PHARMACEUTICAL STEP THERAPY

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Eric K. Hutchings

Senate Sponsor: ____________

LONG TITLE

General Description:

This bill amends health insurance provisions in the Insurance Code.

Highlighted Provisions:

This bill:

- creates definitions;
- prohibits the use of step therapy for pharmaceuticals unless certain conditions are met;
- requires a health insurer to authorize bypass of a step drug when certain conditions are met;
- specifies conditions under which a request for bypass of a step drug is considered authorized; and
- addresses adverse benefit determinations.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

ENACTS:

31a-22-645, Utah Code Annotated 1953

H.B. 266

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31a-22-645** is enacted to read:

31a-22-645. Step therapy.

(1) As used in this section:

(a) "AB-rated generic equivalent of a drug" means a drug that is therapeutically equivalent to another drug, as set forth in the latest edition of, or supplement to, the federal Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations.

(b) "Drug" means the same as that term is defined in Section 58-17b-102.

(c) "Health care provider" means a health care provider, as defined in Section 78B-3-403, with authority to prescribe a step drug.

(d) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).

(e) "Medically necessary" means appropriate, under the applicable standard of care:

(i) to preserve or improve health, life, or function;

(ii) to slow the deterioration of health, life, or function; or

(iii) for the early screening, prevention, evaluation, diagnosis, or treatment of a disease, condition, illness, or injury.

(f) (i) "Step drug" means a drug described in Subsection (1)(g) that must be used before an insured's health benefit plan will pay for a drug ordered by the insured's health care provider.

(ii) "Step drug" may include a drug not covered by the insured's health benefit plan.

(g) "Step therapy" means a fail-first protocol that requires an insured to use a drug, or several drugs in a particular order, before the insured's health benefit plan will pay for a drug ordered by the insured's health care provider.

(2) A health insurer may not offer a health benefit plan that includes step therapy unless the health insurer:

(a) notifies each insured covered by the plan of the process described in Subsections (3) through (7) for bypassing use of a step drug; and

(b) makes available on the health insurer's website forms for an insured to make a request to bypass use of a step drug.

(3) Except as provided in Subsection (5)(a), a health insurer shall authorize an insured to bypass use of one or more step drugs if, for each step drug to be bypassed, the insured

submits to the health insurer information documenting to the satisfaction of the health insurer that one or more of the following conditions have been satisfied:

(a) the step drug:

(i) is contraindicated;

(ii) will likely cause an adverse reaction by the insured;

(iii) will likely cause physical or mental harm to the insured;

(iv) is expected to be ineffective, based on the known clinical characteristics of the insured and the known clinical characteristics of the step drug regimen;

(v) is not medically necessary; or

(vi) was used by the insured previously while the insured was covered by the health benefit plan, another health benefit plan, or no health benefit plan, and the use was discontinued due to an adverse event or a lack of efficacy, including diminished efficacy; or

(b) another drug belonging to the same class of drugs and having the same mechanism of action was used by the insured previously while the insured was covered by the health benefit plan, another health benefit plan, or no health benefit plan, and the use was discontinued due to an adverse event or a lack of efficacy, including diminished efficacy.

(4) Except as provided in Subsection (5)(a), a health insurer shall authorize an insured to bypass use of all step drugs if the insured submits to the health insurer information documenting that one or more of the following conditions have been satisfied:

(a) the insured has been given a terminal diagnosis; or

(b) the insured has achieved a stable medical state on a drug:

(i) prescribed to treat the insured's condition; and

(ii) prescribed while the insured was covered by the health benefit plan, another health benefit plan, or no health benefit plan.

(5) (a) A health insurer is not required to authorize bypass of a step drug under Subsection (3) or (4) if the step drug is an AB-rated generic equivalent of a drug that would be covered by the health benefit plan if the bypass were authorized.

(b) An authorization to bypass use of one or more step drugs is not an authorization for coverage of a drug that is not otherwise covered by the health benefit plan.

(6) (a) If within 72 hours of receipt of a request to bypass use of a step drug, a health insurer fails to notify the insured who made the request whether bypass has been authorized,

bypass shall be considered authorized.

(b) If an insured communicates to a health insurer that a request to bypass use of a step drug is being made under exigent circumstances, the bypass shall be considered authorized if the health insurer fails to notify the insured within 24 hours of receipt of the request whether the bypass has been authorized.

(7) If an insured disagrees with a health insurer's determination made under Subsection (3) or (4), the insured may, in accordance with Section 31A-22-629, submit an adverse benefit determination:

(a) to the insurer; or

(b) for independent review.

(8) This section may not be construed to limit a health care provider's authority to prescribe drugs.

(9) This section applies to a health benefit plan renewed or entered into on or after January 1, 2018.

Legislative Review Note
Office of Legislative Research and General Counsel