514F.9 Continuity of care — nonmedical switching.

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

a. *"Commissioner"* means the commissioner of insurance.

b. *"Cost sharing"* means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

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

d. *"Demonstrated bioavailability"* means the same as defined in section 155A.3.

e. *"Formulary"* means a complete list of prescription drugs eligible for coverage under a health benefit plan.

f. *"Generic name"* means the same as defined in section 155A.3.

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

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

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

j. *"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 the department of health and human services, or a managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

k. *"Interchangeable biological product"* means the same as defined in section 155A.3.

l. *"Utilization review organization"* means the same as defined in section 514F.7.

2. *Nonmedical switching.* With respect to a health carrier that has entered into a health benefit plan with a covered person that covers prescription drug benefits, all of the following apply:

a. A health carrier, health benefit plan, or utilization review organization shall not limit or exclude coverage of a prescription drug for any covered person who is medically stable on such drug as determined by the prescribing health care professional, if all of the following apply:

(1) The prescription drug was previously approved by the health carrier for coverage for the covered person.

(2) The covered person's prescribing health care professional has prescribed the drug for the covered person's medical condition within the previous six months.

(3) The covered person continues to be an enrollee of the health benefit plan.

b. Coverage of a covered person's prescription drug, as described in paragraph *"a"*, shall continue through the last day of the covered person's eligibility under the health benefit plan, or through the last day of the health benefit plan year, whichever is earlier.

c. Prohibited limitations and exclusions referred to in paragraph *"a"* include but are not limited to the following:

(1) Limiting or reducing the maximum coverage of prescription drug benefits.

(2) Increasing cost sharing for a covered prescription drug.

(3) Moving a prescription drug to a more restrictive tier if the health carrier uses a formulary with tiers.

(4) Removing a prescription drug from a formulary, unless the United States food and drug administration has issued a statement about the drug that calls into question the clinical safety of the drug, or the manufacturer of the drug has notified the United States food and drug administration of a manufacturing discontinuance or potential discontinuance of the drug as required by section 506C of the Federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. §356c.

d. This subsection shall not be construed to prohibit a substitution, a formulary change, or a preference by a health carrier for a prescribed drug product that has the same generic name and demonstrated bioavailability, or that is an interchangeable biological product.

3. *Limitations.* This section shall not be construed to do any of the following:

a. Prevent a health care professional from prescribing another drug covered by the health carrier that the health care professional deems medically necessary for the covered person.

b. Prevent a health carrier from doing any of the following:

(1) Adding a prescription drug to its formulary.

(2) Removing a prescription drug from its formulary if the drug manufacturer has removed the drug for sale in the United States.

4. *Enforcement.* The commissioner may take any enforcement action under the commissioner's authority to enforce compliance with this section.

2024 Acts, ch 1144, §1, 2

Section applies to a health benefit plan that is delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2025; 2024 Acts, ch 1144, §2

NEW section