CHAPTER 514F

UTILIZATION AND COST CONTROL

Referred to in §87.4, 296.7, 331.301, 364.4, 505.28, 505.29, 514C.11, 514C.32, 514C.33, 514L.1, 669.14, 670.7

514F.1 Utilization and cost control review committees.

The licensing boards under chapters 148, 149, 151, and 152 shall establish utilization and cost control review committees of licensees under the respective chapters, selected from licensees who have practiced in Iowa for at least the previous five years, or shall accredit and designate other utilization and cost control organizations as utilization and cost control committees under this section, for the purposes of utilization review of the appropriateness of levels of treatment and of giving opinions as to the reasonableness of charges for diagnostic or treatment services of licensees. Persons governed by the various chapters of Title XIII, subtitle 1, of the Code and self-insurers for health care benefits to employees may utilize the services of the utilization and cost control review committees upon the payment of a reasonable fee for the services, to be determined by the respective boards. The respective boards under chapters 148, 149, 151, and 152 shall adopt rules necessary and proper for the administration of this section pursuant to chapter 17A. It is the intent of this general assembly that conduct of the utilization and cost control review committees authorized under this section shall be exempt from challenge under federal or state antitrust laws or other similar laws in regulation of trade or commerce.

86 Acts, ch 1180, §10; 87 Acts, ch 115, §63; 88 Acts, ch 1199, §6; 89 Acts, ch 164, §6; 90 Acts, ch 1233, §32; 2007 Acts, ch 10, §177; 2008 Acts, ch 1088, §135

514F.2 Utilization and cost control.

Nothing contained in the chapters of Title XIII, subtitle 1, of the Code shall be construed to prohibit or discourage insurers, nonprofit service corporations, health maintenance organizations, or self-insurers for health care benefits to employees from providing payments of benefits or providing care and treatment under capitated payment systems, prospective reimbursement rate systems, utilization control systems, incentive systems for the use of least restrictive and least costly levels of care, preferred provider contracts limiting choice of specific provider, or other systems, methods or organizations designed to contain costs without sacrificing care or treatment outcome, provided these systems do not limit or make optional payment or reimbursement for health care services on a basis solely related to the license under or the practices authorized by chapter 151 or on a basis that is dependent upon a method of classification, categorization, or description based upon differences in terminology used by different licensees under the chapters of Title IV, subtitle 3, of the Code in describing human ailments or their diagnosis or treatment.

86 Acts, ch 1180, §10

514F.3 Preferred providers.

The commissioner of insurance shall adopt rules for preferred provider contracts and organizations, both those that limit choice of specific provider and those that do not. The rules adopted shall include, but not be limited to, the following subjects: preferred provider arrangements and participation requirements, health benefit plans, and civil penalties.

88 Acts, ch 1112, §604

514F.4 Utilization review requirements.

1. A third-party payor which provides health benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the

utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner.

2. This section does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under any of the following:

a. Tit. XVIII of the federal Social Security Act.

b. The civilian health and medical program of the uniformed services.

c. Any other federal employee health benefit plan.

3. For purposes of this section, unless the context otherwise requires:

a. *"Third-party payor"* means:

(1) An insurer subject to chapter 509 or 514A.

(2) A health service corporation subject to chapter 514.

(3) A health maintenance organization subject to chapter 514B.

(4) A preferred provider arrangement.

(5) A multiple employer welfare arrangement.

(6) A third-party administrator.

(7) A fraternal benefit society.

(8) A plan established pursuant to chapter 509A for public employees.

(9) Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

b. *"Utilization review"* means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. Such evaluation does not apply to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

99 Acts, ch 41, §5; 2010 Acts, ch 1061, §180

514F.5 Experimental treatment review.

1. A carrier, as defined in section 513B.2, or a plan established pursuant to chapter 509A for public employees, that limits coverage for experimental medical treatment, drugs, or devices, shall develop and implement a procedure to evaluate experimental medical treatments and shall submit a description of the procedure to the division of insurance. The procedure shall be in writing and must describe the process used to determine whether the carrier or chapter 509A plan will provide coverage for new medical technologies and new uses of existing technologies. The procedure, at a minimum, shall require a review of information from appropriate government regulatory agencies and published scientific literature concerning new medical technologies, new uses of existing technologies, and the use of external experts in making decisions. A carrier or chapter 509A plan shall include appropriately licensed or qualified professionals in the evaluation process. The procedure shall provide a process for a person covered under a plan or contract to request a review of a denial of coverage because the proposed treatment is experimental. A review of a particular treatment need not be reviewed more than once a year.

2. A carrier or chapter 509A plan that limits coverage for experimental treatment, drugs, or devices shall clearly disclose such limitations in a contract, policy, or certificate of coverage.

99 Acts, ch 41, §6; 2017 Acts, ch 148, §91

514F.6 Credentialing — retrospective payment.

1. The commissioner shall adopt rules to provide for the retrospective payment of clean claims for covered services provided by a physician, advanced registered nurse practitioner, or physician assistant during the credentialing period, once the physician, advanced registered nurse practitioner, or physician assistant is credentialed.

2. For purposes of this section:

a. "Advanced registered nurse practitioner" means a person currently licensed as a registered nurse under chapter 152 or 152E who is licensed by the board of nursing as an advanced registered nurse practitioner.

b. "Clean claim" means the same as defined in section 507B.4A, subsection 2, paragraph *"b"*.

c. "Credentialing" means a process through which a health insurer makes a determination based on criteria established by the health insurer concerning whether a physician, advanced registered nurse practitioner, or physician assistant is eligible to provide health care services to an insured and to receive reimbursement for the health care services provided under an agreement entered into between the physician, advanced registered nurse practitioner, or physician assistant and the health insurer.

d. "Credentialing period" means the time period between the health insurer's receipt of a physician's, advanced registered nurse practitioner's, or physician assistant's application for credentialing and approval of that application by the health insurer.

e. "Physician" means a licensed doctor of medicine and surgery or a licensed doctor of osteopathic medicine and surgery.

f. "Physician assistant" means a person who is licensed to practice as a physician assistant under the supervision of one or more physicians.

2008 Acts, ch 1123, §28; 2010 Acts, ch 1121, §16; 2013 Acts, ch 90, §155; 2015 Acts, ch 56, §24

514F.7 Use of step therapy protocols.

1. *Definitions.* For the purposes of this section:

a. "Authorized representative" means the same as defined in section 514J.102.

b. "Clinical practice guidelines" means a systematically developed statement to assist health care professionals and covered persons in making decisions about appropriate health care for specific clinical circumstances and conditions.

c. "Clinical review criteria" means the same as defined in section 514J.102.

d. "Covered person" means the same as defined in section 514J.102.

e. "Health benefit plan" means the same as defined in section 514J.102.

f. "Health care professional" means the same as defined in section 514J.102.

g. "Health care services" means the same as defined in section 514J.102.

h. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. *"Health carrier"* does not include a managed care organization as defined in 441 IAC 73.1 when the managed care organization is acting pursuant to a contract with the Iowa department of human services to provide services to Medicaid recipients.

i. "Pharmaceutical sample" means a unit of a prescription drug that is not intended to be sold and is intended to promote the sale of the drug.

j. "Step therapy override exception" means a step therapy protocol should be overridden in favor of coverage of the prescription drug selected by a health care professional within the applicable time frames and in compliance with the requirements specified in section 505.26, subsection 7, for a request for prior authorization of prescription drug benefits. This determination is based on a review of the covered person's or health care professional's request for an override, along with supporting rationale and documentation.

k. "Step therapy protocol" means a protocol or program that establishes a specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular covered person are covered under a pharmacy or medical benefit by a health carrier, a health benefit plan, or a utilization review organization, including self-administered drugs and drugs administered by a health care professional.

l. "Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual. Such evaluation does not apply

to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health benefit plan, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health benefit plan.

m. "*Utilization review organization*" means an entity that performs utilization review, other than a health carrier performing utilization review for its own health benefit plans.

2. *Establishment of step therapy protocols.* A health carrier, health benefit plan, or utilization review organization shall consider available recognized evidence-based and peer-reviewed clinical practice guidelines when establishing a step therapy protocol. Upon written request of a covered person, a health carrier, health benefit plan, or utilization review organization shall provide any clinical review criteria applicable to a specific prescription drug covered by the health carrier, health benefit plan, or utilization review organization.

3. *Step therapy override exceptions process transparency.*

a. When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a health carrier, health benefit plan, or utilization review organization through the use of a step therapy protocol, the covered person and the prescribing health care professional shall have access to a clear, readily accessible, and convenient process to request a step therapy override exception. A health carrier, health benefit plan, or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process used shall be easily accessible on the internet site of the health carrier, health benefit plan, or utilization review organization.

b. A step therapy override exception shall be approved by a health carrier, health benefit plan, or utilization review organization if any of the following circumstances apply:

(1) The prescription drug required under the step therapy protocol is contraindicated pursuant to the drug manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

(a) Cause an adverse reaction to a covered person.

(b) Decrease the ability of a covered person to achieve or maintain reasonable functional ability in performing daily activities.

(c) Cause physical or mental harm to a covered person.

(2) The prescription drug required under the step therapy protocol is expected to be ineffective based on the known clinical characteristics of the covered person, such as the covered person's adherence to or compliance with the covered person's individual plan of care, and any of the following:

(a) The known characteristics of the prescription drug regimen as described in peer-reviewed literature or in the manufacturer's prescribing information for the drug.

(b) The health care professional's medical judgment based on clinical practice guidelines or peer-reviewed journals.

(c) The covered person's documented experience with the prescription drug regimen.

(3) The covered person has had a trial of a therapeutically equivalent dose of the prescription drug under the step therapy protocol while under the covered person's current or previous health benefit plan for a period of time to allow for a positive treatment outcome, and such prescription drug was discontinued by the covered person's health care professional due to lack of effectiveness.

(4) The covered person is currently receiving a positive therapeutic outcome on a prescription drug selected by the covered person's health care professional for the medical condition under consideration while under the covered person's current or previous health benefit plan. This subparagraph shall not be construed to encourage the use of a pharmaceutical sample for the sole purpose of meeting the requirements for a step therapy override exception.

c. Upon approval of a step therapy override exception, the health carrier, health benefit plan, or utilization review organization shall authorize coverage for the prescription drug

selected by the covered person's prescribing health care professional if the prescription drug is a covered prescription drug under the covered person's health benefit plan.

d. A health carrier, health benefit plan, or utilization review organization shall make a determination to approve or deny a request for a step therapy override exception within the applicable time frames and in compliance with the requirements specified in section 505.26, subsection 7, for a request for prior authorization of prescription drug benefits.

e. If a request for a step therapy override exception is denied, the health carrier, health benefit plan, or utilization review organization shall provide the covered person or the covered person's authorized representative and the patient's prescribing health care professional with the reason for the denial and information regarding the procedure to request external review of the denial pursuant to chapter 514J. Any denial of a request for a step therapy override exception that is upheld on appeal shall be considered a final adverse determination for purposes of chapter 514J and is eligible for a request for external review by a covered person or the covered person's authorized representative pursuant to chapter 514J.

4. *Limitations.* This section shall not be construed to do either of the following:

a. Prevent a health carrier, health benefit plan, or utilization review organization from requiring a covered person to try a prescription drug with the same generic name and demonstrated bioavailability or a biological product that is an interchangeable biological product pursuant to section 155A.32 prior to providing coverage for the equivalent branded prescription drug.

b. Prevent a health care professional from prescribing a prescription drug that is determined to be medically appropriate.

2017 Acts, ch 124, §1, 2; 2017 Acts, ch 148, §103

Section applies to health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2018; 2017 Acts, ch 124, §2