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COMMERCE

SENATE FILE 2258

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Passed Senate, Date _____ Passed House, Date _____

Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____

Approved _____

A BILL FOR

An Act relating to the rights of enrollees under managed care plans.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

S.F. 2258

TLSB 3480XS 77

pf/cf/24

S.F. 2258 H.F. _____

Section 1. NEW SECTION. 514I.1 TITLE.

This chapter shall be known and may be cited as the "Health Insurance Consumers' Bill of Rights Act".

Sec. 2. NEW SECTION. 514I.2 DEFINITIONS.

As used in this chapter, unless the context otherwise requires:

1. "Division" means the insurance division of the department of commerce.

2. "Emergency medical condition" means a medical condition which manifests by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of the individual or with respect to a pregnant woman, the health of the woman or the fetus in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

3. "Emergency services" means, with respect to an enrollee under a plan or coverage, inpatient and outpatient services, covered under the plan or coverage, that are furnished by a provider that is qualified to furnish such services under the plan or coverage, and are necessary to evaluate or stabilize an emergency.

4. "Enrollee" means an individual who is entitled to benefits under a group health plan or under health insurance coverage.

5. "Group health plan" means a group health plan as defined in 42 U.S.C. § 300gg(91).

6. "Health care professional" means a person licensed to practice a profession as defined in section 147.1, with the exceptions of cosmetology arts and sciences, barbering, and mortuary sciences, who provides health care services.

7. "Health care provider" means "provider" as defined in

section 514B.1.

8. "Health insurance coverage" means health insurance coverage as defined in 42 U.S.C. § 300gg(91).

9. "Health insurance issuer" means a person who does insurance business in the state who provides health insurance coverage.

10. "Managed care" means, with respect to a group health plan or health insurance coverage, a plan or coverage that provides financial incentives for enrollees to obtain benefits through participating health care providers or professionals.

11. "Nonparticipating" means with respect to a health care provider or professional and a group health plan or health insurance coverage, a provider or professional that is not a participating provider or professional with respect to plan or insurance coverage services.

12. "Participating" means with respect to a health care provider or professional and a group health plan or health insurance coverage offered by a health insurance issuer, a provider or professional that has entered into an agreement or arrangement with the plan or issuer with respect to the provision of health care services to enrollees under the plan or coverage.

13. "Primary care practitioner" means, with respect to a group health plan or health insurance coverage offered by a health insurance issuer, a health care professional who is trained in family practice, general practice, internal medicine, obstetrics and gynecology, or pediatrics and who is practicing within the scope of practice authorized by state law, designated by the plan or issuer to coordinate, supervise, or provide ongoing care to enrollees.

Sec. 3. NEW SECTION. 514I.3 ACCESS TO PERSONNEL AND FACILITIES -- ASSURING ADEQUATE CHOICE OF HEALTH CARE PROFESSIONALS.

The division shall adopt rules regulating managed care group health plans and health insurance issuers offering

managed care group health insurance coverage to ensure that the plans and insurers meet all of the following requirements:

1. Have a sufficient number and type of primary care practitioners and specialists throughout the service area to meet the needs of enrollees and to provide substantive choice.

2. Maintain a mix of primary care practitioners that is adequate to meet the needs of the enrollees' varied characteristics, including age, gender, race, and health status.

3. Include, to the extent possible, a variety of primary care providers, including but not limited to community health centers, rural health clinics, and family planning clinics.

Sec. 4. NEW SECTION. 514I.4 ACCESS TO SPECIALTY CARE.

The division shall adopt rules regulating managed care group health plans and health insurance issuers offering managed care group health insurance coverage to ensure that the plans and issuers provide enrollees with all of the following:

1. Access to specialty care.

2. Standing referrals to specialists.

3. Access to nonparticipating providers.

4. Direct access without the need for a referral to health care professionals trained in obstetrics and gynecology.

5. A process that permits a health care provider trained in obstetrics and gynecology to be designated and treated as a primary care practitioner.

Sec. 5. NEW SECTION. 514I.5 ACCESS TO EMERGENCY CARE.

1. If a group health plan or health insurance coverage provides any benefits with respect to emergency services, the plan or the health insurance issuer offering the coverage shall do all of the following:

a. Provide for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

b. Comply with guidelines prescribed by the secretary of

the United States department of health and human services relating to promoting efficient and timely coordination of appropriate maintenance and poststabilization care of an enrollee after the enrollee has been determined to be stable.

Sec. 6. NEW SECTION. 514I.6 COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

1. If a group health plan provides benefits, or a health insurance issuer offers health insurance coverage to a qualified enrollee, for an approved clinical trial, the plan or issuer shall comply with all of the following:

a. The plan or issuer shall not deny the enrollee participation in the clinical trial.

b. Subject to subsection 3, the plan or issuer shall not deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial.

c. The plan or issuer shall not discriminate against the enrollee on the basis of the enrollee's participation in the trial.

2. For the purposes of this subsection, "qualified enrollee" means an enrollee who meets all of the following conditions:

a. The enrollee has a life-threatening or serious illness for which no standard treatment is effective.

b. The enrollee is eligible to participate in an approved clinical trial with respect to treatment of such illness.

c. The enrollee and the referring physician conclude that the enrollee's participation in the trial would be appropriate.

d. The enrollee's participation in the trial offers potential for significant clinical benefit for the enrollee.

3. a. A plan or issuer shall provide for payment for routine patient costs described in subsection 1, but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an

approved clinical trial.

b. In the case of covered items and services, the payment rate if provided by a participating provider shall be the agreed upon rate and if provided by a nonparticipating provider shall be the payment rate the plan or issuer would normally pay for comparable services under paragraph "a".

4. As used in this section, "approved clinical trial" means a clinical research study or clinical investigation approved by the United States food and drug administration or approved and funded by one or more of the following:

a. The national institutes of health.

b. The United States department of defense.

Sec. 7. NEW SECTION. 514I.7 CONTINUITY OF CARE.

The division shall adopt rules regulating managed care group health plans and health insurance issuers offering managed care group health insurance coverage to ensure that plans and issuers provide continuity of coverage if an enrollee is undergoing a course of treatment with the provider at the time of termination of the coverage.

Sec. 8. NEW SECTION. 514I.8 PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

A contract or agreement, or the operation of a contract or agreement, between a group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan and a health professional shall not prohibit or restrict the health professional from engaging in medical communications with a patient. Any contract provision or agreement that prohibits or restricts such medical communications is null and void.

Sec. 9. NEW SECTION. 514I.9 ACCESS TO NECESSARY PRESCRIPTION DRUGS.

If a group health plan or health insurance issuer offers health insurance coverage that provides benefits with respect to prescription drugs, but the coverage limits benefits to drugs included in a formulary, the plan or issuer shall

ensure, in accordance with rules adopted by the division, that the nature of the formulary restrictions is fully disclosed to enrollees and exceptions from the formulary restrictions are provided when medically necessary or appropriate.

Sec. 10. NEW SECTION. 514I.10 STANDARDS FOR UTILIZATION REVIEW ACTIVITIES, COMPLAINTS, AND APPEALS.

The division shall establish standards by rule for group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan relating to conduct of utilization review activities. The standards shall include all of the following:

1. A requirement that a plan or issuer develop written policies and criteria concerning utilization review activities.

2. A requirement that a plan or issuer provide notice of such policies and criteria and written notice of adverse determinations to enrollees.

3. A restriction on the use of contingent compensation arrangements with providers.

4. A requirement establishing deadlines to ensure timely utilization review determinations.

5. The establishment of an adequate process for filing complaints and appealing decisions concerning utilization review determinations, including the mandatory use of an outside review panel to make decisions on appeals.

6. A requirement that a plan or issuer that utilizes clinical practice guidelines uniformly apply review criteria based on sound scientific principles and the most recent medical evidence.

Sec. 11. NEW SECTION. 514I.11 QUALITY IMPROVEMENT PROGRAM.

A group health plan or health insurance issuer offering health insurance coverage shall make arrangements for an ongoing quality improvement program for health care services provided to enrollees. The program shall meet standards

established by the division, including standards relating to all of the following:

1. The measurement of health outcomes relevant to all populations.

2. Evaluation of high risk services.

3. Monitoring utilization of services.

4. Ensuring appropriate action to improve quality of care.

5. Providing for an independent external review of the program.

Sec. 12. NEW SECTION. 514I.12 NONDISCRIMINATION.

1. A group health plan or health insurance issuer offering health insurance coverage, whether or not a managed care plan or coverage, shall not discriminate or engage directly or through contractual arrangements in any activity, including the selection of service area, that has the effect of discriminating against an individual or group of individuals on the basis of race, culture, national origin, gender, sexual orientation, language, socioeconomic status, age, disability, genetic makeup, health status, payer source, or anticipated need for health care services.

2. A plan or issuer shall not discriminate in the selection of members of the health provider or provider network or in establishing the terms and conditions for membership in the network of the plan or coverage based on any of the factors described in subsection 1.

3. A plan or issuer shall not exclude coverage, including coverage for procedures and drugs, if the effect is to discriminate in violation of subsection 1 or 2.

Sec. 13. NEW SECTION. 514I.13 MEDICAL RECORDS AND CONFIDENTIALITY.

A managed care group health plan or a health insurance issuer offering managed care group health insurance shall do all of the following:

1. Establish written policies and procedures for the handling of medical records and enrollee communications to

ensure enrollee confidentiality.

2. Ensure the confidentiality of specified enrollee information, including prior medical history, medical record information, and claims information, except when disclosure of the information is required by law.

3. Not release any individual patient record information, unless a release is authorized in writing by the enrollee or otherwise required by law.

Sec. 14. NEW SECTION. 514I.14 HEALTH PROSPECTUS, DISCLOSURE OF INFORMATION.

1. A group health plan or health insurance issuer providing health insurance coverage shall provide to each of its enrollees at the time of enrollment and on an annual basis, and shall make available to each prospective enrollee upon request, a prospectus that relates to the plan or coverage offered, in a format specified by the commissioner, for the purpose of comparison by enrollees and prospective enrollees, that provides all of the following:

a. Quality assessment data on the plan or coverage that meets all of the following requirements:

(1) Is similar to the types of data collected for managed care plans under Title XVIII of the federal Social Security Act, taking into account differences between the populations covered under that title and the populations covered under this chapter.

(2) Is collected by independent auditing agencies.

(3) Includes all of the following:

(a) A description of the types of methodologies including capitation, financial incentives or bonuses, fee-for-service, salary, and withholds used by the plan or issuer to reimburse physicians, including the proportions of physicians who have each of these types of arrangements.

(b) Cost-sharing requirements for enrollees.

(c) Upon request, information on the reimbursement methodology used by the plan or insurer or medical groups for

individual physicians. However, this paragraph shall not require the disclosure of specific reimbursement rates.

b. Measures of performance data of the plan or issuer in relation to coverage offered which includes each of the following and other salient data as the commissioner may specify:

(1) The ratio of physicians to enrollees, including the ratio of physicians who are obstetricians and gynecologists to adult female enrollees.

(2) The ratio of specialists, including the types of specialists, to enrollees.

(3) The incentive structure used for payment of primary care physicians and specialists.

(4) Patient outcomes for procedures, including procedures specific to female enrollees.

(5) The average number of grievances filed annually under the plan or coverage.

(6) The number of requests for procedures for which utilization review board review or approval is required and the number and percentage of requests that are denied.

(7) The number of appeals filed from denial of such requests and the number and percentage of such appeals that are approved, and such numbers and percentages by gender of the enrollee involved.

(8) Disenrollment data.

c. The benefits provided under the plan or coverage, as well as explicit exclusions, including a description of all of the following:

(1) The coverage policy with respect to coverage for female-specific benefits, including screening mammography, hormone replacement therapy, bone density testing, osteoporosis screening, maternity care, and reconstructive surgery following a mastectomy.

(2) The costs of copayments for treatments, including any exceptions.

d. Additional information, including all of the following:

(1) The plan's or issuer's structure and provider network, including the names and credentials of physicians in the network.

(2) Coverage provided and excluded, including out-of-area coverage.

(3) Procedures for utilization management.

(4) Procedures for determining coverage for investigational or experimental treatments as well as definitions for coverage terms.

(5) Any restrictive formularies or prior approval requirements for obtaining prescription drugs, including, upon request, information on whether or not specific drugs are covered.

(6) Use of voluntary or mandatory arbitration.

(7) Procedures for receiving emergency care and out-of-network services when those services are not available in the network and information on the coverage of emergency services, including all of the following:

(a) The appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation.

(b) The process and procedures for obtaining emergency services.

(c) The locations of emergency departments and other settings, in which physicians and hospitals provide emergency services and poststabilization care.

(d) How to contact agencies that regulate the plans or issuer.

(e) How to contact consumer assistance agencies.

(f) How to obtain covered services.

(g) How to receive preventive health services and health education.

(h) How to select providers and obtain referrals.

(i) How to appeal health plan decisions and file grievances.

2. This section shall not be construed as preventing the state from requiring health insurance issuers, in relation to their offering of health insurance coverage, to separately disclose information, including comparative ratings of health insurance coverage, in addition to the information required to be disclosed under this section.

Sec. 15. NEW SECTION. 514I.15 PROMOTING GOOD MEDICAL PRACTICE.

1. A group health plan or a health insurance issuer, in connection with the provision of health insurance coverage, shall not impose limits on the manner in which particular services are delivered, if the services are medically necessary or appropriate, to the extent that such procedure or treatment is otherwise a covered benefit.

2. Subsection 1 shall not be construed as requiring coverage of particular services which are not otherwise covered under the terms of the coverage.

EXPLANATION

This bill provides for the establishment of rights for enrollees under managed care health insurance plans. The rights established relate to access to personnel and facilities, provision of choice of health care professionals under a plan, access to specialty and emergency care, coverage for participation in clinical trials, continuity of care when coverage is terminated while an enrollee is undergoing a course of treatment, access to necessary prescription drugs, standards for utilization review, complaints and appeals, a quality improvement program for health care services offered to enrollees, nondiscrimination of plans, medical records and confidentiality, the provision of information regarding the plan and insurer, and the promotion of good medical practices.