

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; establishing a
 6 process for providers to override certain treatment
 7 restrictions; amending s. 627.6131, F.S.; prohibiting
 8 retroactive denial of claims in certain circumstances;
 9 creating s. 627.6466, F.S.; establishing a process for
 10 providers to override certain treatment restrictions;
 11 providing requirements for approval of such overrides;
 12 providing an exception to the override process in
 13 certain circumstances; amending s. 627.6471, F.S.;
 14 requiring insurers to post provider information on a
 15 website; amending s. 641.3155, F.S.; prohibiting
 16 retroactive denial of claims in certain circumstances;
 17 creating s. 641.394, F.S.; establishing a process for
 18 providers to override certain treatment restrictions;
 19 providing requirements for approval of such overrides;
 20 providing an exception to the override process in
 21 certain circumstances; providing an effective date.;
 22 providing an effective date.

24 Be It Enacted by the Legislature of the State of Florida:

26 Section 1. Paragraph (c) of subsection (2) of section

27 409.967, Florida Statutes, is amended to read:

28 409.967 Managed care plan accountability.—

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

33 (c) Access.—

34 1. The agency shall establish specific standards for the
 35 number, type, and regional distribution of providers in managed
 36 care plan networks to ensure access to care for both adults and
 37 children. Each plan must maintain a region wide network of
 38 providers in sufficient numbers to meet the access standards for
 39 specific medical services for all recipients enrolled in the
 40 plan. The exclusive use of mail-order pharmacies may not be
 41 sufficient to meet network access standards. Consistent with the
 42 standards established by the agency, provider networks may
 43 include providers located outside the region. A plan may
 44 contract with a new hospital facility before the date the
 45 hospital becomes operational if the hospital has commenced
 46 construction, will be licensed and operational by January 1,
 47 2013, and a final order has issued in any civil or
 48 administrative challenge. Each plan shall establish and maintain
 49 an accurate and complete electronic database of contracted
 50 providers, including information about licensure or
 51 registration, locations and hours of operation, specialty
 52 credentials and other certifications, specific performance

53 indicators, and such other information as the agency deems
 54 necessary. The database must be available online to both the
 55 agency and the public and have the capability to compare the
 56 availability of providers to network adequacy standards and to
 57 accept and display feedback from each provider's patients. Each
 58 plan shall submit quarterly reports to the agency identifying
 59 the number of enrollees assigned to each primary care provider.

60 2.a. If establishing a prescribed drug formulary or
 61 preferred drug list, a managed care plan shall:

62 (I) Provide a broad range of therapeutic options for the
 63 treatment of disease states consistent with the general needs of
 64 an outpatient population. Whenever feasible, the formulary or
 65 preferred drug list shall include at least two products in a
 66 therapeutic class.

67 (II) Include coverage through prior authorization for each
 68 drug newly approved by the United States Food and Drug
 69 Administration until the Medicaid Pharmaceutical and
 70 Therapeutics Committee reviews such drug for inclusion on the
 71 formulary. The timing of the formulary review must comply with
 72 409.91195.

73 b. Each managed care plan must publish any prescribed drug
 74 formulary or preferred drug list on the plan's website in a
 75 manner that is accessible to and searchable by enrollees and
 76 providers. The plan must update the list within 24 hours after
 77 making a change. Each plan must ensure that the prior
 78 authorization process for prescribed drugs is readily accessible

79 to health care providers, including posting appropriate contact
 80 information on its website and providing timely responses to
 81 providers.

82 c. If a prescription drug on a plan's formulary is removed
 83 or changed, the managed care plan shall permit an enrollee who
 84 was receiving the drug to continue to receive the drug if the
 85 provider submits a written request that demonstrates that the
 86 drug is medically necessary and the enrollee meets clinical
 87 criteria to receive the drug.

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

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

96 4. When medications for the treatment of a medical
 97 condition are restricted for use by a managed care plan by a
 98 step-therapy or fail-first protocol, the prescribing provider
 99 shall have access to a clear and convenient process to request
 100 an override of the protocol from the managed care plan. The
 101 managed care plan shall grant an override of the protocol within
 102 24 hours under the following circumstances:

103 a. The prescribing provider recommends, based on sound
 104 clinical evidence, that the preferred treatment required under

105 the step-therapy or fail-first protocol has been ineffective in
 106 the treatment of the enrollee's disease or medical condition; or

107 b. Based on sound clinical evidence or medical and
 108 scientific evidence:

109 (I) The prescribing provider believes that the preferred
 110 treatment required under the step-therapy or fail-first protocol
 111 is expected or likely to be ineffective based on known relevant
 112 physical or mental characteristics of the enrollee and known
 113 characteristics of the drug regimen; or

114 (II) The prescribing provider believes that the preferred
 115 treatment required under the step-therapy or fail-first protocol
 116 will cause or will likely cause an adverse reaction or other
 117 physical harm to the enrollee.

118
 119 If the prescribing provider allows the enrollee to enter the
 120 step-therapy or fail-first protocol recommended by the managed
 121 care plan, the duration of the step-therapy or fail-first
 122 protocol may not exceed a period deemed appropriate by the
 123 provider. If the prescribing provider deems the treatment
 124 clinically ineffective, the enrollee is entitled to receive the
 125 recommended course of therapy without requiring the prescribing
 126 provider to seek approval for an override of the step-therapy or
 127 fail-first protocol.

128 Section 2. Subsection (11) of section 627.6131, Florida
 129 Statutes, is amended to read:

130 627.6131 Payment of claims.—

131 (11)
 132 (a) A health insurer may not retroactively deny a claim
 133 because of insured ineligibility more than 1 year after the date
 134 of payment of the claim.

135 (b) A health insurer that has verified the eligibility of
 136 an insured at the time of treatment and has provided an
 137 authorization number may not retroactively deny a claim because
 138 of insured ineligibility.

139 (c) A health insurer that has provided the insured with an
 140 identification card as provided in s. 627.642(3) that at the
 141 time of service identifies the insured as eligible to receive
 142 services may not retroactively deny a claim because of insured
 143 ineligibility.

144 Section 3. Section 627.6466, Florida Statutes, is created
 145 to read:

146 627.6466 Fail-first protocols.—When medications for the
 147 treatment of a medical condition are restricted for use by an
 148 insurer by a step-therapy or fail-first protocol, the
 149 prescribing provider shall have access to a clear and convenient
 150 process to request an override of the protocol from the health
 151 benefit plan or health insurance issuer. The plan or issuer
 152 shall grant an override of the protocol within 24 hours under
 153 the following circumstances:

154 (a) The prescribing provider recommends, based on sound
 155 clinical evidence, that the preferred treatment required under
 156 the step-therapy or fail-first protocol has been ineffective in

157 the treatment of the insured's disease or medical condition; or

158 (b) Based on sound clinical evidence or medical and
 159 scientific evidence:

160 1. The prescribing provider believes that the preferred
 161 treatment required under the step-therapy or fail-first protocol
 162 is expected or likely to be ineffective based on known relevant
 163 physical or mental characteristics of the insured and known
 164 characteristics of the drug regimen; or

165 2. The prescribing provider believes that the preferred
 166 treatment required under the step-therapy or fail-first protocol
 167 will cause or is likely to cause an adverse reaction or other
 168 physical harm to the insured.

169
 170 If the prescribing provider allows the patient to enter the
 171 step-therapy or fail-first protocol recommended by the insurer,
 172 the duration of the step-therapy or fail-first protocol may not
 173 exceed a period deemed appropriate by the provider. If the
 174 prescribing provider deems the treatment clinically ineffective,
 175 the patient is entitled to receive the recommended course of
 176 therapy without requiring the prescribing provider to seek
 177 approval for an override of the step-therapy or fail-first
 178 protocol.

179 Section 4. Subsection (2) of section 627.6471, Florida
 180 Statutes, is amended to read:

181 627.6471 Contracts for reduced rates of payment;
 182 limitations; coinsurance and deductibles.—

183 (2) Any insurer issuing a policy of health insurance in
 184 this state, which insurance includes coverage for the services
 185 of a preferred provider, shall ~~must~~ provide each policyholder
 186 and certificate holder with a current list of preferred
 187 providers, shall ~~and must~~ make the list available for public
 188 inspection during regular business hours at the principal office
 189 of the insurer within the state, and shall post a link to the
 190 list of preferred providers on the home page of the insurer's
 191 website. Changes to the list of preferred providers shall be
 192 reflected on the insurer's website within 24 hours.

193 Section 5. Subsection (10) of section 641.3155, Florida
 194 Statutes, is amended to read:

195 641.3155 Prompt payment of claims.—

196 (10)

197 (a) A health maintenance organization may not
 198 retroactively deny a claim because of subscriber ineligibility
 199 more than 1 year after the date of payment of the claim.

200 (b) A health maintenance organization that has verified
 201 the eligibility of a subscriber at the time of treatment and has
 202 provided an authorization number may not retroactively deny a
 203 claim because of subscriber ineligibility.

204 (c) A health maintenance organization that has provided
 205 the subscriber with an identification card as provided in s.
 206 627.642(3) that at the time of service identifies the subscriber
 207 as eligible to receive services may not retroactively deny a
 208 claim because of subscriber ineligibility.

209 Section 6. Section 641.394, Florida Statutes, is created
 210 to read:

211 641.394 Fail-first protocols.— When medications for the
 212 treatment of a medical condition are restricted for use by a
 213 health maintenance organization by a step-therapy or fail-first
 214 protocol, the prescribing provider shall have access to a clear
 215 and convenient process to request an override of the protocol
 216 from the health maintenance organization. The health maintenance
 217 organization shall grant an override of the protocol within 24
 218 hours under the following circumstances:

219 (a) The prescribing provider recommends, based on sound
 220 clinical evidence, that the preferred treatment required under
 221 the step-therapy or fail-first protocol has been ineffective in
 222 the treatment of the insured's disease or medical condition; or

223 (b) Based on sound clinical evidence or medical and
 224 scientific evidence:

225 1. The prescribing provider believes that the preferred
 226 treatment required under the step-therapy or fail-first protocol
 227 is expected or likely to be ineffective based on known relevant
 228 physical or mental characteristics of the insured and known
 229 characteristics of the drug regimen; or

230 2. The prescribing provider believes that the preferred
 231 treatment required under the step-therapy or fail-first protocol
 232 will cause or is likely to cause an adverse reaction or other
 233 physical harm to the insured.

234

PCS for HB 1001

ORIGINAL

2014

235 If the prescribing provider allows the patient to enter the
236 step-therapy or fail-first protocol recommended by the health
237 maintenance organization, the duration of the step-therapy or
238 fail-first protocol may not exceed a period deemed appropriate
239 by the provider. If the prescribing provider deems the treatment
240 clinically ineffective, the patient is entitled to receive the
241 recommended course of therapy without requiring the prescribing
242 provider to seek approval for an override of the step-therapy or
243 fail-first protocol.

244 Section 7. This act shall take effect July 1, 2014.