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LEGISLATIVE ACTION

Senate	.	House
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Floor: WD	.	
05/01/2014 10:36 AM	.	
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Senator Grimsley moved the following:

Senate Amendment (with title amendment)

Between lines 2228 and 2229
insert:

Section 56. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to ~~both~~ the agency and the public and have the capability of comparing ~~to compare~~ the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2. If establishing a prescribed drug formulary or preferred

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drug list, a managed care plan shall:

a. Provide a broad range of therapeutic options for the treatment of disease states which are consistent with the general needs of an outpatient population. If feasible, the formulary or preferred drug list must include at least two products in a therapeutic class.

b. ~~Each managed care plan must~~ Publish the ~~any~~ prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan shall ~~must~~ update the list within 24 hours after making a change. ~~Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.~~

3. For enrollees ~~Medicaid recipients~~ diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

~~3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.~~

4. Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, effective January 1, 2015, a managed care plan shall use a single standardized form for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefit. The form may not exceed two pages in length, excluding

any instructions or guiding documentation.

a. The managed care plan shall make the form available electronically and online to practitioners. The prescribing provider may electronically submit the completed prior authorization form to the managed care plan.

b. If the managed care plan contracts with a pharmacy benefits manager to perform prior authorization services for a medical procedure, course of treatment, or prescription drug benefit, the pharmacy benefits manager must use and accept the standardized prior authorization form.

c. A completed prior authorization request submitted by a health care provider using the standardized prior authorization form is deemed approved upon receipt by the managed care plan unless the managed care plan responds otherwise within 3 business days.

5. If medications for the treatment of a medical condition are restricted for use by a managed care plan by a step-therapy or fail-first protocol, the prescribing provider must have access to a clear and convenient process to request an override of the protocol from the managed care plan.

a. The managed care plan shall grant an override within 72 hours if the prescribing provider documents that:

(I) Based on sound clinical evidence, the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the enrollee’s disease or medical condition; or

(II) Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

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(A) Is expected or is likely to be ineffective based on known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen; or

(B) Will cause or will likely cause an adverse reaction or other physical harm to the enrollee.

b. If the prescribing provider allows the enrollee to enter the step-therapy or fail-first protocol recommended by the managed care plan, the duration of the step-therapy or fail-first protocol may not exceed the customary period for use of the medication if the prescribing provider demonstrates such treatment to be clinically ineffective. If the managed care plan can, through sound clinical evidence, demonstrate that the originally prescribed medication is likely to require more than the customary period to provide any relief or amelioration to the enrollee, the step-therapy or fail-first protocol may be extended for an additional period, but no longer than the original customary period for use of the medication. Notwithstanding this provision, a step-therapy or fail-first protocol shall be terminated if the prescribing provider determines that the enrollee is having an adverse reaction or is suffering from other physical harm resulting from the use of the medication.

Section 57. Section 627.42392, Florida Statutes, is created to read:

627.42392 Prior authorization.—

(1) Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, effective January 1, 2015, a health insurer that delivers, issues for delivery, renews, amends, or continues an individual

or group health insurance policy in this state, including a policy issued to a small employer as defined in s. 627.6699, shall use a single standardized form for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefit. The form may not exceed two pages in length, excluding any instructions or guiding documentation.

(a) The health insurer shall make the form available electronically and online to practitioners. The prescribing provider may submit the completed prior authorization form electronically to the health insurer.

(b) If the health insurer contracts with a pharmacy benefits manager to perform prior authorization services for a medical procedure, course of treatment, or prescription drug benefit, the pharmacy benefits manager must use and accept the standardized prior authorization form.

(c) A completed prior authorization request submitted by a health care provider using the standardized prior authorization form is deemed approved upon receipt by the health insurer unless the health insurer responds otherwise within 3 business days.

(2) This section does not apply to a grandfathered health plan as defined in s. 627.402.

Section 58. Section 627.42393, Florida Statutes, is created to read:

627.42393 Medication protocol override.—If an individual or group health insurance policy, including a policy issued by a small employer as defined in s. 627.6699, restricts medications for the treatment of a medical condition by a step-therapy or fail-first protocol, the prescribing provider must have access

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to a clear and convenient process to request an override of the protocol from the health insurer.

(1) The health insurer shall authorize an override of the protocol within 72 hours if the prescribing provider documents that:

(a) Based on sound clinical evidence, the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

1. Is expected or is likely to be ineffective based on known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

2. Will cause or is likely to cause an adverse reaction or other physical harm to the insured.

(2) If the prescribing provider allows the insured to enter the step-therapy or fail-first protocol recommended by the health insurer, the duration of the step-therapy or fail-first protocol may not exceed the customary period for use of the medication if the prescribing provider demonstrates such treatment to be clinically ineffective. If the health insurer can, through sound clinical evidence, demonstrate that the originally prescribed medication is likely to require more than the customary period for such medication to provide any relief or amelioration to the insured, the step-therapy or fail-first protocol may be extended for an additional period of time, but no longer than the original customary period for the medication.

Notwithstanding this provision, a step-therapy or fail-first protocol shall be terminated if the prescribing provider determines that the insured is having an adverse reaction or is suffering from other physical harm resulting from the use of the medication.

(3) This section does not apply to grandfathered health plans, as defined in s. 627.402.

Section 59. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

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

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

(b) If, under a policy compliant with the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and the regulations adopted pursuant to those acts, the health insurer verified the eligibility of the insured at the time of treatment and provided an authorization number, unless, at the time eligibility was verified, the provider was notified that the insured was delinquent in paying the premium.

Section 60. Subsection (2) of section 627.6471, Florida Statutes, is amended to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(2) An ~~Any~~ insurer issuing a policy of health insurance in this state~~,~~ which ~~insurance~~ includes coverage for the services of a preferred provider shall~~, must~~ provide each policyholder

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and certificateholder with a current list of preferred providers, shall ~~and must~~ make the list available for public inspection during regular business hours at the principal office of the insurer within the state, and shall post a link to the list of preferred providers on the home page of the insurer's website. Changes to the list of preferred providers must be reflected on the insurer's website within 24 hours.

Section 61. Paragraph (c) of subsection (2) of section 627.6515, Florida Statutes, is amended to read:

627.6515 Out-of-state groups.—

(2) Except as otherwise provided in this part, this part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(c) The policy provides the benefits specified in ss. 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675, 627.6691, and 627.66911, and complies with the requirements of s. 627.66996.

Section 62. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

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

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

(b) If, under a policy in compliance with the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and the

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regulations adopted pursuant to those acts, the health maintenance organization verified the eligibility of the subscriber at the time of treatment and provided an authorization number, unless, at the time eligibility was verified, the provider was notified that the subscriber was delinquent in paying the premium.

Section 63. Section 641.393, Florida Statutes, is created to read:

641.393 Prior authorization.—Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, effective January 1, 2015, a health maintenance organization shall use a single standardized form for obtaining prior authorization for prescription drug benefits. The form may not exceed two pages in length, excluding any instructions or guiding documentation.

(1) A health maintenance organization shall make the form available electronically and online to practitioners. A health care provider may electronically submit the completed form to the health maintenance organization.

(2) If a health maintenance organization contracts with a pharmacy benefits manager to perform prior authorization services for prescription drug benefits, the pharmacy benefits manager must use and accept the standardized prior authorization form.

(3) A completed prior authorization request submitted by a health care provider using the standardized prior authorization form required under this section is deemed approved upon receipt by the health maintenance organization unless the health maintenance organization responds otherwise within 3 business

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days.

(4) This section does not apply to grandfathered health plans, as defined in s. 627.402.

Section 64. Section 641.394, Florida Statutes, is created to read:

641.394 Medication protocol override.—If a health maintenance organization contract restricts medications for the treatment of a medical condition by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the health maintenance organization.

(1) The health maintenance organization shall grant an override within 72 hours if the prescribing provider documents that:

(a) Based on sound clinical evidence, the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the subscriber's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

1. Is expected or is likely to be ineffective based on known relevant physical or mental characteristics of the subscriber and known characteristics of the drug regimen; or

2. Will cause or is likely to cause an adverse reaction or other physical harm to the subscriber.

(2) If the prescribing provider allows the subscriber to enter the step-therapy or fail-first protocol recommended by the health maintenance organization, the duration of the step-

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therapy or fail-first protocol may not exceed the customary period for use of the medication if the prescribing provider demonstrates such treatment to be clinically ineffective. If the health maintenance organization can, through sound clinical evidence, demonstrate that the originally prescribed medication is likely to require more than the customary period to provide any relief or amelioration to the subscriber, the step-therapy or fail-first protocol may be extended for an additional period, but no longer than the original customary period for use of the medication. Notwithstanding this provision, a step-therapy or fail-first protocol shall be terminated if the prescribing provider determines that the subscriber is having an adverse reaction or is suffering from other physical harm resulting from the use of the medication.

(3) This section does not apply to grandfathered health plans, as defined in s. 627.402.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete line 201

and insert:

policies that insure warranty associations; amending s. 409.967, F.S.; revising contract requirements for Medicaid managed care programs; providing requirements for plans establishing a drug formulary or preferred drug list; requiring the use of a standardized prior authorization form; providing requirements for the form and for the availability and submission of the form; requiring a pharmacy benefits manager to use and

accept the form under certain circumstances; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override protocol in certain circumstances; creating s. 627.42392, F.S.; requiring health insurers to use a standardized prior authorization form; providing requirements for the form and for the availability and submission of the form; requiring a pharmacy benefits manager to use and accept the form under certain circumstances; providing an exemption; creating s. 627.42393, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override protocol in certain circumstances; providing an exemption; amending s. 627.6131, F.S.; prohibiting an insurer from retroactively denying a claim in certain circumstances; amending s. 627.6471, F.S.; requiring insurers to post preferred provider information on a website; specifying that changes to such a website must be made within a certain time; amending s. 627.6515, F.S.; applying provisions relating to prior authorization and override protocols to out-of-state groups; amending s. 641.3155, F.S.; prohibiting a health maintenance organization from retroactively denying a claim in certain circumstances; creating s. 641.393, F.S.; requiring the use of a standardized prior authorization form by a health maintenance

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organization; providing requirements for the availability and submission of the form; requiring a pharmacy benefits manager to use and accept the form under certain circumstances; providing an exemption; creating s. 641.394, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override protocol in certain circumstances; providing an exemption; providing