COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___ (Y/N)
ADOPTED AS AMENDED	___ (Y/N)
ADOPTED W/O OBJECTION	___ (Y/N)
FAILED TO ADOPT	___ (Y/N)
WITHDRAWN	___ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Market Reform Subcommittee

Representative Massullo offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

(1) As used in this section, the term:

(a) "Electronic prior authorization process" does not include transmissions through a facsimile machine.

(b) "health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.962(10), or a health maintenance organization as defined in s. 641.19(12).

(c) "prior authorization" means a statement from a health insurer that a certain medical service or treatment is covered under the terms of a policy or contract for a specific period of time.

(2) Notwithstanding any other provision of law, effective January 1, 2017, or 6 ~~six (6)~~ months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy benefit~~benefits~~ manager on behalf of the health insurer, ~~which does not provide an electronic prior authorization process for use by its contracted providers,~~ shall only use the prior authorization form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the health insurer to make a decision. At a minimum, the form must include:

(a) ~~(1)~~ Sufficient patient information to identify the member, date of birth, full name, and Health Plan ID number;

(b) ~~(2)~~ The provider's ~~provider~~ name, address and phone number;

(c) ~~(3)~~ The medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed;

(d) ~~(4)~~ Any laboratory documentation required; and

(e) ~~(5)~~ An attestation that all information provided is true and accurate.

(3) The Financial Services Commission in consultation with the Agency for Health Care Administration shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

(4) Electronic prior authorization approvals do not preclude benefit verification or medical review by the insurer under either the medical or pharmacy benefits.

(5) Effective January 1, 2020, a health insurer, or a pharmacy benefits manager on behalf of an insurer, must offer a secure, online electronic prior authorization process for accepting electronic prior authorization forms. All contracted providers must use a health insurer's electronic process to request prior authorization for medical services and treatment provided to an insured or a subscriber. A health insurer may make an electronic request to the provider for additional information, if necessary, to complete its determination to grant or deny a request for prior authorization.

Section 2. Section 627.42393, Florida Statutes, is created to read:

627.42393 Step therapy protocols.—

(1) As used in this section, the term "step therapy protocol" means a written protocol that specifies the order in

which a prescription drug must be used to treat an insured's condition.

(2) As used in this section, the term "health insurer" means a health insurer as defined in s. 627.42392 which is covering or has previously covered the insured under a major medical policy or contract.

(3)(a) A health insurer may not impose a step-therapy protocol for a covered prescription drug if:

1. The insured has been approved to receive the prescription drug through a step-therapy protocol imposed by a health insurer that previously issued major medical coverage to the insured; and,

2. The insured is currently taking the drug, as evidenced by the health insurer that approved the drug as described under subparagraph 1. having made payment for the drug on the insured's behalf within the prior 90 days.

(b) This section does not preclude an insured's new health insurer from imposing a prior authorization requirement for the continued coverage of a drug prescribed pursuant to a step therapy protocol that was imposed by the former health insurer.

(c) A health insurer is not required to add a drug to its prescription drug formulary, or to cover a prescription drug's use for a purpose not currently covered by the insurer, to comply with this section.

(d) This section applies to contracts entered into or

renewed on or after January 1, 2020. This section does not apply to Medicaid managed care plans pursuant to part IV of chapter 409.

Section 3. This act shall take effect July 1, 2019.

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

Remove everything before the enacting clause and insert:
An act relating to prescription drug utilization management; amending s. 627.42392, F.S.; providing definitions; revising the circumstances under which health insurers and pharmacy benefit managers are required to use prior authorization forms for specified purposes; requiring health insurers and pharmacy benefit managers to establish and offer an online prior authorization process; providing requirements for the process; creating s. 627.42393; defining the term "step therapy"; prohibiting health insurers and health maintenance organizations from requiring insureds or subscribers to repeat step therapy protocols; providing that certain health insurers and health maintenance organizations may impose a specified requirement for continued coverage; providing that such entities are not required to take specified actions; providing applicability; providing an effective date.; providing an effective date.