Patients Need the Right Medicine at the Right Time.

THE SITUATION IN FLORIDA

- 88% of Floridians agree that insurance companies that have preferred drug lists should have at least two drugs on the list for every disease so that doctors have choices for their patient's treatment options.
- 90% of Floridians agree that an insurance company should not be allowed to force patients to switch their drugs if there are changes to the insurers preferred drug lists when a doctor deems the medication medically necessary.
- 88% of Floridians believe that all insurance companies should use the same prior authorization form to cut down on the amount of paperwork patients and doctors have to deal with.

THE SOLUTION

Healthcare professionals have the expertise to know what is best for patients and must have access to a full range of therapeutic options to use as they see fit for their patients. They should not have to jump through burdensome bureaucratic hoops to secure the most appropriate therapy. Ultimately, healthcare professionals, not bureaucrats, should make the determination of the best course of treatment and medications for a patient. We need to ensure Florida's patients are receiving the right medicine at the right time.

Streamlining Step Therapy and Fail First Protocols

Streamlining Step Therapy protocols ensures that physicians have a clear pathway to navigate health plan's step therapy protocols. Under a 'fail first" or 'step-therapy' program, patients cannot receive the drug their physician believes is the best medicine for the patient until they try and fail on older and cheaper drugs. Step therapy programs can be impediments to timely care and are contrary to medicine's best practice of getting the right medicines to the right patient at the right time.

Simplified Prior Authorization

This legislation would require each insurer in the state to develop a standard prior authorization form to be used for all requests. Standardization will minimize costs to the state and maximize the efficiency of the prior approval process, while keeping our doctors in the clinical setting instead of navigating time-consuming and inefficient paperwork. In most cases, the prior authorization request is eventually approved but only after considerable delay and administrative expense that is a hardship for patients and a burden for physicians.

Protection against Discriminatory Plan Designs

This legislation seeks to prohibit insurers from discriminating against vulnerable populations through such means as exclusion of certain therapies or conditions, differential reimbursement rates or cost sharing benefits, clinical prerequisites or heightened administrative requirements based on a patient's disease or disability, or burdensome exceptions processes.

In addition, this legislation would also prevent discrimination on the basis of such variables as expected length of life, disease, or health condition. The concept behind this legislative language is a response to a disturbing decision by the state of Oregon to severely restrict access to cancer treatments for patients based on the severity of the illness. Since the Oregon policy was adopted, other states have quickly moved to prohibit similar discriminatory policies.

Providing Continuity of Care for Stable Patients

If a person with a chronic condition is stabilized using a particular drug therapy, that patient should be allowed to continue on that medication as long as it is working and reviewed periodically by their physician. Patients who are seeing such positive results should not be forced to change medications based on the calendar or administrative changes in their coverage plans without the ability to appeal those bureaucratic decisions. This legislation would allow a patient who has maintained a continuous enrollment in a manage care plan to receive continued coverage for a medication that is continuously prescribed and is considered safe for the treatment of their condition.

Offering an Appeals Process for Medical Exceptions

This legislation would require health plans providing Essential Health Benefits (EHBs) to have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. If a person finds their medicine is not covered by their plan, they should have access to a fair process for handling exceptions and appeals, including expedited for urgent or emergency medical conditions as well as continued benefits during the appeal.

ABOUT PATIENT ACCESS FOR FLORIDA

Patient Access for Florida unites organizations committed to public policy to strengthen patient protections and appeals processes, specifically in the areas of streamlining step therapy and fail first protocols, simplified prior authorization, protection against discriminatory plan designs, providing continuity of care for stable patients, and offering an appeals process for medical exceptions. The coalition unites all types of stakeholders—patient, healthcare professionals, and business organizations—to ensure a unified strategy to address these issues.

Physicians Know Best For Patients, Not Bureaucrats.