CHAPTER 27
PREFERRED PROVIDER ARRANGEMENTS

191—27.1(514F) Purpose. The purpose of this chapter is to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements and by establishing minimum standards for preferred arrangements and the health benefit plans associated with those arrangements.

191—27.2(514F) Definitions. As used in this chapter, unless the context otherwise requires:

"*Commissioner*" means the commissioner of insurance.

"*Covered person*" means a person on whose behalf the health care insurer is obligated to pay for or provide health care services.

"*Covered services*" means health care services which the health care insurer is obligated to pay for or provide under the health benefit plan.

"*Emergency services*" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

"*Health benefit plan*" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

"*Health care insurer*" means a third-party payer of health benefits including, but not limited to, a person providing a policy or contract providing for third-party payment or prepayment of health or medical expenses, including the following:

1. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.
2. An individual or group hospital or medical service contract issued pursuant to Iowa Code chapter 509, 514 or 514A.
3. An individual or group health maintenance organization contract regulated under Iowa Code chapter 514B.
4. An individual or group Medicare supplement policy.
5. A fraternal benefit society.

"*Health care provider*" or "*provider*" means a provider of health care services as defined in rule 191—34.2(514).

"*Health care services*" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

"*Preferred provider*" means a health care provider or group of providers who have contracted to provide specified covered services.

"*Preferred provider arrangement*" means a contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this chapter.

191—27.3(514F) Preferred provider arrangements. Notwithstanding any provisions of law to the contrary, any health care insurer may enter into a preferred provider arrangement.

27.3(1) A preferred provider arrangement shall at minimum:

a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

b. Include mechanisms which are designed to minimize the cost of the health benefit plan. These mechanisms may include among others:

(1) The review or control of utilization of health care costs.

(2) A procedure for determining whether health care services rendered are medically necessary.

c. Ensure reasonable access to covered services available under the preferred provider arrangement.

27.3(2) A preferred provider arrangement shall not unfairly deny health benefits for medically necessary covered services.

27.3(3) If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed as a health care insurer, such entity shall file with the commissioner information describing its activities and a description of the contract or agreement it has entered into with the health care providers. An employer which contracts with health care providers for the exclusive benefit of that employer's employees and employees' dependents is exempt from this requirement. This exemption does not apply to any producer, agent, or administrator acting on behalf of one or more employers.

27.3(4) Contracts with the department of human services or counties. A contract between the department of human services and an entity agreeing to provide mental health services for individuals eligible for coverage under Title XIX of the Social Security Act, or any other similar contract with a county for mental health services for county residents, is exempt from the requirements of this chapter.

191—27.4(514F) Health benefit plans.

27.4(1) A health care insurer may issue a health benefit plan which provides for incentives for covered persons to use the health care services of a preferred provider. The policies or subscriber agreements shall contain at least all of the following provisions:

a. A provision that if a covered person receives emergency services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, emergency services rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider, subject to any restriction which may govern payment by a preferred provider for emergency services.

b. A provision which clearly identifies the differentials in benefit levels for health care services of preferred providers and benefit levels for health care services of nonpreferred providers.

27.4(2) If a health benefit plan provides differences in benefit levels payable to preferred providers compared to other providers, such differences shall not unfairly deny payment for covered services and shall be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

191—27.5(514F) Preferred provider participation requirements.

27.5(1) A health care insurer may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there is no discrimination against providers on the basis of religion, race, color, national origin, age, sex or marital status.

27.5(2) Notwithstanding any other provision of this chapter, a health care insurer may issue policies or subscriber agreements which provide benefits for health care services only if the services have been rendered by a preferred provider, provided the program has met all standards imposed by the commissioner for availability and adequacy of covered services.

27.5(3) A health care insurer shall file with the commissioner for the commissioner's prior review a prototype of any preferred provider arrangement and of the health care plan's policy, contract, or subscriber agreement associated with the arrangement, together with any changes in the prototype. Use of the prototypical preferred provider arrangement and health care plan's policy, contract, or subscriber agreement is conditioned upon approval of these documents by the commissioner.

191—27.6(514F) General requirements. A health care insurer subject to this chapter shall be subject to and is required to comply with all other applicable laws and rules and regulations of this state.

191—27.7(514F) Civil penalties. Civil penalties for violation of this chapter shall be imposed in the amount, and pursuant to the procedure, set forth in Iowa Code sections 507B.6, 507B.7, and 507B.8.

191—27.8(514F) Health care insurer requirements.

27.8(1) A health care insurer shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the health care insurer's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health care insurer or a person contracting with the health care insurer.

27.8(2) A health care insurer shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health care insurer that, in the opinion of the provider, jeopardizes patient health or welfare.

These rules are intended to implement Iowa Code section 514F.3.

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