

**Senate Study Bill 3117 - Introduced**

SENATE FILE \_\_\_\_\_  
BY (PROPOSED COMMITTEE ON  
HUMAN RESOURCES BILL BY  
CHAIRPERSON SWEENEY)

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

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

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

27 j. "*Generic name*" means the same as defined in section  
28 155A.3.

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

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

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

35 n. "*Health carrier*" means the same as defined in section

1 514J.102.

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

4 *p.* "Nonmedical switching" means a health benefit plan's  
5 restrictive changes to the health benefit plan's formulary  
6 after the current plan year has begun or during the open  
7 enrollment period for the upcoming plan year, causing a covered  
8 person who is medically stable on the covered person's current  
9 prescribed drug as determined by the prescribing health care  
10 professional, to switch to a less costly alternate prescription  
11 drug.

12 *q.* "Open enrollment" means the yearly time period an  
13 individual can enroll in a health benefit plan.

14 *r.* "Utilization review" means the same as defined in 514F.7.

15 *s.* "Utilization review organization" means the same as  
16 defined in 514F.7.

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

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

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

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

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

33 *b.* Coverage of a covered person's prescription drug, as  
34 described in paragraph "a", shall continue through the last day  
35 of the covered person's eligibility under the health benefit

1 plan, inclusive of any open enrollment period.

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

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

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

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

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

18 d. A drug product with the same generic name and  
19 demonstrated bioavailability, or an interchangeable biological  
20 product, shall be considered equivalent to the prescription  
21 drug prescribed by the covered person's health care  
22 professional.

23 3. *Coverage exemption determination process.*

24 a. To ensure continuity of care, a health carrier, health  
25 plan, or utilization review organization shall provide a  
26 covered person and prescribing health care professional with  
27 access to a clear and convenient process to request a coverage  
28 exemption determination. A health carrier, health plan, or  
29 utilization review organization may use its existing medical  
30 exceptions process to satisfy this requirement. The process  
31 used shall be easily accessible on the internet site of the  
32 health carrier, health benefit plan, or utilization review  
33 organization.

34 b. A health carrier, health benefit plan, or utilization  
35 review organization shall respond to a coverage exemption

1 determination request within seventy-two hours of receipt. In  
2 cases where exigent circumstances exist, a health carrier,  
3 health benefit plan, or utilization review organization shall  
4 respond within twenty-four hours of receipt. If a response by  
5 a health carrier, health benefit plan, or utilization review  
6 organization is not received within the applicable time period,  
7 the coverage exemption shall be deemed granted.

8 *c.* A coverage exemption shall be expeditiously granted for a  
9 discontinued health benefit plan if a covered person enrolls in  
10 a comparable plan offered by the same health carrier, and all  
11 of the following conditions apply:

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

14 (2) The prescribing health care professional continues  
15 to prescribe the drug for the covered person for the medical  
16 condition.

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

19 (a) Limits or reduces the maximum coverage of prescription  
20 drug benefits.

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

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

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

25 *d.* Upon granting of a coverage exemption for a drug  
26 prescribed by a covered person's prescribing health care  
27 professional, a health carrier, health benefit plan, or  
28 utilization review organization shall authorize coverage no  
29 more restrictive than that offered in a discontinued health  
30 benefit plan, or than that offered prior to implementation of  
31 restrictive changes to the health benefit plan's formulary  
32 after the current plan year began.

33 *e.* If a determination is made to deny a request for a  
34 coverage exemption, the health carrier, health benefit plan,  
35 or utilization review organization shall provide the covered

1 person or the covered person's authorized representative and  
2 the authorized person's prescribing health care professional  
3 with the reason for denial and information regarding the  
4 procedure to appeal the denial. Any determination to deny a  
5 coverage exemption may be appealed by a covered person or the  
6 covered person's authorized representative.

7 *f.* A health carrier, health benefit plan, or utilization  
8 review organization shall uphold or reverse a determination to  
9 deny a coverage exemption within seventy-two hours of receipt  
10 of an appeal of denial. In cases where exigent circumstances  
11 exist, a health carrier, health benefit plan, or utilization  
12 review organization shall uphold or reverse a determination to  
13 deny a coverage exemption within twenty-four hours of receipt.  
14 If the determination to deny a coverage exemption is not upheld  
15 or reversed on appeal within the applicable time period, the  
16 denial shall be deemed reversed and the coverage exemption  
17 shall be deemed approved.

18 *g.* If a determination to deny a coverage exemption is  
19 upheld on appeal, the health carrier, health benefit plan,  
20 or utilization review organization shall provide the covered  
21 person or covered person's authorized representative and the  
22 covered person's prescribing health care professional with  
23 the reason for upholding the denial on appeal and information  
24 regarding the procedure to request external review of the  
25 denial pursuant to chapter 514J. Any denial of a request for a  
26 coverage exemption that is upheld on appeal shall be considered  
27 a final adverse determination for purposes of chapter 514J and  
28 is eligible for a request for external review by a covered  
29 person or the covered person's authorized representative  
30 pursuant to chapter 514J.

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

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

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

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

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

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

9 Sec. 2. APPLICABILITY. This Act applies to a health benefit  
10 plan that is delivered, issued for delivery, continued, or  
11 renewed in this state on or after January 1, 2021.

12 EXPLANATION

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

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

18 The bill defines "nonmedical switching" as a health benefit  
19 plan's restrictive changes to the health benefit plan's  
20 formulary after the current plan year has begun or during the  
21 open enrollment period for the upcoming plan year, causing a  
22 covered person who is medically stable on the covered person's  
23 current prescribed drug as determined by the prescribing  
24 health care professional, to switch to a less costly alternate  
25 prescription drug.

26 The bill provides that during a covered person's eligibility  
27 under a health benefit plan, inclusive of any open enrollment  
28 period, a health plan carrier, health benefit plan, or  
29 utilization review organization shall not limit or exclude  
30 coverage of a prescription drug for the covered person if the  
31 covered person is medically stable on the drug as determined  
32 by the prescribing health care professional, the drug was  
33 previously approved by the health carrier for coverage for the  
34 person, and the person's prescribing health care professional  
35 has prescribed the drug for the covered person's medical

1 condition within the previous six months. The bill includes,  
2 as prohibited limitations or exclusions, reducing the maximum  
3 coverage of prescription drug benefits, increasing cost sharing  
4 for a covered drug, moving a drug to a more restrictive tier,  
5 and removing a drug from a formulary. A prescription drug  
6 may, however, be removed from a formulary if the United States  
7 food and drug administration issues a statement regarding the  
8 clinical safety of the drug, or the manufacturer of the drug  
9 notifies the United States food and drug administration of a  
10 manufacturing discontinuance or potential discontinuance of the  
11 drug as required by section 506c of the Federal Food, Drug,  
12 and Cosmetic Act. The bill provides that a drug product with  
13 the same generic name and demonstrated bioavailability, or an  
14 interchangeable biological product, is considered equivalent to  
15 the prescription drug prescribed by the covered person's health  
16 care professional.

17 The bill requires a covered person and prescribing health  
18 care professional to have access to a process to request a  
19 coverage exemption determination. The bill defines "coverage  
20 exemption determination" as a determination made by a  
21 health carrier, health benefit plan, or utilization review  
22 organization whether to cover a prescription drug that is  
23 otherwise excluded from coverage.

24 A coverage exemption determination request must be approved  
25 or denied by the health carrier, health benefit plan, or  
26 utilization review organization within 72 hours, or within 24  
27 hours if exigent circumstances exist. If a determination is  
28 not received within the applicable time period the coverage  
29 exemption is deemed granted.

30 The bill requires a coverage exemption to be expeditiously  
31 granted for a health benefit plan discontinued for the next  
32 plan year if a covered person enrolls in a comparable plan  
33 offered by the same health carrier, and in comparison to the  
34 discontinued health benefit plan, the new health benefit plan  
35 limits or reduces the maximum coverage for a prescription drug,



1 increases cost sharing for the prescription drug, moves the  
2 prescription drug to a more restrictive tier, or excludes the  
3 prescription drug from the formulary.

4 If a coverage exemption is granted, the bill requires an  
5 authorization of coverage that is no more restrictive than that  
6 offered in a discontinued health benefit plan, or than that  
7 offered prior to implementation of restrictive changes to the  
8 health benefit plan's formulary after the current plan year  
9 began.

10 If a determination is made to deny a request for a  
11 coverage exemption, the reason for denial and the procedure  
12 to appeal the denial must be provided to the requestor. Any  
13 determination to deny a coverage exemption may be appealed to  
14 the health carrier, health benefit plan, or utilization review  
15 organization.

16 A determination to uphold or reverse denial of a coverage  
17 exemption must be made within 72 hours of receipt of an appeal,  
18 or within 24 hours if exigent circumstances exist. If a  
19 determination is not made within the applicable time period,  
20 the denial is deemed reversed and the coverage exemption is  
21 deemed approved.

22 If a determination to deny a coverage exemption is upheld on  
23 appeal, the reason for upholding the denial and the procedure  
24 to request external review of the denial pursuant to Code  
25 chapter 514J must be provided to the individual who filed the  
26 appeal. Any denial of a request for a coverage exemption that  
27 is upheld on appeal is considered a final adverse determination  
28 for purposes of Code chapter 514J and is eligible for a request  
29 for external review by a covered person or the covered person's  
30 authorized representative pursuant to Code chapter 514J.

31 The bill shall not be construed to prevent a health care  
32 professional from prescribing another drug covered by the  
33 health carrier that the health care professional deems  
34 medically necessary for the covered person.

35 The bill shall not be construed to prevent a health carrier

1 from adding a drug to its formulary or removing a drug from its  
2 formulary if the drug manufacturer removes the drug for sale in  
3 the United States.

4 The bill allows the commissioner to take any necessary  
5 enforcement action under the commissioner's authority to  
6 enforce compliance with the bill.

7 The bill is applicable to health benefit plans that are  
8 delivered, issued for delivery, continued, or renewed in this  
9 state on or after January 1, 2021.