

**PHARMACEUTICAL STEP THERAPY**

2017 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Eric K. Hutchings**

Senate Sponsor: \_\_\_\_\_

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**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



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

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

30 **31a-22-645. Step therapy.**

31 (1) As used in this section:

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

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

37 (c) "Health care provider" means a health care provider, as defined in Section  
38 [78B-3-403](#), with authority to prescribe a step drug.

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

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

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

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

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

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

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

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

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

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

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

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

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

61 (a) the step drug:

62 (i) is contraindicated;

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

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

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

67 (v) is not medically necessary; or

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

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

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

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

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

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

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

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

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

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

90 bypass shall be considered authorized.

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

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

98 (a) to the insurer; or

99 (b) for independent review.

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

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

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**Legislative Review Note**  
**Office of Legislative Research and General Counsel**