Redevine
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SSB-1161

Human Resources

Succeeded By
SENATE FILE SF/HF 276
BY (PROPOSED COMMITTEE ON HUMAN RESOURCES BILL BY CHAIRPERSON BOETTGER)

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

A BILL FOR

An Act relating to health care service and treatment coverage by providing for continuity of care, discussion and advocacy of treatment options, coverage of emergency room services, utilization review requirements, and an external review process.

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

TLSB 2426XC 78
mj/jw/5

S.F. _____ H.F. _____

Section 1. NEW SECTION. 514C.14 CONTINUITY OF CARE -- PREGNANCY.

1. Except as provided under subsection 2 or 3, a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, which terminates its contract with a participating health care provider, shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

2. A covered person who makes an involuntary change in health plans may request that the new health plan cover the services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Continuation of such coverage shall continue through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit level shall be according to the terms and conditions of the new health plan contract.

3. A carrier, organized delivery system, or plan established under chapter 509A, which terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

Sec. 2. NEW SECTION. 514C.15 TREATMENT OPTIONS.

A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan

established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, doing either of the following:

1. Discussing treatment options with a covered individual, notwithstanding the carrier's, organized delivery system's, or plan's position on such treatment option.

2. Advocating on behalf of a covered individual within a review or grievance process established by the carrier, organized delivery system, or chapter 509A plan, or established by a person contracting with the carrier, organized delivery system, or chapter 509A plan.

Sec. 3. NEW SECTION. 514C.16 EMERGENCY ROOM SERVICES.

1. A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for medically necessary emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. Coverage for emergency services is subject to the terms and conditions of the health benefit plan or contract.

2. Prior authorization for emergency services shall not be required. All services necessary to evaluate and stabilize the covered individual shall be considered covered emergency services.

3. For purposes of this section, unless the context otherwise requires:

a. "Emergency medical condition" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(2) Serious impairment to bodily function.

(3) Serious dysfunction of a bodily organ or part.

b. "Emergency services" means covered inpatient and outpatient health care services that are furnished by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

Sec. 4. NEW SECTION. 514F.4 UTILIZATION REVIEW REQUIREMENTS.

1. A third-party payor which provides health benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner.

2. This section does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under any of the following:

a. Title XVIII of the federal Social Security Act.

b. The civilian health and medical program of the uniformed services.

c. Any other federal employee health benefit plan.

3. For purposes of this section, unless the context otherwise requires:

a. "Third-party payor" means:

(1) An insurer subject to chapter 509 or 514A.

(2) A health service corporation subject to chapter 514.

(3) A health maintenance organization subject to chapter 514B.

(4) A preferred provider arrangement.

(5) A multiple employer welfare arrangement.

(6) A third-party administrator.

(7) A fraternal benefit society.

(8) A plan established pursuant to chapter 509A for public employees.

(9) Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

b. "Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. Such evaluation does not apply to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

Sec. 5. NEW SECTION. 514J.1 LEGISLATIVE INTENT.

It is the intent of the general assembly to provide a mechanism for the appeal of a denial of coverage based on medical necessity.

Sec. 6. NEW SECTION. 514J.2 DEFINITIONS.

1. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of

health insurance, health care benefits, or health care services.

2. "Commissioner" means the commissioner of insurance.

3. "Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

4. "Enrollee" means an individual, or an eligible dependent, who receives health care benefits coverage through a carrier or organized delivery system.

5. "Independent review entity" means a reviewer or entity, certified by the commissioner pursuant to section 514J.6.

6. "Organized delivery system" means an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health, and performing utilization review.

Sec. 7. NEW SECTION. 514J.3 EXCLUSIONS.

This chapter does not apply to a hospital confinement indemnity, credit, dental, vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical payment insurance.

Sec. 8. NEW SECTION. 514J.4 EXTERNAL REVIEW REQUEST.

1. At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee of the right to have the coverage decision reviewed under the external review process.

2. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may file a written request for external review of the coverage decision with the commissioner. The request must be filed within sixty days of the receipt of the coverage decision.

3. The request for external review must be accompanied by a twenty-five dollar filing fee. The commissioner may waive

the filing fee for good cause. The filing fee shall be refunded if the enrollee prevails in the external review process.

Sec. 9. NEW SECTION. 514J.5 ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed service or treatment does not meet the definition of medical necessity as defined in the enrollee's evidence of coverage.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's contract.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the decision.

3. The carrier or organized delivery system has three days to contest the eligibility of the request for external review with the commissioner. If the commissioner finds that the request for external review is not eligible for full review, the commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for full review.

Sec. 10. NEW SECTION. 514J.6 INDEPENDENT REVIEW

ENTITIES.

1. The commissioner shall solicit names of independent review entities from carriers, organized delivery systems, and medical professional associations.

2. Independent review entities include both of the following:

a. Medical peer review organizations.

b. Nationally recognized health experts or institutions.

3. The commissioner shall certify independent review entities to conduct external reviews. An individual who conducts an external review as or as part of a certified independent review entity shall be a health care professional and satisfy both of the following requirements:

a. Hold a current unrestricted license to practice medicine or a health profession in the United States. A health care professional who is a physician shall also hold a current certification by a recognized American medical specialty board.

b. Have no history of disciplinary actions or sanctions, including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

4. Each independent review entity shall have a quality assurance program on file with the commissioner that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

5. The commissioner shall certify independent review entities every two years.

Sec. 11. NEW SECTION. 514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, shall do all of the

following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating physician, of the name, address, and phone number of the independent review entity and of the enrollee's and treating physician's right to submit additional information.

c. Provide any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

d. Provide any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

2. The enrollee, or the enrollee's treating health care provider, may provide any information submitted in support of the internal review, and other newly discovered relevant information. The enrollee shall have ten days from the mailing date of the notification of the independent review entity's selection to provide this information. Failure to provide the information within ten days shall be ground for rejection of consideration of the information by the independent review entity.

3. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 1. The requested information shall

be submitted within five days. Failure to provide the information shall be ground for rejection of consideration of the information by the independent review entity. The carrier or organized delivery system shall be notified of this request.

4. The independent review entity shall submit its decision as soon as possible, but not more than thirty days from the independent review entity's receipt of the request for review. The decision shall be mailed to the enrollee, or the treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system.

5. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 12. NEW SECTION. 514J.8 EXPEDITED REVIEW.

An expedited review shall be conducted within seventy-two hours if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

Sec. 13. NEW SECTION. 514J.9 FUNDING.

All reasonable fees and costs of the independent review entity in conducting an external review shall be paid by the carrier or organized delivery system.

Sec. 14. NEW SECTION. 514J.10 REPORTING.

Each carrier and organized delivery system shall file an annual report with the commissioner containing all of the following:

1. The number of external reviews requested.

2. The number of the external reviews certified by the commissioner.

3. The number of coverage decisions which were upheld by an independent review entity.

The commissioner shall prepare a report by January 31 of each year.

Sec. 15. NEW SECTION. 514J.11 IMMUNITY.

An independent review entity conducting a review under this chapter is not liable for damages arising from determinations made under the review process. This does not apply to any act or omission by the independent review entity made in bad faith or involving gross negligence.

Sec. 16. NEW SECTION. 514J.12 STANDARD OF REVIEW.

The standard of review to be used by an independent review entity shall be whether the health care service or treatment denied by the carrier or organized delivery system was medically necessary as defined by the enrollee's evidence of coverage subject to Iowa law. The independent review entity shall take into consideration factors identified in the review record that impact the delivery of or describe the standard of care for the medical service or treatment under review. The medical service or treatment recommended by the enrollee's treating health care provider shall be upheld upon review so long as it is found to be medically necessary.

Sec. 17. NEW SECTION. 514J.13 EFFECT OF EXTERNAL REVIEW DECISION.

The review decision by the independent review entity conducting the review is binding upon the carrier or organized delivery system. The enrollee or the enrollee's treating health care provider acting on behalf of the enrollee may appeal the review decision by the independent review entity conducting the review by filing a petition for judicial review either in Polk county district court or in the district court in the county in which the enrollee resides. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts.

Sec. 18. NEW SECTION. 514J.14 RULES.

The commissioner shall adopt rules pursuant to chapter 17A as are necessary to administer this chapter.

EXPLANATION

This bill creates several new Code sections and a new Code

chapter relating to the provision of and evaluation of health care services provided to covered individuals in this state.

The bill creates new Code section 514C.14 which provides for continuation of coverage by a carrier, organized delivery system, or plan established pursuant to chapter 509A for public employees, of costs associated with a health care provider providing continued care to a covered person who is in the second or third trimester of pregnancy. Such coverage is to continue through postpartum care if the carrier, organized delivery system, or plan terminates its contract with the health care provider. The section also provides that a covered person who makes a change in health plans involuntarily may request that the new health plan cover services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Such coverage shall continue through postpartum care related to the child birth and delivery. A carrier, organized delivery system, or chapter 509A plan which terminates the contract of a participating health care provider for cause is not liable for health care services provided to a covered person following the date of termination.

New Code section 514C.15 is created and provides that a carrier or an organized delivery system, or a plan established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, discussing treatment options with a covered individual, notwithstanding the carrier's, organized delivery system's, or plan's position on such treatment option; or advocating on behalf of a covered individual within a review or grievance process established by the carrier, organized delivery system, or chapter 509A plan, or established by a person contracting with the carrier, organized delivery system, or chapter 509A plan.

S.F. _____ H.F. _____

New Code section 514C.16 is created and provides that a carrier, an organized delivery system, or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for medically necessary emergency services provided to a covered individual, including services furnished outside the network. Coverage for emergency services is subject to the terms and conditions of the health care benefit plan or contract. The bill provides that prior authorization for emergency services shall not be required and that all services necessary to evaluate and stabilize the covered individual shall be considered covered emergency services.

New Code section 514F.4 is created and provides that a third-party payor which provides health care benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner. The bill provides that new Code section 514F.4 does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under Title XVIII of the federal Social Security Act, the civilian health and medical program of the uniformed services, or any other federal employee health benefit plan.

The bill creates new Code chapter 514J relating to the appeal by an individual receiving health care coverage who is denied covered health care services or treatment.

New Code section 514J.1 states the intent of the general assembly to provide a mechanism for the appeal of a denial of coverage based on medical necessity.

New Code section 514J.2 establishes definitions for key terms used in the chapter.

New Code section 514J.3 provides that the chapter does not apply to a hospital confinement indemnity, credit, dental vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical payment insurance.

New Code section 514J.4 provides that an enrollee or the enrollee's treating health care provider may file a written request for external review of a denial of coverage. The request must be filed within 60 days of the receipt of the denial of coverage. A $25 filing fee is provided for, which may be waived by the commissioner for good cause. The filing fee is to be refunded to the enrollee if the enrollee prevails in the external review process.

New Code section 514J.5 establishes eligibility requirements for the certification of the external review request. The bill provides that the commissioner shall have two business days from receipt of the request for external review to certify the request. The commissioner must certify the request if the enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed, the enrollee has been denied coverage based on a determination that the proposed service or treatment does not meet the definition of medical necessity as defined in the enrollee's evidence of coverage, the enrollee or the enrollee's treatment provider has exhausted all internal appeal mechanisms, and the written request for external review was filed within 60 days of receipt of the coverage denial.

New Code section 514J.6 provides that independent review entities include medical peer review organizations and nationally recognized health experts or institutions as certified by the commissioner.

New Code section 514J.7 establishes an external review process. The bill provides that the carrier or organized delivery system, within three business days of receipt of an

eligible request for external review, shall select an independent review entity from the list certified by the commissioner, notify the enrollee and the enrollee's treatment provider of the independent review entity and of the enrollee's and the enrollee's treatment provider's right to submit additional information, provide any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment; and provide any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided. The independent review entity is to submit its decision as soon as possible.

New Code section 514J.8 provides for an expedited review to be conducted within 72 hours if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

New Code section 514J.9 provides that all reasonable fees and costs of the independent review entity are to be paid by the carrier or organized delivery system.

New Code section 514J.10 directs each carrier and organized delivery system to file with the commissioner an annual report including the number of external reviews requested, the number of external review requests certified by the commissioner, and the number of coverage decisions which were upheld by an independent review entity.

New Code section 514J.11 provides that an independent review entity is not liable for damages arising from a determination under the review process unless the entity acted in bad faith or the determination involved gross negligence.

New Code section 514J.12 provides that the standard of review to be used by an independent review entity is whether the health care service or treatment denied by the carrier or organized delivery system was medically necessary as evidenced

by the enrollee's evidence of coverage.

New Code section 514J.13 establishes the effect of the external review decision. The bill provides that the review decision by the independent review entity conducting the review is binding upon the carrier and the organized delivery system and that the findings of fact by the independent review entity are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts. The bill provides that the enrollee or the enrollee's treating health care provider may appeal the independent review entity's decision in Polk county district court or the district court in the county in which the enrollee resides.

New Code section 514J.14 directs the commissioner to adopt rules necessary to implement new Code chapter 514J.

3-3-99 Defeated

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SENATE FILE 276

BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SSB 1161)
also SSB 1148

Passed Senate, Date 3/10/99 (P. 541) Passed House, Date 4/14/99 (P. 1272)

Vote: Ayes 49 Nays 0 Vote: Ayes 97 Nays 1

Approved _____

A BILL FOR

An Act relating to health care service and treatment coverage by providing for continuity of care, discussion and advocacy of treatment options, coverage of emergency room services, utilization review requirements, and an external review process.

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

SF 276

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1. Except as provided under subsection 2 or 3, a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, which terminates its contract with a participating health care provider, shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

2. A covered person who makes an involuntary change in health plans may request that the new health plan cover the services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Continuation of such coverage shall continue through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit level shall be according to the terms and conditions of the new health plan contract.

3. A carrier, organized delivery system, or plan established under chapter 509A, which terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

Sec. 2. NEW SECTION. 514C.15 TREATMENT OPTIONS.

A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan

established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, doing either of the following:

1. Discussing treatment options with a covered individual, notwithstanding the carrier's, organized delivery system's, or plan's position on such treatment option.

2. Advocating on behalf of a covered individual within a review or grievance process established by the carrier, organized delivery system, or chapter 509A plan, or established by a person contracting with the carrier, organized delivery system, or chapter 509A plan.

Sec. 3. NEW SECTION. 514C.16 EMERGENCY ROOM SERVICES.

1. A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for medically necessary emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. Coverage for emergency services is subject to the terms and conditions of the health benefit plan or contract.

2. Prior authorization for emergency services shall not be required. All services necessary to evaluate and stabilize the covered individual shall be considered covered emergency services.

3. For purposes of this section, unless the context otherwise requires:

a. "Emergency medical condition" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(2) Serious impairment to bodily function.

(3) Serious dysfunction of a bodily organ or part.

b. "Emergency services" means covered inpatient and outpatient health care services that are furnished by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

Sec. 4. NEW SECTION. 514F.4 UTILIZATION REVIEW REQUIREMENTS.

1. A third-party payor which provides health benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner.

2. This section does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under any of the following:

a. Title XVIII of the federal Social Security Act.

b. The civilian health and medical program of the uniformed services.

c. Any other federal employee health benefit plan.

3. For purposes of this section, unless the context otherwise requires:

a. "Third-party payor" means:

(1) An insurer subject to chapter 509 or 514A.

(2) A health service corporation subject to chapter 514.

(3) A health maintenance organization subject to chapter 514B.

(4) A preferred provider arrangement.

(5) A multiple employer welfare arrangement.

(6) A third-party administrator.

(7) A fraternal benefit society.

(8) A plan established pursuant to chapter 509A for public employees.

(9) Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

b. "Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. Such evaluation does not apply to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

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It is the intent of the general assembly to provide a mechanism for the appeal of a denial of coverage based on medical necessity.

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1. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of

health insurance, health care benefits, or health care services.

2. "Commissioner" means the commissioner of insurance.

3. "Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

4. "Enrollee" means an individual, or an eligible dependent, who receives health care benefits coverage through a carrier or organized delivery system.

5. "Independent review entity" means a reviewer or entity, certified by the commissioner pursuant to section 514J.6.

6. "Organized delivery system" means an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health, and performing utilization review.

Sec. 7. NEW SECTION. 514J.3 EXCLUSIONS.

This chapter does not apply to a hospital confinement indemnity, credit, dental, vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical payment insurance.

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1. At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee of the right to have the coverage decision reviewed under the external review process.

2. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may file a written request for external review of the coverage decision with the commissioner. The request must be filed within sixty days of the receipt of the coverage decision.

3. The request for external review must be accompanied by a twenty-five dollar filing fee. The commissioner may waive

the filing fee for good cause. The filing fee shall be refunded if the enrollee prevails in the external review process.

Sec. 9. NEW SECTION. 514J.5 ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed service or treatment does not meet the definition of medical necessity as defined in the enrollee's evidence of coverage.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's contract.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the decision.

3. The carrier or organized delivery system has three business days to contest the eligibility of the request for external review with the commissioner. If the commissioner finds that the request for external review is not eligible for full review, the commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for full review.

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ENTITIES.

1. The commissioner shall solicit names of independent review entities from carriers, organized delivery systems, and medical professional associations.

2. Independent review entities include both of the following:

a. Medical peer review organizations.

b. Nationally recognized health experts or institutions.

3. The commissioner shall certify independent review entities to conduct external reviews. An individual who conducts an external review as or as part of a certified independent review entity shall be a health care professional and satisfy both of the following requirements:

a. Hold a current unrestricted license to practice medicine or a health profession in the United States. A health care professional who is a physician shall also hold a current certification by a recognized American medical specialty board.

b. Have no history of disciplinary actions or sanctions, including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

4. Each independent review entity shall have a quality assurance program on file with the commissioner that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

5. The commissioner shall certify independent review entities every two years.

Sec. 11. NEW SECTION. 514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, shall do all of the

following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and phone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the independent review entity selected by the carrier or organized delivery system by notifying the commissioner within three business days of the receipt of notice from the carrier or organized delivery system. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection, to select an independent review entity, and to provide the notice required by this subsection to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

c. Provide any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

d. Provide any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

2. The enrollee, or the enrollee's treating health care provider, may provide any information submitted in support of

the internal review, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the final notification of the independent review entity's selection to provide this information. Failure to provide the information within ten days shall be ground for rejection of consideration of the information by the independent review entity.

3. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 1. The requested information shall be submitted within five days. Failure to provide the information shall be ground for rejection of consideration of the information by the independent review entity. The carrier or organized delivery system shall be notified of this request.

4. The independent review entity shall submit its decision as soon as possible, but not more than thirty days from the independent review entity's receipt of the request for review. The decision shall be mailed to the enrollee, or the treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system.

5. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 12. NEW SECTION. 514J.8 EXPEDITED REVIEW.

An expedited review shall be conducted within seventy-two hours if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

Sec. 13. NEW SECTION. 514J.9 FUNDING.

All reasonable fees and costs of the independent review entity in conducting an external review shall be paid by the carrier or organized delivery system.

Sec. 14. NEW SECTION. 514J.10 REPORTING.

Each carrier and organized delivery system shall file an annual report with the commissioner containing all of the following:

1. The number of external reviews requested.

2. The number of the external reviews certified by the commissioner.

3. The number of coverage decisions which were upheld by an independent review entity.

The commissioner shall prepare a report by January 31 of each year.

Sec. 15. NEW SECTION. 514J.11 IMMUNITY.

An independent review entity conducting a review under this chapter is not liable for damages arising from determinations made under the review process. This does not apply to any act or omission by the independent review entity made in bad faith or involving gross negligence.

Sec. 16. NEW SECTION. 514J.12 STANDARD OF REVIEW.

Review by the independent review entity is de novo. The standard of review to be used by an independent review entity shall be whether the health care service or treatment denied by the carrier or organized delivery system was medically necessary as defined by the enrollee's evidence of coverage subject to Iowa law and consistent with clinical standards of medical practice. The independent review entity shall take into consideration factors identified in the review record that impact the delivery of or describe the standard of care for the medical service or treatment under review. The medical service or treatment recommended by the enrollee's treating health care provider shall be upheld upon review so long as it is found to be medically necessary and consistent with clinical standards of medical practice.

Sec. 17. NEW SECTION. 514J.13 EFFECT OF EXTERNAL REVIEW DECISION.

The review decision by the independent review entity

conducting the review is binding upon the carrier or organized delivery system. The enrollee or the enrollee's treating health care provider acting on behalf of the enrollee may appeal the review decision by the independent review entity conducting the review by filing a petition for judicial review either in Polk county district court or in the district court in the county in which the enrollee resides. The petition for judicial review must be filed within fifteen business days after the issuance of the review decision. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal. The carrier or organized delivery system shall follow and comply with the review decision of the independent review entity conducting the review, or the decision of the court on appeal. The carrier or organized delivery system and the enrollee's treating health care provider shall not be subject to any penalties, sanctions, or award of damages for following and complying in good faith with the review decision of the independent review entity conducting the review or decision of the court on appeal. The enrollee or the enrollee's treating health care provider may bring an action in Polk county district court or in the district court in the county in which the enrollee resides to enforce the review decision of the independent review entity conducting the review or the decision of the court on appeal.

Sec. 18. NEW SECTION. 514J.14 RULES.

The commissioner shall adopt rules pursuant to chapter 17A as are necessary to administer this chapter.

EXPLANATION

This bill creates several new Code sections and a new Code chapter relating to the provision of and evaluation of health care services provided to covered individuals in this state.

The bill creates new Code section 514C.14 which provides for continuation of coverage by a carrier, organized delivery system, or plan established pursuant to chapter 509A for

public employees, of costs associated with a health care provider providing continued care to a covered person who is in the second or third trimester of pregnancy. Such coverage is to continue through postpartum care if the carrier, organized delivery system, or plan terminates its contract with the health care provider. The section also provides that a covered person who makes a change in health plans involuntarily may request that the new health plan cover services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Such coverage shall continue through postpartum care related to the child birth and delivery. A carrier, organized delivery system, or chapter 509A plan which terminates the contract of a participating health care provider for cause is not liable for health care services provided to a covered person following the date of termination.

New Code section 514C.15 is created and provides that a carrier or an organized delivery system, or a plan established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, discussing treatment options with a covered individual, notwithstanding the carrier's, organized delivery system's, or plan's position on such treatment option; or advocating on behalf of a covered individual within a review or grievance process established by the carrier, organized delivery system, or chapter 509A plan, or established by a person contracting with the carrier, organized delivery system, or chapter 509A plan.

New Code section 514C.16 is created and provides that a carrier, an organized delivery system, or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for medically necessary emergency services provided to a

covered individual, including services furnished outside the network. Coverage for emergency services is subject to the terms and conditions of the health care benefit plan or contract. The bill provides that prior authorization for emergency services shall not be required and that all services necessary to evaluate and stabilize the covered individual shall be considered covered emergency services.

New Code section 514F.4 is created and provides that a third-party payor which provides health care benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner. The bill provides that new Code section 514F.4 does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under Title XVIII of the federal Social Security Act, the civilian health and medical program of the uniformed services, or any other federal employee health benefit plan.

The bill creates new Code chapter 514J relating to the appeal by an individual receiving health care coverage who is denied covered health care services or treatment.

New Code section 514J.1 states the intent of the general assembly to provide a mechanism for the appeal of a denial of coverage based on medical necessity.

New Code section 514J.2 establishes definitions for key terms used in the chapter.

New Code section 514J.3 provides that the chapter does not apply to a hospital confinement indemnity, credit, dental vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile

medical payment insurance.

New Code section 514J.4 provides that an enrollee or the enrollee's treating health care provider may file a written request for external review of a denial of coverage. The request must be filed within 60 days of the receipt of the denial of coverage. A $25 filing fee is provided for, which may be waived by the commissioner for good cause. The filing fee is to be refunded to the enrollee if the enrollee prevails in the external review process.

New Code section 514J.5 establishes eligibility requirements for the certification of the external review request. The bill provides that the commissioner shall have two business days from receipt of the request for external review to certify the request. The commissioner must certify the request if the enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed, the enrollee has been denied coverage based on a determination that the proposed service or treatment does not meet the definition of medical necessity as defined in the enrollee's evidence of coverage, the enrollee or the enrollee's treatment provider has exhausted all internal appeal mechanisms, and the written request for external review was filed within 60 days of receipt of the coverage denial.

New Code section 514J.6 provides that independent review entities include medical peer review organizations and nationally recognized health experts or institutions as certified by the commissioner.

New Code section 514J.7 establishes an external review process. The bill provides that the carrier or organized delivery system, within three business days of receipt of an eligible request for external review, shall select an independent review entity from the list certified by the commissioner, notify the enrollee and the enrollee's treatment provider of the independent review entity and of the enrollee's and the enrollee's treatment provider's right to

submit additional information, provide any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment; and provide any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided. The independent review entity is to submit its decision as soon as possible.

New Code section 514J.8 provides for an expedited review to be conducted within 72 hours if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

New Code section 514J.9 provides that all reasonable fees and costs of the independent review entity are to be paid by the carrier or organized delivery system.

New Code section 514J.10 directs each carrier and organized delivery system to file with the commissioner an annual report including the number of external reviews requested, the number of external review requests certified by the commissioner, and the number of coverage decisions which were upheld by an independent review entity.

New Code section 514J.11 provides that an independent review entity is not liable for damages arising from a determination under the review process unless the entity acted in bad faith or the determination involved gross negligence.

New Code section 514J.12 provides that the standard of review to be used by an independent review entity is whether the health care service or treatment denied by the carrier or organized delivery system was medically necessary as evidenced by the enrollee's evidence of coverage, and consistent with clinical standards of medical practice.

New Code section 514J.13 establishes the effect of the external review decision. The bill provides that the review decision by the independent review entity conducting the

review is binding upon the carrier and the organized delivery system and that the findings of fact by the independent review entity are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts. The bill provides that the enrollee or the enrollee's treating health care provider may appeal the independent review entity's decision in Polk county district court or the district court in the county in which the enrollee resides. A petition for judicial review must be filed within 15 business days after issuance of the review decision.

New Code section 514J.14 directs the commissioner to adopt rules necessary to implement new Code chapter 514J.

SENATE FILE 276

S-3053

Amend Senate File 276 as follows:

1. Page 3, by inserting after line 10 the following:

"Sec. ___. NEW SECTION. 514C.17 CONTINUITY OF CARE -- TERMINAL ILLNESS.

1. Except as provided under subsection 2 or 3, if a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, terminates its contract with a participating health care provider, a covered individual who is undergoing a specified course of treatment for a terminal illness or a related condition, with the recommendation of the covered individual's treating physician licensed under chapter 148, 150, or 150A, may continue to receive coverage for treatment received from the covered individual's physician for the terminal illness or a related condition, for a period of up to ninety days. Payment for covered benefits and benefit level shall be according to the terms and conditions of the contract.

2. A covered person who makes a change in health plans involuntarily may request that the new health plan cover services of the covered person's treating physician licensed under chapter 148, 150, or 150A, who is not a participating health care provider under the new health plan, if the covered person is undergoing a specified course of treatment for a terminal illness or a related condition. Continuation of such coverage shall continue for up to ninety days. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

3. Notwithstanding subsections 1 and 2, a carrier, organized delivery system, or plan established under chapter 509A which terminates the contract of a participating health care provider for cause shall not be required to cover health care services provided by the health care provider to a covered person following the date of termination."

2. Page 4, by inserting after line 23 the following:

"Sec. ___. NEW SECTION. 514F.5 EXPERIMENTAL TREATMENT REVIEW.

1. A carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, that limits coverage for experimental medical treatment, drugs, or devices, shall develop and implement a procedure to

S-3053
Page 2

evaluate experimental medical treatments and shall submit a description of the procedure to the division of insurance. The procedure shall be in writing and must describe the process used to determine whether the carrier, organized delivery system, or chapter 509A plan will provide coverage for new medical technologies and new uses of existing technologies. The procedure, at a minimum, shall require a review of information from appropriate government regulatory agencies and published scientific literature concerning new medical technologies, new uses of existing technologies, and the use of external experts in making decisions. A carrier, organized delivery system, or chapter 509A plan shall include appropriately licensed or qualified professionals in the evaluation process. The procedure shall provide a process for a person covered under a plan or contract to request a review of a denial of coverage because the proposed treatment is experimental. A review of a particular treatment need not be reviewed more than once a year.

2. A carrier, organized delivery system, or chapter 509A plan that limits coverage for experimental treatment, drugs, or devices shall clearly disclose such limitations in a contract, policy, or certificate of coverage."

3. By renumbering as necessary.

By JOHN REDWINE

S-3053 FILED MARCH 10, 1999
ADOPTED

(p. 539)

SENATE FILE 276

S-3050

Amend Senate File 276 as follows:

1. Page 11, by inserting after line 28 the following:

"Sec. ___. NEW SECTION. 514K.1 HEALTH CARE PLAN DISCLOSURES -- INFORMATION TO ENROLLEES.

1. A health maintenance organization, an organized delivery system, or an insurer using a preferred provider arrangement shall provide to each of its enrollees at the time of enrollment, and shall make available to each prospective enrollee upon request, written information as required by rules adopted by the commissioner and the director of public health. The information required by rule shall include, but not be limited to, all of the following:

a. A description of the plan's benefits and exclusions.

b. Enrollee cost-sharing requirements.

c. A list of participating providers.

d. Disclosure of the existence of any drug formularies used and, upon request, information about the specific drugs included in the formulary.

e. An explanation for accessing emergency care services.

f. Any policies addressing investigational or experimental treatments.

g. The methodologies used to compensate providers.

h. Performance measures as determined by the commissioner and the director.

i. Information on how to access internal and external grievance procedures.

2. The commissioner and the director shall annually publish a consumer guide providing a comparison by plan on performance measures, network composition, and other key information to enable consumers to better understand plan differences."

2. By renumbering as necessary.

By ELAINE SZYMONIAK
JOHN REDWINE

S-3050 FILED MARCH 9, 1999

adopted
3/10/99

(P. 539)

MARCH 10, 1999

SENATE FILE 276

S-3048

Amend Senate File 276 as follows:

1. Page 5, line 26, by inserting after the word "enrollee" the following: "in writing".

2. Page 6, line 31, by inserting after the word "commissioner" the following: ", within two business days,".

3. Page 7, line 4, by inserting after the word "medical" the following: "and health care".

4. Page 7, line 5, by striking the words "both of" and inserting the following: ", but are not limited to,".

5. Page 7, line 18, by inserting after the word "board." the following: "A health care professional who is not a physician shall also hold a current certification by such professional's respective specialty board."

6. Page 9, line 29, by inserting after the word "hours" the following: "of notification to the commissioner".

By JOHN REDWINE

adopted 3/10/99 (p.539)

S-3048 FILED MARCH 9, 1999

SENATE FILE 276

S-3049

Amend Senate File 276 as follows:

1. Page 11, by inserting after line 28 the following:

"Sec. ___. EFFECTIVE DATE. Sections 5 through 18 of this Act, which create new chapter 514J, take effect January 1, 2000."

2. Title page, line 5, by inserting after the word "process" the following: ", and providing an effective date".

3. By renumbering as necessary.

By JOHN REDWINE

S-3049 FILED MARCH 9, 1999

adopted 3/10/99 (p.539)

SENATE FILE 276

S-3052

Amend Senate File 276 as follows:

1. Page 2, line 25, by striking the words "the covered individual" and inserting the following: "an emergency medical condition".

By JOHN REDWINE

S-3052 FILED MARCH 10, 1999

ADOPTED (p. 539)

SENATE FILE 276

S-3035

Amend Senate File 276 as follows:

1. Page 5, line 33, by inserting after the word "decision." the following: "However, the enrollee's treating health care provider does not have a duty to request external review."

By JOHN REDWINE

S-3035 FILED MARCH 3, 1999

adopted 3/10/99 (P 539)

SENATE FILE 276

S-3039

Amend Senate File 276 as follows:

1. Page 2, line 18, by striking the words "medically necessary".

2. Page 2, line 30, by striking the words ", the onset of which is sudden,".

By JOHN REDWINE

S-3039 FILED MARCH 3, 1999

adopted 3/10/99 (P. 539)

3-12-99 H-Commerce & Reg.

SENATE FILE 276

BY COMMITTEE ON HUMAN RESOURCES

H - 3/19/99 Do Pass

(SUCCESSOR TO SSB 1161)

(AS AMENDED AND PASSED BY THE SENATE MARCH 10, 1999)

_____ - New Language by the Senate

* - Language Stricken by the Senate

(P. 1272)

Passed Senate, Date 4/14/99 Passed House, Date 4/14/99 (P. 1272)

Vote: Ayes 97 Nays 1 Vote: Ayes 97 Nays 1

Approved April 21, 1999

A BILL FOR

An Act relating to health care service and treatment coverage by providing for continuity of care, discussion and advocacy of treatment options, coverage of emergency room services, utilization review requirements, and an external review process, and providing an effective date.

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

S.F. 276

SF 276

mj/cc/26

S.F. 276 H.F. _____

Section 1. NEW SECTION. 514C.14 CONTINUITY OF CARE -- PREGNANCY.

1. Except as provided under subsection 2 or 3, a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, which terminates its contract with a participating health care provider, shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

2. A covered person who makes an involuntary change in health plans may request that the new health plan cover the services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Continuation of such coverage shall continue through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit level shall be according to the terms and conditions of the new health plan contract.

3. A carrier, organized delivery system, or plan established under chapter 509A, which terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

Sec. 2. NEW SECTION. 514C.15 TREATMENT OPTIONS.

A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan

established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, doing either of the following:

1. Discussing treatment options with a covered individual, notwithstanding the carrier's, organized delivery system's, or plan's position on such treatment option.

2. Advocating on behalf of a covered individual within a review or grievance process established by the carrier, organized delivery system, or chapter 509A plan, or established by a person contracting with the carrier, organized delivery system, or chapter 509A plan.

Sec. 3. NEW SECTION. 514C.16 EMERGENCY ROOM SERVICES.

1. A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. Coverage for emergency services is subject to the terms and conditions of the health benefit plan or contract.

2. Prior authorization for emergency services shall not be required. All services necessary to evaluate and stabilize an emergency medical condition shall be considered covered emergency services.

3. For purposes of this section, unless the context otherwise requires:

a. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

(1) Placing the health of the individual, or with respect

to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(2) Serious impairment to bodily function.

(3) Serious dysfunction of a bodily organ or part.

b. "Emergency services" means covered inpatient and outpatient health care services that are furnished by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

Sec. 4. NEW SECTION. 514C.17 CONTINUITY OF CARE -- TERMINAL ILLNESS.

1. Except as provided under subsection 2 or 3, if a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, terminates its contract with a participating health care provider, a covered individual who is undergoing a specified course of treatment for a terminal illness or a related condition, with the recommendation of the covered individual's treating physician licensed under chapter 148, 150, or 150A, may continue to receive coverage for treatment received from the covered individual's physician for the terminal illness or a related condition, for a period of up to ninety days. Payment for covered benefits and benefit level shall be according to the terms and conditions of the contract.

2. A covered person who makes a change in health plans involuntarily may request that the new health plan cover services of the covered person's treating physician licensed under chapter 148, 150, or 150A, who is not a participating health care provider under the new health plan, if the covered person is undergoing a specified course of treatment for a terminal illness or a related condition. Continuation of such coverage shall continue for up to ninety days. Payment for covered benefits and benefit levels [illegible] according to the

terms and conditions of the contract.

3. Notwithstanding subsections 1 and 2, a carrier, organized delivery system, or plan established under chapter 509A which terminates the contract of a participating health care provider for cause shall not be required to cover health care services provided by the health care provider to a covered person following the date of termination.

Sec. 5. NEW SECTION. 514F.4 UTILIZATION REVIEW REQUIREMENTS.

1. A third-party payor which provides health benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner.

2. This section does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under any of the following:

a. Title XVIII of the federal Social Security Act.

b. The civilian health and medical program of the uniformed services.

c. Any other federal employee health benefit plan.

3. For purposes of this section, unless the context otherwise requires:

a. "Third-party payor" means:

(1) An insurer subject to chapter 509 or 514A.

(2) A health service corporation subject to chapter 514.

(3) A health maintenance organization subject to chapter 514B.

(4) A preferred provider arrangement.

(5) A multiple employer welfare arrangement.

(6) A third-party administrator.

(7) A fraternal benefit society.

(8) A plan established pursuant to chapter 509A for public employees.

(9) Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

b. "Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. Such evaluation does not apply to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

Sec. 6. NEW SECTION. 514F.5 EXPERIMENTAL TREATMENT REVIEW.

1. A carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, that limits coverage for experimental medical treatment, drugs, or devices, shall develop and implement a procedure to evaluate experimental medical treatments and shall submit a description of the procedure to the division of insurance. The procedure shall be in writing and must describe the process used to determine whether the carrier, organized delivery system, or chapter 509A plan will provide coverage for new medical technologies and new uses of existing technologies. The procedure, at a minimum, shall require a review of information from appropriate government regulatory

agencies and published scientific literature concerning new medical technologies, new uses of existing technologies, and the use of external experts in making decisions. A carrier, organized delivery system, or chapter 509A plan shall include appropriately licensed or qualified professionals in the evaluation process. The procedure shall provide a process for a person covered under a plan or contract to request a review of a denial of coverage because the proposed treatment is experimental. A review of a particular treatment need not be reviewed more than once a year.

2. A carrier, organized delivery system, or chapter 509A plan that limits coverage for experimental treatment, drugs, or devices shall clearly disclose such limitations in a contract, policy, or certificate of coverage.

Sec. 7. NEW SECTION. 514J.1 LEGISLATIVE INTENT.

It is the intent of the general assembly to provide a mechanism for the appeal of a denial of coverage based on medical necessity.

Sec. 8. NEW SECTION. 514J.2 DEFINITIONS.

1. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services.

2. "Commissioner" means the commissioner of insurance.

3. "Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

4. "Enrollee" means an individual, or an eligible

dependent, who receives health care benefits coverage through a carrier or organized delivery system.

5. "Independent review entity" means a reviewer or entity, certified by the commissioner pursuant to section 514J.6.

6. "Organized delivery system" means an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health, and performing utilization review.

Sec. 9. NEW SECTION. 514J.3 EXCLUSIONS.

This chapter does not apply to a hospital confinement indemnity, credit, dental, vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical payment insurance.

Sec. 10. NEW SECTION. 514J.4 EXTERNAL REVIEW REQUEST.

1. At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

2. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may file a written request for external review of the coverage decision with the commissioner. The request must be filed within sixty days of the receipt of the coverage decision. However, the enrollee's treating health care provider does not have a duty to request external review.

3. The request for external review must be accompanied by a twenty-five dollar filing fee. The commissioner may waive the filing fee for good cause. The filing fee shall be refunded if the enrollee prevails in the external review process.

Sec. 11. NEW SECTION. 514J.5 ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if the

following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed service or treatment does not meet the definition of medical necessity as defined in the enrollee's evidence of coverage.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's contract.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the decision.

3. The carrier or organized delivery system has three business days to contest the eligibility of the request for external review with the commissioner. If the commissioner finds that the request for external review is not eligible for full review, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for full review.

Sec. 12. NEW SECTION. 514J.6 INDEPENDENT REVIEW ENTITIES.

1. The commissioner shall solicit names of independent review entities from carriers, organized delivery systems, and medical and health care professional associations.

2. Independent review entities include, but are not limited to, the following:

a. Medical peer review organizations.

b. Nationally recognized health experts or institutions.

3. The commissioner shall certify independent review entities to conduct external reviews. An individual who conducts an external review as or as part of a certified independent review entity shall be a health care professional and satisfy both of the following requirements:

a. Hold a current unrestricted license to practice medicine or a health profession in the United States. A health care professional who is a physician shall also hold a current certification by a recognized American medical specialty board. A health care professional who is not a physician shall also hold a current certification by such professional's respective specialty board.

b. Have no history of disciplinary actions or sanctions, including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

4. Each independent review entity shall have a quality assurance program on file with the commissioner that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

5. The commissioner shall certify independent review entities every two years.

Sec. 13. NEW SECTION. 514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition

under review. The independent review entity shall not be a subsidiary of, or owned or controlled by the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and phone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the independent review entity selected by the carrier or organized delivery system by notifying the commissioner within three business days of the receipt of notice from the carrier or organized delivery system. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection, to select an independent review entity, and to provide the notice required by this subsection to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

c. Provide any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

d. Provide any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

2. The enrollee, or the enrollee's treating health care provider, may provide any information submitted in support of the internal review, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the final notification of the independent review entity's selection to provide this information.

Failure to provide the information within ten days shall be ground for rejection of consideration of the information by the independent review entity.

3. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 1. The requested information shall be submitted within five days. Failure to provide the information shall be ground for rejection of consideration of the information by the independent review entity. The carrier or organized delivery system shall be notified of this request.

4. The independent review entity shall submit its decision as soon as possible, but not more than thirty days from the independent review entity's receipt of the request for review. The decision shall be mailed to the enrollee, or the treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system.

5. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 14. NEW SECTION. 514J.8 EXPEDITED REVIEW.

An expedited review shall be conducted within seventy-two hours of notification to the commissioner if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

Sec. 15. NEW SECTION. 514J.9 FUNDING.

All reasonable fees and costs of the independent review entity in conducting an external review shall be paid by the carrier or organized delivery system.

Sec. 16. NEW SECTION. 514J.10 REPORTING.

Each carrier and organized delivery system shall file an annual report with the commissioner containing all of the following:

1. The number of external reviews requested.

2. The number of the external reviews certified by the commissioner.

3. The number of coverage decisions which were upheld by an independent review entity.

The commissioner shall prepare a report by January 31 of each year.

Sec. 17. NEW SECTION. 514J.11 IMMUNITY.

An independent review entity conducting a review under this chapter is not liable for damages arising from determinations made under the review process. This does not apply to any act or omission by the independent review entity made in bad faith or involving gross negligence.

Sec. 18. NEW SECTION. 514J.12 STANDARD OF REVIEW.

Review by the independent review entity is de novo. The standard of review to be used by an independent review entity shall be whether the health care service or treatment denied by the carrier or organized delivery system was medically necessary as defined by the enrollee's evidence of coverage subject to Iowa law and consistent with clinical standards of medical practice. The independent review entity shall take into consideration factors identified in the review record that impact the delivery of or describe the standard of care for the medical service or treatment under review. The medical service or treatment recommended by the enrollee's treating health care provider shall be upheld upon review so long as it is found to be medically necessary and consistent with clinical standards of medical practice.

Sec. 19. NEW SECTION. 514J.13 EFFECT OF EXTERNAL REVIEW DECISION.

The review decision by the independent review entity conducting the review is binding upon the carrier or organized delivery system. The enrollee or the enrollee's treating health care provider acting on behalf of the enrollee may appeal the review decision by the independent review entity

conducting the review by filing a petition for judicial review either in Polk county district court or in the district court in the county in which the enrollee resides. The petition for judicial review must be filed within fifteen business days after the issuance of the review decision. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal. The carrier or organized delivery system shall follow and comply with the review decision of the independent review entity conducting the review, or the decision of the court on appeal. The carrier or organized delivery system and the enrollee's treating health care provider shall not be subject to any penalties, sanctions, or award of damages for following and complying in good faith with the review decision of the independent review entity conducting the review or decision of the court on appeal. The enrollee or the enrollee's treating health care provider may bring an action in Polk county district court or in the district court in the county in which the enrollee resides to enforce the review decision of the independent review entity conducting the review or the decision of the court on appeal.

Sec. 20. NEW SECTION. 514J.14 RULES.

The commissioner shall adopt rules pursuant to chapter 17A as are necessary to administer this chapter.

Sec. 21. NEW SECTION. 514K.1 HEALTH CARE PLAN DISCLOSURES -- INFORMATION TO ENROLLEES.

1. A health maintenance organization, an organized delivery system, or an insurer using a preferred provider arrangement shall provide to each of its enrollees at the time of enrollment, and shall make available to each prospective enrollee upon request, written information as required by rules adopted by the commissioner and the director of public health. The information required by rule shall include, but not be limited to, all of the following:

a. A description of the plan's benefits and exclusions.

b. Enrollee cost-sharing requirements.

c. A list of participating providers.

d. Disclosure of the existence of any drug formularies used and, upon request, information about the specific drugs included in the formulary.

e. An explanation for accessing emergency care services.

f. Any policies addressing investigational or experimental treatments.

g. The methodologies used to compensate providers.

h. Performance measures as determined by the commissioner and the director.

i. Information on how to access internal and external grievance procedures.

2. The commissioner and the director shall annually publish a consumer guide providing a comparison by plan on performance measures, network composition, and other key information to enable consumers to better understand plan differences.

Sec. 22. EFFECTIVE DATE. Sections 7 through 20 of this Act, which create new chapter 514J, take effect January 1, 2000.

SENATE FILE 276

H-1530

Amend the amendment, H-1185, to Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, line 20, by striking the words "shall not have ever" and inserting the following: ", within the immediately preceding ten years, shall not have".
2. Page 1, line 22, by inserting after the word "year" the following: "within such ten-year period".
3. Page 2, line 7, by striking the word "ten-day" and inserting the following: "five-day".

By CHAPMAN of Linn

H-1530 FILED APRIL 12, 1999

adopted 4/14/99 (P 1265)

SENATE FILE 276

H-1532

Amend the amendment, H-1180, to Senate file 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by inserting after line 12 the following:

"___. Page 12, by striking lines 19 and 20 and inserting the following: "necessary and consistent with clinical standards of"."

By OSTERHAUS of Jackson

H-1532 FILED APRIL 12, 1999

adopted 4/13/99 (P. 1250)

SENATE FILE 276

H-1529

Amend the amendment, H-1185, to Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by striking lines 3 through 11.
2. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1529 FILED APRIL 12, 1999

adopted 4-14-99 (P 1264)

SENATE FILE 276

H-1561

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 4, by inserting after line 7 the following:

"Sec. ___. NEW SECTION. 514C.19 MANDATED COVERAGE FOR DENTAL CARE -- ANESTHESIA AND CERTAIN HOSPITAL CHARGES.

1. Notwithstanding section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for anesthesia and hospital charges related to the provision of dental care services provided to any of the following covered individuals:

a. A child under five years of age.

b. An individual who is severely disabled.

c. An individual who has a medical condition that requires hospitalization or general anesthesia for delivery of the dental care services.

2. A policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for general anesthesia and treatment rendered by a dentist for conditions covered under such policy or contract, whether the services are provided in a hospital or a dental office.

3. Prior authorization of hospitalization for dental care procedures may be required in the same manner that prior authorization is required for hospitalization for other coverage under the contract or policy.

4. This section applies to the following contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. An organized delivery system licensed by the director of public health."

2. Title page, line 2, by inserting after the word "care," the following: "anesthesia and certain hospital charges associated with dental care services,".

3. By renumbering as necessary.

By FOEGE of Linn
RAECKER of Polk
HUSER of Polk

Not Germane 4/13/99 (p. 1247)

H-1561 FILED APRIL 13, 1999

SENATE FILE 276

H-1577

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by inserting before line 1 the following:

"Section 1. Section 509.3, subsection 6, Code 1999, is amended by striking the subsection.

Sec. ___. Section 514.7, unnumbered paragraph 3, Code 1999, is amended by striking the unnumbered paragraph.

Sec. ___. Section 514B.1, subsection 5, paragraph c, Code 1999, is amended by striking the paragraph."

2. Page 4, by inserting after line 7 the following:

"Sec. ___. NEW SECTION. 514C.20 DIABETES COVERAGE.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for the cost associated with equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a physician licensed under chapter 148, 150, or 150A. Coverage benefits shall include coverage for the cost associated with all of the following:

a. Blood glucose meter and glucose strips for home monitoring.

b. Payment for diabetes self-management training and education only under all of the following conditions:

(1) The physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition.

(2) The diabetic self-management training and education program is certified by the Iowa department of public health. The department shall consult with the American diabetes association, Iowa affiliate, in developing the standards for certification of diabetes education programs as follows:

(a) Initial training shall cover up to ten hours of initial outpatient diabetes self-management training within a continuous twelve-month period for each individual that meets any of the following conditions:

(i) A new onset of diabetes.

(ii) Poor glycemic control as evidenced by a glycosylated hemoglobin of nine and five-tenths or more in the ninety days before attending the training.

(iii) A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.

(iv) High risk for complications based on poor glycemic control; documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which the individual needed third-party assistance for either emergency room visits or hospitalization.

(v) High risk based on documented complications of a lack of feeling in the foot or other foot complications such as foot ulcer or amputation, pre-proliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine.

(b) An individual who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.

2. a. This section applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to chapter 509A for public employees.

(6) An organized delivery system licensed by the director of public health.

b. This chapter shall not apply to accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital coverage, medical and surgical coverage, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance."

H-1577
Page 3
1 3. Title page, line 2, by inserting after the
2 word "care," the following: "diabetes coverage,".
3 4. By renumbering as necessary.

By MASCHER of Johnson
BELL of Jasper
FOEGE of Linn

H-1577 FILED APRIL 13, 1999
DEFERRED
W/D 4/14/99
(P 1272)

SENATE FILE 276

H-1585
1 Amend Senate File 276, as amended, passed, and
2 reprinted by the Senate, as follows:
3 1. Page 4, by inserting after line 7 the
4 following:
5 "Sec. ___. NEW SECTION. 514C.18 PHARMACEUTICAL
6 SERVICES.
7 1. A policy or contract providing for third-party
8 payment or prepayment for pharmaceutical services
9 shall not discriminate with respect to reimbursement
10 under the policy or contract against a health care
11 provider who is authorized to provide pharmaceutical
12 services and who is providing such services within the
13 health care provider's scope of practice.
14 2. This section applies to the following classes
15 of third-party payor policies or contracts delivered,
16 issued for delivery, continued, or renewed in this
17 state on or after July 1, 1999:
18 a. Individual or group accident and sickness
19 insurance providing coverage on an expense-incurred
20 basis.
21 b. An individual or group hospital or medical
22 service contract issued pursuant to chapter 509, 514,
23 or 514A.
24 c. An individual or group health maintenance
25 organization contract regulated under chapter 514B.
26 d. An individual or group Medicare supplemental
27 policy, unless coverage pursuant to such policy is
28 preempted by federal law.
29 e. An organized delivery system licensed by the
30 director of public health.
31 f. Any other entity engaged in the business of
32 insurance, risk transfer, or risk retention, which is
33 subject to the jurisdiction of the commissioner."
34 2. Title page, line 3, by inserting after the
35 word "services," the following: "coverage of
36 pharmaceutical services,".
37 3. By renumbering as necessary.

By MURPHY of Dubuque

H-1585 FILED APRIL 13, 1999
LOST
(P. 1248)

SENATE FILE 276

H-1583

Amend the amendment, H-1183, to Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by inserting after line 2 the following:

"___. Page 1, by inserting before line 1 the following:

"Section 1. Section 509.3, subsection 6, Code 1999, is amended by striking the subsection.

Sec. ___. Section 514.7, unnumbered paragraph 3, Code 1999, is amended by striking the unnumbered paragraph.

Sec. ___. Section 514B.1, subsection 5, paragraph c, Code 1999, is amended by striking the paragraph."

2. Page 2, by striking line 13 and inserting the following: "covered individual.

Sec. ___. NEW SECTION. 514C.19 MANDATED COVERAGE FOR DENTAL CARE -- ANESTHESIA AND CERTAIN HOSPITAL CHARGES.

1. Notwithstanding section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for anesthesia and hospital charges related to the provision of dental care services provided to any of the following covered individuals:

a. A child under five years of age.

b. An individual who is severely disabled.

c. An individual who has a medical condition that requires hospitalization or general anesthesia for delivery of the dental care services.

2. A policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for general anesthesia and treatment rendered by a dentist for conditions covered under such policy or contract, whether the services are provided in a hospital or a dental office.

3. Prior authorization of hospitalization for dental care procedures may be required in the same manner that prior authorization is required for hospitalization for other coverage under the contract or policy.

4. This section applies to the following contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

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c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. An organized delivery system licensed by the director of public health.

Sec. ___. NEW SECTION. 514C.20 DIABETES COVERAGE.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for the cost associated with equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a physician licensed under chapter 148, 150, or 150A. Coverage benefits shall include coverage for the cost associated with all of the following:

a. Blood glucose meter and glucose strips for home monitoring.

b. Payment for diabetes self-management training and education only under all of the following conditions:

(1) The physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition.

(2) The diabetic self-management training and education program is certified by the Iowa department of public health. The department shall consult with the American diabetes association, Iowa affiliate, in developing the standards for certification of diabetes education programs as follows:

(a) Initial training shall cover up to ten hours of initial outpatient diabetes self-management training within a continuous twelve-month period for each individual that meets any of the following conditions:

(i) A new onset of diabetes.

(ii) Poor glycemic control as evidenced by a glycosylated hemoglobin of nine and five-tenths or more in the ninety days before attending the training.

(iii) A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.

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Page 3

(iv) High risk for complications based on poor glycemic control; documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which the individual needed third-party assistance for either emergency room visits or hospitalization.

(v) High risk based on documented complications of a lack of feeling in the foot or other foot complications such as foot ulcer or amputation, pre-proliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine.

(b) An individual who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.

2. a. This section applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to chapter 509A for public employees.

(6) An organized delivery system licensed by the director of public health.

b. This chapter shall not apply to accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital coverage, medical and surgical coverage, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.""

3. Page 2, line 16, by inserting after the word "coverage," the following: "anesthesia and certain hospital charges associated with dental care services, diabetes coverage,".

4. By renumbering as necessary.

By JOCHUM of Dubuque

H-1583 FILED APRIL 13, 1999
ADOPTED

(P. 1242)

SENATE FILE 276

H-1528

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by inserting before line 1 the following:

"Section 1. Section 507B.4, Code 1999, is amended by adding the following new subsection:

NEW SUBSECTION. 9A. UNAUTHORIZED DISCHARGE FROM HOSPITAL. Communicating to a covered individual who is hospitalized, either directly or through an intermediary, that the covered individual's hospital treatment or hospital stay is completed, without first providing the covered individual with written treatment status confirmation endorsed by the covered individual's attending health care provider."

2. By renumbering as necessary.

By CONNORS of Polk

H-1528 FILED APRIL 8, 1999

Not German
4/13/99 (P.1237)

SENATE FILE 276

H-1523

Amend the amendment, H-1285, to Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, line 33, by striking the figure "1998" and inserting the following: "1999".

By FREVERT of Palo Alto

H-1523 FILED APRIL 8, 1999

adopted
4/13/99 (P.1245)

SENATE FILE 276

H-1524

Amend the amendment, H-1185, to Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, line 5, by striking the words ", if any,".
2. Page 1, by striking lines 7 through 11.
3. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1524 FILED APRIL 8, 1999

0/0
4/14/99
(P.1264)

SENATE FILE 276

H-1419

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 9, by striking lines 29 through 31 and inserting the following:

"1. The commissioner, within three business days of receipt of an eligible request for an external review, shall do all of the".

2. Page 10, line 6, by inserting after the word "Notify" the following: "the carrier or organized delivery system,".

3. Page 10, line 10, by inserting after the word "The" the following: "carrier or organized delivery system, the".

4. Page 10, by striking lines 12 through 22 and inserting the following: "independent review entity selected by the commissioner by notifying the commissioner within five business days of the receipt of notice from the commissioner. If the carrier or organized delivery system, the enrollee, or the enrollee's treating health care provider, objects to the independent review entity selected, the objecting party shall have an opportunity to recommend another independent review entity from the list certified by the commissioner within the five-day period for objection. If the parties agree to the independent review entity recommended by the objecting party, that independent review entity shall perform the external review. If the parties fail to agree to the independent review entity recommended by the objecting party, the independent review entity selected by the commissioner under paragraph "a" shall perform the external review. The parties may waive the five-day period for objection if all parties agree to the independent review entity selected by the commissioner and inform the commissioner of their agreement.

1A. The carrier or organized delivery system, within three days after the selection of the independent review entity that will be conducting the external review, shall do both of the following:

a. Provide any information submitted to the carrier or".

5. Page 10, line 27, by striking the letter "d." and inserting the following: "b".

6. Page 10, lines 34 and 35, by striking the words "independent review entity's" and inserting the following: "commissioner's".

By CHAPMAN of Linn

H-1419 FILED APRIL 5, 1999

Lost (P. 1264)
4/14/99

SENATE FILE 276

H-1285

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 4, by inserting after line 7 the following:

"Sec. ___. NEW SECTION. 514C.18 SERVICES PROVIDED BY LICENSED MENTAL HEALTH COUNSELORS AND MARITAL AND FAMILY THERAPISTS.

Notwithstanding section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary mental health services provided by a mental health counselor or a marital and family therapist licensed pursuant to chapters 147 and 154D and performed within the scope of the license of the licensed mental health counselor or marital and family therapist if the policy or contract would pay for the care and treatment if the services were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery under chapter 148 or 150A. The policy or contract shall provide that policyholders and subscribers under the policy or contract may reject the coverage for services which may be provided by a licensed mental health counselor or a marital and family therapist if the coverage is rejected for all providers of similar services. A policy or contract subject to this section shall not impose a practice or supervision restriction which is inconsistent with or more restrictive than the restriction already imposed by law. This section applies to services provided under a policy or contract delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1998, and to an existing policy or contract, on the policy's or contract's anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is later. This section does not apply to policyholders or subscribers eligible for coverage under Title XVIII of the federal Social Security Act or any similar coverage under a state or federal government plan. For the purposes of this section, third-party payment or prepayment includes an individual or group policy of accident or health insurance or individual or group hospital or health care service contract issued pursuant to chapter 509, 514, or 514A, an individual or group health maintenance organization contract issued and regulated under chapter 514B, an organized delivery system contract regulated under rules adopted by the director of public health, or a preferred provider organization contract regulated pursuant to

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chapter 514F. Nothing in this section shall be interpreted to require an individual or group health maintenance organization, an organized delivery system, or a preferred provider organization or arrangement to provide payment or prepayment for services provided by a licensed mental health counselor or licensed marital and family therapist unless the licensed mental health counselor or licensed marital and family therapist has entered into a contract or other agreement to provide services with the individual or group health maintenance organization, the organized delivery system, or the preferred provider organization or arrangement."

2. By renumbering as necessary.

By FREVERT of Palo Alto

H-1285 FILED MARCH 29, 1999

Pat Gerrone
4/13/99

(p. 1245)

SENATE FILE 276

H-1185

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 7, line 18, by inserting after the word "under" the following: "the carrier or organized delivery systems internal review process, if any, and under".

2. Page 7, line 19, by inserting after the word "process." the following: "The carrier or organized delivery system's internal review process shall be completed within fourteen days of a request for internal review."

3. Page 9, by striking lines 29 through 31 and inserting the following:

"1. The commissioner, at the time the commissioner determines that a request is eligible for external review, shall do all of the".

4. Page 10, line 5, by inserting after the word "member." the following: "The independent review entity or an individual who is part of an independent review entity shall not have ever received more than one percent of the entity's or individual's gross annual income for any tax year from the carrier or organized delivery system."

5. Page 10, line 6, by striking the word "and".

6. Page 10, line 7, by inserting after the word "provider," the following: "and the carrier or organized delivery system,".

7. Page 10, by striking lines 8 through 13 and inserting the following: "independent review entity and of the enrollee's, treating health care provider's, and carrier's or organized delivery system's right to submit additional information. The enrollee, the enrollee's treating health care provider acting on behalf of the enrollee, or the carrier or organized delivery system may object to the independent review entity selected by the commissioner by notifying the commissioner within three".

8. Page 10, by striking line 22 and inserting the following:

"1A. The carrier or organized delivery system, within three business days of notification of an independent review, shall do the following:

a. Provide the independent review entity with any information submitted to the carrier or".

9. Page 10, by striking line 27 and inserting the following:

"b. Provide the independent review entity, the enrollee, and enrollee's treating health care provider with any other relevant documents used by the".

10. Page 11, line 3, by inserting after the word

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Page 2
"entity" the following: ", unless good cause can be shown for the failure to provide the information within the ten-day period".
11. Page 11, line 11, by inserting after the word "entity" the following: ", unless good cause can be shown for the failure to provide the information within the ten-day period".
12. Page 11, line 24, by inserting after the word "conducted" the following: ", and a decision submitted,".
13. By renumbering as necessary.

By OSTERHAUS of Jackson
CHAPMAN of Linn

H-1185 FILED MARCH 23, 1999
Lost 4/14/99 (P. 1265)

SENATE FILE 276

H-1191
Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:
1. Page 13, by inserting after line 21 the following:
"Sec. ___. NEW SECTION. 514J.13A CIVIL PENALTY.
The commissioner may impose a civil penalty upon a carrier or organized delivery system not to exceed ten thousand dollars for each occurrence of a denial of coverage to an enrollee if such carrier or organized delivery system is found to be engaging in a pattern of conduct to circumvent the purposes of this chapter. Evidence that a carrier or organized delivery system has lost sixty percent or more of its external appeals under this chapter shall be considered prima facie evidence of an attempt to circumvent the purposes of this chapter."
2. By renumbering as necessary.

By CHAPMAN of Linn

H-1191 FILED MARCH 23, 1999
Lost 4/14/99 (P. 1268)

SENATE FILE 276

H-1183

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 4, by inserting after line 7 the following:

"Sec. ___. NEW SECTION. 514C.18 MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT COVERAGE.

1. a. Notwithstanding section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for mental health and substance abuse conditions based on rates, terms, and conditions which are no more restrictive than the rates, terms, and conditions for coverage benefits provided for other health or medical conditions under the policy or contract.

b. Coverage required under this section includes the following:

(1) For the treatment of mental illness, services provided by a licensed mental health professional, or services provided in a licensed hospital or health facility.

(2) For the treatment of substance abuse or other addictive disorder, services provided by a qualified professional as defined by rule of the Iowa department of public health, a licensed health facility providing a program for the treatment of substance abuse or other addictive disorder approved by the Iowa department of public health, or a licensed substance abuse treatment and rehabilitation facility.

2. This section applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2000:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. An organized delivery system licensed by the director of public health.

f. Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

3. For purposes of this section, unless the

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Page 2

context otherwise requires:

a. "Mental health or substance abuse condition" means a condition or disorder involving mental illness or substance abuse or other addictive disorder which is included in the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

b. "Rates, terms, and conditions" means lifetime payment limits, deductibles, copayments, coinsurance, and any other cost-sharing requirements, out-of-pocket limits, visit limitations, and any other financial component of benefits coverage that affects the covered individual."

2. Title page, line 2, by inserting after the word "care," the following: "mental health and substance abuse treatment coverage,".

3. By renumbering as necessary.

By JOCHUM of Dubuque
BELL of Jasper
MYERS of Johnson
CHAPMAN of Linn
TAYLOR of Linn
O'BRIEN of Boone
MASCHER of Johnson
PARMENTER of Story
KUHN of Floyd
REYNOLDS of Van Buren
HOLVECK of Polk
WITT of Black Hawk
KREIMAN of Davis
MURPHY of Dubuque
WHITEAD of Woodbury
FOEGE of Linn
MUNDIE of Webster
FORD of Polk
STEVENS of Dickinson

H-1183 FILED MARCH 23, 1999

Not Germane
4-13-99
(p. 1242)

SENATE FILE 276

H-1182

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by inserting before line 1 the following:

"Section 1. NEW SECTION. 135.26 HEALTH CARE PROVIDER RECORDS -- DUPLICATION FOR PROVISION TO PATIENT.

1. For the purposes of this section:

a. "Health care provider" means a person licensed to practice medicine and surgery pursuant to chapter 148, physical therapy pursuant to chapter 148A, occupational therapy pursuant to chapter 148B, acupuncture pursuant to chapter 148E, podiatry pursuant to chapter 149, osteopathy pursuant to chapter 150, osteopathic medicine and surgery pursuant to chapter 150A, chiropractic pursuant to chapter 151, nursing pursuant to chapter 152, dietetics pursuant to chapter 152A, respiratory care pursuant to chapter 152B, massage therapy pursuant to chapter 152C, dentistry pursuant to chapter 153, optometry pursuant to chapter 154, psychology pursuant to chapter 154B, social work pursuant to chapter 154C, behavioral science pursuant to chapter 154D, or licensed as a physician assistant pursuant to chapter 148C, a hospital licensed pursuant to chapter 135B, and a health care facility licensed pursuant to chapter 135C.

b. "Health care record" includes but is not limited to evaluations, diagnoses, prognoses, treatment, history, charts, pictures, laboratory reports, X rays, prescriptions, and other technical information used in assessing a patient's condition.

2. Upon the written request of a patient, a health care provider shall allow the patient to inspect and shall provide the patient with a duplicate of the health care record of the patient. The health care provider may charge a fee, as established by rule of the department, for duplication of the record.

3. A health care provider may withhold the record from the patient if the provider reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to harm the patient or another person. If a record is withheld from the patient under this subsection, the health care provider may provide access to the record or a duplicate of the record to the patient's attorney or personal physician upon request of the patient.

4. The department shall adopt rules pursuant to chapter 17A prescribing uniform fees, based upon the

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actual cost of duplication, that a health care provider may charge for duplication of health care records requested by a patient under this section. The rules may provide for an additional fee based upon the actual costs for postage or other means of delivery and may provide for an annual increase based upon the annual rate of inflation for the preceding calendar year as determined by the consumer price index published by the bureau of labor statistics of the United States department of labor."

2. By renumbering as necessary.

By JOCHUM of Dubuque

H-1182 FILED MARCH 23, 1999

Pat Harmon
4/13/99
(p. 1236)

SENATE FILE 276

H-1181

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 6, by striking line 18 and inserting the following: "the provision of medically necessary or appropriate services."

2. Page 6, line 31, by striking the words "medical necessity" and inserting the following: "the provision of medically necessary or appropriate services".

3. Page 7, by inserting after line 4 the following:

"___. "Medically necessary or appropriate" means, with respect to a service or benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice."

4. Page 8, by striking lines 8 and 9 and inserting the following: "of medically necessary or appropriate."

5. Page 12, by striking lines 19 through 20 and inserting the following: "necessary or appropriate and consistent with clinical standards of".

6. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1181 FILED MARCH 23, 1999

Lost
4/13/99
(P. 1249)

SENATE FILE 276

H-1178

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 3, line 5, by striking the word "covered".

By OSTERHAUS of Jackson

H-1178 FILED MARCH 23, 1999

W/D 4/13/99 (p. 1238)

SENATE FILE 276

H-1179

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 2, line 11, by inserting after the word "plan" the following: ", or advocating on behalf of a covered individual as provided in chapter 514J".

By CHAPMAN of Linn

H-1179 FILED MARCH 23, 1999

Lost 4-13-99 (p. 1238)

SENATE FILE 276

H-1180

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 6, by inserting after line 19 the following:

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

2. Page 8, by striking lines 8 and 9 and inserting the following: "of appropriate and medically necessary."

3. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1180 FILED MARCH 23, 1999

Lost 4/13/99 (p. 1251)

SENATE FILE 276

H-1176

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 14, by inserting after line 18 the following:

"Sec. ___. NEW SECTION. 514K.1 TITLE.

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

Sec. ___. NEW SECTION. 514K.2 DEFINITIONS.

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

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

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

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

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

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

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

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

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

carrier.

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

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

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

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

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

Sec. ___. NEW SECTION. 514K.3 THIRD-PARTY PAYOR DUTY TO EXERCISE ORDINARY CARE -- LIABILITY.

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

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

3. It is a defense in an action brought pursuant to this section against a third-party payor that neither the third-party payor, nor an employee, agent, or representative of the third-party payor controlled, influenced, or participated in the health care services treatment decision; or that the third-party payor did not deny or delay payment for any health

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care services prescribed or recommended by a health care provider to the insured or enrollee.

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

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

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

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

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

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

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

2. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1176 FILED MARCH 23, 1999

Lost 4-14-99 (P. 1272)

SENATE FILE 276

H-1177

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, line 5, by inserting after the figure "158," the following: "and licensed by the director of public health".

By CHAPMAN of Linn

H-1177 FILED MARCH 23, 1999

Lost 4/13/99 (P. 1237)

SENATE FILE 276

H-1172

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 13, by inserting after line 21 the following:

"In addition to an action to enforce the review decision, or the decision of the court on appeal, the enrollee shall have a cause of action against the carrier or organized delivery system for any further harm incurred after the rendering of the external review decision or decision of the court on appeal, and caused by any substantial noncompliance with the external review decision or court decision by the carrier or organized delivery system. The carrier or organized delivery system's failure to substantially comply with an external review decision, or decision of the court on appeal, within twenty-four hours of the decision, shall be prima facie evidence of bad faith."

By CHAPMAN of Linn
OSTERHAUS of Jackson

H-1172 FILED MARCH 23, 1999

Lost 4-14-99
(P.1268)

SENATE FILE 276

H-1173

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 11, by inserting after line 22 the following:

"6. An enrollee's treating health care provider may apply for and shall receive reasonable compensation from the carrier or organized delivery system for time spent by the health care provider to supply information in support of an enrollee's request for external review under this chapter."

By OSTERHAUS of Jackson
CHAPMAN of Linn

H-1173 FILED MARCH 23, 1999

(P.1267)
Lost
4/14/99

SENATE FILE 276

H-1170

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by inserting before line 1 the following:

"Section 1. Section 513B.10, subsection 4, paragraph a, subparagraph (2), Code 1999, is amended to read as follows:

(2) The exclusion extends for a period of not more than ~~twelve~~ six months, or ~~eighteen~~ twelve months in the case of a late enrollee, after the enrollment date.

Sec. 2. Section 513B.10, subsection 4, paragraph d, Code 1999, is amended to read as follows:

d. Health insurance coverage may exclude coverage for late enrollees for preexisting conditions for a period not to exceed ~~eighteen~~ twelve months.

Sec. 3. Section 513C.7, subsection 4, paragraph a, Code 1999, is amended to read as follows:

a. The individual basic or standard health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than ~~twelve~~ six months following the effective date of the individual's coverage due to a preexisting condition. A preexisting condition shall not be defined more restrictively than any of the following:

(1) A condition that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the ~~twelve~~ six months immediately preceding the effective date of coverage.

(2) A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the ~~twelve~~ six months immediately preceding the effective date of coverage.

(3) A pregnancy existing on the effective date of coverage."

2. Title page, line 3, by inserting after the word "services," the following: "preexisting condition provisions,".

3. By renumbering as necessary.

By MURPHY of Dubuque

H-1170 FILED MARCH 23, 1999

Lost
4/13/99
(P. 1234)

SENATE FILE 276

H-1171

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 7, by inserting after line 4, the following:

"___. "Medically necessary" means the provision of a service, item, or procedure that will or is reasonably expected to do any of the following:

a. Arrive at a correct diagnosis.

b. Prevent the onset of an illness, condition, or disability.

c. Reduce or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury, or disability.

d. Assist the individual to achieve or maintain optimum functional capacity in performing age-appropriate daily activities.

e. Minimize the deterioration of health status or reduce or prevent suffering or pain.

Input from multiple individual sources including an individual or an individual's family shall be considered in determining what services are medically necessary. The medically necessary services provided, as well as the type of provider and setting, which may include the individual's home, must be appropriate to the specific health needs of the individual. A determination of medically necessary services shall be made on an individual basis only, and not on a class or group basis. Determinations shall take into account the health care practice guidelines and standards that are issued by professionally recognized organizations or governmental bodies."

2. Page 8, by striking lines 8 and 9 and inserting the following: "of medically necessary."

3. Page 12, by striking lines 19 through 20 and inserting the following: "necessary and consistent with clinical standards of".

4. By renumbering as necessary.

By JOCHUM of Dubuque

H-1171 FILED MARCH 23, 1999

Lost 4/13/99 (p. 1252)

SENATE FILE 276

H-1167

Amend Senate File 276, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, by inserting before line 1 the following:

"Section 1. Section 509.3, subsection 6, Code 1999, is amended by striking the subsection.

Sec. ___. Section 514.7, unnumbered paragraph 3, Code 1999, is amended by striking the unnumbered paragraph.

Sec. ___. Section 514B.1, subsection 5, paragraph c, Code 1999, is amended by striking the paragraph."

2. Page 4, by inserting after line 7 the following:

"Sec. ___. NEW SECTION. 514C.18 COMPARABLE COVERAGE FOR MENTAL HEALTH TREATMENT.

1. Notwithstanding section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage benefits for services for clinical disorders related to mental health which shall be on terms and conditions which are comparable to the terms and conditions for coverage benefits provided for other health or medical disorders under the policy or contract.

2. For purposes of this section, clinical disorders related to mental health for which coverage benefits are to be provided under this section are biological brain diseases including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

3. This section applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is

subject to the jurisdiction of the commissioner.

f. An organized delivery system licensed by the director of public health.

Sec. ___. NEW SECTION. 514C.19 MANDATED COVERAGE FOR DENTAL CARE -- ANESTHESIA AND CERTAIN HOSPITAL CHARGES.

1. Notwithstanding section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for anesthesia and hospital charges related to the provision of dental care services provided to any of the following covered individuals:

a. A child under five years of age.

b. An individual who is severely disabled.

c. An individual who has a medical condition that requires hospitalization or general anesthesia for delivery of the dental care services.

2. A policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage for general anesthesia and treatment rendered by a dentist for conditions covered under such policy or contract, whether the services are provided in a hospital or a dental office.

3. Prior authorization of hospitalization for dental care procedures may be required in the same manner that prior authorization is required for hospitalization for other coverage under the contract or policy.

4. This section applies to the following contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. An organized delivery system licensed by the director of public health.

Sec. ___. NEW SECTION. 514C.20 DIABETES COVERAGE.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide coverage

benefits for the cost associated with equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a physician licensed under chapter 148, 150, or 150A. Coverage benefits shall include coverage for the cost associated with all of the following:

a. Blood glucose meter and glucose strips for home monitoring.

b. Payment for diabetes self-management training and education only under all of the following conditions:

(1) The physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition.

(2) The diabetic self-management training and education program is certified by the Iowa department of public health. The department shall consult with the American diabetes association, Iowa affiliate, in developing the standards for certification of diabetes education programs as follows:

(a) Initial training shall cover up to ten hours of initial outpatient diabetes self-management training within a continuous twelve-month period for each individual that meets any of the following conditions:

(i) A new onset of diabetes.

(ii) Poor glycemic control as evidenced by a glycosylated hemoglobin of nine and five-tenths or more in the ninety days before attending the training.

(iii) A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.

(iv) High risk for complications based on poor glycemic control; documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which the individual needed third-party assistance for either emergency room visits or hospitalization.

(v) High risk based on documented complications of a lack of feeling in the foot or other foot complications such as foot ulcer or amputation, pre-proliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine.

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Page 4

(b) An individual who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.

2. a. This section applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1999:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to chapter 509A for public employees.

(6) An organized delivery system licensed by the director of public health.

b. This chapter shall not apply to accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital coverage, medical and surgical coverage, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance."

3. Title page, line 2, by inserting after the word "care," the following: "mental health treatment, anesthesia and certain hospital charges associated with dental care services, diabetes coverage,".

4. By renumbering as necessary.

By GRUNDBERG of Polk
BLODGETT of Cerro Gordo
MARTIN of Scott
BRAUNS of Muscatine
HOUSER of Pottawattamie
RAYHONS of Hancock
CORMACK of Webster
NELSON of Marshall
BODDICKER of Cedar
DAVIS of Wapello
ARNOLD of Lucas
HEATON of Henry

H-1167 FILED MARCH 23, 1999

W/D
4/13/99
(P. 1232)

SENATE FILE 276

AN ACT

RELATING TO HEALTH CARE SERVICE AND TREATMENT COVERAGE BY PROVIDING FOR CONTINUITY OF CARE, DISCUSSION AND ADVOCACY OF TREATMENT OPTIONS, COVERAGE OF EMERGENCY ROOM SERVICES, UTILIZATION REVIEW REQUIREMENTS, AND AN EXTERNAL REVIEW PROCESS, AND PROVIDING AN EFFECTIVE DATE.

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

Section 1. NEW SECTION. 514C.14 CONTINUITY OF CARE -- PREGNANCY.

1. Except as provided under subsection 2 or 3, a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, which terminates its contract with a participating health care provider, shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

2. A covered person who makes an involuntary change in health plans may request that the new health plan cover the services of the covered person's physician specialist who is not a participating health care provider under the new health plan, if the covered person is in the second or third trimester of pregnancy. Continuation of such coverage shall continue through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit level shall be according to the terms and conditions of the new health plan contract.

3. A carrier, organized delivery system, or plan established under chapter 509A, which terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

Sec. 2. NEW SECTION. 514C.15 TREATMENT OPTIONS.

A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, doing either of the following:

1. Discussing treatment options with a covered individual, notwithstanding the carrier's, organized delivery system's, or plan's position on such treatment option.

2. Advocating on behalf of a covered individual within a review or grievance process established by the carrier, organized delivery system, or chapter 509A plan, or established by a person contracting with the carrier, organized delivery system, or chapter 509A plan.

Sec. 3. NEW SECTION. 514C.16 EMERGENCY ROOM SERVICES.

1. A carrier, as defined in section 513B.2; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health; or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. Coverage for emergency services is subject to the terms and conditions of the health benefit plan or contract.

2. Prior authorization for emergency services shall not be required. All services necessary to evaluate and stabilize an emergency medical condition shall be considered covered emergency services.

3. For purposes of this section, unless the context otherwise requires:

a. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(2) Serious impairment to bodily function.

(3) Serious dysfunction of a bodily organ or part.

b. "Emergency services" means covered inpatient and outpatient health care services that are furnished by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition.

Sec. 4. NEW SECTION. 514C.17 CONTINUITY OF CARE -- TERMINAL ILLNESS.

1. Except as provided under subsection 2 or 3, if a carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, terminates its contract with a participating health care provider, a covered individual who is undergoing a specified course of treatment for a terminal illness or a related condition, with the recommendation of the covered individual's treating physician licensed under chapter 148, 150, or 150A, may continue to receive coverage for treatment received from the covered individual's physician for the terminal illness or a related condition, for a period of up to ninety days. Payment for covered benefits and benefit level shall be according to the terms and conditions of the contract.

2. A covered person who makes a change in health plans involuntarily may request that the new health plan cover

services of the covered person's treating physician licensed under chapter 148, 150, or 150A, who is not a participating health care provider under the new health plan, if the covered person is undergoing a specified course of treatment for a terminal illness or a related condition. Continuation of such coverage shall continue for up to ninety days. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

3. Notwithstanding subsections 1 and 2, a carrier, organized delivery system, or plan established under chapter 509A which terminates the contract of a participating health care provider for cause shall not be required to cover health care services provided by the health care provider to a covered person following the date of termination.

Sec. 5. NEW SECTION. 514F.4 UTILIZATION REVIEW REQUIREMENTS.

1. A third-party payor which provides health benefits to a covered individual residing in this state shall not conduct utilization review, either directly or indirectly, under a contract with a third-party who does not meet the requirements established for accreditation by the utilization review accreditation commission, national committee on quality assurance, or another national accreditation entity recognized and approved by the commissioner.

2. This section does not apply to any utilization review performed solely under contract with the federal government for review of patients eligible for services under any of the following:

a. Title XVIII of the federal Social Security Act.

b. The civilian health and medical program of the uniformed services.

c. Any other federal employee health benefit plan.

3. For purposes of this section, unless the context otherwise requires:

a. "Third-party payor" means:

(1) An insurer subject to chapter 509 or 514A.

(2) A health service corporation subject to chapter 514.

(3) A health maintenance organization subject to chapter 514B.

(4) A preferred provider arrangement.

(5) A multiple employer welfare arrangement.

(6) A third-party administrator.

(7) A fraternal benefit society.

(8) A plan established pursuant to chapter 509A for public employees.

(9) Any other benefit program providing payment, reimbursement, or indemnification for health care costs for an enrollee or an enrollee's eligible dependents.

b. "Utilization review" means a program or process by which an evaluation is made of the necessity, appropriateness, and efficiency of the use of health care services, procedures, or facilities given or proposed to be given to an individual within this state. Such evaluation does not apply to requests by an individual or provider for a clarification, guarantee, or statement of an individual's health insurance coverage or benefits provided under a health insurance policy, nor to claims adjudication. Unless it is specifically stated, verification of benefits, preauthorization, or a prospective or concurrent utilization review program or process shall not be construed as a guarantee or statement of insurance coverage or benefits for any individual under a health insurance policy.

Sec. 6. NEW SECTION. 514F.5 EXPERIMENTAL TREATMENT REVIEW.

1. A carrier, as defined in section 513B.2, an organized delivery system, authorized under 1993 Iowa Acts, chapter 158, or a plan established pursuant to chapter 509A for public employees, that limits coverage for experimental medical treatment, drugs, or devices, shall develop and implement a procedure to evaluate experimental medical treatments and shall submit a description of the procedure to the division of insurance. The procedure shall be in writing and must describe the process used to determine whether the carrier, organized delivery system, or chapter 509A plan will provide

coverage for new medical technologies and new uses of existing technologies. The procedure, at a minimum, shall require a review of information from appropriate government regulatory agencies and published scientific literature concerning new medical technologies, new uses of existing technologies, and the use of external experts in making decisions. A carrier, organized delivery system, or chapter 509A plan shall include appropriately licensed or qualified professionals in the evaluation process. The procedure shall provide a process for a person covered under a plan or contract to request a review of a denial of coverage because the proposed treatment is experimental. A review of a particular treatment need not be reviewed more than once a year.

2. A carrier, organized delivery system, or chapter 509A plan that limits coverage for experimental treatment, drugs, or devices shall clearly disclose such limitations in a contract, policy, or certificate of coverage.

Sec. 7. NEW SECTION. 514J.1 LEGISLATIVE INTENT.

It is the intent of the general assembly to provide a mechanism for the appeal of a denial of coverage based on medical necessity.

Sec. 8. NEW SECTION. 514J.2 DEFINITIONS.

1. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services.

2. "Commissioner" means the commissioner of insurance.

3. "Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

4. "Enrollee" means an individual, or an eligible dependent, who receives health care benefits coverage through a carrier or organized delivery system.

5. "Independent review entity" means a reviewer or entity, certified by the commissioner pursuant to section 514J.6.

6. "Organized delivery system" means an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the director of public health, and performing utilization review.

Sec. 9. NEW SECTION. 514J.3 EXCLUSIONS.

This chapter does not apply to a hospital confinement indemnity, credit, dental, vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical payment insurance.

Sec. 10. NEW SECTION. 514J.4 EXTERNAL REVIEW REQUEST.

1. At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

2. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may file a written request for external review of the coverage decision with the commissioner. The request must be filed within sixty days of the receipt of the coverage decision. However, the enrollee's treating health care provider does not have a duty to request external review.

3. The request for external review must be accompanied by a twenty-five dollar filing fee. The commissioner may waive the filing fee for good cause. The filing fee shall be refunded if the enrollee prevails in the external review process.

Sec. 11. NEW SECTION. 514J.5 ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed service or treatment does not meet the definition of medical necessity as defined in the enrollee's evidence of coverage.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's contract.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the decision.

3. The carrier or organized delivery system has three business days to contest the eligibility of the request for external review with the commissioner. If the commissioner finds that the request for external review is not eligible for full review, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for full review.

Sec. 12. NEW SECTION. 514J.6 INDEPENDENT REVIEW ENTITIES.

1. The commissioner shall solicit names of independent review entities from carriers, organized delivery systems, and medical and health care professional associations.

2. Independent review entities include, but are not limited to, the following:

a. Medical peer review organizations.

b. Nationally recognized health experts or institutions.

3. The commissioner shall certify independent review entities to conduct external reviews. An individual who conducts an external review as or as part of a certified independent review entity shall be a health care professional and satisfy both of the following requirements:

a. Hold a current unrestricted license to practice medicine or a health profession in the United States. A health care professional who is a physician shall also hold a current certification by a recognized American medical specialty board. A health care professional who is not a physician shall also hold a current certification by such professional's respective specialty board.

b. Have no history of disciplinary actions or sanctions, including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency.

4. Each independent review entity shall have a quality assurance program on file with the commissioner that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

5. The commissioner shall certify independent review entities every two years.

Sec. 13. NEW SECTION. 514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and phone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the independent review entity selected by the carrier or organized delivery system by notifying the commissioner within three business days of the receipt of notice from the carrier or organized delivery system. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection, to select an independent review entity, and to provide the notice required by this subsection to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

c. Provide any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

d. Provide any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

2. The enrollee, or the enrollee's treating health care provider, may provide any information submitted in support of the internal review, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the final notification of the independent review entity's selection to provide this information. Failure to provide the information within ten days shall be ground for rejection of consideration of the information by the independent review entity.

3. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation

required under subsection 1. The requested information shall be submitted within five days. Failure to provide the information shall be ground for rejection of consideration of the information by the independent review entity. The carrier or organized delivery system shall be notified of this request.

4. The independent review entity shall submit its decision as soon as possible, but not more than thirty days from the independent review entity's receipt of the request for review. The decision shall be mailed to the enrollee, or the treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system.

5. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 14. NEW SECTION. 514J.8 EXPEDITED REVIEW.

An expedited review shall be conducted within seventy-two hours of notification to the commissioner if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

Sec. 15. NEW SECTION. 514J.9 FUNDING.

All reasonable fees and costs of the independent review entity in conducting an external review shall be paid by the carrier or organized delivery system.

Sec. 16. NEW SECTION. 514J.10 REPORTING.

Each carrier and organized delivery system shall file an annual report with the commissioner containing all of the following:

1. The number of external reviews requested.

2. The number of the external reviews certified by the commissioner.

3. The number of coverage decisions which were upheld by an independent review entity.

The commissioner shall prepare a report by January 31 of each year.

Sec. 17. NEW SECTION. 514J.11 IMMUNITY.

An independent review entity conducting a review under this chapter is not liable for damages arising from determinations made under the review process. This does not apply to any act or omission by the independent review entity made in bad faith or involving gross negligence.

Sec. 18. NEW SECTION. 514J.12 STANDARD OF REVIEW.

Review by the independent review entity is de novo. The standard of review to be used by an independent review entity shall be whether the health care service or treatment denied by the carrier or organized delivery system was medically necessary as defined by the enrollee's evidence of coverage subject to Iowa law and consistent with clinical standards of medical practice. The independent review entity shall take into consideration factors identified in the review record that impact the delivery of or describe the standard of care for the medical service or treatment under review. The medical service or treatment recommended by the enrollee's treating health care provider shall be upheld upon review so long as it is found to be medically necessary and consistent with clinical standards of medical practice.

Sec. 19. NEW SECTION. 514J.13 EFFECT OF EXTERNAL REVIEW DECISION.

The review decision by the independent review entity conducting the review is binding upon the carrier or organized delivery system. The enrollee or the enrollee's treating health care provider acting on behalf of the enrollee may appeal the review decision by the independent review entity conducting the review by filing a petition for judicial review either in Polk county district court or in the district court in the county in which the enrollee resides. The petition for judicial review must be filed within fifteen business days after the issuance of the review decision. The findings of fact by the independent review entity conducting the review are conclusive and binding on appeal. The carrier or organized delivery system shall follow and comply with the review decision of the independent review entity conducting the review, or the decision of the court on appeal. The

carrier or organized delivery system and the enrollee's treating health care provider shall not be subject to any penalties, sanctions, or award of damages for following and complying in good faith with the review decision of the independent review entity conducting the review or decision of the court on appeal. The enrollee or the enrollee's treating health care provider may bring an action in Polk county district court or in the district court in the county in which the enrollee resides to enforce the review decision of the independent review entity conducting the review or the decision of the court on appeal.

Sec. 20. NEW SECTION. 514J.14 RULES.

The commissioner shall adopt rules pursuant to chapter 17A as are necessary to administer this chapter.

Sec. 21. NEW SECTION. 514K.1 HEALTH CARE PLAN DISCLOSURES -- INFORMATION TO ENROLLEES.

1. A health maintenance organization, an organized delivery system, or an insurer using a preferred provider arrangement shall provide to each of its enrollees at the time of enrollment, and shall make available to each prospective enrollee upon request, written information as required by rules adopted by the commissioner and the director of public health. The information required by rule shall include, but not be limited to, all of the following:

a. A description of the plan's benefits and exclusions.

b. Enrollee cost-sharing requirements.

c. A list of participating providers.

d. Disclosure of the existence of any drug formularies used and, upon request, information about the specific drugs included in the formulary.

e. An explanation for accessing emergency care services.

f. Any policies addressing investigational or experimental treatments.

g. The methodologies used to compensate providers.

h. Performance measures as determined by the commissioner and the director.

i. Information on how to access internal and external grievance procedures.

2. The commissioner and the director shall annually publish a consumer guide providing a comparison by plan on performance measures, network composition, and other key information to enable consumers to better understand plan differences.

Sec. 22. EFFECTIVE DATE. Sections 7 through 20 of this Act, which create new chapter 514J, take effect January 1, 2000.

MARY E. KRAMER
President of the Senate

RON J. CORBETT
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 276, Seventy-eighth General Assembly.

MICHAEL E. MARSHALL
Secretary of the Senate

Approved Apr 26, 1999

THOMAS J. VILSACK
Governor