By Senator Steube

23-00630-17 2017530__

1 A bill to be entitled
2 An act relating to health insurance; amending s.
3 627.42392, F.S.; defining terms; providing that a
4 prior authorization form may not require certain
5 information; requiring a utilization review entity or
6 health insurer to make current prior authorization
7 requirements, restrictions, and forms accessible in a
8 specified manner; providing requirements for
9 describing certain requirements and criteria;
10 specifying requirements for a utilization review
11 entity or health insurer that implements a new prior
12 authorization requirement or that amends an existing
13 requirement or restriction; specifying timeframes that
14 a utilization review entity or health insurer must
15 authorize or deny a prior authorization request and
16 notify the patient and treating health care provider
17 of the determination under certain circumstances;
18 making technical changes; creating s. 627.42393, F.S.;
19 defining terms; requiring a plan to publish on the
20 plan's website and provide to an insured a written
21 procedure for requesting a protocol exception;
22 specifying requirements for such procedure; providing
23 an effective date.
24
25 Be It Enacted by the Legislature of the State of Florida:
26
27 Section 1. Section 627.42392, Florida Statutes, is amended
28 to read:
29 627.42392 Prior authorization.—
30 (1) As used in this section, the term<u>:</u>
31 <u>(a)</u> "Health insurer" means an authorized insurer offering
32 health insurance as defined in s. 624.603, a managed care plan

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33 as defined in s. 409.962(10) ~~s. 409.962(9)~~, or a health
34 maintenance organization as defined in s. 641.19(12).
35 (b) “Urgent health care service” means a health care
36 service that if subject to the time period for making a
37 nonexpedited prior authorization, such time period without the
38 service, in the opinion of a physician with knowledge of the
39 patient’s medical condition, could:
40 1. Seriously jeopardize the life or health of the patient;
41 2. Seriously jeopardize the patient’s ability to regain
42 maximum function; or
43 3. Subject the patient to severe pain that cannot be
44 adequately managed.
45 (c) “Utilization review entity” means an entity that
46 performs prior authorization for a health insurer.
47 (2) Notwithstanding any other provision of law, effective
48 January 1, 2017, or 6 ~~six (6)~~ months after the effective date of
49 the rule adopting the prior authorization form, whichever is
50 later, a health insurer, or a pharmacy benefits manager on
51 behalf of the health insurer, which does not provide an
52 electronic prior authorization process for use by its contracted
53 providers, may ~~shall~~ only use the prior authorization form that
54 has been approved by the Financial Services Commission for
55 granting a prior authorization for a medical procedure, course
56 of treatment, or prescription drug benefit. Such form may not
57 exceed two pages in length, excluding any instructions or
58 guiding documentation, and must include all clinical
59 documentation necessary for the health insurer to make a
60 decision. At a minimum, the form must include~~: (1)~~ sufficient
61 patient information to identify the member, date of birth, full

62 name, and Health Plan ID number; ~~(2)~~ provider name, address and
63 phone number; ~~(3)~~ the medical procedure, course of treatment, or
64 prescription drug benefit being requested, including the medical
65 reason therefor, and all services tried and failed; ~~(4)~~ any
66 laboratory documentation required; and ~~(5)~~ an attestation that
67 all information provided is true and accurate.
68 (3) The Financial Services Commission in consultation with
69 the Agency for Health Care Administration shall adopt by rule
70 guidelines for all prior authorization forms which ensure the
71 general uniformity of such forms.
72 (4) Electronic prior authorization approvals do not
73 preclude benefit verification or medical review by the insurer
74 under either the medical or pharmacy benefits.
75 <u>(5) A paper or electronic prior authorization form may not</u>
76 <u>require information that is not needed to facilitate a</u>
77 <u>determination of the medical necessity of or coverage for the</u>
78 <u>requested medical procedure, course of treatment, or</u>
79 <u>prescription drug benefit.</u>
80 <u>(6) A utilization review entity or health insurer must make</u>
81 <u>any current prior authorization requirements, restrictions, and</u>
82 <u>forms readily accessible on its website and in written or</u>
83 <u>electronic form upon request for beneficiaries, health care</u>
84 <u>providers, and the general public. The requirements must be</u>
85 <u>described in detail in clear and easily understandable language.</u>
86 <u>Clinical criteria must be described in language easily</u>
87 <u>understandable by a health care provider.</u>
88 <u>(7) If a utilization review entity or health insurer</u>
89 <u>intends to implement a new prior authorization requirement or</u>
90 <u>restriction or to amend an existing requirement or restriction,</u>

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91 the utilization review entity or health insurer must:
92 (a) Ensure that the new or amended requirement or
93 restriction is not implemented unless the utilization review
94 entity’s or health insurer’s website has been updated to reflect
95 the new or amended requirement or restriction at least 60 days
96 before its implementation. This paragraph does not apply to the
97 expansion of coverage for new health care services.
98 (b) Provide to beneficiaries who are currently using the
99 affected health care service and to all contracted health care
100 physicians who provide the affected health care service written
101 notice of the new or amended requirement or restriction at least
102 60 days before the requirement or restriction is implemented.
103 Such notice may be delivered electronically or by other means as
104 agreed to by the receiving entity.
105 (8) If a utilization review entity or health insurer
106 requires prior authorization of a health care service in
107 nonurgent circumstances, the plan must authorize or deny the
108 prior authorization request and notify the patient and the
109 patient’s treating health care provider of the determination
110 within 3 business days after obtaining all necessary information
111 to make the determination. If a utilization review entity or
112 health insurer requires prior authorization for an urgent health
113 care service, the utilization review entity or health insurer
114 must authorize or deny the prior authorization request and
115 notify the patient and the patient’s treating health care
116 provider of the determination within 24 hours after obtaining
117 all necessary information to make the determination.
118 Section 2. Section 627.42393, Florida Statutes, is created
119 to read:

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120 627.42393 Fail first protocols.—
121 (1) As used in this section, the term:
122 (a) “Fail first protocol” means a protocol that specifies
123 the order in which certain prescription drugs or medical
124 treatments must be used to treat an insured’s condition.
125 (b) “Plan” means an authorized insurer offering health
126 insurance as defined in s. 624.603, a managed care plan as
127 defined in s. 409.962(10), or a health maintenance organization
128 as defined in s. 641.19(12).
129 (c) “Preceding prescription drug or medical treatment”
130 means a prescription drug or medical treatment that according to
131 a fail first protocol, must be used first to treat an insured’s
132 condition and then must be determined, as a result of such
133 treatment, to be inappropriate to treat the insured’s condition
134 before a succeeding treatment with another prescription drug or
135 medical treatment is covered.
136 (d) “Protocol exception” means a plan’s determination,
137 based on a review of a request for the determination and any
138 supporting documentation, that:
139 1. A fail first protocol is not medically appropriate or
140 indicated for treatment of a particular insured’s condition; and
141 2. The plan will not require the insured’s use of a
142 preceding prescription drug or medical treatment under the fail
143 first protocol and will provide immediate coverage for another
144 prescription drug or medical treatment that is prescribed or
145 recommended for the insured.
146 (e) “Urgent care situation” means an injury or condition of
147 an insured which, if medical care or treatment is not provided
148 earlier than the time generally considered by the medical

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149 profession to be reasonable for a nonurgent situation, could:
150 1. Seriously jeopardize the insured’s life or health, based
151 on a prudent layperson’s judgment;
152 2. Seriously jeopardize the insured’s ability to regain
153 maximum function, based on a prudent layperson’s judgment; or
154 3. Subject the insured to severe pain that cannot be
155 adequately managed, based on the insured’s treating health care
156 provider’s judgment.
157 (2) A plan shall publish on the plan’s website and provide
158 in writing to an insured a procedure for requesting a protocol
159 exception. The procedure must provide all of the following
160 provisions:
161 (a) A description of the manner in which an insured may
162 request a protocol exception.
163 (b) That the plan must make a determination concerning a
164 protocol exception request or an appeal of a denial of a
165 protocol exception request:
166 1. Within 24 hours after receiving the request or appeal in
167 an urgent care situation; or
168 2. Within 3 business days after receiving the request or
169 appeal in a nonurgent care situation.
170 (c) That a protocol exception will be granted if any of the
171 following applies:
172 1. A preceding prescription drug or medical treatment is
173 contraindicated or will likely cause an adverse reaction or
174 physical or mental harm to the insured.
175 2. A preceding prescription drug is expected to be
176 ineffective based on both the known clinical characteristics of
177 the insured and the known characteristics of the preceding

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178 prescription drug or medical treatment as found in sound
179 clinical evidence.
180 3. The insured previously received a preceding prescription
181 drug or another prescription drug that is in the same
182 pharmacologic class or that has the same mechanism of action as
183 a preceding prescription drug, and the prescription drug was
184 discontinued due to lack of efficacy or effectiveness,
185 diminished effect, or an adverse event.
186 4. Based on clinical appropriateness, a preceding
187 prescription drug or medical treatment is not in the best
188 interest of the insured because the insured's use of the
189 preceding prescription drug or medical treatment is expected to:
190 a. Cause a significant barrier to the insured's adherence
191 to or compliance with the insured's plan of care;
192 b. Worsen a comorbid condition of the insured; or
193 c. Decrease the insured's ability to achieve or maintain
194 reasonable functional ability in performing daily activities.
195 (d) That when a protocol exception is granted, the plan
196 must notify the insured and the insured's health care provider
197 of the authorization for coverage of the prescription drug or
198 medical treatment that is the subject of the protocol exception.
199 (e) That if a protocol exception request or an appeal of a
200 denied protocol exception request results in a denial of the
201 protocol exception, the plan must provide to the insured and
202 treating health care provider notice of the denial, including a
203 detailed written explanation of the reason for the denial and
204 the clinical rationale that supports the denial.
205 (f) That the plan may request a copy of relevant
206 documentation from the insured's medical record in support of a

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207 protocol exception.

208 Section 3. This act shall take effect July 1, 2017.

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