

1 A bill to be entitled
2 An act relating to health insurance coverage; amending
3 s. 627.4239, F.S.; defining the terms "associated
4 condition" and "health care provider"; prohibiting
5 health maintenance organizations from excluding
6 coverage for certain drugs on a specified ground;
7 prohibiting insurers and health maintenance
8 organizations of certain individual and group health
9 insurance policies and health maintenance contracts
10 from requiring, before certain drugs are covered, that
11 an insured or subscriber undergo a step-therapy
12 protocol or step-therapy override determination;
13 providing applicability; prohibiting such insurers and
14 health maintenance organizations from excluding
15 coverage for certain drugs on a specified ground;
16 requiring coverage for specified services; amending
17 ss. 627.42393 and 641.31, F.S.; revising and providing
18 definitions; requiring health coverage plans to
19 provide on their websites an easily accessible process
20 for requests for a step-therapy protocol override
21 determination under certain circumstances; providing
22 requirements and timeframes for the determination;
23 requiring health coverage plans to grant requests to
24 override step-therapy protocols under certain
25 circumstances; requiring health coverage plans to

26 authorize coverage for a prescription drug prescribed
27 by an insured's or subscriber's health care provider
28 under certain circumstances; providing construction;
29 amending s. 627.6131, F.S.; prohibiting health
30 insurers from retroactively denying a claim because of
31 insured ineligibility at any time under certain
32 circumstances; prohibiting health insurers from
33 imposing additional prior authorization requirements
34 for certain procedures and items under certain
35 circumstances; amending s. 641.3155, F.S.; prohibiting
36 health maintenance organizations from retroactively
37 denying at any time a claim because of subscriber
38 ineligibility under certain circumstances; amending s.
39 641.3156, F.S.; prohibiting health maintenance
40 organizations from imposing additional prior
41 authorization requirements for certain procedures and
42 items under certain circumstances; providing an
43 effective date.

44
45 Be It Enacted by the Legislature of the State of Florida:

46
47 Section 1. Section 627.4239, Florida Statutes, is amended
48 to read:

49 627.4239 Coverage for use of drugs in treatment of
50 cancer.—

51 (1) DEFINITIONS.—As used in this section, the term:
 52 (a) "Associated condition" means a symptom or side effect
 53 that:
 54 1. Is associated with a particular cancer at a particular
 55 stage or with the treatment of that cancer.
 56 2. In the judgment of a health care provider, will further
 57 jeopardize the health of a patient if left untreated. As used in
 58 this subparagraph, the term "health care provider" means a
 59 physician licensed under chapter 458, chapter 459, or chapter
 60 461; a physician assistant licensed under chapter 458 or chapter
 61 459; an advanced practice registered nurse licensed under
 62 chapter 464; or a dentist licensed under chapter 466.
 63 (b) ~~(a)~~ "Medical literature" means scientific studies
 64 published in a United States peer-reviewed national professional
 65 journal.
 66 (c) ~~(b)~~ "Standard reference compendium" means authoritative
 67 compendia identified by the Secretary of the United States
 68 Department of Health and Human Services and recognized by the
 69 federal Centers for Medicare and Medicaid Services.
 70 (2) COVERAGE FOR TREATMENT OF CANCER.—
 71 ~~(a)~~ An insurer or a health maintenance organization may
 72 not exclude coverage in any individual or group health insurance
 73 policy or health maintenance contract issued, amended,
 74 delivered, or renewed in this state which covers the treatment
 75 of cancer for any drug prescribed for the treatment of cancer on

76 | the ground that the drug is not approved by the United States
77 | Food and Drug Administration for a particular indication, if
78 | that drug is recognized for treatment of that indication in a
79 | standard reference compendium or recommended in the medical
80 | literature.

81 | ~~(b) Coverage for a drug required by this section also~~
82 | ~~includes the medically necessary services associated with the~~
83 | ~~administration of the drug.~~

84 | (3) COVERAGE FOR TREATMENT OF STAGE 4 METASTATIC CANCER
85 | AND ASSOCIATED CONDITIONS.—

86 | (a) In any individual or group health insurance policy or
87 | health maintenance contract issued, amended, delivered, or
88 | renewed in this state which covers the treatment of a particular
89 | stage 4 metastatic cancer and its associated conditions, an
90 | insurer or a health maintenance organization may not require
91 | that, before a drug prescribed for the treatment is covered, the
92 | insured or subscriber undergo a step-therapy protocol or step-
93 | therapy override determination under s. 627.42393 or s.
94 | 641.31(46).

95 | (b) Paragraph (a) applies to a drug that is recognized for
96 | the treatment of such stage 4 metastatic cancer or its
97 | associated conditions, as applicable, in a standard reference
98 | compendium or that is recommended in the medical literature. The
99 | insurer or the health maintenance organization may not exclude
100 | coverage for such drug on the ground that the drug is not

101 approved by the United States Food and Drug Administration for
 102 such stage 4 metastatic cancer or its associated conditions, as
 103 applicable.

104 (4) COVERAGE FOR SERVICES ASSOCIATED WITH DRUG
 105 ADMINISTRATION.—Coverage for a drug required under this section
 106 includes the medically necessary services associated with the
 107 administration of the drug.

108 (5)~~(3)~~ APPLICABILITY AND SCOPE.—This section may not be
 109 construed to:

110 (a) Alter any other law with regard to provisions limiting
 111 coverage for drugs that are not approved by the United States
 112 Food and Drug Administration.

113 (b) Require coverage for any drug if the United States
 114 Food and Drug Administration has determined that the use of the
 115 drug is contraindicated.

116 (c) Require coverage for a drug that is not otherwise
 117 approved for any indication by the United States Food and Drug
 118 Administration.

119 (d) Affect the determination as to whether particular
 120 levels, dosages, or usage of a medication associated with bone
 121 marrow transplant procedures are covered under an individual or
 122 group health insurance policy or health maintenance ~~organization~~
 123 contract.

124 (e) Apply to specified disease or supplemental policies.

125 (f)~~(4)~~ Nothing in this section is intended, Expressly or

126 by implication, ~~to~~ create, impair, alter, limit, modify,
127 enlarge, abrogate, prohibit, or withdraw any authority to
128 provide reimbursement for drugs used in the treatment of any
129 other disease or condition.

130 Section 2. Section 627.42393, Florida Statutes, is amended
131 to read:

132 627.42393 Step-therapy protocol.—

133 (1)~~(2)~~ As used in this section, the term:

134 (a) "Health coverage plan" means any of the following
135 which is currently or was previously providing major medical or
136 similar comprehensive coverage or benefits to the insured:

137 1.~~(a)~~ A health insurer as defined in s. 627.42392 ~~or~~
138 ~~health maintenance organization.~~

139 2.~~(b)~~ A plan established or maintained by an individual
140 employer as provided by the Employee Retirement Income Security
141 Act of 1974, Pub. L. No. 93-406.

142 3.~~(c)~~ A multiple-employer welfare arrangement as defined
143 in s. 624.437.

144 4.~~(d)~~ A governmental entity providing a plan of self-
145 insurance.

146 (b) "Step-therapy override determination" means a
147 determination by a health coverage plan that in a particular
148 situation a step-therapy protocol should apply or it should be
149 overridden in favor of immediate coverage of the health care
150 provider's selected prescription drug.

151 (c) "Step-therapy protocol" means a protocol or program
152 that establishes the specific sequence in which prescription
153 drugs determined as medically appropriate for an insured for a
154 specified medical condition are covered by a health coverage
155 plan.

156 (2)~~(1)~~ A health coverage plan under ~~insurer issuing~~ a
157 major medical individual or group policy may not require a step-
158 therapy protocol ~~under the policy~~ for a covered prescription
159 drug requested by an insured if:

160 (a) The insured has previously been approved to receive
161 the prescription drug through the completion of a step-therapy
162 protocol required by a separate health coverage plan; and

163 (b) The insured provides documentation originating from
164 the health coverage plan that approved the prescription drug as
165 described in paragraph (a) indicating that the health coverage
166 plan paid for the drug on the insured's behalf during the 90
167 days immediately before the current request.

168 (3) (a) If coverage of a prescription drug for the
169 treatment of a medical condition is restricted for use by a
170 health coverage plan through the use of a step-therapy protocol,
171 the health coverage plan must provide a clear and convenient
172 process for an insured and health care provider to request a
173 step-therapy override determination. This process must be made
174 easily accessible on the health coverage plan's website. The
175 health coverage plan must provide a prescription drug for

176 treatment of the insured's medical condition at least until the
177 step-therapy override determination is made.

178 (b) The health coverage plan must base the step-therapy
179 override determination on a review of the insured's or health
180 care provider's request for an override and the rationale and
181 documentation supporting the request.

182 (c)1. When an insured or health care provider submits a
183 request for a step-therapy override determination or submits an
184 appeal of a step-therapy override determination decision, the
185 health coverage plan must grant or deny the request or appeal
186 within 24 hours after the submission in an urgent care situation
187 and within 2 business days in a nonurgent care situation.

188 2. If the health coverage plan fails to respond in
189 accordance with the timeframe established in subparagraph 1.,
190 the request or appeal shall be deemed approved.

191 (d) A health coverage plan must grant a request to
192 override a step-therapy protocol in favor of the health care
193 provider's selected prescription drug for any of the following
194 reasons:

195 1. The prescription drug required under the step-therapy
196 protocol is contraindicated, or it is not in the insured's best
197 interest because the drug will likely:

198 a. Cause a significant barrier to the insured's adherence
199 to, or compliance with, the insured's plan of care.

200 b. Be ineffective, based on the insured's medical history

201 and the clinical evidence of the known characteristics of the
202 prescription drug regimen.

203 c. Cause an adverse reaction or physical or mental harm to
204 the insured, including a worsened comorbid condition or a
205 decrease in the insured's ability to achieve or maintain
206 reasonable functional ability in performing daily activities.

207 2. The insured has tried, under his or her current health
208 coverage plan, the required prescription drug or another
209 prescription drug that is in the same pharmacologic class or
210 that has the same mechanism of action, and such prescription
211 drug lacked efficacy or effectiveness or adversely affected the
212 insured.

213 3. The insured is stable on the health care provider's
214 selected prescription drug for the medical condition under
215 consideration.

216 (e) Upon granting a request to override a step-therapy
217 protocol in favor of the health care provider's selected
218 prescription drug, the health coverage plan must authorize
219 immediate coverage of the selected prescription drug if the
220 health coverage plan covers such prescription drug.

221 (4) This section does not prevent a health coverage plan
222 from requiring an insured to try a generic equivalent before
223 providing coverage for the equivalent brand-name prescription
224 drug.

225 (5)~~(3)~~ This section does not require a health coverage

226 | plan insurer to add a drug to its prescription drug formulary or
 227 | to cover a prescription drug that the health coverage plan
 228 | ~~insurer~~ does not otherwise cover.

229 | Section 3. Subsection (11) of section 627.6131, Florida
 230 | Statutes, is amended, and subsection (20) is added to that
 231 | section, to read:

232 | 627.6131 Payment of claims.—

233 | (11) A health insurer may not retroactively deny a claim
 234 | because of insured ineligibility:

235 | (a) At any time, if the health insurer has confirmed
 236 | insured eligibility at the time of treatment or has granted
 237 | prior authorization for a treatment.

238 | (b) Except as provided in paragraph (a), more than 1 year
 239 | after the date of payment of the claim.

240 | (20) A health insurer may not impose any additional prior
 241 | authorization requirement with respect to a surgical or an
 242 | otherwise invasive procedure and with respect to an item
 243 | furnished as part of such surgical or invasive procedure, if
 244 | such procedure or item is furnished:

245 | (a) During the perioperative period of another procedure
 246 | for which prior authorization from the health insurer was
 247 | received.

248 | (b) After the prior authorization described in paragraph
 249 | (a) was received.

250 | Section 4. Subsection (46) of section 641.31, Florida

251 Statutes, is amended to read:

252 641.31 Health maintenance contracts.—

253 (46) ~~(a)-(b)~~ As used in this subsection, the term:

254 1. "Health coverage plan" means any of the following which
255 previously provided or is currently providing major medical or
256 similar comprehensive coverage or benefits to the subscriber:

257 ~~a.1.~~ A health insurer as defined in s. 627.42392 ~~or health~~
258 ~~maintenance organization;~~

259 ~~b.2.~~ A plan established or maintained by an individual
260 employer as provided by the Employee Retirement Income Security
261 Act of 1974, Pub. L. No. 93-406;

262 ~~c.3.~~ A multiple-employer welfare arrangement as defined in
263 s. 624.437; or

264 ~~d.4.~~ A governmental entity providing a plan of self-
265 insurance.

266 2. "Step-therapy override determination" means a
267 determination by a health coverage plan that in a particular
268 situation a step-therapy protocol should apply or it should be
269 overridden in favor of immediate coverage of the health care
270 provider's selected prescription drug.

271 3. "Step-therapy protocol" means a protocol or program
272 that establishes the specific sequence in which prescription
273 drugs determined as medically appropriate for a subscriber for a
274 specified medical condition are covered by a health coverage
275 plan.

276 (b)-(a) A health coverage plan under a maintenance
277 organization issuing major medical coverage through an
278 individual or group contract may not require a step-therapy
279 protocol under the contract for a covered prescription drug
280 requested by a subscriber if:

281 1. The subscriber has previously been approved to receive
282 the prescription drug through the completion of a step-therapy
283 protocol required by a separate health coverage plan; and

284 2. The subscriber provides documentation originating from
285 the health coverage plan that approved the prescription drug as
286 described in subparagraph 1. indicating that the health coverage
287 plan paid for the drug on the subscriber's behalf during the 90
288 days immediately before the current request.

289 (c)1. If coverage of a prescription drug for the treatment
290 of a medical condition is restricted for use by a health
291 coverage plan through the use of a step-therapy protocol, the
292 health coverage plan must provide a clear and convenient process
293 for a subscriber and health care provider to request a step-
294 therapy override determination. This process must be made easily
295 accessible on the health coverage plan's website. The health
296 coverage plan must provide a prescription drug for treatment of
297 the subscriber's medical condition at least until the step-
298 therapy override determination is made.

299 2. The health coverage plan must base the step-therapy
300 override determination on a review of the subscriber's or health

301 care provider's request for an override and the subscriber's or
302 health care provider's rationale and documentation supporting
303 the request.

304 3.a. When a subscriber or health care provider submits a
305 request for a step-therapy override determination or submits an
306 appeal of a step-therapy override determination decision, the
307 health coverage plan must grant or deny the request or appeal
308 within 24 hours after the submission in an urgent care situation
309 and within 2 business days in a nonurgent care situation.

310 b. If the health coverage plan fails to respond in
311 accordance with the timeframe established in sub-subparagraph
312 a., the request or appeal shall be deemed approved.

313 4. A health coverage plan must grant a request to override
314 a step-therapy protocol in favor of the health care provider's
315 selected prescription drug for any of the following reasons:

316 a. The prescription drug required under the step-therapy
317 protocol is contraindicated, or it is not in the subscriber's
318 best interest because the drug will likely:

319 (I) Cause a significant barrier to the subscriber's
320 adherence to, or compliance with, the subscriber's plan of care.

321 (II) Be ineffective, based on the subscriber's medical
322 history and the clinical evidence of the known characteristics
323 of the prescription drug regimen.

324 (III) Cause an adverse reaction or physical or mental harm
325 to the subscriber, including a worsened comorbid condition or a

326 decrease in the subscriber's ability to achieve or maintain
327 reasonable functional ability in performing daily activities.

328 b. The subscriber has tried, under his or her current
329 health coverage plan, the required prescription drug or another
330 prescription drug that is in the same pharmacologic class or
331 that has the same mechanism of action, and such prescription
332 drug lacked efficacy or effectiveness or adversely affected the
333 subscriber.

334 c. The subscriber is stable on the health care provider's
335 selected prescription drug for the medical condition under
336 consideration.

337 5. Upon granting a request to override a step-therapy
338 protocol in favor of the health care provider's selected
339 prescription drug, the health coverage plan must authorize
340 immediate coverage of the selected prescription drug if the
341 health coverage plan covers such prescription drug.

342 (d) This subsection does not prevent a health coverage
343 plan from requiring a subscriber to try a generic equivalent
344 before providing coverage for the brand-name prescription drug.

345 (e)-(e) This subsection does not require a health
346 maintenance organization to add a drug to its prescription drug
347 formulary or to cover a prescription drug that the health
348 maintenance organization does not otherwise cover.

349 Section 5. Subsection (10) of section 641.3155, Florida
350 Statutes, is amended to read:

351 641.3155 Prompt payment of claims.—

352 (10) A health maintenance organization may not
353 retroactively deny a claim because of subscriber ineligibility:

354 (a) At any time, if the health maintenance organization
355 has confirmed subscriber eligibility at the time of treatment or
356 has granted prior authorization for the treatment.

357 (b) Except as provided in paragraph (a), more than 1 year
358 after the date of payment of the claim.

359 Section 6. Subsection (4) is added to section 641.3156,
360 Florida Statutes, to read:

361 641.3156 Treatment authorization; payment of claims.—

362 (4) A health maintenance organization may not impose any
363 additional prior authorization requirement with respect to a
364 surgical or an otherwise invasive procedure and with respect to
365 an item furnished as part of such surgical or invasive
366 procedure, if such procedure or item is furnished:

367 (a) During the perioperative period of another procedure
368 for which prior authorization from the health maintenance
369 organization was received.

370 (b) After the prior authorization described in paragraph
371 (a) was received.

372 Section 7. This act shall take effect January 1, 2021.