1 A bill to be entitled
2 An act relating to prior authorization for
3 prescription drugs and medical services; amending s.
4 627.42392, F.S.; providing definitions; revising the
5 procedures for health care providers to submit prior
6 authorization requests for prescription drug and
7 medical service benefits; deleting provisions
8 requiring prior authorization forms to be approved by
9 the Financial Services Commission under certain
10 circumstances; requiring health insurers and certain
11 pharmacy benefit managers to establish an online prior
12 authorization process beginning on a specified date;
13 requiring prior authorization requests to be made
14 online beginning on a specified date; prohibiting the
15 process from requiring certain information; requiring
16 health insurers and certain pharmacy benefit managers
17 to make certain information accessible on their
18 websites; prohibiting health insurers and certain
19 pharmacy benefit managers from implementing certain
20 new requirements or restrictions or making certain
21 changes; providing exceptions; providing
22 applicability; providing timeframes for decisions by
23 health insurers and certain pharmacy benefit managers
24 on prior authorization requests; prohibiting
25 additional prior authorization requirements under

26 certain circumstances; amending ss. 627.6131 and
27 641.3156, F.S.; conforming provisions to changes made
28 by the act; providing an effective date.
29
30 Be It Enacted by the Legislature of the State of Florida:
31
32 Section 1. Section 627.42392, Florida Statutes, is amended
33 to read:
34 627.42392 Prior authorization requirements for
35 prescription drug and medical service benefits.—
36 (1) As used in this section, the term:
37 (a) "Electronic" or "online" does not include
38 transmissions through a facsimile machine.
39 (b) "Health insurer" means an authorized insurer offering
40 health insurance as defined in s. 624.603, a managed care plan
41 as defined in s. 409.962(10), or a health maintenance
42 organization as defined in s. 641.19(12).
43 (c) "Pharmacy benefit manager" means a person or entity
44 doing business in this state which contracts to administer
45 prescription drug benefits on behalf of a health insurer to
46 residents of this state.
47 (d) "Urgent health care service" means a health care
48 service that, in the opinion of a physician with knowledge of
49 the patient's medical condition, is necessary to be provided to
50 the patient without the timeframe requirement for a nonexpedited

51 prior authorization determination to prevent:
52 1. Serious jeopardy to the patient's life or health;
53 2. Serious impairment to the patient's ability to regain
54 maximum function; or
55 3. Severe pain that cannot be adequately managed.
56 (2) Beginning January 1, 2022, a health insurer, or a
57 pharmacy benefit manager on behalf of the health insurer, must
58 establish a secure, interactive online prior authorization
59 process for accepting electronic prior authorization requests.
60 The process must allow a person seeking a prior authorization
61 for a prescription drug, medical procedure, course of treatment,
62 or any other medical service benefit to upload documentation if
63 such documentation is required by the health insurer or pharmacy
64 benefit manager to make a determination on the prior
65 authorization request.
66 (3) Beginning January 1, 2022, all prior authorization
67 requests to a health insurer or pharmacy benefit manager by a
68 health care provider for a prescription drug, medical procedure,
69 course of treatment, or any other medical service benefit must
70 be made using the interactive online prior authorization process
71 established in subsection (2).
72 ~~(2) Notwithstanding any other provision of law, effective~~
73 ~~January 1, 2017, or six (6) months after the effective date of~~
74 ~~the rule adopting the prior authorization form, whichever is~~
75 ~~later, a health insurer, or a pharmacy benefits manager on~~

76 ~~behalf of the health insurer, which does not provide an~~
77 ~~electronic prior authorization process for use by its contracted~~
78 ~~providers, shall only use the prior authorization form that has~~
79 ~~been approved by the Financial Services Commission for granting~~
80 ~~a prior authorization for a medical procedure, course of~~
81 ~~treatment, or prescription drug benefit. Such form may not~~
82 ~~exceed two pages in length, excluding any instructions or~~
83 ~~guiding documentation, and must include all clinical~~
84 ~~documentation necessary for the health insurer to make a~~
85 ~~decision. At a minimum, the form must include: (1) sufficient~~
86 ~~patient information to identify the member, date of birth, full~~
87 ~~name, and Health Plan ID number; (2) provider name, address and~~
88 ~~phone number; (3) the medical procedure, course of treatment, or~~
89 ~~prescription drug benefit being requested, including the medical~~
90 ~~reason therefor, and all services tried and failed; (4) any~~
91 ~~laboratory documentation required; and (5) an attestation that~~
92 ~~all information provided is true and accurate.~~
93 ~~(3) The Financial Services Commission in consultation with~~
94 ~~the Agency for Health Care Administration shall adopt by rule~~
95 ~~guidelines for all prior authorization forms which ensure the~~
96 ~~general uniformity of such forms.~~
97 (4) Electronic prior authorization approvals do not
98 preclude benefit verification or medical review by the insurer
99 under either the medical or pharmacy benefits.
100 (5) The prior authorization process may not require

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101 information that is not needed to make a determination or
102 facilitate a determination of medical necessity of the requested
103 prescription drug, medical procedure, course of treatment, or
104 any other medical service benefit.
105 (6) A health insurer, or a pharmacy benefit manager on
106 behalf of the health insurer, shall make any current prior
107 authorization requirements and restrictions readily accessible
108 on its website.
109 (7) A health insurer, or a pharmacy benefit manager on
110 behalf of the health insurer, may not implement any new
111 requirements or restrictions or make changes to existing
112 requirements or restrictions on obtaining prior authorization
113 unless:
114 (a) The new requirements or restrictions or the changes to
115 existing requirements or restrictions have been available on a
116 publicly accessible website for at least 60 days before they are
117 implemented.
118 (b) Insureds and health care providers who are affected by
119 the new requirements or restrictions or the changes to existing
120 requirements and restrictions are provided with a written notice
121 of the changes at least 60 days before they are implemented.
122 Such notice must be delivered electronically or by other means
123 as agreed to by the insured or the health care provider.
124
125 This subsection does not apply to the expansion of health care

126 services coverage.
127 (8) If a health insurer, or a pharmacy benefit manager on
128 behalf of the health insurer, requires prior authorization of a
129 health care service in nonurgent circumstances, the health
130 insurer or the pharmacy benefit manager must authorize or deny
131 the prior authorization request and notify the insured and the
132 insured's treating health care provider of the decision within 3
133 calendar days after obtaining all necessary information to make
134 the decision on the prior authorization request. If a health
135 insurer, or a pharmacy benefit manager on behalf of the health
136 insurer, requires prior authorization for an urgent health care
137 service, the health insurer or pharmacy benefit manager must
138 authorize or deny the prior authorization request and notify the
139 insured and the insured's treating health care provider of the
140 decision within 24 hours after obtaining all necessary
141 information to make the decision on the prior authorization
142 request.
143 (9) A health insurer may not impose an additional prior
144 authorization requirement with respect to a surgical or
145 otherwise invasive procedure, or any item furnished as part of
146 the surgical or invasive procedure, if the procedure or item is
147 furnished during the perioperative period of another procedure
148 for which prior authorization was granted by the health insurer.
149 Section 2. Subsection (20) is added to section 627.6131,
150 Florida Statutes, to read:

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151 627.6131 Payment of claims.—
152 (20) A health insurer may not impose an additional prior
153 authorization requirement with respect to a surgical or
154 otherwise invasive procedure, or any item furnished as part of
155 the surgical or invasive procedure, if the procedure or item is
156 furnished during the perioperative period of another procedure
157 for which prior authorization was granted by the health insurer.
158 Section 3. Subsection (4) is added to section 641.3156,
159 Florida Statutes, to read:
160 641.3156 Treatment authorization; payment of claims.—
161 (4) A health maintenance organization may not impose an
162 additional prior authorization requirement with respect to a
163 surgical or otherwise invasive procedure, or any item furnished
164 as part of the surgical or invasive procedure, if the procedure
165 or item is furnished during the perioperative period of another
166 procedure for which prior authorization was granted by the
167 health maintenance organization.
168 Section 4. This act shall take effect July 1, 2021.