



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:



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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.

40 2. If establishing a prescribed drug formulary or preferred



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

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

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

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



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70 any instructions or guiding documentation.

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

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

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

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

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

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

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



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

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

104 b. If the prescribing provider allows the enrollee to enter
105 the step-therapy or fail-first protocol recommended by the
106 managed care plan, the duration of the step-therapy or fail-
107 first protocol may not exceed the customary period for use of
108 the medication if the prescribing provider demonstrates such
109 treatment to be clinically ineffective. If the managed care plan
110 can, through sound clinical evidence, demonstrate that the
111 originally prescribed medication is likely to require more than
112 the customary period to provide any relief or amelioration to
113 the enrollee, the step-therapy or fail-first protocol may be
114 extended for an additional period, but no longer than the
115 original customary period for use of the medication.

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

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

123 627.42392 Prior authorization.—

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



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

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

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

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

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

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

152 627.42393 Medication protocol override.—If an individual or
153 group health insurance policy, including a policy issued by a
154 small employer as defined in s. 627.6699, restricts medications
155 for the treatment of a medical condition by a step-therapy or
156 fail-first protocol, the prescribing provider must have access



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

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

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

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

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

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

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



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

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

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

195 627.6131 Payment of claims.—

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

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

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

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

210 627.6471 Contracts for reduced rates of payment;
211 limitations; coinsurance and deductibles.—

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



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

222 Section 61. Paragraph (c) of subsection (2) of section
223 627.6515, Florida Statutes, is amended to read:

224 627.6515 Out-of-state groups.—

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

229 (c) The policy provides the benefits specified in ss.
230 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579,
231 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675,
232 627.6691, and 627.66911, and complies with the requirements of
233 s. 627.66996.

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

236 641.3155 Prompt payment of claims.—

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

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

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



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

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

252 641.393 Prior authorization.—Notwithstanding any other law,
253 in order to establish uniformity in the submission of prior
254 authorization forms, effective January 1, 2015, a health
255 maintenance organization shall use a single standardized form
256 for obtaining prior authorization for prescription drug
257 benefits. The form may not exceed two pages in length, excluding
258 any instructions or guiding documentation.

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

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

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



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273 days.

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

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

278 641.394 Medication protocol override.—If a health
279 maintenance organization contract restricts medications for the
280 treatment of a medical condition by a step-therapy or fail-first
281 protocol, the prescribing provider shall have access to a clear
282 and convenient process to request an override of the protocol
283 from the health maintenance organization.

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

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

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

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

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

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



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

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

318
319 ===== T I T L E A M E N D M E N T =====

320 And the title is amended as follows:

321 Delete line 201

322 and insert:

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



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331 accept the form under certain circumstances;
332 establishing a process for providers to override
333 certain treatment restrictions; providing requirements
334 for approval of such overrides; providing an exception
335 to the override protocol in certain circumstances;
336 creating s. 627.42392, F.S.; requiring health insurers
337 to use a standardized prior authorization form;
338 providing requirements for the form and for the
339 availability and submission of the form; requiring a
340 pharmacy benefits manager to use and accept the form
341 under certain circumstances; providing an exemption;
342 creating s. 627.42393, F.S.; establishing a process
343 for providers to override certain treatment
344 restrictions; providing requirements for approval of
345 such overrides; providing an exception to the override
346 protocol in certain circumstances; providing an
347 exemption; amending s. 627.6131, F.S.; prohibiting an
348 insurer from retroactively denying a claim in certain
349 circumstances; amending s. 627.6471, F.S.; requiring
350 insurers to post preferred provider information on a
351 website; specifying that changes to such a website
352 must be made within a certain time; amending s.
353 627.6515, F.S.; applying provisions relating to prior
354 authorization and override protocols to out-of-state
355 groups; amending s. 641.3155, F.S.; prohibiting a
356 health maintenance organization from retroactively
357 denying a claim in certain circumstances; creating s.
358 641.393, F.S.; requiring the use of a standardized
359 prior authorization form by a health maintenance



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