HUMAN RESOURCES

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SENATE FILE 195

BY TINSMAN

Passed Senate, Date _____ Passed House, Date _____

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

Approved _____

A BILL FOR

An Act establishing a managed care consumer protection Act.

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

SF 195 HUMAN RESOURCES

TLSB 1331SS 78

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S.F. 195 H.F. _____

Section 1. NEW SECTION. 514J.1 PURPOSE AND INTENT.

The purpose of this chapter is to ensure that enrollees receive adequate health care services under a managed care plan. The intent of this chapter is to ensure that:

1. Enrollees have full and timely access to clinically and culturally appropriate health care personnel and facilities.

2. Enrollees can choose from an adequate selection of accessible and qualified health care professionals.

3. Open communication between health care professionals and enrollees is ensured.

4. Enrollees have access to comprehensive pharmaceutical services.

5. Enrollees have access to information regarding limits on coverage of experimental treatments.

6. The quality of care is high within a managed care plan.

7. Medical decisions are made by the appropriate medical personnel.

8. Health care professionals within a plan are in good standing in their profession.

9. Managed care plan data is available to consumers.

10. Full public access to information regarding health care service delivery exists within plans.

11. The proper state entities are authorized to oversee all managed care plans.

12. A mechanism exists in a managed care plan for timely and fair resolution of enrollee complaints, grievances, and appeals.

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

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

1. "Appeal" means a formal process whereby an enrollee, whose care has been reduced, denied, or terminated, or whereby the enrollee deems the care inappropriate, can contest an adverse grievance decision by the managed care plan.

2. "Emergency" means a medical condition, the onset of

which is sudden and unexpected, that manifests itself by symptoms of sufficient severity, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably assume that the condition requires immediate medical treatment, and could expect the absence of medical attention to result in serious impairment to bodily functions or place the person's health in serious jeopardy.

3. "Enrollee" means an individual who is enrolled in a managed care plan.

4. "Expedited review" means a review process which results in a decision no more than seventy-two hours after the review is commenced.

5. "Experimental treatment" means treatment that, while not commonly used for a particular condition or illness, is recognized for treatment of the particular condition or illness, a treatment for which there is no clearly superior, nonexperimental treatment alternative available to the enrollee, or a treatment that is considered an experimental treatment under Title XVIII or Title XIX of the federal Social Security Act and follows Medicare and Medicaid guidelines.

6. "Grievance" means a written complaint submitted by or on behalf of the enrollee.

7. "Health care professional" means a physician or other person providing health care services.

8. "Health care provider" means a clinic, hospital, physician organization, preferred provider organization, independent practice association, or other appropriately licensed provider of health care services or supplies.

9. "Health care services" means services for the diagnosis, prevention, or treatment of a health condition, illness, injury, or disease deemed medically necessary under Title XIX of the federal Social Security Act.

10. "Managed care entity" means any entity including an insurer, hospital, or medical service plan, health maintenance organization, limited health services organization, preferred

provider organization, third party administrator, or any person or entity that establishes, operates, or maintains a network of participating health care professionals that is licensed by the state.

11. "Managed care plan" or "plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in the plan, with financial incentives for persons enrolled in the plan to use the participating health care professionals and procedures covered by the plan.

12. "Participating" means a health care professional who has entered into an agreement with a managed care entity to provide health care services to an enrollee in a managed care plan.

13. "Point-of-service option" means an option for the enrollee to choose to receive health care services from a nonparticipating health care professional or health care provider.

14. "Primary care practitioner" means a health care professional under contract with a managed care plan, who has been designated by the plan to coordinate, supervise, or provide ongoing health care services to an enrollee.

15. "Prudent layperson" is a person without specific medical training for the illness or condition in question who acts as a reasonable person would under similar circumstances.

16. "Quality assurance" means the ongoing evaluation of the quality of health care services provided to enrollees.

Sec. 3. NEW SECTION. 514J.3 ACCESS TO PERSONNEL AND FACILITIES.

1. A managed care plan shall include a sufficient number and type of primary care practitioners and specialists, throughout the service area, to meet the needs of enrollees and to provide meaningful choice. A managed care plan shall demonstrate that the managed care plan offers all of the following:

a. An adequate number of accessible acute care hospital services, within a reasonable distance or travel time.

b. An adequate number of accessible primary care practitioners, within a reasonable distance or travel time. For the purposes of this requirement, primary care practitioners shall include family practice and general practice physicians, internists, obstetricians and gynecologists, and pediatricians.

c. An adequate number of accessible specialists and subspecialists, within a reasonable distance or travel time. When the type of medical specialists needed for a specific condition is not offered, enrollees shall have access to nonparticipating health care professionals.

d. The availability of specialty health care services, including physical therapy, occupational therapy, and rehabilitation services.

e. The availability of nonparticipating health care professional specialists, when a patient's unique medical circumstances so warrant.

2. A managed care plan shall provide for continuity of care with established primary care practitioners, when a health care professional's contract is terminated.

3. A managed care plan shall provide telephone access to the managed care plan during business and evening hours to ensure enrollee access for routine care, and twenty-four-hour telephone access to either the managed care plan or a participating health care provider or health care professional for emergencies.

4. A managed care plan shall establish standards for reasonable waiting times to obtain appointments, except as otherwise provided for emergency services. Such standards shall include appointment scheduling guidelines based on the type of health care service, including prenatal care appointments, well-child visits and immunizations, routine physicals, follow-up appointments for chronic conditions, and

urgent care.

5. A managed care plan shall cover and reimburse expenses for emergency services obtained without prior authorization.

6. A managed care plan shall demonstrate that it has developed an access plan to meet the needs of vulnerable and underserved populations.

a. The plan shall provide culturally appropriate health care services to the greatest extent possible.

b. When a significant number of enrollees in the plan do not speak English, the plan shall provide access to personnel fluent in languages other than English, to the greatest extent possible.

c. The plan shall develop standards for continuity of care following enrollment, including sufficient information on how to access care within the plan.

7. A managed care plan shall hold enrollees harmless against claims for payment of the cost of covered health care services from participating health care providers and health care professionals in the managed care plan.

Sec. 4. NEW SECTION. 514J.4 CHOICE OF HEALTH CARE PROFESSIONAL.

1. A managed care plan shall offer an adequate selection of health care professionals who are accessible and qualified under the managed care plan.

2. A managed care plan shall permit enrollees to choose their own primary care practitioner from a list of health care professionals within the plan. This list shall be updated as health care professionals are added or removed and shall include all of the following:

a. A sufficient number of primary care practitioners who are accepting new enrollees as patients.

b. A sufficient combination of primary care practitioners that reflects a diversity that is adequate to meet the needs of the enrolled population's varied characteristics including age, gender, race, and health status.

3. A managed care plan shall develop a system to permit enrollees to use a health care professional specialist as a primary care practitioner when the enrollee's medical condition so warrants.

4. A managed care plan shall provide continuity of care and appropriate referral to health care professional specialists within the plan, when speciality care is warranted.

a. Enrollees shall have access to health care professional specialists on a timely basis.

b. Enrollees shall be provided with a choice of health care professional specialists when a referral is made.

c. Children with special health care needs shall be managed by pediatric health care professional subspecialists.

5. A managed care plan shall offer a point-of-service option. The point-of-service option may require that the enrollee in the plan pay a reasonable portion of the costs of such health care services provided by nonparticipating health care providers or health care professionals.

6. A managed care plan shall provide enrollees with access to consultation for a second opinion.

Sec. 5. NEW SECTION. 514J.5 INFORMATION DISCLOSURE RULES.

1. A managed care plan shall not contract with a health care provider to limit a health care professional's disclosure to an enrollee or on behalf of an enrollee of any information relating to the enrollee's medical condition or treatment options.

2. A health care professional shall not be penalized and a health care professional's contract with a managed care plan shall not be terminated because the health care professional offers referrals, or discusses medically necessary or appropriate care with, or on behalf of, an enrollee. The following information shall be permitted to be disclosed under all managed care plans:

a. All treatment options.

b. Other information, determined by the health care professional to be in the best interest of the enrollee.

3. A health care professional shall not be penalized for discussing financial incentives and financial arrangements between the health care professional and the managed care entity.

Sec. 6. NEW SECTION. 514J.6 DRUGS AND DEVICES.

1. A managed care plan shall provide coverage for all drugs and devices approved by the United States food and drug administration, whether or not any such drug or device has been approved for the specific treatment or condition, if the primary care practitioner or other health care professional treating an enrollee determines the drug or device to be medically necessary and appropriate for the enrollee's treatment or condition.

2. The prescribing health care professional shall determine the appropriate drug therapy for an enrollee. Substitutions shall not be made without the direct approval of the prescriber.

3. A managed care plan shall establish and operate a drug utilization review program. The primary emphasis of the program shall be to enhance quality health care services provided to enrollees by ensuring appropriate drug therapy. The program shall provide all of the following:

a. Education of health care professionals, enrollees, and pharmacists regarding the appropriate use of prescription drugs.

b. Retrospective review of prescription drugs furnished to enrollees.

c. Ongoing periodic examination of data on prescription drugs used in the outpatient setting to ensure quality therapeutic outcomes for enrollees.

d. The use of clinically relevant criteria and standards for drug therapy; nonproprietary criteria and standards

developed and revised through an open, professional consensus process; and interventions which focus on improving therapeutic outcomes.

Sec. 7. NEW SECTION. 514J.7 EXPERIMENTAL TREATMENTS.

1. A managed care plan that limits coverage for health care services shall define the limitation and disclose the limits in any agreement or certificate of coverage. The disclosure shall include the person authorized to make such a determination and the criteria used to determine whether a health care service is experimental.

2. A managed care plan that denies coverage for an experimental treatment, procedure, drug, or device, for an enrollee who has a terminal condition or illness shall provide the enrollee with a denial letter within twenty working days of receipt of a request submitted by the enrollee or on behalf of the enrollee. The letter shall include all of the following:

a. The name and title of the individual who made the decision.

b. A statement setting forth the specific medical and scientific reasons for denying coverage.

c. A description of alternative treatment, services, or supplies covered by the plan, if any.

d. A copy of the plan's grievance and appeal procedures.

Sec. 8. NEW SECTION. 514J.8 QUALITY ASSURANCE PROGRAM.

1. A managed care plan shall establish comprehensive quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of health care services. These standards shall include all of the following:

a. An ongoing, written, internal quality assurance program.

b. Specific written guidelines for quality of health care services studies and monitoring, including attention to vulnerable populations.

c. Performance-based and clinical outcomes-based criteria.

d. A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action.

e. A plan for data gathering and assessment.

f. A peer review process.

2. A managed care plan shall have a process for selection of health care professionals as the plan's participating health care professionals, with written policies and procedures for review and approval used by the plan.

a. The plan shall establish minimum health care professional requirements.

b. The plan shall demonstrate that the plan has consulted with appropriately qualified health care professionals to establish the requirements.

c. The plan's process shall include verification of the individual health care professional's license, history of suspension or revocation, and liability claims history.

d. The plan shall establish a formal, written, ongoing process for the reevaluation of all participating health care professionals within a specified number of years following initial acceptance. Reevaluations shall include updates of the previous evaluation criteria and an assessment of the performance pattern based on criteria including enrollee clinical outcomes, number of complaints, and malpractice actions.

3. The plan shall not require a health care professional to provide health care services beyond, or outside of, the health care professional's scope of practice.

Sec. 9. NEW SECTION. 514J.8 DATA SYSTEMS AND CONFIDENTIALITY.

1. A managed care plan shall provide information on the plan's structure, decision-making process, health care services coverages and exclusions, cost and cost-sharing requirements, participating health care professionals, and

grievance and appeal procedures, to all potential enrollees, to all enrollees covered by the plan, and to the insurance division of the department of commerce.

2. A managed care plan shall collect and report annually to the insurance division of the department of commerce specified data to be available to the public including all of the following:

a. Gross outpatient and hospital utilization data.

b. Enrollee clinical outcome data.

c. The number and types of enrollee grievances or complaints filed during the year, the status of decisions, and the average time required to reach a decision.

d. The number, amount, and disposition of malpractice claims resolved during the year by the managed care plan and any of its participating health care professionals.

3. A managed care plan shall establish written policies and procedures for the handling of medical records and enrollee communications to ensure enrollee confidentiality.

4. A managed care plan shall ensure the confidentiality of specified enrollee information, including, but not limited to, prior medical history, medical record information, and claims information, except where disclosure of this information is authorized by law.

5. A managed care plan shall be prohibited from releasing any individual patient record information, unless such a release is authorized in writing by the enrollee or the enrollee's designee or is otherwise required or authorized by law.

Sec. 10. NEW SECTION. 514J.9 CLINICAL DECISION MAKING.

1. A managed care plan shall appoint a medical director who is a licensed health care professional in Iowa. The medical director is responsible for treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan.

2. A managed care plan shall inform enrollees, upon

request, of the financial arrangements between the plan and participating health care professionals and pharmacists, if those arrangements include incentives or bonuses for restriction of services.

Sec. 11. NEW SECTION. 514J.10 OVERSIGHT AUTHORITY -- INSURANCE DIVISION.

1. The insurance division of the department of commerce shall perform audits on an annual basis, to review enrollee clinical outcome data, enrollee service data, and operational and financial data.

2. This chapter shall not preclude the insurance division from investigating complaints, grievances, or appeals on behalf of enrollees or health care professionals.

Sec. 12. NEW SECTION. 514J.11 CITATION.

This chapter shall be known and may be cited as the "Managed Care Consumer Protection Act".

EXPLANATION

This bill establishes a new Code chapter 514J which provides protections for consumers of managed care. The Code chapter may be referred to as the "Managed Care Consumer Protection Act".

The bill states the purposes and intent of the chapter, including providing access and choice with regard to health care and providers of health care, providing quality health care services through appropriate providers who are in good standing professionally, providing for open communication between patients and providers, and providing a process for timely resolution of complaints and grievances.

The bill provides definitions of terms used in the new Code chapter. The bill requires that a managed care plan provide adequate access to sufficient numbers and types of providers, facilities, and specialists; provide for continuity of care when a provider's contract is terminated; provide adequate telephone access to the managed care plan by consumers; provide standards for waiting times to obtain appointments;

provide coverage for emergency health care services when the situation meets the prudent lay person standard defined in the bill; develop an access plan for underserved populations; and hold harmless enrollees against claims of providers for payment of costs of covered health care services.

With regard to choice of health care professionals, the bill requires the managed care plan to provide for adequate choice among accessible and qualified providers; requires that an enrollee be allowed to choose the enrollee's own primary care practitioner from the list of practitioners within the plan; requires that an enrollee may choose a specialist as a primary care provider if the enrollee's medical condition so warrants; requires provision of continuity of care and referrals to specialists within the plan; requires provision of a point-of-service option and for consultation for a second opinion.

The bill prohibits a managed care plan from contracting with a provider to limit disclosures to an enrollee or on behalf of an enrollee or to penalize a provider for relaying any information relating to the enrollee's condition or treatment options, and prohibits the plan from penalizing a provider for discussing financial incentives and arrangements between the plan and the provider.

The bill requires a plan to provide coverage for any United States federal drug administration (FDA)-approved drugs or devices if the drugs or devices are medically necessary as determined by the provider; requires a drug utilization review program which includes education and periodic examination of data related to outcomes.

The bill requires the plan to define and disclose any limitations of the plan and requires notice and information to the enrollee of any denial of coverage for experimental treatment for an enrollee who has a terminal condition or illness.

The bill requires each managed care plan to have quality

assurance standards, have a process for selection of providers participating in the plan, have a formal, written, ongoing process of evaluation for all participating providers, and limits providers to providing care only within the provider's scope of practice.

The bill requires that the managed care plan provide certain information to enrollees and the division of insurance; collect and report specified data to the division of insurance annually; provide the data to the public on a timely basis; ensure enrollee confidentiality through written policies and procedures for the handling of medical records and enrollee communications; ensure confidentiality of specified enrollee information; and prohibits the plan from releasing the enrollee's individual patient records without written authorization by the enrollee or the enrollee's designee, or unless otherwise authorized by law.

The bill requires each managed care plan to appoint a medical director who is a licensed health care professional in Iowa. A plan is required to inform enrollees of financial arrangements between the plan and participating health care professionals and pharmacists if incentives or bonuses are involved.

The bill provides that the division of insurance is to annually audit the plan and does not preclude the division from investigating complaints, grievances, or appeals of enrollees and providers.