

Senate File 86 - Introduced

SENATE FILE 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.