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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/04/2015	.	
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The Committee on Banking and Insurance (Montford) recommended the following:

Senate Amendment (with title amendment)

Delete lines 254 - 491

and insert:

condition for the covered patient.

(a) For purposes of this section, the term, "a coverage limitation imposed at the point of service" means a limitation that is not universally applicable to all covered lives, but instead depends on an insurer's consideration of specific patient characteristics and conditions that have been reported

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by a physician in the process of providing medical care.

(b) The term "sufficient clinical evidence" means:

1. A body of research consisting of well-controlled studies conducted by independent researchers and published in peer reviewed journals or comparable publications which consistently support the treatment protocol or other coverage limitation as a best practice for the specific diagnosis or combination of presenting complaints.

2. Results of a multivariate predictive model which indicate that the probability of achieving desired outcomes is not negatively altered or delayed by adherence to the proposed protocol.

(2) The Clinical Practices Review Commission established under s. 402.90 shall determine whether sufficient clinical evidence exists for a proposed coverage limitation imposed by the insurer at the point of service. In each instance in which the commission finds that sufficient clinical evidence exists to support a coverage limitation, the office shall approve the coverage limitation.

(3) If an insurer, without the approval of the office, imposes a coverage limitation at the point of service, including, but not limited to, a prior authorization procedure, step therapy requirement, treatment protocol, or other utilization management procedure that restricts access to covered services, the insurer and its chief medical officer shall be liable for any injuries or damages, as defined in s. 766.202, and economic damages, as defined in s. 768.81(1)(b), that result from the restricted access to services determined medically necessary by the physician treating the patient. An

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insurer that imposes such a coverage limitation at the point of service shall establish reserves sufficient to pay for such damages.

Section 5. Subsection (2) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(2) The outline of coverage must ~~shall~~ contain:

(a) A statement identifying the applicable category of coverage afforded by the policy, based on the minimum basic standards set forth in the rules issued to effect compliance with s. 627.643.

(b) A brief description of the principal benefits and coverage provided in the policy.

(c) A summary statement of the principal exclusions and limitations or reductions contained in the policy, including, but not limited to, preexisting conditions, probationary periods, elimination periods, deductibles, coinsurance, and any age limitations or reductions.

(d) A summary statement identifying specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol. The insurer shall post the summary statement at a prominent and readily accessible location on the Internet.

(e) A summary statement identifying any specific diagnostic or therapeutic procedures that are subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol. The insurer shall post the summary statement at a prominent and readily accessible

location on the Internet.

(f) ~~(d)~~ A summary statement of the renewal and cancellation provisions, including any reservation of the insurer of a right to change premiums.

(g) ~~(e)~~ A statement that the outline contains a summary only of the details of the policy as issued or of the policy as applied for and that the issued policy should be referred to for the actual contractual governing provisions.

(h) ~~(f)~~ When home health care coverage is provided, a statement that such benefits are provided in the policy.

Section 6. 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 that~~, which insurance~~ includes coverage for the services of a preferred provider~~,~~ must provide each policyholder and certificateholder with a current list of preferred providers, ~~and~~ must make the list available for public inspection during regular business hours at the principal office of the insurer within the state, and must post a link to the list of preferred providers on the home page of the insurer's website. Such insurer must post on its website a change to the list of preferred providers within 10 business days after such change.

Section 7. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.—

(4) This section does not apply to any plan that ~~which~~ is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8) ~~627.662(7)~~. This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 8. Present subsections (7) through (14) of section 627.662, Florida Statutes, are redesignated as subsections (8) through (15), respectively, and a new subsection (7) is added to that section, to read:

627.662 Other provisions applicable.—The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(7) Section 627.642(2)(d) and (e), relating to coverage limitations on prescription drugs and diagnostic or therapeutic procedures.

Section 9. Paragraph (b) of subsection (12) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.—

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a

high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue Service, which ~~that~~ meet the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan," "basic health benefit plan," and "high deductible plan" mean policies or contracts that a small employer carrier offers to eligible small employers which ~~that~~ contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; ~~and~~

b. A procedure for preauthorization or prior authorization by the small employer carrier, or its designees;

c. A summary statement identifying specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol. The carrier shall post the summary statement in a prominent and readily accessible location on the Internet; and

d. A summary statement identifying any specific diagnostic or therapeutic procedures subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol. The carrier shall post the summary statement in a prominent and readily accessible location on the Internet.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to

s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for children with disabilities ~~handicapped children~~ pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan must ~~shall~~ include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan must ~~shall~~ place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding such ~~said~~ provisions, the plans may specify limits on the number of

authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. The high-deductible ~~high deductible~~ plan associated with a health savings account or a health reimbursement arrangement must ~~shall~~ include all the benefits specified in subparagraph 4.

9. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association if ~~when~~ such services are available and the osteopathic hospital agrees to provide the service.

Section 10. Subsection (4) of section 641.31, Florida Statutes, is amended and subsection (44) is added to that section, to read:

641.31 Health maintenance contracts.—

(4) Each ~~Every~~ health maintenance contract, certificate, or member handbook must ~~shall~~ clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the benefits, services, or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity that ~~which~~ is underwriting any of the services offered by the health maintenance organization. The contract, certificate, or member handbook must ~~shall~~ also state where and in what manner the comprehensive health care services may be obtained. The health maintenance organization shall prominently post the statement regarding limitations on benefits, services, or kinds of services provided on its website in a readily accessible

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location on the Internet. The statement must include, but need not be limited to:

(a) The identification of specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol.

(b) The identification of any specific diagnostic or therapeutic procedures that are subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol.

(44) Health maintenance organizations are prohibited from establishing prior authorization procedures, step therapy requirements, treatment protocols, or other utilization management procedures that restrict access to covered services unless expressly authorized to do so under this subsection. A coverage limitation imposed by a health maintenance organization at the point of service must be supported, as determined by the Clinical Practices Review Commission established pursuant to s. 402.90, by sufficient clinical evidence, as defined in s. 627.6051(1), which demonstrates that the limitation does not inhibit the timely diagnosis or optimal treatment of the specific illness or condition for the covered patient. For purposes of this subsection, the term, "a coverage limitation imposed by a health maintenance organization at the point of service" means a limitation that is not universally applicable to all covered lives, but instead depends on a health maintenance organization's consideration of specific patient characteristics and conditions that have been reported by a physician in the process of providing medical care.

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Section 11. 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 and may not retroactively deny a claim because of subscriber ineligibility at any time if the health maintenance organization verified the eligibility of a subscriber at the time of treatment and has provided an authorization number.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 23 - 62

and insert:

limitation at the point of service; defining the terms "a coverage limitation imposed at the point of service" and "sufficient clinical evidence"; requiring the commission to determine whether sufficient clinical evidence exists and the Office of Insurance Regulation to approve coverage limitations if the commission determines that such evidence exists; providing for the liability of a health insurer and its chief medical officer for injuries and damages resulting from restricted access to services if the insurer has imposed coverage limitations without the approval of the office; requiring insurers to establish reserves to pay for such damages; amending ss. 627.642 and 627.6699, F.S.; requiring an outline

of coverage and certain plans offered by a small employer carrier to include summary statements identifying specific prescription drugs and procedures that are subject to specified restrictions and limitations; requiring insurers and small employer carriers to post the summaries on the Internet; amending s. 627.6471, F.S.; requiring an insurer to post a link to the list of preferred providers on its website and to update the list within 10 business days after a change; amending s. 627.651, F.S.; conforming a cross-reference; amending s. 627.662, F.S.; specifying that specified provisions relating to coverage limitations on prescription drugs and diagnostic or therapeutic procedures apply to group health insurance, blanket health insurance, and franchise health insurance; amending s. 641.31, F.S.; requiring a health maintenance contract summary statement to include a statement of any limitations on benefits, the identification of specific prescription drugs, and certain procedures that are subject to specified restrictions and limitations; requiring a health maintenance organization to post the summaries on the Internet; prohibiting a health maintenance organization from establishing certain procedures and requirements that restrict access to covered services; requiring a coverage limitation to be supported, as determined by the commission, by clinical evidence demonstrating that the limitation does not inhibit the diagnosis or treatment of the patient; defining the

term "a coverage limitation imposed at the point of service"; amending s. 641.3155, F.S.; prohibiting the retroactive denial of a claim because of subscriber ineligibility at any time if the health maintenance organization verified the eligibility of such subscriber at the time of treatment and provided an authorization number; providing an effective date.