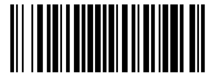
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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/27/2017	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Steube) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 627.42392, Florida Statutes, is amended
6 to read:
7 627.42392 Prior authorization.—
8 (1) As used in this section, the term:
9 (a) “Health insurer” means an authorized insurer offering
10 an individual or group insurance policy that provides major

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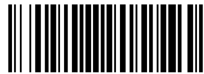
11 medical or similar comprehensive coverage or a health
12 maintenance organization as defined in s. 641.19 ~~health~~
13 ~~insurance as defined in s. 624.603, a managed care plan as~~
14 ~~defined in s. 409.962(9), or a health maintenance organization~~
15 ~~as defined in s. 641.19(12)~~.
16 (b) “Urgent care situation” has the same meaning as in s.
17 627.42393.
18 (2) Notwithstanding any other provision of law, effective
19 January 1, 2017, or six (6) months after the effective date of
20 the rule adopting the prior authorization form, whichever is
21 later, a health insurer, or a pharmacy benefits manager on
22 behalf of the health insurer, which does not provide an
23 electronic prior authorization process for use by its contracted
24 providers, shall only use the prior authorization form that has
25 been approved by the Financial Services Commission for granting
26 a prior authorization for a medical procedure, course of
27 treatment, or prescription drug benefit. Such form may not
28 exceed two pages in length, excluding any instructions or
29 guiding documentation, and must include all clinical
30 documentation necessary for the health insurer to make a
31 decision. At a minimum, the form must include: (1) sufficient
32 patient information to identify the member, date of birth, full
33 name, and Health Plan ID number; (2) provider name, address and
34 phone number; (3) the medical procedure, course of treatment, or
35 prescription drug benefit being requested, including the medical
36 reason therefor, and all services tried and failed; (4) any
37 laboratory documentation required; and (5) an attestation that
38 all information provided is true and accurate. The form, whether
39 in electronic or paper format, may not require information that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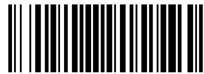
40 is not necessary for the determination of medical necessity of,
41 or coverage for, the requested medical procedure, course of
42 treatment, or prescription drug.
43 (3) The Financial Services Commission in consultation with
44 the Agency for Health Care Administration shall adopt by rule
45 guidelines for all prior authorization forms which ensure the
46 general uniformity of such forms.
47 (4) Electronic prior authorization approvals do not
48 preclude benefit verification or medical review by the insurer
49 under either the medical or pharmacy benefits.
50 (5) A health insurer or a pharmacy benefits manager on
51 behalf of the health insurer must provide the following
52 information in writing or in an electronic format upon request,
53 and on a publicly accessible Internet website:
54 (a) Detailed descriptions of requirements and restrictions
55 to obtain prior authorization for coverage of a medical
56 procedure, course of treatment, or prescription drug in clear,
57 easily understandable language. Clinical criteria must be
58 described in language easily understandable by a health care
59 provider.
60 (b) Prior authorization forms.
61 (6) A health insurer or a pharmacy benefits manager on
62 behalf of the health insurer may not implement any new
63 requirements or restrictions or make changes to existing
64 requirements or restrictions to obtain prior authorization
65 unless:
66 (a) The changes have been available on a publicly
67 accessible Internet website at least 60 days before the
68 implementation of the changes.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69 (b) Policyholders and health care providers who are
70 affected by the new requirements and restrictions or changes to
71 the requirements and restrictions are provided with a written
72 notice of the changes at least 60 days before the changes are
73 implemented. Such notice may be delivered electronically or by
74 other means as agreed to by the insured or health care provider.
75
76 This subsection does not apply to expansion of health care
77 services coverage.
78 (7) A health insurer or a pharmacy benefits manager on
79 behalf of the health insurer must authorize or deny a prior
80 authorization request and notify the patient and the patient's
81 treating health care provider of the decision within:
82 (a) Seventy-two hours of obtaining a completed prior
83 authorization form for nonurgent care situations.
84 (b) Twenty-four hours of obtaining a completed prior
85 authorization form for urgent care situations.
86 Section 2. Section 627.42393, Florida Statutes, is created
87 to read:
88 627.42393 Fail-first protocols.—
89 (1) As used in this section, the term:
90 (a) "Fail-first protocol" means a written protocol that
91 specifies the order in which a certain medical procedure, course
92 of treatment, or prescription drug must be used to treat an
93 insured's condition.
94 (b) "Health insurer" has the same meaning as provided in s.
95 627.42392.
96 (c) "Preceding prescription drug or medical treatment"
97 means a medical procedure, course of treatment, or prescription

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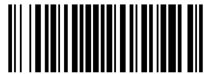
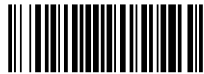
98 drug that must be used pursuant to a health insurer’s fail-first
99 protocol as a condition of coverage under a health insurance
100 policy or a health maintenance contract to treat an insured’s
101 condition.
102 (d) “Protocol exception” means a determination by a health
103 insurer that a fail-first protocol is not medically appropriate
104 or indicated for treatment of an insured’s condition and the
105 health insurer authorizes the use of another medical procedure,
106 course of treatment, or prescription drug prescribed or
107 recommended by the treating health care provider for the
108 insured’s condition.
109 (e) “Urgent care situation” means an injury or condition of
110 an insured which, if medical care and treatment is not provided
111 earlier than the time generally considered by the medical
112 profession to be reasonable for a nonurgent situation, in the
113 opinion of the insured’s treating physician, would:
114 1. Seriously jeopardize the insured’s life, health, or
115 ability to regain maximum function; or
116 2. Subject the insured to severe pain that cannot be
117 adequately managed.
118 (2) A health insurer must publish on its website, and
119 provide to an insured in writing, a procedure for an insured and
120 health care provider to request a protocol exception. The
121 procedure must include:
122 (a) A description of the manner in which an insured or
123 health care provider may request a protocol exception.
124 (b) The manner and timeframe in which the health insurer is
125 required to authorize or deny a protocol exception request or
126 respond to an appeal to a health insurer’s authorization or

 187710

127 denial of a request.
128 (c) The conditions in which the protocol exception request
129 must be granted.
130 (3)(a) The health insurer must authorize or deny a protocol
131 exception request or respond to an appeal to a health insurer's
132 authorization or denial of a request within:
133 1. Seventy-two hours of obtaining a completed prior
134 authorization form for nonurgent care situations.
135 2. Twenty-four hours of obtaining a completed prior
136 authorization form for urgent care situations.
137 (b) An authorization of the request must specify the
138 approved medical procedure, course of treatment, or prescription
139 drug benefits.
140 (c) A denial of the request must include a detailed,
141 written explanation of the reason for the denial, the clinical
142 rationale that supports the denial, and the procedure to appeal
143 the health insurer's determination.
144 (4) A health insurer must grant a protocol exception
145 request if:
146 (a) A preceding prescription drug or medical treatment is
147 contraindicated or will likely cause an adverse reaction or
148 physical or mental harm to the insured;
149 (b) A preceding prescription drug is expected to be
150 ineffective, based on the medical history of the insured and the
151 clinical evidence of the characteristics of the preceding
152 prescription drug or medical treatment;
153 (c) The insured has previously received a preceding
154 prescription drug or medical treatment that is in the same
155 pharmacologic class or has the same mechanism of action, and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156 such drug or treatment lacked efficacy or effectiveness or
157 adversely affected the insured; or
158 (d) A preceding prescription drug or medical treatment is
159 not in the best interest of the insured because the insured's
160 use of such drug or treatment is expected to:
161 1. Cause a significant barrier to the insured's adherence
162 to or compliance with the insured's plan of care;
163 2. Worsen an insured's medical condition that exists
164 simultaneously but independently with the condition under
165 treatment; or
166 3. Decrease the insured's ability to achieve or maintain
167 his or her ability to perform daily activities.
168 (5) The health insurer may request a copy of relevant
169 documentation from the insured's medical record in support of a
170 protocol exception request.
171 Section 3. This act shall take effect July 1, 2017.
172
173 ================= T I T L E A M E N D M E N T ================
174 And the title is amended as follows:
175 Delete everything before the enacting clause
176 and insert:
177 A bill to be entitled
178 An act relating to health insurer authorization;
179 amending s. 627.42392, F.S.; revising and providing
180 definitions; revising criteria for prior authorization
181 forms; requiring health insurers and pharmacy benefits
182 managers on behalf of health insurers to provide
183 certain information relating to prior authorization in
184 a specified manner; prohibiting such insurers and

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185 pharmacy benefits managers from implementing or making
186 changes to requirements or restrictions to obtain
187 prior authorization, except under certain
188 circumstances; providing applicability; requiring such
189 insurers or pharmacy benefits managers to authorize or
190 deny prior authorization requests and provide certain
191 notices within specified timeframes; creating s.
192 627.42393, F.S.; providing definitions; requiring
193 health insurers to publish on their websites and
194 provide in writing to insureds a specified procedure
195 to obtain protocol exceptions; specifying timeframes
196 in which health insurers must authorize or deny
197 protocol exception requests and respond to an appeal
198 to a health insurer's authorization or denial of a
199 request; requiring authorizations or denials to
200 specify certain information; providing circumstances
201 in which health insurers must grant a protocol
202 exception request; authorizing health insurers to
203 request documentation in support of a protocol
204 exception request; providing an effective date.