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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/08/2014	.	
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	.	
	.	

The Committee on Banking and Insurance (Diaz de la Portilla) recommended the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Paragraph (c) of subsection (2) of section
6 409.967, Florida Statutes, is amended to read:
7 409.967 Managed care plan accountability.—
8 (2) The agency shall establish such contract requirements
9 as are necessary for the operation of the statewide managed care
10 program. In addition to any other provisions the agency may deem

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11 necessary, the contract must require:
12 (c) *Access.*—
13 1. The agency shall establish specific standards for the
14 number, type, and regional distribution of providers in managed
15 care plan networks to ensure access to care for both adults and
16 children. Each plan must maintain a regionwide network of
17 providers in sufficient numbers to meet the access standards for
18 specific medical services for all recipients enrolled in the
19 plan. The exclusive use of mail-order pharmacies may not be
20 sufficient to meet network access standards. Consistent with the
21 standards established by the agency, provider networks may
22 include providers located outside the region. A plan may
23 contract with a new hospital facility before the date the
24 hospital becomes operational if the hospital has commenced
25 construction, will be licensed and operational by January 1,
26 2013, and a final order has issued in any civil or
27 administrative challenge. Each plan shall establish and maintain
28 an accurate and complete electronic database of contracted
29 providers, including information about licensure or
30 registration, locations and hours of operation, specialty
31 credentials and other certifications, specific performance
32 indicators, and such other information as the agency deems
33 necessary. The database must be available online to ~~both~~ the
34 agency and the public and have the capability of comparing ~~to~~
35 ~~compare~~ the availability of providers to network adequacy
36 standards and to accept and display feedback from each
37 provider's patients. Each plan shall submit quarterly reports to
38 the agency identifying the number of enrollees assigned to each
39 primary care provider.

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40 2. If establishing a prescribed drug formulary or preferred
41 drug list, a managed care plan shall:
42 a. Provide a broad range of therapeutic options for the
43 treatment of disease states which are consistent with the
44 general needs of an outpatient population. If feasible, the
45 formulary or preferred drug list must include at least two
46 products in a therapeutic class.
47 b. Include coverage through prior authorization for each
48 new drug approved by the United States Food and Drug
49 Administration until the Medicaid Pharmaceutical and
50 Therapeutics Committee reviews such drug for inclusion on the
51 formulary. The timing of the formulary review must comply with
52 s. 409.91195.
53 c. ~~Each managed care plan must~~ Publish the ~~any~~ prescribed
54 drug formulary or preferred drug list on the plan's website in a
55 manner that is accessible to and searchable by enrollees and
56 providers. The plan shall ~~must~~ update the list within 24 hours
57 after making a change. ~~Each plan must ensure that the prior~~
58 ~~authorization process for prescribed drugs is readily accessible~~
59 ~~to health care providers, including posting appropriate contact~~
60 ~~information on its website and providing timely responses to~~
61 ~~providers.~~
62 d. If a prescription drug on a plan's formulary is removed
63 or changed, permit an enrollee who was receiving the drug to
64 continue to receive the drug if the prescribing provider submits
65 a written request that demonstrates that the drug is medically
66 necessary and that the enrollee meets clinical criteria to
67 receive the drug.
68 3. For enrollees ~~Medicaid recipients~~ diagnosed with

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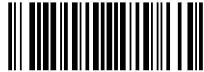
69 hemophilia who have been prescribed anti-hemophilic-factor
70 replacement products, the agency shall provide for those
71 products and hemophilia overlay services through the agency’s
72 hemophilia disease management program.
73 4. Notwithstanding any other law, in order to establish
74 uniformity in the submission of prior authorization forms, after
75 January 1, 2015, a managed care plan shall use only the
76 standardized prior authorization form adopted by the Financial
77 Services Commission pursuant to s. 627.42392 for obtaining prior
78 authorization for a medical procedure, a course of treatment, or
79 prescription drug benefits.
80 a. If a managed care plan contracts with a pharmacy
81 benefits manager to perform prior authorization services for
82 prescription drug benefits, the pharmacy benefits manager shall
83 use and accept the standardized prior authorization form. The
84 Office of Insurance Regulation and the managed care plan shall
85 make the form electronically available on their respective
86 websites.
87 b.~~3.~~ Managed care plans, and their fiscal agents or
88 intermediaries, must accept prior authorization requests for any
89 service electronically.
90 c. A completed prior authorization request submitted by a
91 health care provider using the standardized prior authorization
92 form required under this subparagraph is deemed approved upon
93 receipt by the managed care plan unless the managed care plan
94 responds otherwise within 2 business days.
95 5. If medications for the treatment of a medical condition
96 are restricted for use by a managed care plan by a step-therapy
97 or fail-first protocol, the prescribing provider must have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98 access to a clear and convenient process to request an override
99 of the protocol from the managed care plan.
100 a. The managed care plan shall grant an override within 24
101 hours if the prescribing provider believes that:
102 (I) Based on sound clinical evidence, the preferred
103 treatment required under the step-therapy or fail-first protocol
104 has been ineffective in the treatment of the enrollee's disease
105 or medical condition; or
106 (II) Based on sound clinical evidence or medical and
107 scientific evidence, the preferred treatment required under the
108 step-therapy or fail-first protocol:
109 (A) Is expected or likely to be ineffective based on known
110 relevant physical or mental characteristics of the enrollee and
111 known characteristics of the drug regimen; or
112 (B) Will cause or will likely cause an adverse reaction or
113 other physical harm to the enrollee.
114 b. If the prescribing provider allows the enrollee to enter
115 the step-therapy or fail-first protocol recommended by the
116 managed care plan, the duration of the step-therapy or fail-
117 first protocol may not exceed a period deemed appropriate by the
118 provider. If the prescribing provider deems the treatment
119 clinically ineffective, the enrollee is entitled to receive the
120 recommended course of therapy without requiring the prescribing
121 provider to seek approval for an override of the step-therapy or
122 fail-first protocol.
123 Section 2. Section 627.42392, Florida Statutes, is created
124 to read:
125 627.42392 Prior authorization.—Notwithstanding any other
126 law, in order to establish uniformity in the submission of prior

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127 authorization forms, after January 1, 2015, a health insurer
128 that delivers, issues for delivery, renews, amends, or continues
129 an individual or group health insurance policy in this state,
130 including a policy issued to a small employer as defined in s.
131 627.6699, shall use only the standardized prior authorization
132 form adopted by the commission for obtaining prior authorization
133 for a medical procedure, course of treatment, or prescription
134 drug benefits.
135 (1) If a health insurer contracts with a pharmacy benefits
136 manager to perform prior authorization services for prescription
137 drug benefits, the pharmacy benefits manager shall use and
138 accept the standardized prior authorization form. The commission
139 shall adopt rules prescribing the prior authorization form on or
140 before January 1, 2015, and the office may consult with health
141 insurers or other organizations as necessary in the development
142 of the form. The form may not exceed two pages in length,
143 excluding any instructions or guiding documentation. The office
144 and the health insurer shall make the form electronically
145 available on their respective websites. The prescribing provider
146 may electronically submit the completed form to the health
147 insurer. The adoption of the form by the commission does not
148 constitute a determination that affects the substantial
149 interests of a party under chapter 120.
150 (2) A completed prior authorization request submitted by a
151 prescribing provider using the standardized prior authorization
152 form required under subsection (1) is deemed approved upon
153 receipt by the health insurer unless the health insurer responds
154 otherwise within 2 business days.
155 (3) This section does not apply to a grandfathered health

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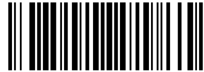
156 plan as defined in s. 627.402.
157 Section 3. Section 627.42393, Florida Statutes, is created
158 to read:
159 627.42393 Medication protocol override.—If an individual or
160 group health insurance policy, including a policy issued by a
161 small employer, as defined in s. 627.6699, restricts medications
162 for the treatment of a medical condition by a step-therapy or
163 fail-first protocol, the prescribing provider must have access
164 to a clear and convenient process to request an override of the
165 protocol from the health insurer.
166 (1) The health insurer shall authorize an override of the
167 protocol within 24 hours if the prescribing provider believes
168 that:
169 (a) Based on sound clinical evidence, the preferred
170 treatment required under the step-therapy or fail-first protocol
171 has been ineffective in the treatment of the insured's disease
172 or medical condition; or
173 (b) Based on sound clinical evidence or medical and
174 scientific evidence, the preferred treatment required under the
175 step-therapy or fail-first protocol:
176 1. Is expected or likely to be ineffective based on known
177 relevant physical or mental characteristics of the insured and
178 known characteristics of the drug regimen; or
179 2. Will cause or is likely to cause an adverse reaction or
180 other physical harm to the insured.
181 (2) If the prescribing provider allows the insured to enter
182 the step-therapy or fail-first protocol recommended by the
183 health insurer, the duration of the step-therapy or fail-first
184 protocol may not exceed a period deemed appropriate by the

 798756

185 provider. If the prescribing provider deems the treatment
186 clinically ineffective, the insured is entitled to receive the
187 recommended course of therapy without requiring the prescribing
188 provider to seek approval for an override of the step-therapy or
189 fail-first protocol.
190 (3) This section does not apply to grandfathered health
191 plans, as defined in s. 627.402.
192 Section 4. Subsection (11) of section 627.6131, Florida
193 Statutes, is amended to read:
194 627.6131 Payment of claims.—
195 (11) A health insurer may not retroactively deny a claim
196 because of insured ineligibility:
197 (a) More than 1 year after the date of payment of the
198 claim;~~.~~
199 (b) If the health insurer verified the eligibility of the
200 insured at the time of treatment and provided an authorization
201 number; or
202 (c) If the health insurer provided the insured with an
203 identification card as provided under s. 627.642(3), which at
204 the time of service identified the insured as eligible to
205 receive services.
206 Section 5. Subsection (2) of section 627.6471, Florida
207 Statutes, is amended to read:
208 627.6471 Contracts for reduced rates of payment;
209 limitations; coinsurance and deductibles.—
210 (2) An ~~Any~~ insurer issuing a policy of health insurance in
211 this state~~,~~ which ~~insurance~~ includes coverage for the services
212 of a preferred provider~~,~~ shall ~~must~~ provide each policyholder
213 and certificateholder with a current list of preferred

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214 providers, shall ~~and must~~ make the list available for public
215 inspection during regular business hours at the principal office
216 of the insurer within the state, and shall post a link to the
217 list of preferred providers on the home page of the insurer’s
218 website. Changes to the list of preferred providers must be
219 reflected on the insurer’s website within 24 hours.
220 Section 6. Paragraph (c) of subsection (2) of section
221 627.6515, Florida Statutes, is amended to read:
222 627.6515 Out-of-state groups.—
223 (2) Except as otherwise provided in this part, this part
224 does not apply to a group health insurance policy issued or
225 delivered outside this state under which a resident of this
226 state is provided coverage if:
227 (c) The policy provides the benefits specified in ss.
228 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579,
229 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675,
230 627.6691, and 627.66911, and complies with the requirements of
231 s. 627.66996.
232 Section 7. Subsection (10) of section 641.3155, Florida
233 Statutes, is amended to read:
234 641.3155 Prompt payment of claims.—
235 (10) A health maintenance organization may not
236 retroactively deny a claim because of subscriber ineligibility:
237 (a) More than 1 year after the date of payment of the
238 claim;~~.~~
239 (b) If the health maintenance organization verified the
240 eligibility of the subscriber at the time of treatment and
241 provided an authorization number; or
242 (c) If the health maintenance organization provided the

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243 subscriber with an identification card as provided under s.
244 627.642(3), which at the time of service identified the
245 subscriber as eligible to receive services.
246 Section 8. Section 641.393, Florida Statutes, is created to
247 read:
248 641.393 Prior authorization.—Notwithstanding any other law,
249 in order to establish uniformity in the submission of prior
250 authorization forms, after January 1, 2015, a health maintenance
251 organization shall use only the standardized prior authorization
252 form adopted by the Financial Services Commission pursuant to s.
253 627.42392 for obtaining prior authorization for a medical
254 procedure, a course of treatment, or prescription drug benefits.
255 (1) If a health maintenance organization contracts with a
256 pharmacy benefits manager to perform prior authorization
257 services for prescription drug benefits, the pharmacy benefits
258 manager must use and accept the standardized prior authorization
259 form. The office and health maintenance organization shall make
260 the form electronically available on their respective websites.
261 (2) A health care provider may submit the completed form
262 electronically to the health maintenance organization.
263 (3) A completed prior authorization request submitted by a
264 health care provider using the standardized prior authorization
265 form required under this section is deemed approved upon receipt
266 by the health maintenance organization unless the health
267 maintenance organization responds otherwise within 2 business
268 days.
269 (4) This section does not apply to grandfathered health
270 plans, as defined in s. 627.402.
271 Section 9. Section 641.394, Florida Statutes, is created to

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272 read:
273 641.394 Medication protocol override.—If a health
274 maintenance organization contract restricts medications for the
275 treatment of a medical condition by a step-therapy or fail-first
276 protocol, the prescribing provider shall have access to a clear
277 and convenient process to request an override of the protocol
278 from the health maintenance organization.
279 (1) The health maintenance organization shall grant an
280 override within 24 hours if the prescribing provider believes
281 that:
282 (a) Based on sound clinical evidence, the preferred
283 treatment required under the step-therapy or fail-first protocol
284 has been ineffective in the treatment of the subscriber's
285 disease or medical condition; or
286 (b) Based on sound clinical evidence or medical and
287 scientific evidence, the preferred treatment required under the
288 step-therapy or fail-first protocol:
289 1. Is expected or likely to be ineffective based on known
290 relevant physical or mental characteristics of the subscriber
291 and known characteristics of the drug regimen; or
292 2. Will cause or is likely to cause an adverse reaction or
293 other physical harm to the subscriber.
294 (2) If the prescribing provider allows the subscriber to
295 enter the step-therapy or fail-first protocol recommended by the
296 health maintenance organization, the duration of the step-
297 therapy or fail-first protocol may not exceed a period deemed
298 appropriate by the provider. If the prescribing provider deems
299 the treatment clinically ineffective, the subscriber is entitled
300 to receive the recommended course of therapy without requiring

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301 the prescribing provider to seek approval for an override of the
302 step-therapy or fail-first protocol.
303 (3) This section does not apply to grandfathered health
304 plans, as defined in s. 627.402.
305 Section 10. This act shall take effect July 1, 2014.
306
307 ================= T I T L E A M E N D M E N T ================
308 And the title is amended as follows:
309 Delete everything before the enacting clause
310 and insert:
311 A bill to be entitled
312 An act relating to health care; amending s. 409.967,
313 F.S.; revising contract requirements for Medicaid
314 managed care programs; providing requirements for
315 plans establishing a drug formulary or preferred drug
316 list; requiring the plan to authorize an enrollee to
317 continue a drug that is removed or changed, under
318 certain circumstances; requiring the use of a
319 standardized prior authorization form; requiring a
320 pharmacy benefits manage to use and accept the form
321 under certain circumstances; providing requirements
322 for the form and for the availability and submission
323 of the form; establishing a process for providers to
324 override certain treatment restrictions; providing
325 requirements for approval of such overrides; providing
326 an exception to the override protocol in certain
327 circumstances; creating s. 627.42392, F.S.; requiring
328 health insurers to use a standardized prior
329 authorization form; requiring a pharmacy benefits

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330 manage to use and accept the form under certain
331 circumstances; providing requirements for the form and
332 for the availability and submission of the form;
333 providing an exemption; creating s. 627.42393, F.S.;
334 establishing a process for providers to override
335 certain treatment restrictions; providing requirements
336 for approval of such overrides; providing an exception
337 to the override protocol in certain circumstances;
338 providing an exemption; amending s. 627.6131, F.S.;
339 prohibiting an insurer from retroactively denying a
340 claim in certain circumstances; amending s. 627.6471,
341 F.S.; requiring insurers to post preferred provider
342 information on a website; amending s. 627.6515, F.S.;
343 applying provisions relating to prior authorization
344 and override protocols to out-of-state groups;
345 amending s. 641.3155, F.S.; prohibiting a health
346 maintenance organization from retroactively denying a
347 claim in certain circumstances; creating s. 641.393,
348 F.S.; requiring the use of a standardized prior
349 authorization form by a health maintenance
350 organization; requiring a pharmacy benefits manager to
351 use and accept the form under certain circumstances;
352 providing requirements for the availability and
353 submission of the form; providing an exemption;
354 creating s. 641.394, F.S.; establishing a process for
355 providers to override certain treatment restrictions;
356 providing requirements for approval of such overrides;
357 providing an exception to the override protocol in
358 certain circumstances; providing an exemption;

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359 providing an effective date.