HANSEN: Chair
Bradley
Metcalf
Chapman
Osterhaus

HSB 212
COMMERCE AND REGULATION

Succeeded SF/HF S.

SENATE/HOUSE FILE _____
BY (PROPOSED GOVERNOR'S BILL)

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to the rights of enrollees in health maintenance organizations, organized delivery systems, or preferred provider organizations.

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

TLSB 1524XL 78
pf/cf/24

S.F. _____ H.F. _____

Section 1. NEW SECTION. 514J.1 DEFINITIONS.

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

1. "Commissioner" means the commissioner of insurance.

2. "Director" means the director of public health.

3. "Emergency medical condition" means a medical condition which manifests itself 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 one 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.

4. "Emergency services" means, with respect to an individual enrolled with a health maintenance organization, organized delivery system, or preferred provider 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.

5. "Enrollee" means an individual who is entitled to coverage under a health maintenance organization, organized delivery system, or preferred provider organization contract.

6. "Health care professional" means a person licensed to or certified to practice a profession as defined in section 147.1 and who provides health care services.

7. "Health care provider" means a provider as defined in section 514B.1.

8. "Health care services" means services included in the furnishing to any individual of medical or dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as furnishing to any person of all

other services for the purposes of preventing, alleviating, caring, or healing human illness, injury, or physical disability.

9. "Health maintenance organization" means health maintenance organization as defined in section 514B.1.

10. "Organized delivery system" means organized delivery system as defined in section 513C.3.

11. "Participating" means, with respect to a health care professional or health care provider, entering into an agreement or arrangement with a health maintenance organization, organized delivery system, or preferred provider organization to provide health care services to enrollees.

12. "Physician" means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, osteopathy, or chiropractic under the laws of this state.

13. "Preferred provider organization" means preferred provider organization described in section 514F.3.

14. "Primary care provider" means 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, and designated by the health maintenance organization, organized delivery system, or preferred provider organization to coordinate, supervise, or provide ongoing health care services to enrollees.

15. "Service area" means an established service area as defined in section 513C.3.

Sec. 2. NEW SECTION. 514J.2 ACCESS TO CARE.

The commissioner shall adopt rules that address the ability of a health maintenance organization or preferred provider organization to serve its enrollees residing anywhere in the service area. The rules shall address, but are not limited to, addressing all of the following:

1. Geographic limits for travel to receive primary care, including inpatient and outpatient health care services.

2. Health care provider networks that ensure that a sufficient number and type of participating primary care providers and specialists exist throughout the service area to adequately meet the needs of enrollees.

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

4. The ability of a parent to designate a pediatrician as the primary care provider for the parent's child.

Sec. 3. NEW SECTION. 514J.3 EMERGENCY SERVICES.

Emergency services, including both inpatient and outpatient health care services, shall be provided by a health maintenance organization, organized delivery system, or preferred provider organization, through the organization's or system's participating health care providers or through guaranteed arrangements with other health care providers, on a twenty-four-hour per day basis. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services.

Sec. 4. NEW SECTION. 514J.4 PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

1. A health maintenance organization, organized delivery system, or preferred provider organization shall not prohibit a participating health care professional or health care provider from, or penalize a participating health care professional or health care provider for, discussing treatment options with enrollees that do not reflect the position of the organization or system, or from advocating on behalf of enrollees within the utilization review or grievance processes established under the organization's or system's contract.

2. A health maintenance organization, organized delivery system, or preferred provider organization shall not penalize a participating health care professional or health care provider because the health care professional or provider, in good faith, reports to state or federal authorities any act or

practice by the health maintenance organization, organized delivery system, or preferred provider organization that, in the opinion of the health care professional or health care provider, jeopardizes patient health or welfare.

Sec. 5. NEW SECTION. 514J.5 EXTERNAL REVIEW PROCESS.

The commissioner shall adopt rules which require health maintenance organizations and preferred provider organizations and the director shall adopt rules which require organized delivery systems to establish an external review process for enrollees to appeal a denial of coverage based on medical necessity. The rules shall include provisions for a timely review, including provisions for expedited review for situations in which delay could pose a serious health threat to the enrollee. The rules shall also require the review to be conducted by an independent review organization which includes health care professionals with expertise in the specific area of coverage being reviewed.

Sec. 6. NEW SECTION. 514J.6 HEALTH INFORMATION DISCLOSURE -- HEALTH PROSPECTUS.

1. A health maintenance organization, organized delivery system, or preferred provider organization 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 containing information that allows the enrollee to determine the performance of the health maintenance organization, organized delivery system, or preferred provider organization.

2. The commissioner shall adopt rules for health maintenance organizations and preferred provider organizations and the director shall adopt rules for organized delivery systems which establish the format and content of the prospectus. The content requirement shall include but is not limited to all of the following:

a. Quality assessment data.

b. The type, frequency, and outcomes of and the filing

procedure for enrollee complaints and grievances.

c. Covered and excluded benefits.

d. Compensation arrangements with participating health care professionals and health care providers.

3. The commissioner and the director shall collect the information provided in the prospectus and shall compile the information in a format and manner that is useful to the public. The compiled information shall be available to the public in both electronic and printed formats.

EXPLANATION

This bill establishes a new chapter which provides certain rights for enrollees of a health maintenance organization (HMO), organized delivery system (ODS), or preferred provider organization (PPO). The bill provides definitions used in the new Code chapter. The bill directs the commissioner of insurance to adopt rules for HMOs and PPOs relating to access to care. Rules relating to access to care currently exist for ODSs. The rules relate to access to care, include rules relating to geographic limits for travel to receive primary care, the requirement that a sufficient number of primary care health care professionals and specialists be available in the service area, the requirement of direct access to an obstetrician and gynecologist, and the requirement that a parent be allowed to designate a pediatrician as the primary care health care professional for the parent's child.

The bill requires the availability of emergency services, through a physician and ancillary personnel, on a 24-hour per day basis for HMOs, ODSs, and PPOs.

The bill provides that a participating health care professional or health care provider cannot be prohibited from or penalized for discussing treatment options with an enrollee and from advocating for an enrollee within the utilization review or grievance processes. The bill prohibits an HMO, ODS, or PPO from penalizing a health care professional or health care provider from reporting an act or practice of the

HMO, ODS, or PPO to state or federal authorities if the professional or provider believes, in good faith, that the act or practice jeopardizes patient health or welfare.

The bill requires an external review process for enrollee appeals.

The bill requires HMOs, ODSs, and PPOs to provide enrollees and prospective enrollees with a prospectus containing information required by rule of the commissioner or by rule of the director of public health which will assist the enrollee or prospective enrollee in determining the performance of the HMO, ODS, or PPO. The information contained in the prospectus submitted by each HMO, ODS, and PPO is to be compiled by the commissioner and the director and is to be made available to the public in both electronic and printed formats.

MAR 8 1999

COMMERCE AND REGULATION

HOUSE FILE 555

BY SCHRADER, BUKTA, HUSER, FALCK, PARMENTER, KUHN, FREVERT, MURPHY, DODERER, LARKIN, JOCHUM, WEIGEL, WARNSTADT, O'BRIEN, SHOULTZ, OSTERHAUS, BURNETT, FOEGE, WITT, MASCHER, MUNDIE, MERTZ, CONNORS, DOTZLER, CHIODO, WHITEAD, STEVENS, THOMAS, FORD, REYNOLDS, HOLVECK, BELL, RICHARDSON, SCHERRMAN, WISE, MYERS, TAYLOR, and KREIMAN

Formerly HSB 212

Passed House, Date _____ Passed Senate, Date _____

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

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