

By Senator Harrell

25-00636-21

2021528__

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

25-00636-21

2021528__

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

25-00636-21

2021528__

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

25-00636-21

2021528__

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

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

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

95 (2) COVERAGE FOR TREATMENT OF CANCER.—

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

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

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

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

25-00636-21

2021528__

117 subscriber fail or have previously failed to respond
118 successfully to a different drug.

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

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

132 (5)~~(3)~~ APPLICABILITY AND SCOPE.—This section may not be
133 construed to:

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

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

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

25-00636-21

2021528__

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

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

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

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

159 627.42392 Prior authorization.—

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

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

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

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

25-00636-21

2021528__

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

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

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

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

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

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

194

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

201 (3) The Financial Services Commission, in consultation with
202 the Agency for Health Care Administration, shall adopt by rule
203 guidelines for all prior authorization forms which ensure the

25-00636-21

2021528__

204 general uniformity of such forms.

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

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

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

218 (b) Prior authorization forms.

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

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

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

25-00636-21

2021528__

233 provider.

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

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

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

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

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

247 627.42393 Step-therapy protocol restrictions and
248 exceptions.-

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

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

253 1. A health insurer or health maintenance organization.

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

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

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

261 (b) "Health insurer" has the same meaning as provided in s.

25-00636-21

2021528__

262 627.42392.

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

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

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

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

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

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

289 (2) STEP-THERAPY PROTOCOL RESTRICTIONS.—In addition to
290 protocol exceptions granted under subsection (3) and the

25-00636-21

2021528__

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

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

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

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

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

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

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

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

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

25-00636-21

2021528__

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

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

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

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

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

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

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

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

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

348 a. Cause a significant barrier to the insured's adherence

25-00636-21

2021528__

349 to or compliance with his or her plan of care;

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

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

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

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

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

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

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

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

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

373 (4)(3) CONSTRUCTION.—This section does not require a health
 374 insurer to add a drug to its prescription drug formulary or to
 375 cover a prescription drug that the insurer does not otherwise
 376 cover.

377 Section 4. Subsection (11) of section 627.6131, Florida

25-00636-21

2021528__

378 Statutes, is amended, and subsection (20) is added to that
379 section, to read:

380 627.6131 Payment of claims.—

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

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

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

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

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

396 641.31 Health maintenance contracts.—

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

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

401 a. A health insurer or health maintenance organization.

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

405 c. A multiple-employer welfare arrangement as defined in s.
406 624.437.

25-00636-21

2021528__

407 d. A governmental entity providing a plan of self-
408 insurance.

409 2. "Preceding prescription drug or medical treatment" means
410 a prescription drug, medical procedure, or course of treatment
411 that must be used pursuant to a health maintenance
412 organization's step-therapy protocol as a condition of coverage
413 under a health maintenance contract to treat a subscriber's
414 condition.

415 3. "Protocol exception" means a determination by a health
416 maintenance organization that a step-therapy protocol is not
417 medically appropriate or indicated for treatment of a
418 subscriber's condition, and the health maintenance organization
419 authorizes the use of another medical procedure, course of
420 treatment, or prescription drug prescribed or recommended by the
421 treating health care provider for the subscriber's condition.

422 4. "Step-therapy protocol" means a written protocol that
423 specifies the order in which certain medical procedures, courses
424 of treatment, or prescription drugs must be used to treat a
425 subscriber's condition.

426 5. "Urgent care situation" means an injury or condition of
427 a subscriber which, if medical care and treatment are not
428 provided earlier than the time the medical profession generally
429 considers reasonable for a nonurgent situation, in the opinion
430 of the subscriber's treating physician, physician assistant, or
431 advanced practice registered nurse, would:

432 a. Seriously jeopardize the subscriber's life, health, or
433 ability to regain maximum function; or

434 b. Subject the subscriber to severe pain that cannot be
435 adequately managed.

25-00636-21

2021528__

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

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

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

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

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

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

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

463 c. The conditions under which the protocol exception
464 request must be granted.

25-00636-21

2021528__

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

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

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

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

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

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

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

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

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

25-00636-21

2021528__

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

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

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

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

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

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

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

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

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

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

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

522 (d)(e) Construction.—This subsection does not require a

25-00636-21

2021528__

523 health maintenance organization to add a drug to its
524 prescription drug formulary or to cover a prescription drug that
525 the health maintenance organization does not otherwise cover.

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

528 641.3155 Prompt payment of claims.—

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

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

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

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

538 641.3156 Treatment authorization; payment of claims.—

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

546 Section 8. This act shall take effect January 1, 2022.