

By Senator Harrell

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1                   A bill to be entitled  
2           An act relating to health insurance prior  
3           authorization; amending s. 627.4239, F.S.; defining  
4           the terms "associated condition" and "health care  
5           provider"; prohibiting health maintenance  
6           organizations from excluding coverage for certain  
7           cancer treatment drugs; prohibiting health insurers  
8           and health maintenance organizations from requiring,  
9           before providing prescription drug coverage for the  
10          treatment of stage 4 metastatic cancer and associated  
11          conditions, that treatment has failed with a different  
12          drug; providing applicability; prohibiting insurers  
13          and health maintenance organizations from excluding  
14          coverage for certain drugs on certain grounds;  
15          revising construction; amending s. 627.42392, F.S.;  
16          revising the definition of the term "health insurer";  
17          defining the term "urgent care situation"; specifying  
18          a requirement for the prior authorization form adopted  
19          by the Financial Services Commission by rule;  
20          authorizing the commission to adopt certain rules;  
21          specifying requirements for, and restrictions on,  
22          health insurers and pharmacy benefits managers  
23          relating to prior authorization information,  
24          requirements, restrictions, and changes; providing  
25          applicability; specifying timeframes in which prior  
26          authorization requests must be authorized or denied  
27          and the patient and the patient's provider must be  
28          notified; amending s. 627.42393, F.S.; defining terms;  
29          requiring health insurers to provide and disclose

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30 procedures for insureds to request exceptions to step-  
31 therapy protocols; specifying requirements for such  
32 procedures and disclosures; requiring health insurers  
33 to authorize or deny protocol exception requests and  
34 respond to certain appeals within specified  
35 timeframes; specifying required information in  
36 authorizations and denials of such requests; requiring  
37 health insurers to grant a protocol exception request  
38 under specified circumstances; authorizing health  
39 insurers to request certain documentation; conforming  
40 provisions to changes made by the act; amending s.  
41 627.6131, F.S.; prohibiting health insurers, under  
42 certain circumstances, from retroactively denying a  
43 claim at any time because of insured ineligibility;  
44 prohibiting health insurers from imposing an  
45 additional prior authorization requirement with  
46 respect to certain surgical or invasive procedures or  
47 certain items; amending s. 641.31, F.S.; defining  
48 terms; requiring health maintenance organizations to  
49 provide and disclose procedures for subscribers to  
50 request exceptions to step-therapy protocols;  
51 specifying requirements for such procedures and  
52 disclosures; requiring health maintenance  
53 organizations to authorize or deny protocol exception  
54 requests and respond to certain appeals within  
55 specified timeframes; specifying required information  
56 in authorizations and denials of such requests;  
57 requiring health maintenance organizations to grant a  
58 protocol exception request under specified

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59 circumstances; authorizing health maintenance  
60 organizations to request certain documentation;  
61 conforming provisions to changes made by the act;  
62 amending s. 641.3155, F.S.; prohibiting health  
63 maintenance organizations, under certain  
64 circumstances, from retroactively denying a claim at  
65 any time because of subscriber ineligibility; amending  
66 s. 641.3156, F.S.; prohibiting health maintenance  
67 organizations from imposing an additional prior  
68 authorization requirement with respect to certain  
69 surgical or invasive procedures or certain items;  
70 providing an effective date.

71

72 Be It Enacted by the Legislature of the State of Florida:

73

74 Section 1. Section 627.4239, Florida Statutes, is amended  
75 to read:

76 627.4239 Coverage for use of drugs in treatment of cancer.—

77 (1) DEFINITIONS.—As used in this section, the term:

78 (a) "Associated condition" means a symptom or side effect  
79 that:

80 1. Is associated with a particular cancer at a particular  
81 stage or with the treatment of that cancer; and

82 2. In the judgment of a health care provider, will further  
83 jeopardize the health of a patient if left untreated. As used in  
84 this subparagraph, the term "health care provider" means a  
85 physician licensed under chapter 458, chapter 459, or chapter  
86 461, a physician assistant licensed under chapter 458 or chapter  
87 459, an advanced practice registered nurse licensed under

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88 chapter 464, or a dentist licensed under chapter 466.

89 (b)~~(a)~~ "Medical literature" means scientific studies  
90 published in a United States peer-reviewed national professional  
91 journal.

92 (c)~~(b)~~ "Standard reference compendium" means authoritative  
93 compendia identified by the Secretary of the United States  
94 Department of Health and Human Services and recognized by the  
95 federal Centers for Medicare and Medicaid Services.

96 (2) COVERAGE FOR TREATMENT OF CANCER.—

97 ~~(a)~~ An insurer or a health maintenance organization may not  
98 exclude coverage in any individual or group health insurance  
99 policy or health maintenance contract issued, amended,  
100 delivered, or renewed in this state which covers the treatment  
101 of cancer for any drug prescribed for the treatment of cancer on  
102 the ground that the drug is not approved by the United States  
103 Food and Drug Administration for a particular indication, if  
104 that drug is recognized for treatment of that indication in a  
105 standard reference compendium or recommended in the medical  
106 literature.

107 ~~(b) Coverage for a drug required by this section also~~  
108 ~~includes the medically necessary services associated with the~~  
109 ~~administration of the drug.~~

110 (3) COVERAGE FOR TREATMENT OF STAGE 4 METASTATIC CANCER AND  
111 ASSOCIATED CONDITIONS.—

112 (a) An insurer or a health maintenance organization may not  
113 require in any individual or group health insurance policy or  
114 health maintenance contract issued, amended, delivered, or  
115 renewed in this state which covers the treatment of stage 4  
116 metastatic cancer and its associated conditions that, before a

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117 drug prescribed for the treatment is covered, the insured or  
118 subscriber fail or have previously failed to respond  
119 successfully to a different drug.

120 (b) Paragraph (a) applies to a drug that is recognized for  
121 the treatment of such stage 4 metastatic cancer or its  
122 associated conditions, as applicable, in a standard reference  
123 compendium or that is recommended in the medical literature. The  
124 insurer or health maintenance organization may not exclude  
125 coverage for such drug on the ground that the drug is not  
126 approved by the United States Food and Drug Administration for  
127 such stage 4 metastatic cancer or its associated conditions, as  
128 applicable.

129 (4) COVERAGE FOR SERVICES ASSOCIATED WITH DRUG  
130 ADMINISTRATION.—Coverage for a drug required by this section  
131 also includes the medically necessary services associated with  
132 the administration of the drug.

133 (5) ~~(3)~~ APPLICABILITY AND SCOPE.—This section may not be  
134 construed to:

135 (a) Alter any other law with regard to provisions limiting  
136 coverage for drugs that are not approved by the United States  
137 Food and Drug Administration, except for drugs for the treatment  
138 of stage 4 metastatic cancer or its associated conditions.

139 (b) Require coverage for any drug, except for a drug for  
140 the treatment of stage 4 metastatic cancer or its associated  
141 conditions, if the United States Food and Drug Administration  
142 has determined that the use of the drug is contraindicated.

143 (c) Require coverage for a drug that is not otherwise  
144 approved for any indication by the United States Food and Drug  
145 Administration, except for a drug for the treatment of stage 4

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146 metastatic cancer or its associated conditions.

147 (d) Affect the determination as to whether particular  
148 levels, dosages, or usage of a medication associated with bone  
149 marrow transplant procedures are covered under an individual or  
150 group health insurance policy or health maintenance organization  
151 contract.

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

153 (f) ~~(4) Nothing in this section is intended,~~ Expressly or by  
154 implication, ~~to~~ create, impair, alter, limit, modify, enlarge,  
155 abrogate, prohibit, or withdraw any authority to provide  
156 reimbursement for drugs used in the treatment of any other  
157 disease or condition.

158 Section 2. Section 627.42392, Florida Statutes, is amended  
159 to read:

160 627.42392 Prior authorization.—

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

162 (a) "Health insurer" means an authorized insurer offering  
163 an individual or group health insurance policy that provides  
164 major medical or similar comprehensive coverage ~~health insurance~~  
165 ~~as defined in s. 624.603, a managed care plan as defined in s.~~  
166 409.962(10), or a health maintenance organization as defined in  
167 s. 641.19(12).

168 (b) "Urgent care situation" has the same meaning as  
169 provided in s. 627.42393(1).

170 (2) Notwithstanding any other ~~provision of~~ law, effective  
171 January 1, 2017, or six (6) months after the effective date of  
172 the rule adopting the prior authorization form, whichever is  
173 later, a health insurer, or a pharmacy benefits manager on  
174 behalf of the health insurer, which does not provide an

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175 electronic prior authorization process for use by its contracted  
176 providers, shall only use the prior authorization form that has  
177 been approved by the Financial Services Commission for granting  
178 a prior authorization for a medical procedure, course of  
179 treatment, or prescription drug benefit. Such form may not  
180 exceed two pages in length, excluding any instructions or  
181 guiding documentation, and must include all clinical  
182 documentation necessary for the health insurer to make a  
183 decision. At a minimum, the form must include:

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

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

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

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

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

195  
196 The form, whether in electronic or paper format, must require  
197 only information that is necessary for the determination of  
198 medical necessity of, or coverage for, the requested medical  
199 procedure, course of treatment, or prescription drug benefit.  
200 The commission may adopt rules prescribing such necessary  
201 information.

202 (3) The Financial Services Commission, in consultation with  
203 the Agency for Health Care Administration, shall adopt by rule

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204 guidelines for all prior authorization forms which ensure the  
205 general uniformity of such forms.

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

209 (5) A health insurer, or a pharmacy benefits manager on  
210 behalf of the health insurer, shall provide upon request the  
211 following information in writing or in an electronic format and  
212 publish it on a publicly accessible website:

213 (a) Detailed descriptions in clear, easily understandable  
214 language of the requirements for, and restrictions on, obtaining  
215 prior authorization for coverage of a medical procedure, course  
216 of treatment, or prescription drug. Clinical criteria must be  
217 described in language a health care provider can easily  
218 understand.

219 (b) Prior authorization forms.

220 (6) A health insurer, or a pharmacy benefits manager on  
221 behalf of the health insurer, may not implement any new  
222 requirements or restrictions or make changes to existing  
223 requirements or restrictions on obtaining prior authorization  
224 unless:

225 (a) The changes have been available on a publicly  
226 accessible website for at least 60 days before they are  
227 implemented; and

228 (b) Policyholders and health care providers who are  
229 affected by the new requirements and restrictions or changes to  
230 the requirements and restrictions are provided with a written  
231 notice of the changes at least 60 days before they are  
232 implemented. Such notice may be delivered electronically or by



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233 other means as agreed to by the insured or the health care  
234 provider.

235

236 This subsection does not apply to the expansion of health care  
237 services coverage.

238 (7) A health insurer, or a pharmacy benefits manager on  
239 behalf of the health insurer, must authorize or deny a prior  
240 authorization request and notify the patient and the patient's  
241 treating health care provider of the decision within:

242 (a) Seventy-two hours after receiving a completed prior  
243 authorization form for nonurgent care situations.

244 (b) Twenty-four hours after receiving a completed prior  
245 authorization form for urgent care situations.

246 Section 3. Section 627.42393, Florida Statutes, is amended  
247 to read:

248 627.42393 Step-therapy protocol restrictions and  
249 exceptions.-

250 (1) DEFINITIONS.-As used in this section, the term:

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

254 1. A health insurer or health maintenance organization.

255 2. A plan established or maintained by an individual  
256 employer as provided by the Employee Retirement Income Security  
257 Act of 1974, Pub. L. No. 93-406.

258 3. A multiple-employer welfare arrangement as defined in s.  
259 624.437.

260 4. A governmental entity providing a plan of self-  
261 insurance.

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262 (b) "Health insurer" has the same meaning as provided in s.  
263 627.42392.

264 (c) "Preceding prescription drug or medical treatment"  
265 means a prescription drug, medical procedure, or course of  
266 treatment that must be used pursuant to a health insurer's step-  
267 therapy protocol as a condition of coverage under a health  
268 insurance policy to treat an insured's condition.

269 (d) "Protocol exception" means a determination by a health  
270 insurer that a step-therapy protocol is not medically  
271 appropriate or indicated for treatment of an insured's  
272 condition, and the health insurer authorizes the use of another  
273 medical procedure, course of treatment, or prescription drug  
274 prescribed or recommended by the treating health care provider  
275 for the insured's condition.

276 (e) "Step-therapy protocol" means a written protocol that  
277 specifies the order in which certain medical procedures, courses  
278 of treatment, or prescription drugs must be used to treat an  
279 insured's condition.

280 (f) "Urgent care situation" means an injury or condition of  
281 an insured which, if medical care and treatment are not provided  
282 earlier than the time the medical profession generally considers  
283 reasonable for a nonurgent situation, in the opinion of the  
284 insured's treating physician, physician assistant, or advanced  
285 practice registered nurse, would:

286 1. Seriously jeopardize the insured's life, health, or  
287 ability to regain maximum function; or

288 2. Subject the insured to severe pain that cannot be  
289 adequately managed.

290 (2) STEP-THERAPY PROTOCOL RESTRICTIONS.—In addition to

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291 protocol exceptions granted under subsection (3) and the  
292 restriction under s. 627.4239(3), a health insurer issuing a  
293 major medical individual or group policy may not require a step-  
294 therapy protocol under the policy for a covered prescription  
295 drug requested by an insured if:

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

299 (b) The insured provides documentation originating from the  
300 health coverage plan that approved the prescription drug as  
301 described in paragraph (a) indicating that the health coverage  
302 plan paid for the drug on the insured's behalf during the 90  
303 days immediately before the request.

304 (3) STEP-THERAPY PROTOCOL EXCEPTIONS; REQUIREMENTS AND  
305 PROCEDURES.-

306 (a) A health insurer shall publish on its website and  
307 provide to an insured in writing a procedure for the insured and  
308 his or her health care provider to request a protocol exception.

309 The procedure must include:

310 1. The manner in which an insured or health care provider  
311 may request a protocol exception.

312 2. The manner and timeframe in which the health insurer is  
313 required to authorize or deny a protocol exception request or to  
314 respond to an appeal of the health insurer's authorization or  
315 denial of a request.

316 3. The conditions under which the protocol exception  
317 request must be granted.

318 (b)1. A health insurer must authorize or deny a protocol  
319 exception request or respond to an appeal of a health insurer's

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320 authorization or denial of a request within:

321 a. Seventy-two hours after receiving a completed prior  
322 authorization form for nonurgent care situations.

323 b. Twenty-four hours after receiving a completed prior  
324 authorization form for urgent care situations.

325 2. An authorization of the request must specify the  
326 approved medical procedure, course of treatment, or prescription  
327 drug benefits.

328 3. A denial of the request must include a detailed written  
329 explanation of the reason for the denial, the clinical rationale  
330 that supports the denial, and the procedure for appealing the  
331 health insurer's determination.

332 (c) A health insurer must grant a protocol exception  
333 request if any of the following applies:

334 1. A preceding prescription drug or medical treatment is  
335 contraindicated or will likely cause an adverse reaction or  
336 physical or mental harm to the insured.

337 2. A preceding prescription drug or medical treatment is  
338 expected to be ineffective based on the insured's medical  
339 history and the clinical evidence of the characteristics of the  
340 preceding prescription drug or medical treatment.

341 3. The insured has previously received a preceding  
342 prescription drug or medical treatment that is in the same  
343 pharmacologic class or has the same mechanism of action and such  
344 drug or treatment lacked efficacy or effectiveness or adversely  
345 affected the insured.

346 4. A preceding prescription drug or medical treatment is  
347 not in the insured's best interest because his or her use of the  
348 drug or treatment is expected to:

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349 a. Cause a significant barrier to the insured's adherence  
 350 to or compliance with his or her plan of care;

351 b. Worsen the insured's medical condition that exists  
 352 simultaneously with, but independently of, the condition under  
 353 treatment; or

354 c. Decrease the insured's ability to achieve or maintain  
 355 his or her ability to perform daily activities.

356 5. A preceding prescription drug is an opioid and the  
 357 protocol exception request is for a nonopioid prescription drug  
 358 or treatment with a likelihood of similar or better results.

359 (d) A health insurer may request a copy of relevant  
 360 documentation from an insured's medical record in support of a  
 361 protocol exception request.

362 ~~(2) As used in this section, the term "health coverage~~  
 363 ~~plan" means any of the following which is currently or was~~  
 364 ~~previously providing major medical or similar comprehensive~~  
 365 ~~coverage or benefits to the insured:~~

366 ~~(a) A health insurer or health maintenance organization.~~

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

370 ~~(c) A multiple-employer welfare arrangement as defined in~~  
 371 ~~s. 624.437.~~

372 ~~(d) A governmental entity providing a plan of self-~~  
 373 ~~insurance.~~

374 (4) ~~(3)~~ CONSTRUCTION.—This section does not require a health  
 375 insurer to add a drug to its prescription drug formulary or to  
 376 cover a prescription drug that the insurer does not otherwise  
 377 cover.

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378 Section 4. Subsection (11) of section 627.6131, Florida  
 379 Statutes, is amended, and subsection (20) is added to that  
 380 section, to read:

381 627.6131 Payment of claims.—

382 (11) A health insurer may not retroactively deny a claim  
 383 because of insured ineligibility:

384 (a) More than 1 year after the date of payment of the  
 385 claim; or

386 (b) At any time, if the health insurer verified the  
 387 insured's eligibility at the time of treatment or provided an  
 388 authorization number.

389 (20) A health insurer may not impose an additional prior  
 390 authorization requirement with respect to a surgical or  
 391 otherwise invasive procedure, or any item furnished as part of  
 392 the surgical or invasive procedure, if the procedure or item is  
 393 furnished during the perioperative period of another procedure  
 394 for which prior authorization was granted by the health insurer.

395 Section 5. Subsection (46) of section 641.31, Florida  
 396 Statutes, is amended to read:

397 641.31 Health maintenance contracts.—

398 (46) (a) Definitions.—As used in this subsection, the term:

399 1. "Health coverage plan" means any of the following which  
 400 is currently or was previously providing major medical or  
 401 similar comprehensive coverage or benefits to the subscriber:

402 a. A health insurer or health maintenance organization.

403 b. A plan established or maintained by an individual  
 404 employer as provided by the Employee Retirement Income Security  
 405 Act of 1974, Pub. L. No. 93-406.

406 c. A multiple-employer welfare arrangement as defined in s.

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407 624.437.408 d. A governmental entity providing a plan of self-  
409 insurance.410 2. "Preceding prescription drug or medical treatment" means  
411 a prescription drug, medical procedure, or course of treatment  
412 that must be used pursuant to a health maintenance  
413 organization's step-therapy protocol as a condition of coverage  
414 under a health maintenance contract to treat a subscriber's  
415 condition.416 3. "Protocol exception" means a determination by a health  
417 maintenance organization that a step-therapy protocol is not  
418 medically appropriate or indicated for treatment of a  
419 subscriber's condition, and the health maintenance organization  
420 authorizes the use of another medical procedure, course of  
421 treatment, or prescription drug prescribed or recommended by the  
422 treating health care provider for the subscriber's condition.423 4. "Step-therapy protocol" means a written protocol that  
424 specifies the order in which certain medical procedures, courses  
425 of treatment, or prescription drugs must be used to treat a  
426 subscriber's condition.427 5. "Urgent care situation" means an injury or condition of  
428 a subscriber which, if medical care and treatment are not  
429 provided earlier than the time the medical profession generally  
430 considers reasonable for a nonurgent situation, in the opinion  
431 of the subscriber's treating physician, physician assistant, or  
432 advanced practice registered nurse, would:433 a. Seriously jeopardize the subscriber's life, health, or  
434 ability to regain maximum function; or435 b. Subject the subscriber to severe pain that cannot be

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436 adequately managed.

437 (b) Step-therapy protocol restrictions.—In addition to  
438 protocol exceptions granted under paragraph (c) and the  
439 restriction under s. 627.4239(3), a health maintenance  
440 organization issuing major medical coverage through an  
441 individual or group contract may not require a step-therapy  
442 protocol under the contract for a covered prescription drug  
443 requested by a subscriber if:

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

447 2. The subscriber provides documentation originating from  
448 the health coverage plan that approved the prescription drug as  
449 described in subparagraph 1. indicating that the health coverage  
450 plan paid for the drug on the subscriber's behalf during the 90  
451 days immediately before the request.

452 (c) Step-therapy protocol exceptions; requirements and  
453 procedures.—

454 1. A health maintenance organization shall publish on its  
455 website and provide to a subscriber in writing a procedure for  
456 the subscriber and his or her health care provider to request a  
457 protocol exception. The procedure must include:

458 a. The manner in which a subscriber or health care provider  
459 may request a protocol exception.

460 b. The manner and timeframe in which the health maintenance  
461 organization is required to authorize or deny a protocol  
462 exception request or to respond to an appeal of the health  
463 maintenance organization's authorization or denial of a request.

464 c. The conditions under which the protocol exception



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465 request must be granted.

466 2.a. A health maintenance organization must authorize or  
467 deny a protocol exception request or respond to an appeal of a  
468 health maintenance organization's authorization or denial of a  
469 request within:

470 (I) Seventy-two hours after receiving a completed prior  
471 authorization form for nonurgent care situations.

472 (II) Twenty-four hours after receiving a completed prior  
473 authorization form for urgent care situations.

474 b. An authorization of the request must specify the  
475 approved medical procedure, course of treatment, or prescription  
476 drug benefits.

477 c. A denial of the request must include a detailed written  
478 explanation of the reason for the denial, the clinical rationale  
479 that supports the denial, and the procedure for appealing the  
480 health maintenance organization's determination.

481 3. A health maintenance organization must grant a protocol  
482 exception request if any of the following applies:

483 a. A preceding prescription drug or medical treatment is  
484 contraindicated or will likely cause an adverse reaction or  
485 physical or mental harm to the subscriber.

486 b. A preceding prescription drug or medical treatment is  
487 expected to be ineffective based on the subscriber's medical  
488 history and the clinical evidence of the characteristics of the  
489 preceding prescription drug or medical treatment.

490 c. The subscriber has previously received a preceding  
491 prescription drug or medical treatment that is in the same  
492 pharmacologic class or has the same mechanism of action and such  
493 drug or treatment lacked efficacy or effectiveness or adversely

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494 affected the subscriber.

495 d. A preceding prescription drug or medical treatment is  
496 not in the subscriber's best interest because his or her use of  
497 the drug or treatment is expected to:

498 (I) Cause a significant barrier to the subscriber's  
499 adherence to or compliance with his or her plan of care;

500 (II) Worsen the subscriber's medical condition that exists  
501 simultaneously with, but independently of, the condition under  
502 treatment; or

503 (III) Decrease the subscriber's ability to achieve or  
504 maintain his or her ability to perform daily activities.

505 e. A preceding prescription drug is an opioid and the  
506 protocol exception request is for a nonopioid prescription drug  
507 or treatment with a likelihood of similar or better results.

508 4. A health maintenance organization may request a copy of  
509 relevant documentation from a subscriber's medical record in  
510 support of a protocol exception request.

511 ~~(b) As used in this subsection, the term "health coverage~~  
512 ~~plan" means any of the following which previously provided or is~~  
513 ~~currently providing major medical or similar comprehensive~~  
514 ~~coverage or benefits to the subscriber:~~

515 ~~1. A health insurer or health maintenance organization;~~

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

519 ~~3. A multiple-employer welfare arrangement as defined in s.~~  
520 ~~624.437; or~~

521 ~~4. A governmental entity providing a plan of self-~~  
522 ~~insurance.~~

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523        (d)~~(e)~~ Construction.—This subsection does not require a  
524 health maintenance organization to add a drug to its  
525 prescription drug formulary or to cover a prescription drug that  
526 the health maintenance organization does not otherwise cover.

527        Section 6. Subsection (10) of section 641.3155, Florida  
528 Statutes, is amended to read:

529        641.3155 Prompt payment of claims.—

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

532        (a) More than 1 year after the date of payment of the  
533 claim; or

534        (b) At any time, if the health maintenance organization  
535 verified the subscriber's eligibility at the time of treatment  
536 or provided an authorization number.

537        Section 7. Subsection (4) is added to section 641.3156,  
538 Florida Statutes, to read:

539        641.3156 Treatment authorization; payment of claims.—

540        (4) A health maintenance organization may not impose an  
541 additional prior authorization requirement with respect to a  
542 surgical or otherwise invasive procedure, or any item furnished  
543 as part of the surgical or invasive procedure, if the procedure  
544 or item is furnished during the perioperative period of another  
545 procedure for which prior authorization was granted by the  
546 health maintenance organization.

547        Section 8. This act shall take effect January 1, 2021.