

Senate File 292 - Introduced

SENATE FILE 292

BY GREENE

(COMPANION TO HF 204 BY MOORE)

A BILL FOR

1 An Act relating to continuity of care and nonmedical switching
2 by health carriers, health benefit plans, and utilization
3 review organizations, and including applicability
4 provisions.

5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. NEW SECTION. 514F.8 Continuity of care —
2 nonmedical switching.

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

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

6 b. "*Commissioner*" means the commissioner of insurance.

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

10 d. "*Coverage exemption*" means a determination made by a
11 health carrier, health benefit plan, or utilization review
12 organization to cover a prescription drug that is otherwise
13 excluded from coverage.

14 e. "*Coverage exemption determination*" means a determination
15 made by a health carrier, health benefit plan, or utilization
16 review organization whether to cover a prescription drug that
17 is otherwise excluded from coverage.

18 f. "*Covered person*" means the same as defined in section
19 514J.102.

20 g. "*Discontinued health benefit plan*" means a covered
21 person's existing health benefit plan that is discontinued by a
22 health carrier during open enrollment for the next plan year.

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

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

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

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

31 l. "*Health carrier*" means the same as defined in section
32 514J.102.

33 m. "*Nonmedical switching*" means a health benefit plan's
34 restrictive changes to the health benefit plan's formulary
35 after the current plan year has begun or during the open

1 enrollment period for the upcoming plan year, causing a covered
2 person who is medically stable on the covered person's current
3 prescribed drug as determined by the prescribing health care
4 professional, to switch to a less costly alternate prescription
5 drug.

6 *n.* "Open enrollment" means the yearly time period an
7 individual can enroll in a health benefit plan.

8 *o.* "Utilization review" means the same as defined in 514F.7.

9 *p.* "Utilization review organization" means the same as
10 defined in 514F.7.

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

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

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

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

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

27 *b.* Coverage of a covered person's prescription drug, as
28 described in paragraph "a", shall continue through the last day
29 of the covered person's eligibility under the health benefit
30 plan, inclusive of any open enrollment period.

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

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

35 (2) Increasing cost sharing for a covered prescription

1 drug.

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

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

12 3. *Coverage exemption determination process.*

13 a. To ensure continuity of care, a health carrier, health
14 plan, or utilization review organization shall provide a
15 covered person and prescribing health care professional with
16 access to a clear and convenient process to request a coverage
17 exemption determination. A health carrier, health plan, or
18 utilization review organization may use its existing medical
19 exceptions process to satisfy this requirement. The process
20 used shall be easily accessible on the internet site of the
21 health carrier, health benefit plan, or utilization review
22 organization.

23 b. A health carrier, health benefit plan, or utilization
24 review organization shall respond to a coverage exemption
25 determination request within seventy-two hours of receipt. In
26 cases where exigent circumstances exist, a health carrier,
27 health benefit plan, or utilization review organization shall
28 respond within twenty-four hours of receipt. If a response by
29 a health carrier, health benefit plan, or utilization review
30 organization is not received within the applicable time period,
31 the coverage exemption shall be deemed granted.

32 c. A coverage exemption shall be expeditiously granted for a
33 discontinued health benefit plan if a covered person enrolls in
34 a comparable plan offered by the same health carrier, and all
35 of the following conditions apply:

1 (1) The covered person is medically stable on a prescription
2 drug as determined by the prescribing health care professional.

3 (2) The prescribing health care professional continues
4 to prescribe the drug for the covered person for the medical
5 condition.

6 (3) In comparison to the discontinued health benefit plan,
7 the new health benefit plan does any of the following:

8 (a) Limits or reduces the maximum coverage of prescription
9 drug benefits.

10 (b) Increases cost sharing for the prescription drug.

11 (c) Moves the prescription drug to a more restrictive tier
12 if the health carrier uses a formulary with tiers.

13 (d) Excludes the prescription drug from the formulary.

14 *d.* Upon granting of a coverage exemption for a drug
15 prescribed by a covered person's prescribing health care
16 professional, a health carrier, health benefit plan, or
17 utilization review organization shall authorize coverage no
18 more restrictive than that offered in a discontinued health
19 benefit plan, or than that offered prior to implementation of
20 restrictive changes to the health benefit plan's formulary
21 after the current plan year began.

22 *e.* If a determination is made to deny a request for a
23 coverage exemption, the health carrier, health benefit plan,
24 or utilization review organization shall provide the covered
25 person or the covered person's authorized representative and
26 the authorized person's prescribing health care professional
27 with the reason for denial and information regarding the
28 procedure to appeal the denial. Any determination to deny a
29 coverage exemption may be appealed by a covered person or the
30 covered person's authorized representative.

31 *f.* A health carrier, health benefit plan, or utilization
32 review organization shall uphold or reverse a determination to
33 deny a coverage exemption within seventy-two hours of receipt
34 of an appeal of denial. In cases where exigent circumstances
35 exist, a health carrier, health benefit plan, or utilization

1 review organization shall uphold or reverse a determination to
2 deny a coverage exemption within twenty-four hours of receipt.
3 If the determination to deny a coverage exemption is not upheld
4 or reversed on appeal within the applicable time period, the
5 denial shall be deemed reversed and the coverage exemption
6 shall be deemed approved.

7 *g.* If a determination to deny a coverage exemption is
8 upheld on appeal, the health carrier, health benefit plan,
9 or utilization review organization shall provide the covered
10 person or covered person's authorized representative and the
11 covered person's prescribing health care professional with
12 the reason for upholding the denial on appeal and information
13 regarding the procedure to request external review of the
14 denial pursuant to chapter 514J. Any denial of a request for a
15 coverage exemption that is upheld on appeal shall be considered
16 a final adverse determination for purposes of chapter 514J and
17 is eligible for a request for external review by a covered
18 person or the covered person's authorized representative
19 pursuant to chapter 514J.

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

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

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

26 (1) Adding a prescription drug to its formulary.

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

30 (3) Requiring a pharmacist to effect a substitution of a
31 generic or interchangeable biological drug product pursuant to
32 section 155A.32.

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

1 6. *Applicability.* This section is applicable to a health
2 benefit plan that is delivered, issued for delivery, continued,
3 or renewed in this state on or after January 1, 2020.

4

EXPLANATION

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

7

This bill relates to the continuity of care for a covered
8 person and nonmedical switching by health carriers, health
9 benefit plans, and utilization review organizations.

10

The bill defines "nonmedical switching" as a health benefit
11 plan's restrictive changes to the health benefit plan's
12 formulary after the current plan year has begun or during the
13 open enrollment period for the upcoming plan year, causing a
14 covered person who is medically stable on the covered person's
15 current prescribed drug as determined by the prescribing
16 health care professional, to switch to a less costly alternate
17 prescription drug.

18

The bill provides that during a covered person's eligibility
19 under a health benefit plan, inclusive of any open enrollment
20 period, a health plan carrier, health benefit plan, or
21 utilization review organization shall not limit or exclude
22 coverage of a prescription drug for the covered person if the
23 covered person is medically stable on the drug as determined
24 by the prescribing health care professional, the drug was
25 previously approved by the health carrier for coverage for the
26 person, and the person's prescribing health care professional
27 has prescribed the drug for the covered person's medical
28 condition within the previous six months. The bill includes,
29 as prohibited limitations or exclusions, reducing the maximum
30 coverage of prescription drug benefits, increasing cost sharing
31 for a covered drug, moving a drug to a more restrictive tier,
32 and removing a drug from a formulary. A prescription drug
33 may, however, be removed from a formulary if the United States
34 food and drug administration issues a statement regarding the
35 clinical safety of the drug, or the manufacturer of the drug

1 notifies the United States food and drug administration of a
2 manufacturing discontinuance or potential discontinuance of the
3 drug as required by section 506c of the Federal Food, Drug, and
4 Cosmetic Act.

5 The bill requires a covered person and prescribing health
6 care professional to have access to a process to request a
7 coverage exemption determination. The bill defines "coverage
8 exemption determination" as a determination made by a
9 health carrier, health benefit plan, or utilization review
10 organization whether to cover a prescription drug that is
11 otherwise excluded from coverage.

12 A coverage exemption determination request must be approved
13 or denied by the health carrier, health benefit plan, or
14 utilization review organization within 72 hours, or within 24
15 hours if exigent circumstances exist. If a determination is
16 not received within the applicable time period the coverage
17 exemption is deemed granted.

18 The bill requires a coverage exemption to be expeditiously
19 granted for a health benefit plan discontinued for the next
20 plan year if a covered person enrolls in a comparable plan
21 offered by the same health carrier, and in comparison to the
22 discontinued health benefit plan, the new health benefit plan
23 limits or reduces the maximum coverage for a prescription drug,
24 increases cost sharing for the prescription drug, moves the
25 prescription drug to a more restrictive tier, or excludes the
26 prescription drug from the formulary.

27 If a coverage exemption is granted, the bill requires the
28 authorization of coverage that is no more restrictive than that
29 offered in a discontinued health benefit plan, or than that
30 offered prior to implementation of restrictive changes to the
31 health benefit plan's formulary after the current plan year
32 began.

33 If a determination is made to deny a request for a
34 coverage exemption, the reason for denial and the procedure
35 to appeal the denial must be provided to the requestor. Any

1 determination to deny a coverage exemption may be appealed to
2 the health carrier, health benefit plan, or utilization review
3 organization.

4 A determination to uphold or reverse denial of a coverage
5 exemption must be made within 72 hours of receipt of an appeal,
6 or within 24 hours if exigent circumstances exist. If a
7 determination is not made within the applicable time period,
8 the denial is deemed reversed and the coverage exemption is
9 deemed approved.

10 If a determination to deny a coverage exemption is upheld on
11 appeal, the reason for upholding the denial and the procedure
12 to request external review of the denial pursuant to Code
13 chapter 514J must be provided to the individual who filed the
14 appeal. Any denial of a request for a coverage exemption that
15 is upheld on appeal is considered a final adverse determination
16 for purposes of Code chapter 514J and is eligible for a request
17 for external review by a covered person or the covered person's
18 authorized representative pursuant to Code chapter 514J.

19 The bill shall not be construed to prevent a health care
20 professional from prescribing another drug covered by the
21 health carrier that the health care professional deems
22 medically necessary for the covered person.

23 The bill shall not be construed to prevent a health carrier
24 from adding a drug to its formulary or removing a drug from its
25 formulary if the drug manufacturer removes the drug for sale in
26 the United States.

27 The bill shall not be construed to require a pharmacist
28 to effect a substitution of a generic or interchangeable
29 biological drug product pursuant to Code section 155A.32.

30 The bill allows the commissioner to take any necessary
31 enforcement action under the commissioner's authority to
32 enforce compliance with the bill.

33 The bill is applicable to health benefit plans that are
34 delivered, issued for delivery, continued, or renewed in this
35 state on or after January 1, 2020.