HOUSE FILE 2376
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO HSB 653)

A BILL FOR

1 An Act requiring the development and use of a standard process
2 and form for prior authorization of prescription drug
3 benefits.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. NEW SECTION. **505.26 Prior authorization for**
2 **prescription drug benefits — standard process and form.**
3 1. As used in this section:
4 *a. "Facility"* means an institution providing health care
5 services or a health care setting, including but not limited
6 to hospitals and other licensed inpatient centers, ambulatory
7 surgical or treatment centers, skilled nursing centers,
8 residential treatment centers, diagnostic, laboratory, and
9 imaging centers, and rehabilitation and other therapeutic
10 health settings.
11 *b. "Health benefit plan"* means a policy, contract,
12 certificate, or agreement offered or issued by a health carrier
13 to provide, deliver, arrange for, pay for, or reimburse any of
14 the costs of health care services.
15 *c. "Health care professional"* means a physician or other
16 health care practitioner licensed, accredited, registered, or
17 certified to perform specified health care services consistent
18 with state law.
19 *d. "Health care provider"* means a health care professional
20 or a facility.
21 *e. "Health care services"* means services for the diagnosis,
22 prevention, treatment, cure, or relief of a health condition,
23 illness, injury, or disease.
24 *f. "Health carrier"* means an entity subject to the insurance
25 laws of this state, or subject to the jurisdiction of the
26 commissioner, including an insurance company offering sickness
27 and accident plans, a health maintenance organization, a
28 nonprofit health service corporation, a plan established
29 pursuant to chapter 509A for public employees, or any other
30 entity providing a plan of health insurance, health care
31 benefits, or health care services. *"Health carrier"* includes,
32 for purposes of this section, an organized delivery system.
33 *g. "Pharmacy benefits manager"* means the same as defined in
34 section 510B.1.
35 2. The commissioner shall develop, by rule, a standard prior

1 authorization process and form for use by health carriers and
2 pharmacy benefits managers that require prior authorization for
3 prescription drug benefits pursuant to a health benefit plan,
4 by January 1, 2015.
5 3. Prior to development of the standard prior authorization
6 process and form, the commissioner shall hold at least one
7 public hearing to gather input in developing the standard
8 process and form from interested parties.
9 4. The standard prior authorization process shall meet all
10 of the following requirements:
11 *a.* Health carriers and pharmacy benefits managers shall
12 allow health care providers to submit a prior authorization
13 request electronically.
14 *b.* Health carriers and pharmacy benefits managers shall
15 provide that approval of a prior authorization request shall be
16 valid for a minimum of one hundred eighty days.
17 *c.* Health carriers and pharmacy benefits managers shall
18 ensure that the prior authorization process allows a health
19 carrier or pharmacy benefits manager to substitute a generic
20 drug for a previously approved brand-name drug with the health
21 care provider´s approval and the patient´s consent.
22 *d.* Health carriers and pharmacy benefits managers shall make
23 the following available and accessible on their internet sites:
24 (1) Prior authorization requirements and restrictions,
25 including a list of drugs that require prior authorization.
26 (2) Clinical criteria that are easily understandable
27 to health care providers, including clinical criteria for
28 reauthorization of a previously approved drug after the prior
29 authorization period has expired.
30 (3) Standards for submitting and considering requests,
31 including evidence-based guidelines, when possible, for making
32 prior authorization determinations.
33 *e.* Health carriers and pharmacy benefits managers shall
34 provide a process for health care providers to appeal a prior
35 authorization determination.

5. The standard prior authorization form shall meet all of the following requirements:

a. Not exceed two pages in length.

b. Be available in an electronic format.

c. Be transmissible in an electronic format.

6. Health carriers and pharmacy benefits managers shall use and accept the standard prior authorization form beginning on July 1, 2015. Health care providers shall use and submit the standard prior authorization form, when prior authorization is required by a health benefit plan, beginning on July 1, 2015.

7. *a.* If a health carrier or pharmacy benefits manager fails to use or accept the standard prior authorization form or to respond to a health care provider's request for prior authorization of prescription drug benefits within seventy-two hours of the health care provider's submission of the form, the request for prior authorization shall be considered to be approved.

b. However, if the prior authorization request is incomplete, the health carrier or pharmacy benefits manager may request the additional information within the seventy-two-hour period and once the additional information is provided the provisions of paragraph "*a*" shall again apply.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill requires the development and use of a standard process and form to obtain prior authorization for prescription drug benefits under a health benefit plan.

The bill requires the commissioner of insurance to develop, by rule, a standard process and form by January 1, 2015. Before developing the process and form, the commissioner is required to hold at least one public hearing to obtain input from interested parties. The form must not exceed two pages in length and must be available and transmissible in an electronic format.

1 Health carriers are defined as all types of entities
2 providing health insurance or health benefit coverages and
3 pharmacy benefits managers are defined as an entity providing
4 prescription drug benefit management services to all types
5 of entities providing health insurance or health benefit
6 coverages, including employers and unions. Health carriers and
7 pharmacy benefits managers are required to use and accept the
8 standard prior authorization form, and health care providers
9 are required to use and submit the form, beginning on July 1,
10 2015. If a health carrier fails to use or accept the standard
11 form or to respond to a health care provider´s request for
12 prior authorization of prescription drug benefits within 72
13 hours of the provider´s submission of the form, the request
14 shall be considered to be granted, unless the request is
15 incomplete and additional information is needed to process the
16 request.
17 Health care providers are defined as health care
18 professionals or health care institutions and are required to
19 use and submit the standard prior authorization form, beginning
20 on July 1, 2015.
21 The standard prior authorization process must include
22 the capability of electronic submissions, 180-day prior
23 authorization approvals, substitution of generic drugs,
24 internet access to prior authorization requirements such as
25 listing of drugs and understandable clinical criteria for
26 authorization and reauthorization, and an appeal process.
27 The prior authorization form must not exceed two pages in
28 length and must be available and transmissible in an electronic
29 format.