Senate Study Bill 211

Conference Committee Text

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Section 1. NEW SECTION. 13.35 HEALTH EDUCATION AND ADVOCACY PROGRAM ESTABLISHED.

1. A health education and advocacy program is established in the department of justice which shall do all of the following:

a. Assist health care consumers to make more informed choices in the health care marketplace, and to be able to participate in decisions concerning the consumers' health care.

b. Promote the interest of health care consumers in this state in the health care marketplace.

2. a. The program shall provide assistance to health care consumers for all of the following:

(1) Understanding their health care bills and third-party coverage.

(2) Identifying improper billing or coverage determinations.

(3) Reporting billing or coverage problems to appropriate entities, including the attorney general, insurance division, or other appropriate government agencies.

b. If a billing or coverage issue concerns the adequacy or propriety of a service or treatment, the program shall refer the matter to an appropriate professional, licensing, or disciplinary body, as applicable. The program shall monitor the progress of the concerns raised by health care consumers through the referrals.

c. If a billing or coverage issue concerns a matter within the jurisdiction of the commissioner of insurance, the program shall refer the matter to the commissioner. The program shall monitor the progress of the concerns raised by health care consumers through the referrals.

d. The program shall work with the appropriate state agency to assist with the resolution of billing or coverage questions as necessary.

3. a. The program shall recommend to the attorney general, the governor, the general assembly, or any other appropriate state agency, any measure that will promote the interests of health care consumers in the health marketplace.

b. The program shall present for consideration relevant information on the effects of the program on health care consumers generally in any agency proceeding open to the public.

Sec. 2. NEW SECTION. 514I.1 TITLE.

This chapter shall be known and may be cited as the "Consumer Health Insurance Protection Act".

Sec. 3. NEW SECTION. 514I.2 DEFINITION.

"Insurer" means any insurer issuing an individual or group accident and sickness insurance policy on an expense-incurred basis and any individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A, or any individual or group health maintenance organization contract under chapter 514B, or any organized delivery system licensed by the department of public health or any other person providing a plan of health insurance subject to state regulation.

Sec. 4. NEW SECTION. 514I.3 REQUIRED DISCLOSURE.

1. An insurer shall make disclosure in solicitation and sales materials provided to the general public of any provisions in a policy or contract relating to the following:

a. Preexisting condition provision.

b. Renewability of coverage.

c. Preauthorization of covered services, the person conducting the preauthorization, the address and telephone number of the person conducting the preauthorization, the average time for such preauthorization to be completed, and the annual percentage of preauthorizations which are declined.

d. An appeals procedure related to such preauthorization.

e. A restricted network provision or any exceptions to services or providers which are not covered under the policy or contract, as applicable.

f. The number of insureds or subscribers per physician, if applicable.

g. The annual percentage of claims or expenses denied, as appropriate.

h. An appeals procedure for claims and expenses which are denied.

i. Incentives, financial or otherwise, for controlling costs which are offered to providers who are reimbursed under the policy or contract.

2. An insurer shall also disclose the information identified in subsection 1 to an insured, enrollee, or subscriber at the time of purchase and renewal of a policy or contract.

3. a. An insurer shall annually disclose to the commissioner of insurance and to each insured, enrollee, or subscriber all of the following:

(1) The cumulative loss ratio for each class of policy or contract offered by the insurer. The loss ratio is determined on the basis of incurred claims and earned premiums for all calculating or rating periods. However, where coverage under a policy or contract is provided on a direct service rather than indemnity basis, the loss ratio is determined on the basis of incurred health care expenses and earned premiums for such period. An insurer shall provide an explanation, approved by the commissioner, which defines or describes the cumulative loss ratio in such terms as to render the explanation likely to be understood by an ordinary consumer.

(2) The annual percentage of claims or expenses denied, as appropriate.

b. Information disclosed pursuant to this subsection shall be updated at least annually pursuant to rules adopted by the commissioner.

c. Information required to be disclosed to an insured, enrollee, or subscriber pursuant to this section shall be included in each billing statement of the insured, enrollee, or subscriber.

Sec. 5. NEW SECTION. 514I.4 STANDARDS FOR LOSS RATIOS &endash; HEALTH MAINTENANCE ORGANIZATIONS AND ORGANIZED DELIVERY SYSTEMS.

A health maintenance organization and an organized delivery system subject to this chapter shall return a cumulative loss ratio of at least eighty-five percent. The loss ratio is on the basis of incurred claims and earned income for coverage provided by the health maintenance organization or organized delivery system for all calculating or rating periods such that the cumulative loss ratio from inception equals or exceeds the eighty-five percent minimum loss ratio. Where coverage is provided on a direct service rather than indemnity basis, the loss ratio is on the basis of incurred health care expenses and earned premiums for such period. For purposes of achieving and maintaining the minimum cumulative loss ratio, the experience of all contracts of a health maintenance organization or organized delivery system is combined.

Sec. 6. NEW SECTION. 514I.5 USE OF PREMIUMS FOR POLITICAL PURPOSES PROHIBITED.

An insurer subject to this chapter shall not expend or use any amount of premium income received by the insurer for a political purpose as defined in section 56.2, for the payment of compensation to a lobbyist as defined in section 68B.2, or for payment of expenses associated with any political advertisement or the distribution of other political material.

Sec. 7. NEW SECTION. 514I.6 COMPLAINT PROCEDURE &endash; APPROVAL BY COMMISSIONER.

1. An insurer subject to this chapter shall establish a consumer response procedure for the purpose of responding to consumer questions and complaints. An insurer shall file a plan for establishing its procedure, or a proposal to change its procedure, with the commissioner. The commissioner shall review the procedure to ensure that the procedure will protect the interests of insureds, enrollees, or subscribers and will provide for an expeditious resolution or response to an insured, enrollee, or subscriber.

2. The commissioner shall review the proposed procedure as soon as possible after receipt of the proposal and shall approve or disapprove the procedure. The commissioner shall notify the insurer in writing of the approval or disapproval. If approved the commissioner shall direct the insurer to implement the procedure as soon as possible and shall, in consultation with the insurer, establish a date by which the procedure shall be in operation. If disapproved, the commissioner shall include in the notification to the insurer any objection of the commissioner which resulted in the disapproval and direct the insurer to resubmit its proposal after modification in response to such objection.

Sec. 8. NEW SECTION. 514I.7 PREAUTHORIZATION REQUIREMENTS.

An insurer subject to this chapter which requires preauthorization for covered services shall establish and maintain a telephone line, which shall be available on a twenty-four hour a day, seven-day a week basis for the purpose of providing preauthorization to insureds, enrollees, or subscribers. The insurer shall assure that appropriate individuals are available to respond to preauthorization requests received as a result of maintaining this telephone line and assure that such requests receive a prompt response and resolution, which response time in no case shall be longer than twenty-four hours, pursuant to rules adopted by the commissioner of insurance.

EXPLANATION

This bill establishes a health education and advocacy program in the department of justice to assist health care consumers to make more informed health care decisions and to promote the interests of health care consumers in this state. The program is to help consumers understand their health care bills, identify improper billing or coverage determinations, and report billing or coverage problems. The program is to make recommendations to the attorney general, governor, general assembly, or other appropriate state agency, which will promote the interest of health care consumers.

The bill creates new chapter 514I to be cited as the "Consumer Health Insurance Protection Act". The chapter applies to any person who provides health insurance or health coverage in this state, and includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or any other person providing a plan of health insurance subject to state insurance regulation.

The bill requires an insurer to disclose certain information in the insurer's solicitation and sales materials, and at the time a person purchases or renews a policy or contract. The disclosure is to include policy or contract

information relating to any preexisting condition provision, renewability of coverage, preauthorization of covered services, the person conducting the preauthorization, and the average time for such preauthorization to be completed, an appeals procedure related to such preauthorization, a restricted network provision, if applicable, the number of insureds, enrollees, or subscribers per physician, if applicable, the annual percentage of claims denied, and any incentives, financial or otherwise, for controlling costs through the use of less costly treatment alternatives. An insurer is also required to annually disclose its cumulative loss ratio and annual percentage of claims or expenses denied to the insurance commissioner and each insured, enrollee, or subscriber.

The bill provides that an insurer is to return a cumulative loss ratio of at least 85 percent, based on incurred claims or health care expenses and earned premiums for all calculating or rating periods.

The bill prohibits the use by an insurer of any premium income for a political purpose as defined in section 56.2, for payment of compensation of a lobbyist as defined in section 68B.2, or for expenses associated with any political advertisement or the distribution of other political material.

The bill also requires an insurer to establish a consumer response procedure for the purpose of responding to consumer questions and complaints.

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