

House File 656 - Introduced

HOUSE FILE 656
BY COMMITTEE ON HUMAN
RESOURCES

(SUCCESSOR TO HF 372)

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 an entity subject to the

1 insurance laws and regulations of this state, or subject
2 to the jurisdiction of the commissioner, including an
3 insurance company offering sickness and accident plans, a
4 health maintenance organization, a nonprofit health service
5 corporation, a plan established pursuant to chapter 509A
6 for public employees, or any other entity providing a plan
7 of health insurance, health care benefits, or health care
8 services. "Health carrier" does not include the department
9 of human services, or a managed care organization acting
10 pursuant to a contract with the department of human services to
11 administer the medical assistance program under chapter 249A
12 or the healthy and well kids in Iowa (hawk-i) program under
13 chapter 514I.

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

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

24 q. "Open enrollment" means the yearly time period during
25 which an individual can enroll in a health benefit plan.

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

27 s. "Utilization review organization" means the same as
28 defined in 514F.7.

29 2. *Nonmedical switching.* With respect to a health carrier
30 that has entered into a health benefit plan with a covered
31 person that covers prescription drug benefits, all of the
32 following apply:

33 a. A health carrier, health benefit plan, or utilization
34 review organization shall not limit or exclude coverage of
35 a prescription drug for any covered person who is medically

1 stable on such drug as determined by the prescribing health
2 care professional, if all of the following apply:

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

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

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

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

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

16 (1) Limiting or reducing the maximum coverage of
17 prescription drug benefits.

18 (2) Increasing cost sharing for a covered prescription
19 drug.

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

22 (4) Removing a prescription drug from a formulary, unless
23 the United States food and drug administration has issued a
24 statement about the drug that calls into question the clinical
25 safety of the drug, or the manufacturer of the drug has
26 notified the United States food and drug administration of a
27 manufacturing discontinuance or potential discontinuance of the
28 drug as required by section 506C of the Federal Food, Drug, and
29 Cosmetic Act, as codified in 21 U.S.C. §356c.

30 *d.* A drug product with the same generic name and
31 demonstrated bioavailability, or an interchangeable biological
32 product, shall be considered equivalent to the prescription
33 drug prescribed by the covered person's health care
34 professional.

35 3. *Coverage exemption determination process.*

1 *a.* To ensure continuity of care, a health carrier, health
2 plan, or utilization review organization shall provide a
3 covered person and prescribing health care professional
4 with access to a clear and convenient process to request a
5 coverage exemption determination. A health carrier, health
6 plan, or utilization review organization may use its existing
7 medical exceptions process to satisfy this requirement. The
8 process shall be easily accessible on the internet site of the
9 health carrier, health benefit plan, or utilization review
10 organization.

11 *b.* A health carrier, health benefit plan, or utilization
12 review organization shall respond to a coverage exemption
13 determination request within five calendar days of receipt. In
14 cases where exigent circumstances exist, the health carrier,
15 health benefit plan, or utilization review organization shall
16 respond within seventy-two hours of receipt. If a response by
17 the health carrier, health benefit plan, or utilization review
18 organization is not received within the applicable time period,
19 the coverage exemption shall be deemed granted.

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

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

26 (2) The prescribing health care professional continues
27 to prescribe the drug for the covered person for the covered
28 person's medical condition.

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

31 (a) Limits or reduces the maximum coverage of prescription
32 drug benefits.

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

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

1 (d) Excludes the prescription drug from the health benefit
2 plan's formulary.

3 d. Upon granting of a coverage exemption for a drug
4 prescribed by a covered person's prescribing health care
5 professional, a health carrier, health benefit plan, or
6 utilization review organization shall authorize coverage no
7 more restrictive than that offered in a discontinued health
8 benefit plan, or than that offered prior to implementation of
9 restrictive changes to the health benefit plan's formulary
10 after the current plan year began.

11 e. If a determination is made to deny a request for a
12 coverage exemption, the health carrier, health benefit plan,
13 or utilization review organization shall provide the covered
14 person or the covered person's authorized representative and
15 the authorized person's prescribing health care professional
16 with the reason for denial and information regarding the
17 procedure to appeal the denial. Any determination to deny a
18 coverage exemption may be appealed by a covered person or the
19 covered person's authorized representative.

20 f. A health carrier, health benefit plan, or utilization
21 review organization shall uphold or reverse a determination to
22 deny a coverage exemption within five calendar days of receipt
23 of an appeal of denial. In cases where exigent circumstances
24 exist, a health carrier, health benefit plan, or utilization
25 review organization shall uphold or reverse a determination to
26 deny a coverage exemption within seventy-two hours of receipt.
27 If the determination to deny a coverage exemption is not upheld
28 or reversed on appeal within the applicable time period, the
29 denial shall be deemed reversed and the coverage exemption
30 shall be deemed approved.

31 g. If a determination to deny a coverage exemption is
32 upheld on appeal, the health carrier, health benefit plan,
33 or utilization review organization shall provide the covered
34 person or the covered person's authorized representative and
35 the covered person's prescribing health care professional with

1 the reason for upholding the denial on appeal and information
2 regarding the procedure to request external review of the
3 denial pursuant to chapter 514J. Any denial of a request for a
4 coverage exemption that is upheld on appeal shall be considered
5 a final adverse determination for purposes of chapter 514J and
6 is eligible for a request for external review by a covered
7 person or the covered person's authorized representative
8 pursuant to chapter 514J.

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

11 a. Prevent a health care professional from prescribing
12 another drug covered by the health carrier that the health care
13 professional deems medically necessary for the covered person.

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

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

16 (2) Removing a prescription drug from its formulary if the
17 drug manufacturer has removed the drug for sale in the United
18 States.

19 5. *Enforcement.* The commissioner may take any enforcement
20 action under the commissioner's authority to enforce compliance
21 with this section.

22 Sec. 2. APPLICABILITY. This Act applies to a health benefit
23 plan that is delivered, issued for delivery, continued, or
24 renewed in this state on or after January 1, 2022.

25 EXPLANATION

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

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

31 The bill defines "nonmedical switching" as a health benefit
32 plan's restrictive changes to the health benefit plan's
33 formulary after the current plan year has begun or during the
34 open enrollment period for the upcoming plan year, causing a
35 covered person who is medically stable on the covered person's

1 current prescribed drug as determined by the prescribing
2 health care professional, to switch to a less costly alternate
3 prescription drug. "Health benefit plan", "health carrier",
4 and "utilization review organization" are also defined in the
5 bill.

6 The bill provides that during a covered person's eligibility
7 under a health benefit plan, inclusive of any open enrollment
8 period, a health plan carrier, health benefit plan, or
9 utilization review organization shall not limit or exclude
10 coverage of a prescription drug for the covered person if the
11 covered person is medically stable on the drug as determined
12 by the prescribing health care professional, the drug was
13 previously approved by the health carrier for coverage for
14 the person, and the covered person's prescribing health care
15 professional has prescribed the drug for the person's medical
16 condition within the previous six months. The bill includes,
17 as prohibited limitations or exclusions, reducing the maximum
18 coverage of prescription drug benefits, increasing cost sharing
19 for a covered drug, moving a drug to a more restrictive tier,
20 and removing a drug from a formulary. A prescription drug
21 may, however, be removed from a formulary if the United States
22 food and drug administration issues a statement regarding the
23 clinical safety of the drug, or the manufacturer of the drug
24 notifies the United States food and drug administration of a
25 manufacturing discontinuance or potential discontinuance of the
26 drug as required by section 506c of the Federal Food, Drug,
27 and Cosmetic Act. The bill provides that a drug product with
28 the same generic name and demonstrated bioavailability, or an
29 interchangeable biological product, is considered equivalent to
30 the prescription drug prescribed by the covered person's health
31 care professional.

32 The bill requires a covered person and prescribing health
33 care professional to have access to a process to request a
34 coverage exemption determination. The bill defines "coverage
35 exemption determination" as a determination made by a

1 health carrier, health benefit plan, or utilization review
2 organization whether to cover a prescription drug that is
3 otherwise excluded from coverage.

4 A coverage exemption determination request must be approved
5 or denied by the health carrier, health benefit plan, or
6 utilization review organization within five calendar days,
7 or within 72 hours if exigent circumstances exist. If a
8 determination is not received within the applicable time period
9 the coverage exemption is deemed granted.

10 The bill requires a coverage exemption to be expeditiously
11 granted for a health benefit plan that is discontinued for the
12 next plan year if a covered person enrolls in a comparable
13 plan offered by the same health carrier, and in comparison
14 to the discontinued health benefit plan, the new health
15 benefit plan limits or reduces the maximum coverage for a
16 prescription drug, increases cost sharing for the prescription
17 drug, moves the prescription drug to a more restrictive
18 tier, or excludes the prescription drug from the formulary.
19 If a coverage exemption is granted, the bill requires an
20 authorization of coverage that is no more restrictive than
21 that offered in the discontinued health benefit plan, or than
22 that offered prior to implementation of restrictive changes
23 to the health benefit plan's formulary after the current plan
24 year began. If a determination is made to deny a request for
25 a coverage exemption, the reason for denial and the procedure
26 to appeal the denial must be provided to the requestor. Any
27 determination to deny a coverage exemption may be appealed to
28 the health carrier, health benefit plan, or utilization review
29 organization. A determination to uphold or reverse denial
30 of a coverage exemption must be made within five calendar
31 days of receipt of an appeal, or within 72 hours if exigent
32 circumstances exist. If a determination is not made within the
33 applicable time period, the denial is deemed reversed and the
34 coverage exemption is deemed approved.

35 If a determination to deny a coverage exemption is upheld on

1 appeal, the reason for upholding the denial and the procedure
2 to request external review of the denial pursuant to Code
3 chapter 514J must be provided to the individual who filed the
4 appeal. Any denial of a request for a coverage exemption that
5 is upheld on appeal is considered a final adverse determination
6 for purposes of Code chapter 514J and is eligible for a request
7 for external review by a covered person or the covered person's
8 authorized representative pursuant to Code chapter 514J.

9 The bill shall not be construed to prevent a health care
10 professional from prescribing another drug covered by the
11 health carrier that the health care professional deems
12 medically necessary for the covered person.

13 The bill shall not be construed to prevent a health carrier
14 from adding a drug to its formulary, or from removing a drug
15 from its formulary if the drug manufacturer removes the drug
16 for sale in the United States.

17 The bill allows the commissioner to take any necessary
18 enforcement action under the commissioner's authority to
19 enforce compliance with the bill.

20 The bill is applicable to health benefit plans that are
21 delivered, issued for delivery, continued, or renewed in this
22 state on or after January 1, 2022.