing a process for
45 providers to override certain treatment restrictions;
46 providing requirements for approval of such overrides;
47 providing an exception to the override protocol in
48 certain circumstances; providing an exemption;
49 providing an effective date.

50
51 Be It Enacted by the Legislature of the State of Florida:

52
53 Section 1. Paragraph (c) of subsection (2) of section
54 409.967, Florida Statutes, is amended to read:

55 409.967 Managed care plan accountability.—

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

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59 necessary, the contract must require:

60 (c) Access.—

61 1. The agency shall establish specific standards for the
62 number, type, and regional distribution of providers in managed
63 care plan networks to ensure access to care for both adults and
64 children. Each plan must maintain a regionwide network of
65 providers in sufficient numbers to meet the access standards for
66 specific medical services for all recipients enrolled in the
67 plan. The exclusive use of mail-order pharmacies may not be
68 sufficient to meet network access standards. Consistent with the
69 standards established by the agency, provider networks may
70 include providers located outside the region. A plan may
71 contract with a new hospital facility before the date the
72 hospital becomes operational if the hospital has commenced
73 construction, will be licensed and operational by January 1,
74 2013, and a final order has issued in any civil or
75 administrative challenge. Each plan shall establish and maintain
76 an accurate and complete electronic database of contracted
77 providers, including information about licensure or
78 registration, locations and hours of operation, specialty
79 credentials and other certifications, specific performance
80 indicators, and such other information as the agency deems
81 necessary. The database must be available online to ~~both~~ the
82 agency and the public and have the capability of comparing ~~to~~
83 ~~compare~~ the availability of providers to network adequacy
84 standards and to accept and display feedback from each
85 provider's patients. Each plan shall submit quarterly reports to
86 the agency identifying the number of enrollees assigned to each
87 primary care provider.

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

90 a. Provide a broad range of therapeutic options for the
91 treatment of disease states which are consistent with the
92 general needs of an outpatient population. If feasible, the
93 formulary or preferred drug list must include at least two
94 products in a therapeutic class.

95 b. Include coverage through prior authorization for each
96 new drug approved by the United States Food and Drug
97 Administration until the Medicaid Pharmaceutical and
98 Therapeutics Committee reviews such drug for inclusion on the
99 formulary. The timing of the formulary review must comply with
100 s. 409.91195.

101 c. Each managed care plan must Publish the any prescribed
102 drug formulary or preferred drug list on the plan's website in a
103 manner that is accessible to and searchable by enrollees and
104 providers. The plan shall ~~must~~ update the list within 24 hours
105 after making a change. ~~Each plan must ensure that the prior~~
106 authorization process for prescribed drugs is readily accessible
107 to health care providers, including posting appropriate contact
108 information on its website and providing timely responses to
109 providers.

110 d. If a prescription drug on a plan's formulary is removed
111 or changed, permit an enrollee who was receiving the drug to
112 continue to receive the drug if the prescribing provider submits
113 a written request that demonstrates that the drug is medically
114 necessary and that the enrollee meets clinical criteria to
115 receive the drug.

116 3. For enrollees ~~Medicaid recipients~~ diagnosed with

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117 hemophilia who have been prescribed anti-hemophilic-factor
118 replacement products, the agency shall provide for those
119 products and hemophilia overlay services through the agency's
120 hemophilia disease management program.

121 4. Notwithstanding any other law, in order to establish
122 uniformity in the submission of prior authorization forms, after
123 January 1, 2015, a managed care plan shall use only the
124 standardized prior authorization form adopted by the Financial
125 Services Commission pursuant to s. 627.42392 for obtaining prior
126 authorization for a medical procedure, a course of treatment, or
127 prescription drug benefits.

128 a. If a managed care plan contracts with a pharmacy
129 benefits manager to perform prior authorization services for
130 prescription drug benefits, the pharmacy benefits manager shall
131 use and accept the standardized prior authorization form. The
132 Office of Insurance Regulation and the managed care plan shall
133 make the form electronically available on their respective
134 websites.

135 b.3. Managed care plans, and their fiscal agents or
136 intermediaries, must accept prior authorization requests for any
137 service electronically.

138 c. A completed prior authorization request submitted by a
139 health care provider using the standardized prior authorization
140 form required under this subparagraph is deemed approved upon
141 receipt by the managed care plan unless the managed care plan
142 responds otherwise within 2 business days.

143 5. If medications for the treatment of a medical condition
144 are restricted for use by a managed care plan by a step-therapy
145 or fail-first protocol, the prescribing provider must have

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146 access to a clear and convenient process to request an override
147 of the protocol from the managed care plan.

148 a. The managed care plan shall grant an override within 24
149 hours if the prescribing provider believes that:

150 (I) Based on sound clinical evidence, the preferred
151 treatment required under the step-therapy or fail-first protocol
152 has been ineffective in the treatment of the enrollee's disease
153 or medical condition; or

154 (II) Based on sound clinical evidence or medical and
155 scientific evidence, the preferred treatment required under the
156 step-therapy or fail-first protocol:

157 (A) Is expected or likely to be ineffective based on known
158 relevant physical or mental characteristics of the enrollee and
159 known characteristics of the drug regimen; or

160 (B) Will cause or will likely cause an adverse reaction or
161 other physical harm to the enrollee.

162 b. If the prescribing provider allows the enrollee to enter
163 the step-therapy or fail-first protocol recommended by the
164 managed care plan, the duration of the step-therapy or fail-
165 first protocol may not exceed a period deemed appropriate by the
166 provider. If the prescribing provider deems the treatment
167 clinically ineffective, the enrollee is entitled to receive the
168 recommended course of therapy without requiring the prescribing
169 provider to seek approval for an override of the step-therapy or
170 fail-first protocol.

171 Section 2. Section 627.42392, Florida Statutes, is created
172 to read:

173 627.42392 Prior authorization.—Notwithstanding any other
174 law, in order to establish uniformity in the submission of prior

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175 authorization forms, after January 1, 2015, a health insurer
176 that delivers, issues for delivery, renews, amends, or continues
177 an individual or group health insurance policy in this state,
178 including a policy issued to a small employer as defined in s.
179 627.6699, shall use only the standardized prior authorization
180 form adopted by the commission for obtaining prior authorization
181 for a medical procedure, course of treatment, or prescription
182 drug benefits.

183 (1) If a health insurer contracts with a pharmacy benefits
184 manager to perform prior authorization services for prescription
185 drug benefits, the pharmacy benefits manager shall use and
186 accept the standardized prior authorization form. The commission
187 shall adopt rules prescribing the prior authorization form on or
188 before January 1, 2015, and the office may consult with health
189 insurers or other organizations as necessary in the development
190 of the form. The form may not exceed two pages in length,
191 excluding any instructions or guiding documentation. The office
192 and the health insurer shall make the form electronically
193 available on their respective websites. The prescribing provider
194 may electronically submit the completed form to the health
195 insurer. The adoption of the form by the commission does not
196 constitute a determination that affects the substantial
197 interests of a party under chapter 120.

198 (2) A completed prior authorization request submitted by a
199 prescribing provider using the standardized prior authorization
200 form required under subsection (1) is deemed approved upon
201 receipt by the health insurer unless the health insurer responds
202 otherwise within 2 business days.

203 (3) This section does not apply to a grandfathered health

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204 plan as defined in s. 627.402.

205 Section 3. Section 627.42393, Florida Statutes, is created
206 to read:

207 627.42393 Medication protocol override.—If an individual or
208 group health insurance policy, including a policy issued by a
209 small employer, as defined in s. 627.6699, restricts medications
210 for the treatment of a medical condition by a step-therapy or
211 fail-first protocol, the prescribing provider must have access
212 to a clear and convenient process to request an override of the
213 protocol from the health insurer.

214 (1) The health insurer shall authorize an override of the
215 protocol within 24 hours if the prescribing provider believes
216 that:

217 (a) Based on sound clinical evidence, the preferred
218 treatment required under the step-therapy or fail-first protocol
219 has been ineffective in the treatment of the insured's disease
220 or medical condition; or

221 (b) Based on sound clinical evidence or medical and
222 scientific evidence, the preferred treatment required under the
223 step-therapy or fail-first protocol:

224 1. Is expected or likely to be ineffective based on known
225 relevant physical or mental characteristics of the insured and
226 known characteristics of the drug regimen; or

227 2. Will cause or is likely to cause an adverse reaction or
228 other physical harm to the insured.

229 (2) If the prescribing provider allows the insured to enter
230 the step-therapy or fail-first protocol recommended by the
231 health insurer, the duration of the step-therapy or fail-first
232 protocol may not exceed a period deemed appropriate by the

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233 provider. If the prescribing provider deems the treatment
 234 clinically ineffective, the insured is entitled to receive the
 235 recommended course of therapy without requiring the prescribing
 236 provider to seek approval for an override of the step-therapy or
 237 fail-first protocol.

238 (3) This section does not apply to grandfathered health
 239 plans, as defined in s. 627.402.

240 Section 4. Subsection (11) of section 627.6131, Florida
 241 Statutes, is amended to read:

242 627.6131 Payment of claims.—

243 (11) A health insurer may not retroactively deny a claim
 244 because of insured ineligibility:

245 (a) More than 1 year after the date of payment of the
 246 claim; or

247 (b) If, under a policy compliant with the federal Patient
 248 Protection and Affordable Care Act, as amended by the Health
 249 Care and Education Reconciliation Act of 2010, and regulations
 250 adopted pursuant to those acts, the health insurer verified the
 251 eligibility of the insured at the time of treatment and provided
 252 an authorization number unless, at the time eligibility was
 253 verified, the provider was notified that the insured was
 254 delinquent in paying the premium.

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

257 627.6471 Contracts for reduced rates of payment;
 258 limitations; coinsurance and deductibles.—

259 (2) An ~~Any~~ insurer issuing a policy of health insurance in
 260 this state, ~~which insurance~~ shall ~~must~~ provide each policyholder
 261 of a preferred provider, shall ~~must~~ provide each policyholder

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262 and certificateholder with a current list of preferred
263 providers, shall ~~and must~~ make the list available for public
264 inspection during regular business hours at the principal office
265 of the insurer within the state, and shall post a link to the
266 list of preferred providers on the home page of the insurer's
267 website. Changes to the list of preferred providers must be
268 reflected on the insurer's website within 24 hours.

269 Section 6. Paragraph (c) of subsection (2) of section
270 627.6515, Florida Statutes, is amended to read:

271 627.6515 Out-of-state groups.—

272 (2) Except as otherwise provided in this part, this part
273 does not apply to a group health insurance policy issued or
274 delivered outside this state under which a resident of this
275 state is provided coverage if:

276 (c) The policy provides the benefits specified in ss.
277 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579,
278 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675,
279 627.6691, and 627.66911, and complies with the requirements of
280 s. 627.66996.

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

283 641.3155 Prompt payment of claims.—

284 (10) A health maintenance organization may not
285 retroactively deny a claim because of subscriber ineligibility:

286 (a) More than 1 year after the date of payment of the
287 claim; or

288 (b) If, under a policy compliant with the federal Patient
289 Protection and Affordable Care Act, as amended by the Health
290 Care and Education Reconciliation Act of 2010, and regulations

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291 adopted pursuant to those acts, the health maintenance
292 organization verified the eligibility of the subscriber at the
293 time of treatment and provided an authorization number unless,
294 at the time eligibility was verified, the provider was notified
295 that the subscriber was delinquent in paying the premium.

296 Section 8. Section 641.393, Florida Statutes, is created to
297 read:

298 641.393 Prior authorization.—Notwithstanding any other law,
299 in order to establish uniformity in the submission of prior
300 authorization forms, after January 1, 2015, a health maintenance
301 organization shall use only the standardized prior authorization
302 form adopted by the Financial Services Commission pursuant to s.
303 627.42392 for obtaining prior authorization for a medical
304 procedure, a course of treatment, or prescription drug benefits.

305 (1) If a health maintenance organization contracts with a
306 pharmacy benefits manager to perform prior authorization
307 services for prescription drug benefits, the pharmacy benefits
308 manager must use and accept the standardized prior authorization
309 form. The office and health maintenance organization shall make
310 the form electronically available on their respective websites.

311 (2) A health care provider may submit the completed form
312 electronically to the health maintenance organization.

313 (3) A completed prior authorization request submitted by a
314 health care provider using the standardized prior authorization
315 form required under this section is deemed approved upon receipt
316 by the health maintenance organization unless the health
317 maintenance organization responds otherwise within 2 business
318 days.

319 (4) This section does not apply to grandfathered health

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320 plans, as defined in s. 627.402.

321 Section 9. Section 641.394, Florida Statutes, is created to
322 read:

323 641.394 Medication protocol override.—If a health
324 maintenance organization contract restricts medications for the
325 treatment of a medical condition by a step-therapy or fail-first
326 protocol, the prescribing provider shall have access to a clear
327 and convenient process to request an override of the protocol
328 from the health maintenance organization.

329 (1) The health maintenance organization shall grant an
330 override within 24 hours if the prescribing provider believes
331 that:

332 (a) Based on sound clinical evidence, the preferred
333 treatment required under the step-therapy or fail-first protocol
334 has been ineffective in the treatment of the subscriber's
335 disease or medical condition; or

336 (b) Based on sound clinical evidence or medical and
337 scientific evidence, the preferred treatment required under the
338 step-therapy or fail-first protocol:

339 1. Is expected or likely to be ineffective based on known
340 relevant physical or mental characteristics of the subscriber
341 and known characteristics of the drug regimen; or

342 2. Will cause or is likely to cause an adverse reaction or
343 other physical harm to the subscriber.

344 (2) If the prescribing provider allows the subscriber to
345 enter the step-therapy or fail-first protocol recommended by the
346 health maintenance organization, the duration of the step-
347 therapy or fail-first protocol may not exceed a period deemed
348 appropriate by the provider. If the prescribing provider deems

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349 the treatment clinically ineffective, the subscriber is entitled
350 to receive the recommended course of therapy without requiring
351 the prescribing provider to seek approval for an override of the
352 step-therapy or fail-first protocol.

353 (3) This section does not apply to grandfathered health
354 plans, as defined in s. 627.402.

355 Section 10. This act shall take effect July 1, 2014.