Senate File 489 - Introduced

SENATE FILE 489
BY COMMITTEE ON HUMAN
RESOURCES

(SUCCESSOR TO SF 292)

A BILL FOR

1 An Act relating to continuity of care for covered persons with
2 epilepsy, and nonmedical switching by health carriers,
3 health benefit plans, and utilization review organizations,
4 and including applicability 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 a policyholder, subscriber,
19 enrollee, or other individual participating in a health benefit
20 plan who has been diagnosed with epilepsy.
21 *g. "Discontinued health benefit plan"* means a covered
22 person's existing health benefit plan that is discontinued by a
23 health carrier during open enrollment for the next plan year.
24 *h. "Formulary"* means a complete list of prescription drugs
25 eligible for coverage under a health benefit plan.
26 *i. "Health benefit plan"* means the same as defined in
27 section 514J.102.
28 *j. "Health care professional"* means the same as defined in
29 section 514J.102.
30 *k. "Health care services"* means services for the diagnosis,
31 prevention, treatment, cure, or relief of a health condition,
32 illness, injury, or disease.
33 *l. "Health carrier"* means the same as defined in section
34 514J.102.
35 *m. "Nonmedical switching"* means a health benefit plan's

1 restrictive changes to the health benefit plan's formulary
2 after the current plan year has begun or during the open
3 enrollment period for the upcoming plan year, causing a covered
4 person who is medically stable on the covered person's current
5 prescribed drug as determined by the prescribing health care
6 professional, to switch to a less costly alternate prescription
7 drug.
8 *n. "Open enrollment"* means the yearly time period an
9 individual can enroll in a health benefit plan.
10 *o. "Utilization review"* means the same as defined in 514F.7.
11 *p. "Utilization review organization"* means the same as
12 defined in 514F.7.
13 2. *Nonmedical switching.* With respect to a health carrier
14 that has entered into a health benefit plan with a covered
15 person that covers prescription drug benefits, all of the
16 following apply:
17 *a.* A health carrier, health benefit plan, or utilization
18 review organization shall not limit or exclude coverage of
19 a prescription drug for any covered person who is medically
20 stable on such drug as determined by the prescribing health
21 care professional, if all of the following apply:
22 (1) The prescription drug was previously approved by the
23 health carrier for coverage for the covered person.
24 (2) The covered person's prescribing health care
25 professional has prescribed the drug for the medical condition
26 within the previous six months.
27 (3) The covered person continues to be an enrollee of the
28 health benefit plan.
29 *b.* Coverage of a covered person's prescription drug, as
30 described in paragraph *"a"*, shall continue through the last day
31 of the covered person's eligibility under the health benefit
32 plan, inclusive of any open enrollment period.
33 *c.* Prohibited limitations and exclusions referred to in
34 paragraph *"a"* include but are not limited to the following:
35 (1) Limiting or reducing the maximum coverage of

1 prescription drug benefits.
2 (2) Increasing cost sharing for a covered prescription
3 drug.
4 (3) Moving a prescription drug to a more restrictive tier if
5 the health carrier uses a formulary with tiers.
6 (4) Removing a prescription drug from a formulary, unless
7 the United States food and drug administration has issued a
8 statement about the drug that calls into question the clinical
9 safety of the drug, or the manufacturer of the drug has
10 notified the United States food and drug administration of a
11 manufacturing discontinuance or potential discontinuance of the
12 drug as required by section 506C of the Federal Food, Drug, and
13 Cosmetic Act, as codified in 21 U.S.C. §356c.
14 3. *Coverage exemption determination process.*
15 *a.* To ensure continuity of care, a health carrier, health
16 plan, or utilization review organization shall provide a
17 covered person and prescribing health care professional with
18 access to a clear and convenient process to request a coverage
19 exemption determination. A health carrier, health plan, or
20 utilization review organization may use its existing medical
21 exceptions process to satisfy this requirement. The process
22 used shall be easily accessible on the internet site of the
23 health carrier, health benefit plan, or utilization review
24 organization.
25 *b.* A health carrier, health benefit plan, or utilization
26 review organization shall respond to a coverage exemption
27 determination request within seventy-two hours of receipt. In
28 cases where exigent circumstances exist, a health carrier,
29 health benefit plan, or utilization review organization shall
30 respond within twenty-four hours of receipt. If a response by
31 a health carrier, health benefit plan, or utilization review
32 organization is not received within the applicable time period,
33 the coverage exemption shall be deemed granted.
34 *c.* A coverage exemption shall be expeditiously granted for a
35 discontinued health benefit plan if a covered person enrolls in

1 a comparable plan offered by the same health carrier, and all
2 of the following conditions apply:
3 (1) The covered person is medically stable on a prescription
4 drug as determined by the prescribing health care professional.
5 (2) The prescribing health care professional continues
6 to prescribe the drug for the covered person for the medical
7 condition.
8 (3) In comparison to the discontinued health benefit plan,
9 the new health benefit plan does any of the following:
10 (a) Limits or reduces the maximum coverage of prescription
11 drug benefits.
12 (b) Increases cost sharing for the prescription drug.
13 (c) Moves the prescription drug to a more restrictive tier
14 if the health carrier uses a formulary with tiers.
15 (d) Excludes the prescription drug from the formulary.
16 *d.* Upon granting of a coverage exemption for a drug
17 prescribed by a covered person's prescribing health care
18 professional, a health carrier, health benefit plan, or
19 utilization review organization shall authorize coverage no
20 more restrictive than that offered in a discontinued health
21 benefit plan, or than that offered prior to implementation of
22 restrictive changes to the health benefit plan's formulary
23 after the current plan year began.
24 *e.* If a determination is made to deny a request for a
25 coverage exemption, the health carrier, health benefit plan,
26 or utilization review organization shall provide the covered
27 person or the covered person's authorized representative and
28 the authorized person's prescribing health care professional
29 with the reason for denial and information regarding the
30 procedure to appeal the denial. Any determination to deny a
31 coverage exemption may be appealed by a covered person or the
32 covered person's authorized representative.
33 *f.* A health carrier, health benefit plan, or utilization
34 review organization shall uphold or reverse a determination to
35 deny a coverage exemption within seventy-two hours of receipt

1 of an appeal of denial. In cases where exigent circumstances
2 exist, a health carrier, health benefit plan, or utilization
3 review organization shall uphold or reverse a determination to
4 deny a coverage exemption within twenty-four hours of receipt.
5 If the determination to deny a coverage exemption is not upheld
6 or reversed on appeal within the applicable time period, the
7 denial shall be deemed reversed and the coverage exemption
8 shall be deemed approved.

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

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

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

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

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

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

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

35 5. *Enforcement.* The commissioner may take any enforcement

1 action under the commissioner's authority to enforce compliance
2 with this section.
3 6. *Applicability.* This section is applicable to a health
4 benefit plan that is delivered, issued for delivery, continued,
5 or renewed in this state on or after January 1, 2020.
6 EXPLANATION
7 The inclusion of this explanation does not constitute agreement with
8 the explanation's substance by the members of the general assembly.
9 This bill relates to the continuity of care for covered
10 persons with epilepsy, and nonmedical switching by health
11 carriers, health benefit plans, and utilization review
12 organizations.
13 The bill defines "nonmedical switching" as a health benefit
14 plan's restrictive changes to the health benefit plan's
15 formulary after the current plan year has begun or during the
16 open enrollment period for the upcoming plan year, causing a
17 covered person who is medically stable on the covered person's
18 current prescribed drug as determined by the prescribing
19 health care professional, to switch to a less costly alternate
20 prescription drug.
21 The bill provides that during a covered person's eligibility
22 under a health benefit plan, inclusive of any open enrollment
23 period, a health plan carrier, health benefit plan, or
24 utilization review organization shall not limit or exclude
25 coverage of a prescription drug for the covered person if the
26 covered person is medically stable on the drug as determined
27 by the prescribing health care professional, the drug was
28 previously approved by the health carrier for coverage for the
29 person, and the person's prescribing health care professional
30 has prescribed the drug for the covered person's medical
31 condition within the previous six months. The bill includes,
32 as prohibited limitations or exclusions, reducing the maximum
33 coverage of prescription drug benefits, increasing cost sharing
34 for a covered drug, moving a drug to a more restrictive tier,
35 and removing a drug from a formulary. A prescription drug

1 may, however, be removed from a formulary if the United States
2 food and drug administration issues a statement regarding the
3 clinical safety of the drug, or the manufacturer of the drug
4 notifies the United States food and drug administration of a
5 manufacturing discontinuance or potential discontinuance of the
6 drug as required by section 506c of the Federal Food, Drug, and
7 Cosmetic Act.
8 The bill requires a covered person and prescribing health
9 care professional to have access to a process to request a
10 coverage exemption determination. The bill defines "coverage
11 exemption determination" as a determination made by a
12 health carrier, health benefit plan, or utilization review
13 organization whether to cover a prescription drug that is
14 otherwise excluded from coverage.
15 A coverage exemption determination request must be approved
16 or denied by the health carrier, health benefit plan, or
17 utilization review organization within 72 hours, or within 24
18 hours if exigent circumstances exist. If a determination is
19 not received within the applicable time period the coverage
20 exemption is deemed granted.
21 The bill requires a coverage exemption to be expeditiously
22 granted for a health benefit plan discontinued for the next
23 plan year if a covered person enrolls in a comparable plan
24 offered by the same health carrier, and in comparison to the
25 discontinued health benefit plan, the new health benefit plan
26 limits or reduces the maximum coverage for a prescription drug,
27 increases cost sharing for the prescription drug, moves the
28 prescription drug to a more restrictive tier, or excludes the
29 prescription drug from the formulary.
30 If a coverage exemption is granted, the bill requires the
31 authorization of coverage that is no more restrictive than that
32 offered in a discontinued health benefit plan, or than that
33 offered prior to implementation of restrictive changes to the
34 health benefit plan's formulary after the current plan year
35 began.

1 If a determination is made to deny a request for a
2 coverage exemption, the reason for denial and the procedure
3 to appeal the denial must be provided to the requestor. Any
4 determination to deny a coverage exemption may be appealed to
5 the health carrier, health benefit plan, or utilization review
6 organization.

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

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

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

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

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

33 The bill allows the commissioner to take any necessary
34 enforcement action under the commissioner′s authority to
35 enforce compliance with the bill.

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