By Senator Polsky

29-01491-21 20211846__

A bill to be entitled

An act relating to health insurance prior authorization; amending s. 627.42392, F.S.; defining the terms "pharmacy benefit manager" and "urgent health care service"; requiring health insurers and pharmacy benefit managers to establish an online electronic prior authorization process by a certain date; specifying requirements for, and restrictions on, such online electronic prior authorization process; requiring all prior authorization requests to health insurers and pharmacy benefit managers to be made using such online electronic prior authorization process by a certain date; deleting provisions requiring prior authorization forms to be approved by the Financial Services Commission under certain circumstances; specifying requirements for, and restrictions on, health insurers and pharmacy benefit managers relating to prior authorization information, requirements, restrictions, and changes; providing applicability; specifying timeframes within which prior authorization requests must be authorized or denied and the patient and the patient's provider must be notified; amending ss. 627.6131 and 641.3156, F.S.; prohibiting health insurers and health maintenance organizations, respectively, from imposing an additional prior authorization requirement with respect to certain surgical or invasive procedures or certain items; providing an effective date.

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

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

627.42392 Prior authorization.—

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

(a) "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).

(b) "Pharmacy benefit manager" has the same meaning as provided in s. 624.490.

(c) "Urgent health care service" means a health care service that, if not provided earlier than the time the medical profession generally considers reasonable for making a nonurgent prior authorization, in the opinion of a physician with knowledge of the patient's medical condition, could:

1. Seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or

2. Subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the prior authorization request.

(2) Beginning January 1, 2022, a health insurer, or a pharmacy benefit manager on behalf of the health insurer, must establish and offer a secure, interactive online electronic prior authorization process for accepting electronic prior authorization requests. The process must allow a person seeking the prior authorization to upload documentation if such documentation is required by the health insurer or pharmacy

benefit manager to adjudicate the prior authorization request. The electronic prior authorization process may not include transmissions through a facsimile machine.

(3) Beginning January 1, 2022, all prior authorization requests to a health insurer or to a pharmacy benefit manager by a health care provider for medical procedures, surgical procedures, prescription drugs, or any other medical service must be made using the interactive online prior authorization process required in subsection (2).

~~(2) Notwithstanding any other provision of law, effective January 1, 2017, or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy 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: (1) sufficient patient information to identify the member, date of birth, full name, and Health Plan ID number; (2) provider name, address and phone number; (3) the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed; (4) any laboratory documentation required; and (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) The prior authorization process may not require information that is not needed to make a determination or facilitate a determination of medical necessity of the requested medical procedure, course of treatment, or prescription drug benefit.

(6) A health insurer, or a pharmacy benefit manager on behalf of the health insurer, shall make any current prior authorization requirements and restrictions readily accessible on its website.

(7) A health insurer, or a pharmacy benefit manager on behalf of the health insurer, may not implement any new requirements or restrictions or make changes to existing requirements for or restrictions on obtaining prior authorization unless:

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

(b) Policyholders and health care providers who are affected by the new requirements and restrictions or changes to the requirements and restrictions are provided with a written notice of the changes at least 60 days before they are

implemented. Such notice must be delivered electronically or by other means as agreed to by the insured or the health care provider.

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

(8) A health insurer, or a pharmacy benefit manager on behalf of the health insurer, must authorize or deny a prior authorization request and notify the patient and the patient's treating health care provider of the decision within:

(a) Three calendar days after receiving all necessary information to make the decision on the prior authorization request for nonurgent care situations.

(b) Twenty-four hours after receiving all necessary information to make the decision on the prior authorization request for urgent care situations.

Section 2. Subsection (20) is added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

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

Section 3. Subsection (4) is added to section 641.3156, Florida Statutes, to read:

641.3156 Treatment authorization; payment of claims.—

(4) A health maintenance organization may not impose an

additional prior authorization requirement with respect to a surgical or otherwise invasive procedure, or any item furnished as part of the surgical or invasive procedure, if the procedure or item is furnished during the perioperative period of another procedure for which prior authorization was granted by the health maintenance organization.

Section 4. This act shall take effect July 1, 2021.