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
Referred to in §514F.8

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.

1. *Retrospective payment.* 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. *Credentialing process.*

a. A health insurer shall respond to a physician, advanced registered nurse practitioner, or physician assistant's request for credentialing within fifty-six calendar days from the date of the request.

b. If a physician's, advanced registered nurse practitioner's, or physician assistant's request for credentialing is denied by the health insurer, the health insurer shall provide a reason for the denial, in writing, to the physician, advanced registered nurse practitioner, or physician assistant.

3. *Definitions.* 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 the same as defined in section 148C.1.

2008 Acts, ch 1123, §28; 2010 Acts, ch 1121, §16; 2013 Acts, ch 90, §155; 2015 Acts, ch 56, §24; 2025 Acts, ch 72, §1
Section amended

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 department of health and 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, as defined in section 155A.3, 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; 2023 Acts, ch 19, §1203; 2024 Acts, ch 1056, §26

Referred to in §514F.9

514F.8 Prior authorizations — reimbursement.

1. For purposes of this section:

a. "*Covered person*" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

b. "*Facility*" means the same as defined in section 514J.102.

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

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

e. "*Health care provider*" means a health care professional or a facility.

f. "*Health care services*" means services provided by a health care provider for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. "*Health care services*" includes the provision of durable medical equipment. "*Health care services*" does not include prescription drugs or dental care services as that term is defined in section 514J.102.

g. "*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.

h. *"Prior authorization"* means a determination by a utilization review organization that a specific health care service proposed by a health care provider for a covered person is medically necessary or medically appropriate, and the determination is made prior to the provision of the health care service to the covered person, and, if applicable, includes a utilization review organization's requirement that a covered person or a health care provider notify the utilization review organization prior to receiving or providing a specific health care service.

i. *"Utilization review"* means the same as defined in section 514F.4, subsection 3.

j. *"Utilization review organization"* means an entity that performs utilization review, including a health carrier that meets the requirements established for accreditation set by the utilization review accreditation commission or the national committee on quality assurance and that performs utilization review for the health carrier's health benefit plans.

2. *a.* A utilization review organization shall provide a determination to a request for prior authorization from a health care provider as follows:

(1) Within forty-eight hours after receipt for urgent requests.

(2) Within ten calendar days after receipt for nonurgent requests.

(3) Within fifteen calendar days after receipt for nonurgent requests if there are complex or unique circumstances or the utilization review organization is experiencing an unusually high volume of prior authorization requests.

b. Within twenty-four hours after receipt of a prior authorization request, the utilization review organization shall notify the health care provider of, or make available to the health care provider, a receipt for the request for prior authorization.

c. A utilization review organization shall conduct an annual review and submit the findings in a report to the commissioner pursuant to the reporting procedures and deadlines established by the commissioner. The commissioner shall publish, within sixty calendar days of receipt, the report on a publicly accessible internet site. The annual report shall include all of the following:

(1) The total number of, and percentage of, urgent prior authorization requests that the utilization review organization approved, aggregated for all health care services and items.

(2) The total number of, and percentage of, urgent prior authorization requests that the utilization review organization denied, aggregated for all health care services or items.

(3) The total number of, and percentage of, nonurgent prior authorization requests that the utilization review organization approved, aggregated for all health care services or items.

(4) The total number of, and percentage of, nonurgent prior authorization requests that the utilization review organization denied, aggregated for all health care services or items.

(5) The total number of, and percentage of, nonurgent prior authorization requests that were complex or involved unique circumstances that the utilization review organization approved, aggregated for all health care services or items.

(6) The average and median time that elapsed between the submission of a prior authorization request and a determination by the utilization review organization for the prior authorization request, aggregated for all health care services or items.

(7) The average and median time that elapsed between the submission of an urgent prior authorization request and a determination by the utilization review organization for the urgent prior authorization request, aggregated for all health care services or items.

(8) The average and median time that elapsed between the submission of a nonurgent prior authorization request and a determination by the utilization review organization for the nonurgent prior authorization request, aggregated for all health care services or items.

3. *a.* A utilization review organization shall not revoke, or impose a limitation, condition, or restriction on, a prior authorization after the date on which a health care provider provides a health care service to a covered person per the prior authorization.

b. A health carrier shall reimburse a health care provider at the contracted reimbursement rate for a health care service provided by the health care provider to a covered person per a prior authorization.

c. Paragraphs *"a"* and *"b"* shall not apply in any of the following circumstances:

(1) The health care provider or the covered person committed fraud, waste, or abuse.

(2) The health care provider or the covered person provided inaccurate information that the utilization review organization relied on for the utilization review organization's prior authorization determination.

(3) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the health care service was no longer a benefit covered by the covered person's health benefit plan.

(4) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the health care provider was no longer contracted with the health carrier that provides the covered person's health benefit plan.

(5) The health care provider failed to meet the health carrier's requirements related to timely filing of claims for submission of a claim for the health care service provided by the health care provider to the covered person per the prior authorization.

(6) Due to coordination of benefits, the health carrier does not have liability for a claim for the health care service provided by the health care provider to the covered person per a prior authorization.

(7) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the covered person was no longer a participant in the health benefit plan in which the covered person participated on the date that the prior authorization was received by the health care provider.

4. *a.* A utilization review organization shall, at least annually, review all health care services for which the health benefit plan requires prior authorization and shall eliminate prior authorization requirements for health care services for which prior authorization requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality, or reduce health care spending, to a degree sufficient to justify the health benefit plan's administrative costs to require the prior authorization.

b. A utilization review organization shall submit an annual report containing the findings of the review conducted under paragraph "*a*" to the commissioner pursuant to the reporting procedures and deadlines established by the commissioner. The commission shall publish, within sixty days of receipt, the report on a publicly accessible internet site. The annual report shall include all of the following:

(1) The total number of prior authorizations the utilization review organization evaluated as part of the annual review.

(2) The number of prior authorizations the utilization review organization eliminated as a result of the annual review, and the reason for the elimination.

(3) A list of prior authorizations that had at least eighty percent of requests approved in the previous twelve months for a specific health care service covered by a health benefit plan, but which prior authorizations were retained due to medical or scientific evidence, as defined in section 514J.102, that justified continuing such requirement.

(4) The total number of prior authorization requests submitted in the previous twelve months for each eliminated prior authorization, and the total number of health care providers that submitted a request for prior authorization in the previous twelve months for each eliminated prior authorization requirement.

(5) For each health care service for which prior authorization was eliminated under subparagraph (2), the report shall include data regarding any increase or decrease of ten percent or greater in the average number of claims submitted per health care provider for that health care service compared to the twelve months immediately preceding the elimination of the prior authorization.

5. A prior authorization for a specific health care service for a covered person shall be valid for the specific health care service for not less than ninety days from the date that the covered person's health care provider receives the prior authorization from a utilization review organization, provided that during the ninety days the covered person remains a participant in the same health benefit plan in which the covered person participated on the date the prior authorization was received by the health care provider.

6. Complaints regarding a utilization review organization's compliance with this chapter

may be directed to the insurance division. The insurance division shall notify a utilization review organization of all complaints regarding the utilization review organization's noncompliance with this chapter. All complaints received pursuant to this subsection shall not be considered public records for purposes of chapter 22.

7. The commissioner may adopt rules pursuant to chapter 17A as necessary to administer this chapter.

2022 Acts, ch 1056, §1, 2; 2023 Acts, ch 19, §1204; 2025 Acts, ch 108, §1; 2025 Acts, ch 159, §16

NEW subsection 2 and former subsection 2 renumbered as 3
NEW subsection 4 and former subsection 3 renumbered as 5
NEW subsection 6 and former subsection 4 renumbered as 7

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