1 A bill to be entitled
2 An act relating to health care; amending s. 409.967,
3 F.S.; revising contract requirements for managed care
4 programs; providing requirements for plans
5 establishing a drug formulary or list; mandating the
6 use of a standardized form; establishing a process for
7 providers to override certain treatment restrictions;
8 amending s. 627.6131, F.S.; prohibiting retroactive
9 denial of claims in certain circumstances; creating s.
10 627.6465, F.S.; mandating the use of a standardized
11 form; authorizing the commission to adopt rules to
12 prescribe the form; providing requirements for the
13 form; providing requirements for submission of the
14 form; creating s. 627.6466, F.S.; establishing a
15 process for providers to override certain treatment
16 restrictions; providing requirements for approval of
17 such overrides; providing an exception to the override
18 process in certain circumstances; amending s.
19 627.6471, F.S.; requiring insurers to post provider
20 information on a website; amending s. 641.3155, F.S.;
21 prohibiting retroactive denial of claims in certain
22 circumstances; creating s. 641.393, F.S.; mandating
23 the use of a standardized form; providing requirements
24 for submission of the form; creating s. 641.394, F.S.;
25 establishing a process for providers to override
26 certain treatment restrictions; providing requirements

27 for approval of such overrides; providing an exception
28 to the override process in certain circumstances;
29 providing an effective date.
30
31 Be It Enacted by the Legislature of the State of Florida:
32
33 Section 1. Paragraph (c) of subsection (2) of section
34 409.967, Florida Statutes, is amended to read:
35 409.967 Managed care plan accountability.—
36 (2) The agency shall establish such contract requirements
37 as are necessary for the operation of the statewide managed care
38 program. In addition to any other provisions the agency may deem
39 necessary, the contract must require:
40 (c) Access.—
41 1. The agency shall establish specific standards for the
42 number, type, and regional distribution of providers in managed
43 care plan networks to ensure access to care for both adults and
44 children. Each plan must maintain a regionwide network of
45 providers in sufficient numbers to meet the access standards for
46 specific medical services for all recipients enrolled in the
47 plan. The exclusive use of mail-order pharmacies may not be
48 sufficient to meet network access standards. Consistent with the
49 standards established by the agency, provider networks may
50 include providers located outside the region. A plan may
51 contract with a new hospital facility before the date the
52 hospital becomes operational if the hospital has commenced

53 construction, will be licensed and operational by January 1,
54 2013, and a final order has issued in any civil or
55 administrative challenge. Each plan shall establish and maintain
56 an accurate and complete electronic database of contracted
57 providers, including information about licensure or
58 registration, locations and hours of operation, specialty
59 credentials and other certifications, specific performance
60 indicators, and such other information as the agency deems
61 necessary. The database must be available online to both the
62 agency and the public and have the capability to compare the
63 availability of providers to network adequacy standards and to
64 accept and display feedback from each provider's patients. Each
65 plan shall submit quarterly reports to the agency identifying
66 the number of enrollees assigned to each primary care provider.
67 2.a. If establishing a prescribed drug formulary or
68 preferred drug list, a managed care plan shall:
69 (I) Provide a broad range of therapeutic options for the
70 treatment of disease states consistent with the general needs of
71 an outpatient population. Whenever feasible, the formulary or
72 preferred drug list shall include at least two products in a
73 therapeutic class.
74 (II) Include coverage through prior authorization for each
75 drug newly approved by the United States Food and Drug
76 Administration until the Medicaid Pharmaceutical and
77 Therapeutics Committee reviews such drug for inclusion on the
78 formulary. The timing of the formulary review must comply with

79 s. 409.91195.
80 b. Each managed care plan shall ~~must~~ publish any
81 prescribed drug formulary or preferred drug list on the plan's
82 website in a manner that is accessible to and searchable by
83 enrollees and providers. The plan shall ~~must~~ update the list
84 within 24 hours after making a change. ~~Each plan must ensure~~
85 ~~that the prior authorization process for prescribed drugs is~~
86 ~~readily accessible to health care providers, including posting~~
87 ~~appropriate contact information on its website and providing~~
88 ~~timely responses to providers.~~
89 c. If a prescription drug on a plan's formulary is removed
90 or changed, the managed care plan shall permit an enrollee who
91 was receiving the drug to continue to receive the drug if the
92 provider submits a written request that demonstrates that the
93 drug is medically necessary and the enrollee meets clinical
94 criteria to receive the drug.
95 d. For enrollees ~~Medicaid recipients~~ diagnosed with
96 hemophilia who have been prescribed anti-hemophilic-factor
97 replacement products, the agency shall provide for those
98 products and hemophilia overlay services through the agency's
99 hemophilia disease management program.
100 3.a. Notwithstanding any other provision of law, in order
101 to establish uniformity in the submission of prior authorization
102 forms, after January 1, 2015, a managed care plan shall use only
103 the standardized prior authorization form adopted by the
104 Financial Services Commission pursuant to s. 627.6465 for

105 obtaining prior authorization for a medical procedure, course of
106 treatment, or prescription drug benefits. If a managed care plan
107 contracts with a pharmacy benefits manager to perform prior
108 authorization services for prescription drug benefits, the
109 pharmacy benefits manager shall use and accept the standardized
110 prior authorization form. The form shall be made available
111 electronically by the commission and on the managed care plan's
112 website. The prescribing provider may submit the completed form
113 electronically to the managed care plan.
114 b. Upon receipt of a completed prior authorization request
115 from a health care provider submitted using the standardized
116 prior authorization form required in sub-subparagraph a., the
117 request is deemed approved unless the managed care plan responds
118 within 2 business days.
119 c. Managed care plans, and their fiscal agents or
120 intermediaries, must accept prior authorization requests for any
121 service electronically.
122 4. When medications for the treatment of a medical
123 condition are restricted for use by a managed care plan by a
124 step-therapy or fail-first protocol, the prescribing provider
125 shall have access to a clear and convenient process to request
126 an override of the protocol from the managed care plan. The
127 managed care plan shall grant an override of the protocol within
128 24 hours under the following circumstances:
129 a. The prescribing provider recommends, based on sound
130 clinical evidence, that the preferred treatment required under

131 the step-therapy or fail-first protocol has been ineffective in
132 the treatment of the enrollee's disease or medical condition; or
133 b. Based on sound clinical evidence or medical and
134 scientific evidence:
135 (I) The prescribing provider believes that the preferred
136 treatment required under the step-therapy or fail-first protocol
137 is expected or likely to be ineffective based on known relevant
138 physical or mental characteristics of the enrollee and known
139 characteristics of the drug regimen; or
140 (II) The prescribing provider believes that the preferred
141 treatment required under the step-therapy or fail-first protocol
142 will cause or will likely cause an adverse reaction or other
143 physical harm to the enrollee.
144
145 If the prescribing provider allows the enrollee to enter the
146 step-therapy or fail-first protocol recommended by the managed
147 care plan, the duration of the step-therapy or fail-first
148 protocol may not exceed a period deemed appropriate by the
149 provider. If the prescribing provider deems the treatment
150 clinically ineffective, the enrollee is entitled to receive the
151 recommended course of therapy without requiring the prescribing
152 provider to seek approval for an override of the step-therapy or
153 fail-first protocol.
154 Section 2. Subsection (11) of section 627.6131, Florida
155 Statutes, is amended to read:
156 627.6131 Payment of claims.—

157 (11)
158 (a) A health insurer may not retroactively deny a claim
159 because of insured ineligibility more than 1 year after the date
160 of payment of the claim.
161 (b) A health insurer that has verified the eligibility of
162 an insured at the time of treatment and has provided an
163 authorization number may not retroactively deny a claim because
164 of insured ineligibility.
165 (c) A health insurer that has provided the insured with an
166 identification card as provided in s. 627.642(3) that at the
167 time of service identifies the insured as eligible to receive
168 services may not retroactively deny a claim because of insured
169 ineligibility.
170 Section 3. Section 627.6465, Florida Statutes, is created
171 to read:
172 627.6465 Prior authorization.—
173 (1) Notwithstanding any other provision of law, in order
174 to establish uniformity in the submission of prior authorization
175 forms, after January 1, 2015, a health insurance issuer, managed
176 care plan as defined in s. 409.901(13), or health maintenance
177 organization as defined in 641.19(12), shall use only the
178 standardized prior authorization form adopted by the Financial
179 Services Commission for obtaining prior authorization for a
180 medical procedure, course of treatment, or prescription drug
181 benefits. If a health insurance issuer, managed care plan, or
182 health maintenance organization contracts with a pharmacy

183 benefits manager to perform prior authorization services for
184 prescription drug benefits, the pharmacy benefits manager shall
185 use and accept the standardized prior authorization form. The
186 Financial Services Commission shall adopt rules prescribing the
187 prior authorization form on or before January 1, 2015, and may
188 consult with health insurance issuers or other organizations as
189 necessary in the development of the form. The form must not
190 exceed 2 pages in length, excluding any instructions or guiding
191 documentation. The form shall be made available electronically
192 by the commission and on the website of the health insurance
193 issuer, managed care plan, or health maintenance organization.
194 The prescribing provider may submit the completed form
195 electronically to the health benefit plan. The adoption of the
196 form by the Financial Services Commission does not constitute a
197 determination that affects the substantial interests of a party
198 under chapter 120.
199 (2) Upon receipt of a completed prior authorization
200 request from a prescribing provider submitted using the
201 standardized prior authorization form required by subsection
202 (1), the request is deemed approved unless the health insurance
203 issuer responds within 2 business days.
204 Section 4. Section 627.6466, Florida Statutes, is created
205 to read:
206 627.6466 Fail-first protocols.—When medications for the
207 treatment of a medical condition are restricted for use by an
208 insurer by a step-therapy or fail-first protocol, the

209 prescribing provider shall have access to a clear and convenient
210 process to request an override of the protocol from the health
211 benefit plan or health insurance issuer. The plan or issuer
212 shall grant an override of the protocol within 24 hours under
213 the following circumstances:
214 (a) The prescribing provider recommends, based on sound
215 clinical evidence, that the preferred treatment required under
216 the step-therapy or fail-first protocol has been ineffective in
217 the treatment of the insured's disease or medical condition; or
218 (b) Based on sound clinical evidence or medical and
219 scientific evidence:
220 1. The prescribing provider believes that the preferred
221 treatment required under the step-therapy or fail-first protocol
222 is expected or likely to be ineffective based on known relevant
223 physical or mental characteristics of the insured and known
224 characteristics of the drug regimen; or
225 2. The prescribing provider believes that the preferred
226 treatment required under the step-therapy or fail-first protocol
227 will cause or is likely to cause an adverse reaction or other
228 physical harm to the insured.
229
230 If the prescribing provider allows the patient to enter the
231 step-therapy or fail-first protocol recommended by the insurer,
232 the duration of the step-therapy or fail-first protocol may not
233 exceed a period deemed appropriate by the provider. If the
234 prescribing provider deems the treatment clinically ineffective,

235 the patient is entitled to receive the recommended course of
236 therapy without requiring the prescribing provider to seek
237 approval for an override of the step-therapy or fail-first
238 protocol.
239 Section 5. Subsection (2) of section 627.6471, Florida
240 Statutes, is amended to read:
241 627.6471 Contracts for reduced rates of payment;
242 limitations; coinsurance and deductibles.—
243 (2) Any insurer issuing a policy of health insurance in
244 this state, which insurance includes coverage for the services
245 of a preferred provider, shall ~~must~~ provide each policyholder
246 and certificateholder with a current list of preferred
247 providers, shall ~~and must~~ make the list available for public
248 inspection during regular business hours at the principal office
249 of the insurer within the state, and shall post a link to the
250 list of preferred providers on the home page of the insurer's
251 website. Changes to the list of preferred providers shall be
252 reflected on the insurer's website within 24 hours.
253 Section 6. Subsection (10) of section 641.3155, Florida
254 Statutes, is amended to read:
255 641.3155 Prompt payment of claims.—
256 (10)
257 (a) A health maintenance organization may not
258 retroactively deny a claim because of subscriber ineligibility
259 more than 1 year after the date of payment of the claim.
260 (b) A health maintenance organization that has verified

261 the eligibility of a subscriber at the time of treatment and has
262 provided an authorization number may not retroactively deny a
263 claim because of subscriber ineligibility.
264 (c) A health maintenance organization that has provided
265 the subscriber with an identification card as provided in s.
266 627.642(3) that at the time of service identifies the subscriber
267 as eligible to receive services may not retroactively deny a
268 claim because of subscriber ineligibility.
269 Section 7. Section 641.393, Florida Statutes, is created
270 to read:
271 641.393 Prior authorization.—
272 (1) Notwithstanding any other provision of law, in order
273 to establish uniformity in the submission of prior authorization
274 forms, after January 1, 2015, a health maintenance organization
275 shall use only the standardized prior authorization form adopted
276 by the Financial Services Commission pursuant to s. 627.6465 for
277 obtaining prior authorization for a medical procedure, course of
278 treatment, or prescription drug benefits. If a health
279 maintenance organization contracts with a pharmacy benefits
280 manager to perform prior authorization services for prescription
281 drug benefits, the pharmacy benefits manager shall use and
282 accept the standardized prior authorization form. The form shall
283 be made available electronically by the commission and on the
284 website of the health insurance issuer, managed care plan, or
285 health maintenance organization. The health care provider may
286 submit the completed form electronically to the health benefit

287 plan.
288 (2) Upon receipt of a completed prior authorization
289 request from a health care provider submitted using the
290 standardized prior authorization form required by subsection
291 (1), the request is deemed approved unless the health
292 maintenance organization responds within 2 business days.
293 Section 8. Section 641.394, Florida Statutes, is created
294 to read:
295 641.394 Fail-first protocols.— When medications for the
296 treatment of a medical condition are restricted for use by a
297 health maintenance organization by a step-therapy or fail-first
298 protocol, the prescribing provider shall have access to a clear
299 and convenient process to request an override of the protocol
300 from the health maintenance organization. The health maintenance
301 organization shall grant an override of the protocol within 24
302 hours under the following circumstances:
303 (a) The prescribing provider recommends, based on sound
304 clinical evidence, that the preferred treatment required under
305 the step-therapy or fail-first protocol has been ineffective in
306 the treatment of the insured's disease or medical condition; or
307 (b) Based on sound clinical evidence or medical and
308 scientific evidence:
309 1. The prescribing provider believes that the preferred
310 treatment required under the step-therapy or fail-first protocol
311 is expected or likely to be ineffective based on known relevant
312 physical or mental characteristics of the insured and known

313 characteristics of the drug regimen; or
314 2. The prescribing provider believes that the preferred
315 treatment required under the step-therapy or fail-first protocol
316 will cause or is likely to cause an adverse reaction or other
317 physical harm to the insured.
318
319 If the prescribing provider allows the patient to enter the
320 step-therapy or fail-first protocol recommended by the health
321 maintenance organization, the duration of the step-therapy or
322 fail-first protocol may not exceed a period deemed appropriate
323 by the provider. If the prescribing provider deems the treatment
324 clinically ineffective, the patient is entitled to receive the
325 recommended course of therapy without requiring the prescribing
326 provider to seek approval for an override of the step-therapy or
327 fail-first protocol.
328 Section 9. This act shall take effect July 1, 2014.