

MAR 10 1999

COMMERCE AND REGULATION

HOUSE FILE 594
BY OSTERHAUS

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

A BILL FOR

1 An Act relating to health care coverage including the rights of
2 enrollees and the review of and liability for certain health
3 care services treatment decisions.

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

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HF 594

1 Section 1. NEW SECTION. 514J.1 TITLE.

2 This chapter shall be known and may be cited as "Third-
3 party Payor Liability Act".

4 Sec. 2. NEW SECTION. 514J.2 DEFINITIONS.

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

7 1. "Appropriate and medically necessary" means the
8 standard for health care services as determined by a physician
9 or health care provider consistent with accepted practices and
10 standards of care provided by the medical profession in the
11 community.

12 2. "Enrollee" means an individual who is enrolled in a
13 health care plan, including covered dependents.

14 3. "Health care plan" means a plan under which a person
15 undertakes to provide, arrange for, pay for, or reimburse any
16 part of the cost of any health care services.

17 4. "Health care provider" means a person licensed or
18 certified under chapter 147, 148, 148A, 148C, 149, 150, 150A,
19 151, 152, 153, 154, 154B, or 155A to provide in this state
20 professional health care services to an individual during that
21 individual's medical care, treatment, or confinement.

22 5. "Health care treatment decision" means a determination
23 made when health care services are actually provided under the
24 health care plan and a decision which affects the quality of
25 the diagnosis, care, or treatment provided to the plan's
26 insureds or enrollees.

27 6. "Health insurance carrier" means an entity subject to
28 the insurance laws and regulations of this state, or subject
29 to the jurisdiction of the commissioner of insurance, that
30 contracts or offers to contract, or that subcontracts or
31 offers to subcontract, to provide, deliver, arrange for, pay
32 for, or reimburse any of the costs of providing health care
33 services, including an insurance company offering sickness and
34 accident plans, a health maintenance organization, a nonprofit
35 health service corporation, or any other entity providing a

1 plan of health insurance, health benefits, or health services.

2 7. "Health maintenance organization" means a health
3 maintenance organization as defined in section 514B.1.

4 8. "Insured" means an individual who is covered by a
5 health care plan provided by a health insurance carrier.

6 9. "Managed care entity" means an entity that provides a
7 health care plan that selects and contracts with health care
8 providers; manages and coordinates health care services
9 delivery; monitors necessity, appropriateness, and quality of
10 health care services delivered by health care providers; and
11 performs utilization review and cost control.

12 10. "Ordinary care" means, in the case of a third-party
13 payor, that degree of care that a third-party of ordinary
14 prudence would provide under the same or similar
15 circumstances. In the case of a person who is an employee,
16 agent, or representative of a third-party payor, "ordinary
17 care" means that degree of care that a person of ordinary
18 prudence in the same profession, specialty, or area of
19 practice as such person would use in the same or similar
20 circumstances.

21 11. "Organized delivery system" means an organized
22 delivery system as licensed by the director of public health.

23 12. "Physician" means an individual licensed under chapter
24 148, 150, or 150A to practice medicine and surgery,
25 osteopathy, or osteopathic medicine and surgery.

26 13. "Third-party payor" means a health insurance carrier,
27 health maintenance organization, managed care entity, or
28 organized delivery system.

29 Sec. 3. NEW SECTION. 514J.3 THIRD-PARTY PAYOR DUTY TO
30 EXERCISE ORDINARY CARE -- LIABILITY.

31 1. A third-party payor has the duty to exercise ordinary
32 care when making health care treatment decisions and is liable
33 for damages for harm to an insured or enrollee proximately
34 caused by the third-party payor's failure to exercise such
35 ordinary care.

1 2. A third-party payor is also liable for damages for harm
2 to an insured or enrollee proximately caused by the health
3 care services treatment decisions made by an employee, agent,
4 or representative of the third-party payor who is acting on
5 behalf of the third-party payor and over whom the third-party
6 payor has the right to exercise influence or control or has
7 actually exercised influence or control if such decision
8 results in the failure to exercise ordinary care.

9 3. It is a defense in an action brought pursuant to this
10 section against a third-party payor that neither the third-
11 party payor, nor an employee, agent, or representative of the
12 third-party payor controlled, influenced, or participated in
13 the health care services treatment decision; or that the
14 third-party payor did not deny or delay payment for any health
15 care services prescribed or recommended by a health care
16 provider to the insured or enrollee.

17 4. Subsections 1 and 2 do not create an obligation on the
18 part of the third-party payor to provide any health care
19 services to an insured or enrollee that are not covered by the
20 health care plan offered by the third-party payor.

21 5. This chapter does not create any liability on the part
22 of an employer or an employer group purchasing organization
23 that purchases health care services coverage or assumes risk
24 on behalf of its employees for providing health care services.

25 6. A third-party payor shall not remove a health care
26 provider from its plan or refuse to renew the participation of
27 a health care provider under its plan for advocating
28 appropriate and medically necessary health care services for
29 an insured or enrollee.

30 7. A third-party payor shall not enter into a contract
31 with a hospital or health care provider or pharmaceutical
32 company which includes an indemnification or hold harmless
33 clause for the acts or conduct of the third-party payor. Any
34 such indemnification or hold harmless clause in an existing
35 contract is void.

1 8. A provision under state law prohibiting a third-party
2 payor from practicing medicine or being licensed to practice
3 medicine shall not be asserted as a defense by such third-
4 party payor in an action brought against it pursuant to this
5 section or any other applicable law.

6 9. In an action against a third-party payor, a finding
7 that a health care provider is an employee, agent, or
8 representative of such third-party payor shall not be based
9 solely on proof that such a health care provider's name
10 appears in a listing of approved health care providers made
11 available to an insured or enrollee under a health care plan.

12 10. This chapter does not apply to workers' compensation
13 coverages.

14 Sec. 4. NEW SECTION. 514K.1 DEFINITIONS.

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

17 1. "Commissioner" means the commissioner of insurance.

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

19 3. "Emergency medical condition" means a medical condition
20 which manifests itself by acute symptoms of sufficient
21 severity, including severe pain, such that a prudent layperson
22 who possesses an average knowledge of health and medicine
23 could reasonably expect the absence of immediate medical
24 attention to result in one of the following:

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

28 b. Serious impairment to bodily functions.

29 c. Serious dysfunction of any bodily organ or part.

30 4. "Emergency services" means, with respect to an
31 individual enrolled with a health maintenance organization,
32 organized delivery system, or preferred provider organization,
33 covered inpatient and outpatient services that are furnished
34 by a provider that is qualified to furnish such services and
35 are needed to evaluate or stabilize an emergency medical

1 condition.

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

5 6. "Health care professional" means a person licensed to
6 or certified to practice a profession as defined in section
7 147.1 and who provides health care services.

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

10 8. "Health care services" means services included in the
11 furnishing to any individual of medical or dental care, or
12 hospitalization, or incident to the furnishing of such care or
13 hospitalization, as well as furnishing to any person of all
14 other services for the purposes of preventing, alleviating,
15 caring, or healing human illness, injury, or physical
16 disability.

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

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

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

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

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

31 14. "Primary care provider" means a health care
32 professional who is trained in family practice, general
33 practice, internal medicine, obstetrics and gynecology, or
34 pediatrics and who is practicing within the scope of practice
35 authorized by state law, and designated by the health

1 maintenance organization, organized delivery system, or
2 preferred provider organization to coordinate, supervise, or
3 provide ongoing health care services to enrollees.

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

6 Sec. 5. NEW SECTION. 514K.2 ACCESS TO CARE.

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

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

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

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

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

23 Sec. 6. NEW SECTION. 514K.3 EMERGENCY SERVICES.

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

33 Sec. 7. NEW SECTION. 514K.4 PROHIBITION OF INTERFERENCE
34 WITH CERTAIN MEDICAL COMMUNICATIONS.

35 1. A health maintenance organization, organized delivery

1 system, or preferred provider organization shall not prohibit
2 a participating health care professional or health care
3 provider from, or penalize a participating health care
4 professional or health care provider for, discussing treatment
5 options with enrollees that do not reflect the position of the
6 organization or system, or from advocating on behalf of
7 enrollees within the utilization review or grievance processes
8 established under the organization's or system's contract.

9 2. A health maintenance organization, organized delivery
10 system, or preferred provider organization shall not penalize
11 a participating health care professional or health care
12 provider because the health care professional or provider, in
13 good faith, reports to state or federal authorities any act or
14 practice by the health maintenance organization, organized
15 delivery system, or preferred provider organization that, in
16 the opinion of the health care professional or health care
17 provider, jeopardizes patient health or welfare.

18 Sec. 8. NEW SECTION. 514K.5 EXTERNAL REVIEW PROCESS.

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

31 Sec. 9. NEW SECTION. 514K.6 HEALTH INFORMATION
32 DISCLOSURE -- HEALTH PROSPECTUS.

33 1. A health maintenance organization, organized delivery
34 system, or preferred provider organization shall provide, to
35 each of its enrollees at the time of enrollment and on an

1 annual basis, and shall make available to each prospective
2 enrollee upon request, a prospectus containing information
3 that allows the enrollee to determine the performance of the
4 health maintenance organization, organized delivery system, or
5 preferred provider organization.

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

12 a. Quality assessment data.

13 b. The type, frequency, and outcomes of and the filing
14 procedure for enrollee complaints and grievances.

15 c. Covered and excluded benefits.

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

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

23 EXPLANATION

24 This bill creates new Code chapter 514J. The bill provides
25 that a third-party payor has the duty to exercise ordinary
26 care when making health care treatment decisions and is liable
27 for damages for harm to an insured or enrollee proximately
28 caused by its failure to exercise such ordinary care. The
29 bill establishes certain defenses to such an action for
30 failure to use ordinary care and provides that the duty to
31 exercise ordinary care does not create an obligation on the
32 part of the third-party payor to provide health care services
33 to an insured or enrollee which is not covered by the health
34 care plan offered by the third-party payor. The bill defines
35 "third-party payor" as a health insurance carrier, health

1 maintenance organization, managed care entity, or organized
2 delivery system.

3 This bill also establishes a new Code chapter 514K which
4 provides certain rights for enrollees of a health maintenance
5 organization (HMO), organized delivery system (ODS), or
6 preferred provider organization (PPO). The bill provides
7 definitions used in the new Code chapter. The bill directs
8 the commissioner of insurance to adopt rules for HMOs and PPOs
9 relating to access to care. Rules relating to access to care
10 currently exist for ODSs. The rules relate to access to care,
11 include rules relating to geographic limits for travel to
12 receive primary care, the requirement that a sufficient number
13 of primary care health care professionals and specialists be
14 available in the service area, the requirement of direct
15 access to an obstetrician and gynecologist, and the
16 requirement that a parent be allowed to designate a
17 pediatrician as the primary care health care professional for
18 the parent's child.

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

22 The bill provides that a participating health care
23 professional or health care provider cannot be prohibited from
24 or penalized for discussing treatment options with an enrollee
25 and from advocating for an enrollee within the utilization
26 review or grievance processes. The bill prohibits an HMO,
27 ODS, or PPO from penalizing a health care professional or
28 health care provider from reporting an act or practice of the
29 HMO, ODS, or PPO to state or federal authorities if the
30 professional or provider believes, in good faith, that the act
31 or practice jeopardizes patient health or welfare.

32 The bill requires an external review process for enrollee
33 appeals.

34 The bill requires HMOs, ODSs, and PPOs to provide enrollees
35 and prospective enrollees with a prospectus containing

1 information required by rule of the commissioner or by rule of
2 the director of public health which will assist the enrollee
3 or prospective enrollee in determining the performance of the
4 HMO, ODS, or PPO. The information contained in the prospectus
5 submitted by each HMO, ODS, and PPO is to be compiled by the
6 commissioner and the director and is to be made available to
7 the public in both electronic and printed formats.

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