

By the Committees on Rules; and Judiciary; and Senators Steube and Mayfield

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1 A bill to be entitled
2 An act relating to health insurer authorization;
3 amending s. 627.42392, F.S.; redefining the term
4 "health insurer"; defining the term "urgent care
5 situation"; prohibiting prior authorization forms from
6 requiring certain information; authorizing the
7 Financial Services Commission to adopt certain rules;
8 requiring health insurers and pharmacy benefits
9 managers on behalf of health insurers to provide
10 certain information relating to prior authorization by
11 specified means; prohibiting such insurers and
12 pharmacy benefits managers from implementing or making
13 changes to requirements or restrictions to obtain
14 prior authorization except under certain
15 circumstances; providing applicability; requiring such
16 insurers and pharmacy benefits managers to authorize
17 or deny prior authorization requests and provide
18 certain notices within specified timeframes; creating
19 s. 627.42393, F.S.; defining terms; requiring health
20 insurers to publish on their websites and provide to
21 insureds in writing a procedure for insureds and
22 health care providers to request protocol exceptions;
23 specifying requirements for such procedure; requiring
24 health insurers, within specified timeframes, to
25 authorize or deny a protocol exception request or
26 respond to appeals of their authorizations or denials;
27 requiring authorizations or denials to specify certain
28 information; requiring health insurers to grant
29 protocol exception requests under certain

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30 circumstances; authorizing health insurers to request
31 documentation in support of a protocol exception
32 request; providing an effective date.
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34 Be It Enacted by the Legislature of the State of Florida:
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36 Section 1. Section 627.42392, Florida Statutes, is amended
37 to read:

38 627.42392 Prior authorization.—

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

40 (a) "Health insurer" means an authorized insurer offering
41 an individual or group health insurance policy that provides
42 major medical or similar comprehensive coverage ~~health insurance~~
43 ~~as defined in s. 624.603~~, a managed care plan as defined in s.
44 409.962(10), or a health maintenance organization as defined in
45 s. 641.19(12).

46 (b) "Urgent care situation" has the same meaning as in s.
47 627.42393.

48 (2) Notwithstanding any other provision of law, effective
49 January 1, 2017, or six (6) months after the effective date of
50 the rule adopting the prior authorization form, whichever is
51 later, a health insurer, or a pharmacy benefits manager on
52 behalf of the health insurer, which does not provide an
53 electronic prior authorization process for use by its contracted
54 providers, shall only use the prior authorization form that has
55 been approved by the Financial Services Commission for granting
56 a prior authorization for a medical procedure, course of
57 treatment, or prescription drug benefit. Such form may not
58 exceed two pages in length, excluding any instructions or

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59 guiding documentation, and must include all clinical
60 documentation necessary for the health insurer to make a
61 decision. At a minimum, the form must include: (1) sufficient
62 patient information to identify the member, date of birth, full
63 name, and Health Plan ID number; (2) provider name, address and
64 phone number; (3) the medical procedure, course of treatment, or
65 prescription drug benefit being requested, including the medical
66 reason therefor, and all services tried and failed; (4) any
67 laboratory documentation required; and (5) an attestation that
68 all information provided is true and accurate. The form, whether
69 in electronic or paper format, may not require information that
70 is not necessary for the determination of medical necessity of,
71 or coverage for, the requested medical procedure, course of
72 treatment, or prescription drug. The commission may adopt rules
73 prescribing such necessary information.

74 (3) The Financial Services Commission in consultation with
75 the Agency for Health Care Administration shall adopt by rule
76 guidelines for all prior authorization forms which ensure the
77 general uniformity of such forms.

78 (4) Electronic prior authorization approvals do not
79 preclude benefit verification or medical review by the insurer
80 under either the medical or pharmacy benefits.

81 (5) A health insurer or a pharmacy benefits manager on
82 behalf of the health insurer must provide the following
83 information in writing or in an electronic format upon request,
84 and on a publicly accessible Internet website:

85 (a) Detailed descriptions of requirements and restrictions
86 to obtain prior authorization for coverage of a medical
87 procedure, course of treatment, or prescription drug in clear,

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88 easily understandable language. Clinical criteria must be
89 described in language easily understandable by a health care
90 provider.

91 (b) Prior authorization forms.

92 (6) A health insurer or a pharmacy benefits manager on
93 behalf of the health insurer may not implement any new
94 requirements or restrictions or make changes to existing
95 requirements or restrictions to obtain prior authorization
96 unless:

97 (a) The changes have been available on a publicly
98 accessible Internet website at least 60 days before the
99 implementation of the changes.

100 (b) Policyholders and health care providers who are
101 affected by the new requirements and restrictions or changes to
102 the requirements and restrictions are provided with a written
103 notice of the changes at least 60 days before the changes are
104 implemented. Such notice may be delivered electronically or by
105 other means as agreed to by the insured or health care provider.

106
107 This subsection does not apply to expansion of health care
108 services coverage.

109 (7) A health insurer or a pharmacy benefits manager on
110 behalf of the health insurer must authorize or deny a prior
111 authorization request and notify the patient and the patient's
112 treating health care provider of the decision within:

113 (a) Seventy-two hours of obtaining a completed prior
114 authorization form for nonurgent care situations.

115 (b) Twenty-four hours of obtaining a completed prior
116 authorization form for urgent care situations.

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117 Section 2. Section 627.42393, Florida Statutes, is created
118 to read:

119 627.42393 Fail-first protocols.-

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

121 (a) "Fail-first protocol" means a written protocol that
122 specifies the order in which a certain medical procedure, course
123 of treatment, or prescription drug must be used to treat an
124 insured's condition.

125 (b) "Health insurer" has the same meaning as provided in s.
126 627.42392.

127 (c) "Preceding prescription drug or medical treatment"
128 means a medical procedure, course of treatment, or prescription
129 drug that must be used pursuant to a health insurer's fail-first
130 protocol as a condition of coverage under a health insurance
131 policy or a health maintenance contract to treat an insured's
132 condition.

133 (d) "Protocol exception" means a determination by a health
134 insurer that a fail-first protocol is not medically appropriate
135 or indicated for treatment of an insured's condition and the
136 health insurer authorizes the use of another medical procedure,
137 course of treatment, or prescription drug prescribed or
138 recommended by the treating health care provider for the
139 insured's condition.

140 (e) "Urgent care situation" means an injury or condition of
141 an insured which, if medical care and treatment are not provided
142 earlier than the time generally considered by the medical
143 profession to be reasonable for a nonurgent situation, in the
144 opinion of the insured's treating physician, physician
145 assistant, or advanced registered nurse practitioner, would:

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

148 2. Subject the insured to severe pain that cannot be
149 adequately managed.

150 (2) A health insurer must publish on its website and
151 provide to an insured in writing a procedure for an insured and
152 health care provider to request a protocol exception. The
153 procedure must include:

154 (a) A description of the manner in which an insured or
155 health care provider may request a protocol exception.

156 (b) The manner and timeframe in which the health insurer is
157 required to authorize or deny a protocol exception request or
158 respond to an appeal of a health insurer's authorization or
159 denial of a request.

160 (c) The conditions under which the protocol exception
161 request must be granted.

162 (3) (a) The health insurer must authorize or deny a protocol
163 exception request or respond to an appeal of a health insurer's
164 authorization or denial of a request within:

165 1. Seventy-two hours of obtaining a completed prior
166 authorization form for nonurgent care situations.

167 2. Twenty-four hours of obtaining a completed prior
168 authorization form for urgent care situations.

169 (b) An authorization of the request must specify the
170 approved medical procedure, course of treatment, or prescription
171 drug benefits.

172 (c) A denial of the request must include a detailed,
173 written explanation of the reason for the denial, the clinical
174 rationale that supports the denial, and the procedure to appeal

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175 the health insurer's determination.

176 (4) A health insurer must grant a protocol exception
177 request if:

178 (a) A preceding prescription drug or medical treatment is
179 contraindicated or will likely cause an adverse reaction or
180 physical or mental harm to the insured;

181 (b) A preceding prescription drug is expected to be
182 ineffective, based on the medical history of the insured and the
183 clinical evidence of the characteristics of the preceding
184 prescription drug or medical treatment;

185 (c) The insured has previously received a preceding
186 prescription drug or medical treatment that is in the same
187 pharmacologic class or has the same mechanism of action, and
188 such drug or treatment lacked efficacy or effectiveness or
189 adversely affected the insured; or

190 (d) A preceding prescription drug or medical treatment is
191 not in the best interest of the insured because the insured's
192 use of such drug or treatment is expected to:

193 1. Cause a significant barrier to the insured's adherence
194 to or compliance with the insured's plan of care;

195 2. Worsen an insured's medical condition that exists
196 simultaneously but independently with the condition under
197 treatment; or

198 3. Decrease the insured's ability to achieve or maintain
199 his or her ability to perform daily activities.

200 (5) The health insurer may request a copy of relevant
201 documentation from the insured's medical record in support of a
202 protocol exception request.

203 Section 3. This act shall take effect January 1, 2019.