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LEGISLATIVE ACTION

| Senate | . | House |
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| Floor: 1c/RE/2R | . | |
| 05/03/2017 07:06 PM | . | |
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Senator Steube moved the following:

**Senate Amendment to Amendment (449058) (with title amendment)**

Between lines 755 and 756
insert:

Section 17. 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) At any time, if the health insurer verified the


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eligibility of an insured at the time of treatment and provided an authorization number. This paragraph applies to policies entered into or renewed on or after January 1, 2018.

(b) More than 1 year after the date of payment of the claim.

Section 18. 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) At any time, if the health maintenance organization verified the eligibility of a subscriber at the time of treatment and provided an authorization number. This paragraph applies to contracts entered into or renewed on or after January 1, 2018. This paragraph does not apply to Medicaid managed care plans pursuant to part IV of chapter 409.

(b) More than 1 year after the date of payment of the claim.

Section 19. Section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

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

(a) "Health insurer" means an authorized insurer offering an individual or group insurance policy that provides major medical or similar comprehensive coverage ~~health insurance as defined in s. 624.603~~, a managed care plan as defined in s. 409.962(10) ~~s. 409.962(9)~~, or a health maintenance organization as defined in s. 641.19(12).

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



627.42393.

(2) Notwithstanding any other provision of law, effective January 1, 2017, or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy benefits manager on behalf of the health insurer, which does not provide an electronic prior authorization process for use by its contracted providers, shall only use the prior authorization form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the health insurer to make a decision. At a minimum, the form must include: (1) sufficient patient information to identify the member, date of birth, full name, and Health Plan ID number; (2) provider name, address and phone number; (3) the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed; (4) any laboratory documentation required; and (5) an attestation that all information provided is true and accurate. The form, whether in electronic or paper format, may not require information that is not necessary for the determination of medical necessity of, or coverage for, the requested medical procedure, course of treatment, or prescription drug.

(3) The Financial Services Commission in consultation with the Agency for Health Care Administration shall adopt by rule guidelines for all prior authorization forms which ensure the



general uniformity of such forms.

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

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

(a) Detailed descriptions of requirements and restrictions to obtain prior authorization for coverage of a medical procedure, course of treatment, or prescription drug in clear, easily understandable language. Clinical criteria must be described in language easily understandable by a health care provider.

(b) Prior authorization forms.

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

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

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

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

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

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

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

Section 20. Section 627.42393, Florida Statutes, is created to read:

627.42393 Fail-first protocols.—

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

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

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

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

(d) "Protocol exception" means a determination by a health insurer that a fail-first protocol is not medically appropriate

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or indicated for treatment of an insured's condition and the health insurer authorizes the use of another medical procedure, course of treatment, or prescription drug prescribed or recommended by the treating health care provider for the insured's condition.

(e) "Urgent care situation" means an injury or condition of an insured which, if medical care and treatment is not provided earlier than the time generally considered by the medical profession to be reasonable for a nonurgent situation, in the opinion of the insured's treating physician, would:

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

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

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

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

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

(c) The conditions in which the protocol exception request must be granted.

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

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

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

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

(c) A denial of the request must include a detailed, written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure to appeal the health insurer's determination.

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

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

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

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

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

1. Cause a significant barrier to the insured's adherence

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to or compliance with the insured's plan of care;

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

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

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

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

And the title is amended as follows:

Delete line 851

and insert:

under the code under certain circumstances; amending s. 627.6131, F.S.; prohibiting a health insurer from retroactively denying a claim under specified circumstances; providing applicability; amending s. 641.3155, F.S.; prohibiting a health maintenance organization from retroactively denying a claim under specified circumstances; providing applicability; exempting certain Medicaid managed care plans; amending s. 627.42392, F.S.; revising and providing definitions; revising criteria for prior authorization forms; requiring health insurers and pharmacy benefits managers on behalf of health insurers to provide certain information relating to prior authorization in a specified manner; prohibiting such insurers and pharmacy benefits managers from implementing or making

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changes to requirements or restrictions to obtain prior authorization, except under certain circumstances; providing applicability; requiring such insurers and pharmacy benefits managers to authorize or deny prior authorization requests and provide certain notices within specified timeframes; creating s. 627.42393, F.S.; providing definitions; requiring health insurers to publish on their websites and provide in writing to insureds a specified procedure to obtain protocol exceptions; specifying timeframes in which health insurers must authorize or deny protocol exception requests and respond to an appeal to a health insurer’s authorization or denial of a request; requiring authorizations or denials to specify certain information; providing circumstances in which health insurers must grant a protocol exception request; authorizing health insurers to request documentation in support of a protocol exception request; providing