1 A bill to be entitled
2 An act relating to health insurer authorization;
3 amending s. 627.42392, F.S.; redefining the term
4 "health insurer"; defining the term "urgent care
5 situation"; prohibiting prior authorization forms from
6 requiring certain information; requiring health
7 insurers and pharmacy benefits managers on behalf of
8 health insurers to provide certain information
9 relating to prior authorization by specified means;
10 prohibiting such insurers and pharmacy benefits
11 managers from implementing or making changes to
12 requirements or restrictions to obtain prior
13 authorization except under certain circumstances;
14 providing applicability; requiring such insurers and
15 pharmacy benefits managers to authorize or deny prior
16 authorization requests and provide certain notices
17 within specified timeframes; creating s. 627.42393,
18 F.S.; defining terms; requiring health insurers to
19 publish on their websites and provide to insureds in
20 writing a procedure for insureds and health care
21 providers to request protocol exceptions; specifying
22 requirements for such procedure; requiring health
23 insurers, within specified timeframes, to authorize or
24 deny a protocol exception request or respond to
25 appeals of their authorizations or denials; requiring

26 authorizations or denials to specify certain
27 information; requiring health insurers to grant
28 protocol exception requests under certain
29 circumstances; authorizing health insurers to request
30 documentation in support of a protocol exception
31 request; providing an effective date.
32
33 Be It Enacted by the Legislature of the State of Florida:
34
35 Section 1. Section 627.42392, Florida Statutes, is amended
36 to read:
37 627.42392 Prior authorization.—
38 (1) As used in this section, the term:
39 (a) "Health insurer" means an authorized insurer offering
40 an individual or group insurance policy that provides major
41 medical or similar comprehensive coverage ~~health insurance as~~
42 ~~defined in s. 624.603~~, a managed care plan as defined in s.
43 409.962(10), or a health maintenance organization as defined in
44 s. 641.19(12).
45 (b) "Urgent care situation" has the same meaning as in s.
46 627.42393.
47 (2) Notwithstanding any other provision of law, effective
48 January 1, 2017, or 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, shall only use the prior authorization form that has
54 been approved by the Financial Services Commission for granting
55 a prior authorization for a medical procedure, course of
56 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. The form, whether
68 in electronic or paper format, may not require information that
69 is not necessary for the determination of medical necessity of,
70 or coverage for, the requested medical procedure, course of
71 treatment, or prescription drug.
72 (3) The Financial Services Commission in consultation with
73 the Agency for Health Care Administration shall adopt by rule
74 guidelines for all prior authorization forms which ensure the
75 general uniformity of such forms.

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76 (4) Electronic prior authorization approvals do not
77 preclude benefit verification or medical review by the insurer
78 under either the medical or pharmacy benefits.
79 (5) A health insurer or a pharmacy benefits manager on
80 behalf of the health insurer must provide the following
81 information in writing or in an electronic format upon request,
82 and on a publicly accessible Internet website:
83 (a) Detailed descriptions of requirements and restrictions
84 to obtain prior authorization for coverage of a medical
85 procedure, course of treatment, or prescription drug in clear,
86 easily understandable language. Clinical criteria must be
87 described in language easily understandable by a health care
88 provider.
89 (b) Prior authorization forms.
90 (6) A health insurer or a pharmacy benefits manager on
91 behalf of the health insurer may not implement any new
92 requirements or restrictions or make changes to existing
93 requirements or restrictions to obtain prior authorization
94 unless:
95 (a) The changes have been available on a publicly
96 accessible Internet website at least 60 days before the
97 implementation of the changes.
98 (b) Policyholders and health care providers who are
99 affected by the new requirements and restrictions or changes to
100 the requirements and restrictions are provided with a written

101 notice of the changes at least 60 days before the changes are
102 implemented. Such notice may be delivered electronically or by
103 other means as agreed to by the insured or health care provider.
104
105 This subsection does not apply to expansion of health care
106 services coverage.
107 (7) A health insurer or a pharmacy benefits manager on
108 behalf of the health insurer must authorize or deny a prior
109 authorization request and notify the patient and the patient's
110 treating health care provider of the decision within:
111 (a) Seventy-two hours of obtaining a completed prior
112 authorization form for nonurgent care situations.
113 (b) Twenty-four hours of obtaining a completed prior
114 authorization form for urgent care situations.
115 Section 2. Section 627.42393, Florida Statutes, is created
116 to read:
117 627.42393 Fail-first protocols.—
118 (1) As used in this section, the term:
119 (a) "Fail-first protocol" means a written protocol that
120 specifies the order in which a certain medical procedure, course
121 of treatment, or prescription drug must be used to treat an
122 insured's condition.
123 (b) "Health insurer" has the same meaning as provided in
124 s. 627.42392.
125 (c) "Preceding prescription drug or medical treatment"

126 means a medical procedure, course of treatment, or prescription
127 drug that must be used pursuant to a health insurer's fail-first
128 protocol as a condition of coverage under a health insurance
129 policy or a health maintenance contract to treat an insured's
130 condition.
131 (d) "Protocol exception" means a determination by a health
132 insurer that a fail-first protocol is not medically appropriate
133 or indicated for treatment of an insured's condition and the
134 health insurer authorizes the use of another medical procedure,
135 course of treatment, or prescription drug prescribed or
136 recommended by the treating health care provider for the
137 insured's condition.
138 (e) "Urgent care situation" means an injury or condition
139 of an insured which, if medical care and treatment are not
140 provided earlier than the time generally considered by the
141 medical profession to be reasonable for a nonurgent situation,
142 in the opinion of the insured's treating physician, would:
143 1. Seriously jeopardize the insured's life, health, or
144 ability to regain maximum function; or
145 2. Subject the insured to severe pain that cannot be
146 adequately managed.
147 (2) A health insurer must publish on its website and
148 provide to an insured in writing a procedure for an insured and
149 health care provider to request a protocol exception. The
150 procedure must include:

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151 (a) A description of the manner in which an insured or
152 health care provider may request a protocol exception.
153 (b) The manner and timeframe in which the health insurer
154 is required to authorize or deny a protocol exception request or
155 respond to an appeal of a health insurer's authorization or
156 denial of a request.
157 (c) The conditions under which the protocol exception
158 request must be granted.
159 (3)(a) The health insurer must authorize or deny a
160 protocol exception request or respond to an appeal of a health
161 insurer's authorization or denial of a request within:
162 1. Seventy-two hours of obtaining a completed prior
163 authorization form for nonurgent care situations.
164 2. Twenty-four hours of obtaining a completed prior
165 authorization form for urgent care situations.
166 (b) An authorization of the request must specify the
167 approved medical procedure, course of treatment, or prescription
168 drug benefits.
169 (c) A denial of the request must include a detailed,
170 written explanation of the reason for the denial, the clinical
171 rationale that supports the denial, and the procedure to appeal
172 the health insurer's determination.
173 (4) A health insurer must grant a protocol exception
174 request if:
175 (a) A preceding prescription drug or medical treatment is

176 contraindicated or will likely cause an adverse reaction or
177 physical or mental harm to the insured;
178 (b) A preceding prescription drug is expected to be
179 ineffective, based on the medical history of the insured and the
180 clinical evidence of the characteristics of the preceding
181 prescription drug or medical treatment;
182 (c) The insured has previously received a preceding
183 prescription drug or medical treatment that is in the same
184 pharmacologic class or has the same mechanism of action, and
185 such drug or treatment lacked efficacy or effectiveness or
186 adversely affected the insured; or
187 (d) A preceding prescription drug or medical treatment is
188 not in the best interest of the insured because the insured's
189 use of such drug or treatment is expected to:
190 1. Cause a significant barrier to the insured's adherence
191 to or compliance with the insured's plan of care;
192 2. Worsen an insured's medical condition that exists
193 simultaneously but independently with the condition under
194 treatment; or
195 3. Decrease the insured's ability to achieve or maintain
196 his or her ability to perform daily activities.
197 (5) The health insurer may request a copy of relevant
198 documentation from the insured's medical record in support of a
199 protocol exception request.
200 Section 3. This act shall take effect July 1, 2018.

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