CHAPTER 40
HEALTH MAINTENANCE ORGANIZATIONS

(Health and Insurance—Joint Rules)
Appeared as Ch 12, July 1974 Supplement
[Prior to 10/22/86, Insurance Department [510]]

PREAMBLE

The following rules developed by the division of insurance govern the organization and regulation of health maintenance organizations pursuant to the authority set forth in Iowa Code chapter 514B.

191—40.1(514B) Definitions.

"Act" when used in these rules shall mean Iowa Code chapter 514B.

"Complaint" means a written communication expressing a grievance concerning a health maintenance organization.

"Dental care" means care by licensed dentists or by appropriate auxiliary dental personnel working under the supervision of a dentist. It includes the necessary diagnostic, treatment, and preventive services required to maintain proper oral health.

"Governing body" means the persons in which the ultimate responsibility and authority for the conduct of the HMO is vested.

"HMO" means health maintenance organization and shall be abbreviated as HMO in these rules.

"Inpatient hospital care" means inpatient hospital care provided through a licensed hospital on a 24-hour basis.

"Outpatient medical services" means outpatient medical services provided within or outside of a hospital. This shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

"Physician care" means care by a licensed physician or by paramedical or other ancillary health personnel under the direction of the licensed physician. It shall be of sufficient type and amount to adequately provide for the contracted services including emergency care, inpatient hospital care, and outpatient medical services.

191—40.2(514B) Application. An application on forms provided by the insurance division accompanied by a filing fee of $100 payable to State Treasurer, State of Iowa, shall be completed by an officer or authorized representative of the health maintenance organization. The application with copies in duplicate shall be verified and shall be accompanied by the information found in Iowa Code section 514B.3(1 to 14). An application shall not be deemed to be filed until all information necessary to properly process said application has been received by the commissioner. See 40.11(514B).

An amendment to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

191—40.3(514B) Inspection of evidence of coverage. An enrollee may, if evidence of coverage is not satisfactory for any reason, return evidence of coverage within ten days of receipt of same and receive full refund of the deposit paid, if any. This right shall not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the enrollee utilizes the services of the HMO within the ten-day period.

191—40.4(514B) Governing body and enrollee representation. An HMO shall have a basic written organizational document setting forth its scheme of organization and establishing a governing body appropriate to its form of organization. The governing body shall be responsible for matters of policy and operation.

The HMO shall develop bylaws or guidelines which describe the scope of the health care services the HMO renders to enrollees either directly by its medical staff or dental staff, if dental care is provided, or

through arrangements with others outside of the organization. Initial bylaws, guidelines, and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The bylaws, guidelines, or similar document shall provide for "reasonable representation" on the governing body by enrollees. "Reasonable representation" as used in Iowa Code section 514B.7 shall require not less than 30 percent of the governing board members be enrollees who are not providers or are not associated with a provider. Enrollees shall have the opportunity to nominate said enrollee representatives.

The HMO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the HMO. Such members shall serve until the first annual meeting or election. If there are no enrollee representatives on the initial governing board, they shall be elected at the first annual meeting or election.

The nomination procedures for enrollee representatives should provide for the following to assure an adequate opportunity for participation by enrollees:

40.4(1) An opportunity for adult enrollees to nominate candidates for the governing body.

40.4(2) Notice to all adult enrollees of the nomination and election procedures.

The HMO shall be deemed to have complied with these requirements if it provides notice in its regular newsletter to enrollees of the opportunity to and the procedures for nomination of enrollee representatives.

Nomination procedures may be waived by the commissioner for a period of up to three years from the HMO's commencement of delivery of services to enrollees.

For purposes of this rule, an HMO operated directly by a corporation or corporations subject to Iowa Code chapter 514 and rule 191—34.7(514) shall be deemed to be in compliance with this rule if it is or they are in compliance with Iowa Code section 514.4 and rule 191—34.7(514).

This rule is intended to implement Iowa Code section 514B.7.

191—40.5(514B) Quality of care. Each HMO shall:

40.5(1) Provide primary care physicians' services commensurate with the need of the enrollees, but at a level of not less than that established in the community.

40.5(2) Advise the insurance division annually pursuant to Iowa Code section 514B.12 of the ratio of full-time equivalent physicians, paramedical and ancillary health personnel to enrollees and fee-for-service patients. Changes in the physician ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

40.5(3) Provide assurance that all physicians, paramedical and ancillary health personnel engaged in the provisions of health services to enrollees and fee-for-service patients are currently licensed or certified by the appropriate state agency where they are located to practice their respective profession. These personnel shall be no less qualified in their respective profession than the current level of qualification, which is maintained in their community.

40.5(4) When health care facilities are utilized by the health maintenance organization, these facilities shall be licensed by the appropriate state agency where they are located. These facilities shall be either accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid.

40.5(5) Have a qualified administrator designated by the governing body who shall be responsible for the management of the HMO.

40.5(6) Have a formally organized medical staff.

40.5(7) Have a chief of the medical staff designated by the governing body who shall be responsible for the development of medical staff bylaws, rules which shall include assurance to enrollees that a continuum of health care services will be provided without unreasonable periods of delay.

40.5(8) Provide for an ongoing internal peer review program.

40.5(9) Each HMO shall provide a continuous program of general health education for disease prevention and identification without additional cost to the enrollee. Such a program may include publications, media presentations, and classroom instruction. Programs of wellness education including stress management, smoking cessation, nutritional education, physical fitness programs, and other such

programs as approved by the division of insurance shall be open to all enrollees on a voluntary basis and may be subject to a copayment requirement. These programs shall be conducted by qualified personnel.

The HMO must periodically remind and encourage the enrollees of an HMO to utilize benefits including physical examinations which are available and designed to prevent illness. The HMO must also offer periodic screening programs which in the opinion of the medical staff would effectively identify conditions indicative of a health problem. These periodic screening programs shall not carry a copayment. Each HMO shall keep a record of all activities it has conducted to satisfy this requirement and the cost thereof.

40.5(10) Maintain a medical records system which includes at a minimum the following information:

a. Documentation of utilization rates for every enrollee.

b. Patient's name, identification number, age, sex, and place of residence and employment.

c. Services provided, when provided, where provided, and by whom.

d. Medical diagnosis, treatment prescribed, therapy prescribed and drugs administered.

e. Statement in regard to the status of the patient's health.

40.5(11) Provide by contract or other arrangement for peer reviews. The plans for internal and external peer review shall be submitted to the commissioner of insurance for approval.

a. Internal peer review shall be conducted by the HMO staff on a continuing basis using Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or American Dental Association, if appropriate, standards as a general guide and shall be structured to review the total episode of illness that the HMO is responsible for. The HMO staff may use parts of the total episode of illness peer review done by other internal review committees to avoid duplication of work. This review shall include but not be limited to the following:

(1) Utilization review and evaluation of the quality of care provided enrollees.

(2) The process or method by which care is given.

(3) The outcome of care including the morbidity and mortality rates that result.

b. External review—criteria and methodology for the selection of an external review group (ERG):

(1) Application to be the ERG may be made in the form of a letter to the commissioner of insurance, describing the qualifications of the ERG and how the ERG meets the criteria set forth in this rule.

(2) Deleted per agency memo, 9/29/93 IAC.

(3) The commissioner shall invite an application from any ERG upon the request of any HMO.

(4) The commissioner may also invite applications from any group which might have the capability of carrying out a review.

(5) The commissioner will consider all applications and appoint one, based on the following criteria:

1. The group's experience in evaluating the quality of medical care.

2. The degree to which the group is representative of the licensed physician community in Iowa.

3. The degree to which the group is knowledgeable about the health delivery system in Iowa.

4. The degree to which selection of the group will avoid duplication with other review activities in Iowa.

5. The group's ability to coordinate its activities with other review groups, and with practitioners and providers of health care in Iowa.

6. The group's knowledge of current and accepted medical opinion, and its ability to make qualitative evaluations of clinical practice.

7. The degree to which at least 50 percent of the physician members of the group (or that part of the group responsible for HMO inspections) are members of an HMO medical staff.

(6) No physician shall review an HMO of which the physician is a member.

(7) Appointment of an ERG will be for a four-year period, and only one ERG will be appointed at a time. Applications for appointment or reappointment will be accepted between 180 days and 90 days before the expiration of the acting ERG's four-year term.

c. External review—criteria and methodology by which an ERG will evaluate the effectiveness of an HMO's peer review program:

(1) The ERG will conduct an on-site inspection of each Iowa-certified HMO every two years, or on a schedule requested by the health department.

(2) The inspection will consist of interviewing HMO staff and physicians, and a review of such records (including clinical records of HMO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the HMO or any of its physician members which pertain to HMO quality assurance operations or HMO patients, excluding financial records.

(3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an HMO's internal peer review program, and to report its findings to the health department.

(4) The following items will be considered by the ERG in making its determination:

1. The extent and acuity of the HMO's peer review program in evaluating the clinical management of enrollees provided by HMO physicians.

2. The ability of the HMO's program to identify aberrant practices in clinical management, and to take appropriate disciplinary action.

3. The method within the HMO by which the peer review program reports its findings to the medical staff and the governing body.

4. The authority with the HMO to correct practices which the peer review program has found to be detrimental.

5. The system developed within the HMO to facilitate the work of the peer review program.

6. The commitment on the part of the HMO governing body and medical staff toward an active peer review program with a goal of quality assurance.

d. External review—procedures to be followed upon completion of an ERG's inspection:

(1) Within 30 days of the completion of its inspection, the ERG will submit a written report of its findings to the HMO.

(2) The HMO will have 45 days to respond to the ERG.

(3) The ERG must file its final report with the insurance division within 90 days of the completion of its inspection. The final report must include any comments received from the HMO.

(4) The insurance division may extend the time periods referred to in this paragraph *"d,"* subparagraphs (1) to (3).

(5) After considering the report of the ERG, the insurance commissioner shall determine if the HMO's certificate of authority is to be either continued, suspended or revoked.

This rule is intended to implement Iowa Code section 514B.4.

191—40.6(514B) Change of name. No name other than that certified by the division may be used. The name of the HMO may not be changed without prior approval of the division.

191—40.7(514B) Change of ownership. Each HMO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the HMO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

191—40.8(514B) Termination of services. When an HMO desires to cease offering a service, such service may not be terminated without prior approval of the division. Arrangements equitable to the enrollees providing for a rate adjustment or substitution of an equivalent service satisfactory to the division must be made.

191—40.9(514B) Complaints.

40.9(1) Each health maintenance organization shall provide in its bylaws for a system to resolve and record complaints.

40.9(2) The complaint system shall provide for the resolution of the following kinds of complaints and the recording of the information required to be reported to the commissioner:

a. Complaints about the quality of health care services provided by the health maintenance organization.

b. Complaints about the availability of such services.

c. Complaints relating to enrollee participation in the operation of the health maintenance organization.

40.9(3) The complaint system shall provide for the recording of the information required to be reported to the commissioner relative to the following kinds of complaints:

a. Complaints to the health maintenance organization concerning benefits provided by other than the health maintenance organization under the provisions of any indemnity policy or contract provided by the health maintenance organization. Such complaints shall be referred to the person providing the benefits and a copy shall be forwarded to the commissioner.

b. Malpractice claims settled during the year by the health maintenance organization and any of its providers.

40.9(4) The information required to be reported to the commissioner shall be included in the annual report to the commissioner on the form provided therewith.

40.9(5) All complaint files shall be retained by the health maintenance organization until the examination for the period during which the complaint was received has been completed.

191—40.10(514B) Cancellation of enrollees.

40.10(1) Membership of an enrollee in a health maintenance organization may be terminated by the health maintenance organization for the following reasons and no other:

a. Nonpayment of charges when due.

b. Termination of the conditions, other than a change in the health of the enrollee, under which the enrollee became eligible to be enrolled under a group contract.

c. Termination of the group contract under which the enrollee was enrolled.

d. Change of place of residence of the enrollee from the geographic area served by the health maintenance organization.

e. Failure of the enrollee to pay deductible or coinsurance charges permitted under Iowa Code section 514B.5(3).

f. Unreasonable refusal of the enrollee to follow a prescribed course of treatment.

g. A materially false statement or misrepresentation by the enrollee in an application for membership or benefits.

40.10(2) When membership of an enrollee is terminated by the HMO for a reason other than nonpayment of charges, nonpayment of deductible or coinsurance charges, unreasonable refusal of the enrollee to accept services, or a materially false statement or misrepresentation by the enrollee in the application for membership, the HMO shall arrange to have offered to the enrollee an opportunity to have issued to the enrollee, at the expense of the enrollee, without evidence of insurability, individual or family policy or policies of hospital and medical expense insurance, or individual or family contracts with hospital and medical service corporations. The form of such policies or contracts shall be that shown in the Application for Certificate of Authority of the HMO or the latest approved amendment thereto. The conversion policy or contract shall provide coverage substantially similar to that provided by the HMO. The conversion policy or contract shall also provide at least $250,000 lifetime benefits. If the HMO enrolls persons on other than a group basis, it shall also offer to the enrollee, if the enrollment was canceled for the reason stated in 40.10(1)*"b"* or 40.10(1)*"c,"* an option to be enrolled as an individual enrollee. In the event of insolvency of an HMO and revocation of its certificate of authority, all other HMOs shall offer enrollees of the insolvent HMO an open enrollment period of 30 days after the date of revocation of the certificate.

40.10(3) Membership of an enrollee in a health maintenance organization may be terminated only upon giving a notice of cancellation not less than 30 days before the date of termination. Such notice shall:

a. Be given by delivery of the notice in duplicate to the enrollee in person or by certified mail addressed to the enrollee at the last address known to the health maintenance organization.

b. State the date and hour upon which the enrollment shall terminate.

c. State the reason for cancellation.

d. If cancellation is for nonpayment of charges, state the amount of charges due, the cost of preparing and serving the notice, and the total cost of charges and preparing the notice, and that if the enrollee pays the amount of charges due plus the cost of preparing and serving the notice at any time before the cancellation date the coverage will remain in force.

e. State that the enrollee has the right to a hearing before the commissioner if requested by the enrollee within 20 days after receipt of notice of cancellation.

f. Provide for the enrollee to indicate on the notice that the enrollee requests such hearing.

g. If the enrollee is entitled to have policies or contracts issued as provided in 40.10(2), it shall be stated how the enrollee may apply for such policies or contracts.

h. State that the enrollee may request such hearing by forwarding one copy of the notice of cancellation, marked to request a hearing, to the Commissioner of Insurance, Two Ruan Center, 601 Locust Street, Fourth Floor, Des Moines, Iowa 50309.

40.10(4) When a hearing is requested, the commissioner may require the HMO to continue to provide coverage during the pendency of the hearing and a period of not more than ten days after the decision is made known. The commissioner may require the enrollee, as a condition of granting continued coverage, to pay the HMO the charges for such period of coverage.

40.10(5) The hearing shall be held before the commissioner or the delegated hearing officer in the following manner:

a. Upon receipt of a request for hearing, the commissioner shall notify the health maintenance organization and the enrollee of the time and place of hearing.

b. Formal rules of evidence need not be observed, but no evidence shall be received which does not relate to the issue.

c. The burden of proof shall be upon the health maintenance organization to show by a preponderance of the evidence that it had good cause for cancellation for one or more of the reasons stated in the notice and provided herein, except that when the cancellation is for nonpayment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.

d. At the close of the hearing, or as soon thereafter as possible, the commissioner shall advise the parties of the commissioner's decision.

This rule is intended to implement Iowa Code section 514B.17.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

191—40.11(514B) Application for certificate of authority. The application for certificate of authority shall be in the following form:

HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY

_____

(Name of Health Maintenance Organization)

Organized as _____
under the laws of the state of _____, hereby makes application to the commissioner of insurance for a certificate of authority to establish and operate a health maintenance organization in compliance with Iowa Code chapter 514B.

Attached hereto and hereby made a part of this application are exhibits bearing numbers corresponding to the following:

1. A copy of the basic organizational document, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all of its amendments.

2. A copy of the bylaws, rules or similar document, regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

3.1 A list of the names and addresses of each owner of 5 percent or more of the health maintenance organization.

4. A copy of any contract made or to be made between any providers and the applicant

4.1 A copy of any contract made or to be made between the applicant and any person listed in item (3).

4.2 A copy of any contract made or to be made between the applicant and any person for management services.

5. A statement generally describing the health maintenance organization including, but not limited to, a description of its facilities and personnel.

6. A copy of the form of evidence of coverage.

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement is attached.

8.1 A copy of any contract made or to be made between the applicant and its reinsurer.

8.2 A copy of any contract made or to be made between the applicant and any person for cash or asset management services.

9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.

10. A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner, his successors in office and deputies as the true and lawful attorney of the applicant for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served and assessing in detail the economic feasibility of the HMO's projected operation.

12. A description of the complaint procedures to be utilized as required under Iowa Code section 514B.14.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the commissioner of insurance in consideration, when deemed appropriate, with the director of public health, under Iowa Code section 514B.4.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by Iowa Code section 514B.7.

14.1 A copy of the notice to be given to enrollees of the procedure for nomination and election of members of the governing body.

15. A schedule of the liability and workmen's compensation insurance to be maintained in force by the health maintenance organization.

15.1 Copies of the forms of policies or contracts to be offered to terminated enrollees as provided in 40.10(2).

VERIFICATION

The undersigned deposes and says that deponent has duly executed the attached application dated _____, 20 _____, for and on behalf of _____;
(Name of Applicant)

that deponent is the _____ of such company,
(Title of Officer)

and that deponent is authorized to execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Subscribed and sworn to before me by _____on this _____ day of _____, 20 _____.

_____

(Notary Public)

191—40.12(514B) Net worth.

40.12(1) An HMO shall not be authorized to transact business with a net worth less than $1 million.

40.12(2) No HMO incorporated by or organized under the laws of any other state or government shall transact business in this state unless it possesses the net worth required of an HMO organized by the laws of this state and is authorized to do business in this state.

40.12(3) As deemed necessary by the division, each health maintenance organization that is a subsidiary of another person shall file with the division, in a form satisfactory to it, a guarantee of the HMO's obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

40.12(4) Each health maintenance organization shall, at the time of application, pay to the division a one-time, nonrefundable fee of $10,000 to be used by the division to create a special fund solely for the payment of administrative expenses in connection with the solvency of an HMO.

191—40.13(514B) Fidelity bond. A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of cancellation or termination has been filed with the commissioner unless an earlier date of cancellation or termination is approved by the commissioner.

This rule is intended to implement Iowa Code section 514B.5(1).

191—40.14(514B) Annual report. A health maintenance organization shall annually, on or before the first day of March, file with the commissioner of insurance a report verified by at least two of its principal officers and covering the preceding calendar year.

The report shall be on the form designated by the National Association of Insurance Commissioners (NAIC) as the report form for health maintenance organizations. The report shall be completed using "statutory accounting practices" (SAP), and shall include any other information required under law or rule.

The commissioner of insurance may request additional reports and information from a health maintenance organization as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

This rule is intended to implement Iowa Code section 514B.12.

191—40.15(514B) Cash or asset management agreements. If an HMO utilizes a cash or asset management arrangement with its parent, affiliate, or any other person, the arrangement shall be written and subject to prior approval by the commissioner. Cash or asset management agreements shall meet the following minimum requirements:

40.15(1) Cash receipts shall be under the direct control of the HMO that generated the receipts. If the system is under the control of the HMO's parent or affiliate, then receipts shall be transferred to the HMO within five working days.

40.15(2) Securities purchased shall be in the name of the HMO generating the funds for the security purchase.

40.15(3) An HMO's investments shall not be pooled with other entities' investments unless there is an agreement which vests an undivided interest in the pooled arrangement to the HMO. Such an agreement shall be subject to prior approval by the commissioner.

40.15(4) An HMO's cash or investments shall not be commingled with the cash or investments of any other person.

40.15(5) Investments made on behalf of an HMO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.15.

40.15(6) The agreement shall provide for prompt notice and verification of investments, establish responsibility for brokerage and other fees and provide for periodic reports on earnings and expenses.

40.15(7) A parent, affiliate, person, and employees thereof providing cash or asset management services shall be bonded and responsible for any physical loss of investments.

191—40.16(514B) Deductibles and coinsurance charges. Rescinded IAB 10/15/03, effective 11/19/03.

191—40.17(514B) Reinsurance. Reinsurance contracts and stop-loss agreements entered into by an HMO shall be subject to prior approval and shall meet the following minimum requirements:

40.17(1) Reinsurance contracts and stop-loss agreements shall provide that the commissioner of insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.

40.17(2) Retention levels shall be reasonable in light of the HMO's financial condition and potential liabilities.

191—40.18(514B) Provider contracts. An HMO's arrangements for health care services shall be by written contract. Initial provider contracts shall be subject to prior approval. Thereafter, any provider contract deviating from previously submitted or approved contracts shall be submitted to the division within 30 days of execution for informational purposes. In all instances, all provider contracts shall include the following provision:

(Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the HMO acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between HMO and subscriber/enrollee.

(Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

191—40.19(514B) Producers' duties. In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in a health maintenance organization, a producer must comply with the licensing rules set forth in 191—Chapter 10 of the Iowa Administrative Code and in particular

submit to an examination to determine the applicant's competence to sell accident and health insurance as described in rule 191—10.7(522), classification 6.

191—40.20(514B) Emergency services. Benefits shall be available by the HMO for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since HMOs may not contract with every emergency care provider in an area, HMOs shall make every effort to inform members of participating providers.

40.20(1) The term "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.

40.20(2) 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:

a. 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;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

191—40.21(514B) Reimbursement. Reimbursement to a provider of "emergency services," as defined in 191—40.1(514B), shall not be denied by any health maintenance organization without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the HMO as outlined in rule 40.9(514B). Upon denial of reimbursement for emergency services, the HMO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—40.22(514B) Health maintenance organization requirements.

40.22(1) A health maintenance organization shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the health maintenance organization'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 maintenance organization or a person contracting with the health maintenance organization.

40.22(2) A health maintenance organization shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health maintenance organization that, in the opinion of the provider, jeopardizes patient health or welfare.

191—40.23(514B) Disclosure requirements. All HMOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, an HMO offering a plan that includes a prescription drug formulary shall inform enrollees of the plan, and prospective enrollees of the plan during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All HMOs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—40.24(514B) Provider access. A health maintenance organization shall allow a female enrollee direct access to obstetrical and gynecological services from network or participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

191—40.25(514B) Electronic delivery of accident and health group insurance certificates.

40.25(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of accident and health group insurance certificates in an efficient manner by health maintenance organizations and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 514B.9 and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

40.25(2) *Scope.* This rule shall apply to all health maintenance organizations holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapter 514B.

40.25(3) *Electronic delivery—health maintenance organizations.* The health maintenance organization will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The health maintenance organization takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the health maintenance organization furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

40.25(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

This rule is intended to implement Iowa Code chapter 514B.

191—40.26(514B) Notice of cancellation, rescission, discontinuance or termination of enrollment.

40.26(1) *Purpose.* The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, rescission, discontinuance or termination by a health maintenance organization, so as to

implement the various consumer protections intended by Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B). Presumption of receipt in the context of a postal service mailing is a well-settled principle of Iowa law (see *Montgomery Ward v. Davis,* 398 N.W.2d 869, 870-871 (Iowa 1982)), but Iowa courts have not yet recognized a presumption of receipt for electronic transmissions. Notwithstanding Iowa Code section 554D.110(4)*"b,"* delivery by electronic transmission, for the purposes of this rule, does not provide for satisfactory verification or acknowledgment of receipt, as required by Iowa Code section 505B.1(6).

40.26(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to operate an HMO under the provisions of Iowa Code chapter 514B.

40.26(3) *Delivery and receipt.* For any notice of cancellation, rescission, discontinuance or termination by a health maintenance organization under Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) to be effective, a health maintenance organization must, within the time frame established by law, either deliver the notice to the named insured in person or mail the notice through the U.S. Postal Service to the last-known address of the named insured. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) for certified mail or certificate of mailing as proof of mailing.

40.26(4) *Electronic transmissions.* Electronic transmissions do not currently satisfy the notice requirements of Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B). However, additional communication of notices by electronic means may be provided by an insurer as a service to the named insured.

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code chapter 514B and 1999 Iowa Acts, Senate File 276.

[Filed March 18, 1974]
[Filed 5/7/82, Notice 3/31/82—published 5/26/82, effective 6/30/82]
[Filed 7/30/82, Notice 6/23/82—published 8/18/82, effective 9/30/82]
[Filed 5/18/84, Notice 12/21/83—published 6/6/84, effective 7/11/84]
[Filed 9/18/84, Notice 8/1/84—published 10/10/84, effective 11/14/84]
[Filed 1/23/85, Notice 11/21/84—published 2/13/85, effective 4/24/85]
[Filed emergency after Notice 5/17/85, Notice 2/13/85—published 6/5/85, effective 5/17/85]
[Filed emergency 6/3/85—published 6/19/85, effective 7/1/85]
[Filed 9/18/85, Notice 6/19/85—published 10/9/85, effective 11/13/85]
[Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]
[Filed 1/8/87, Notice 10/22/86—published 1/28/87, effective 3/4/87]
[Filed 3/6/87, Notice 1/28/87—published 3/25/87, effective 7/1/87]
[Filed 10/21/88, Notice 4/20/88—published 11/16/88, effective 12/21/88]
[Filed 12/9/88, Notice 9/21/88—published 12/28/88, effective 2/1/89]
[Filed 4/16/92, Notice 1/8/92—published 5/13/92, effective 6/17/92]
[Filed emergency 9/10/93—published 9/29/93, effective 9/10/93]
[Filed 2/21/97, Notice 1/1/97—published 3/12/97, effective 4/16/97]
[Filed 4/1/98, Notice 2/11/98—published 4/22/98, effective 5/27/98]
[Filed emergency 10/16/98—published 11/4/98, effective 10/16/98]
[Filed 3/5/99, Notice 11/4/98—published 3/24/99, effective 4/28/99]
[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]
[Filed 9/3/99, Notice 7/14/99—published 9/22/99, effective 10/27/99]
[Filed 9/24/03, Notice 7/23/03—published 10/15/03, effective 11/19/03]
[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]