

**House File 96 - Introduced**

HOUSE FILE 96

BY MOORE

(COMPANION TO SF 86 BY KLIMESH)

**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.9 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. "Open enrollment" means the yearly time period during  
17 which an individual can enroll in a health benefit plan.

18 q. "Utilization review" means the same as defined in section  
19 514F.7.

20 r. "Utilization review organization" means the same as  
21 defined in section 514F.7.

22 2. *Nonmedical switching.* With respect to a health carrier  
23 that has entered into a health benefit plan with a covered  
24 person that covers prescription drug benefits, all of the  
25 following apply:

26 a. A health carrier, health benefit plan, or utilization  
27 review organization shall not limit or exclude coverage of  
28 a prescription drug for any covered person who is medically  
29 stable on such drug as determined by the prescribing health  
30 care professional, if all of the following apply:

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

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

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

3 b. Coverage of a covered person's prescription drug, as  
4 described in paragraph "a", shall continue through the last day  
5 of the covered person's eligibility under the health benefit  
6 plan, inclusive of any open enrollment period.

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

9 (1) Limiting or reducing the maximum coverage of  
10 prescription drug benefits.

11 (2) Increasing cost sharing for a covered prescription  
12 drug.

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

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

23 d. This subsection shall not be construed to prohibit  
24 a substitution, a formulary change, or a preference by a  
25 health carrier for a prescribed drug product that has the same  
26 generic name and demonstrated bioavailability, or that is an  
27 interchangeable biological product.

28 3. *Coverage exemption determination process.*

29 a. To ensure continuity of care, a health carrier, health  
30 plan, or utilization review organization shall provide a  
31 covered person and prescribing health care professional  
32 with access to a clear and convenient process to request a  
33 coverage exemption determination. A health carrier, health  
34 plan, or utilization review organization may use its existing  
35 medical exceptions process to satisfy this requirement. The

1 process shall be easily accessible on the internet site of the  
2 health carrier, health benefit plan, or utilization review  
3 organization.

4     *b.* A health carrier, health benefit plan, or utilization  
5 review organization shall respond to a coverage exemption  
6 determination request within five calendar days of receipt. In  
7 cases where exigent circumstances exist, the health carrier,  
8 health benefit plan, or utilization review organization shall  
9 respond within seventy-two hours of receipt. If a response by  
10 the health carrier, health benefit plan, or utilization review  
11 organization is not received within the applicable time period,  
12 the coverage exemption shall be deemed granted.

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

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

19         (2) The prescribing health care professional continues  
20 to prescribe the drug for the covered person for the covered  
21 person's medical condition.

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

24             (a) Limits or reduces the maximum coverage of prescription  
25 drug benefits.

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

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

29             (d) Excludes the prescription drug from the health benefit  
30 plan's formulary.

31     *d.* Upon granting of a coverage exemption for a drug  
32 prescribed by a covered person's prescribing health care  
33 professional, a health carrier, health benefit plan, or  
34 utilization review organization shall authorize coverage no  
35 more restrictive than that offered in a discontinued health

1 benefit plan, or than that offered prior to implementation of  
2 restrictive changes to the health benefit plan's formulary  
3 after the current plan year began.

4 e. If a determination is made to deny a request for a  
5 coverage exemption, the health carrier, health benefit plan,  
6 or utilization review organization shall provide the covered  
7 person or the covered person's authorized representative and  
8 the authorized person's prescribing health care professional  
9 with the reason for denial and information regarding the  
10 procedure to appeal the denial. Any determination to deny a  
11 coverage exemption may be appealed by a covered person or the  
12 covered person's authorized representative.

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

24 g. If a determination to deny a coverage exemption is  
25 upheld on appeal, 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 covered person's prescribing health care professional with  
29 the reason for upholding the denial on appeal and information  
30 regarding the procedure to request external review of the  
31 denial pursuant to chapter 514J. Any denial of a request for a  
32 coverage exemption that is upheld on appeal shall be considered  
33 a final adverse determination for purposes of chapter 514J and  
34 is eligible for a request for external review by a covered  
35 person or the covered person's authorized representative

1 pursuant to chapter 514J.

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

4 a. Prevent a health care professional from prescribing  
5 another drug covered by the health carrier that the health care  
6 professional deems medically necessary for the covered person.

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

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

9 (2) Removing a prescription drug from its formulary if the  
10 drug manufacturer has removed the drug for sale in the United  
11 States.

12 5. *Enforcement.* The commissioner may take any enforcement  
13 action under the commissioner's authority to enforce compliance  
14 with this section.

15 Sec. 2. **APPLICABILITY.** This Act applies to a health benefit  
16 plan that is delivered, issued for delivery, continued, or  
17 renewed in this state on or after January 1, 2024.

18 **EXPLANATION**

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

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

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

1 coverage of prescription drug benefits, increasing cost sharing  
2 for a covered drug, moving a drug to a more restrictive tier,  
3 and removing a drug from a formulary. A prescription drug  
4 may, however, be removed from a formulary if the United States  
5 food and drug administration issues a statement regarding the  
6 clinical safety of the drug, or the manufacturer of the drug  
7 notifies the United States food and drug administration of  
8 a manufacturing discontinuance or potential discontinuance  
9 of the drug as required by section 506c of the Federal Food,  
10 Drug, and Cosmetic Act. The bill shall not be construed to  
11 prohibit a substitution, a formulary change, or a preference  
12 by a health carrier for a prescribed drug product that has the  
13 same generic name and demonstrated bioavailability, or that is  
14 an interchangeable biological product. "Health benefit plan",  
15 "health carrier", and "utilization review organization" are  
16 defined in the bill.

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 five calendar days,  
27 or within 72 hours if exigent circumstances exist. If a  
28 determination is not received within the applicable time period  
29 the coverage exemption is deemed granted.

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



1 prescription drug, increases cost sharing for the prescription  
2 drug, moves the prescription drug to a more restrictive  
3 tier, or excludes the 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  
6 that offered in the discontinued health benefit plan, or than  
7 that offered prior to implementation of restrictive changes  
8 to the health benefit plan's formulary after the current plan  
9 year began. If a determination is made to deny a request for  
10 a coverage exemption, the reason for denial and the procedure  
11 to appeal the denial must be provided to the requestor. Any  
12 determination to deny a coverage exemption may be appealed to  
13 the health carrier, health benefit plan, or utilization review  
14 organization. A determination to uphold or reverse denial  
15 of a coverage exemption must be made within five calendar  
16 days of receipt of an appeal, or within 72 hours if exigent  
17 circumstances exist. If a determination is not made within the  
18 applicable time period, the denial is deemed reversed and the  
19 coverage exemption is deemed approved.

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

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

33 The bill shall not be construed to prevent a health carrier  
34 from adding a drug to its formulary, or from removing a drug  
35 from its formulary if the drug manufacturer removes the drug

1 for sale in the United States.

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

5 The bill is applicable to health benefit plans that are  
6 delivered, issued for delivery, continued, or renewed in this  
7 state on or after January 1, 2024.