

Redwine  
Boettger  
Szymoniak

SSB-1161

Human Resources

Succeeded By

SENATE FILE SE/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**

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

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

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1 Section 1. ~~9 hahamuy2~~ NEW SECTION. 514C.14 CONTINUITY OF CARE --  
2 PREGNANCY. ~~WV 10~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 (2) Serious impairment to bodily function.

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

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

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

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

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

25 a. Title XVIII of the federal Social Security Act.

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

28 c. Any other federal employee health benefit plan.

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

31 a. "Third-party payor" means:

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

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

34 (3) A health maintenance organization subject to chapter  
35 514B.

- 1 (4) A preferred provider arrangement.
- 2 (5) A multiple employer welfare arrangement.
- 3 (6) A third-party administrator.
- 4 (7) A fraternal benefit society.
- 5 (8) A plan established pursuant to chapter 509A for public
- 6 employees.
- 7 (9) Any other benefit program providing payment,
- 8 reimbursement, or indemnification for health care costs for an
- 9 enrollee or an enrollee's eligible dependents.

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

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

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

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

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

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

3 2. "Commissioner" means the commissioner of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ENTITIES.

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

5 2. Independent review entities include both of the  
6 following:

7 a. Medical peer review organizations.

8 b. Nationally recognized health experts or institutions.

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

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

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

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

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

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

31 The external review process shall meet the following  
32 criteria:

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



1 following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 1. The number of external reviews requested.

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

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

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

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

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

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

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

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

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

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

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

34 EXPLANATION

35 This bill creates several new Code sections and a new Code

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 by the enrollee's evidence of coverage.

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

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

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FILED MAR 2 1999

SENATE FILE 276  
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SSB 1161)  
*also SSB 1148*

*(P. 54)*  
Passed Senate, Date 3/10/99

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

Vote: Ayes 49 Nays 0

Vote: Ayes 97 Nays 1

Approved \_\_\_\_\_

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SF 276

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34 delivery system authorized under 1993 Iowa Acts, chapter 158,  
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2 shall not prohibit a participating provider from, or penalize  
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4 1. Discussing treatment options with a covered individual,  
5 notwithstanding the carrier's, organized delivery system's, or  
6 plan's position on such treatment option.

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

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

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

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

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

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

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

4 (2) Serious impairment to bodily function.

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

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

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

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

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

25 a. Title XVIII of the federal Social Security Act.

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

28 c. Any other federal employee health benefit plan.

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

31 a. "Third-party payor" means:

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

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

34 (3) A health maintenance organization subject to chapter  
35 514B.

- 1 (4) A preferred provider arrangement.
- 2 (5) A multiple employer welfare arrangement.
- 3 (6) A third-party administrator.
- 4 (7) A fraternal benefit society.
- 5 (8) A plan established pursuant to chapter 509A for public
- 6 employees.
- 7 (9) Any other benefit program providing payment,
- 8 reimbursement, or indemnification for health care costs for an
- 9 enrollee or an enrollee's eligible dependents.

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

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

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

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

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

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

3 2. "Commissioner" means the commissioner of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ENTITIES.

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

5 2. Independent review entities include both of the  
6 following:

- 7 a. Medical peer review organizations.
- 8 b. Nationally recognized health experts or institutions.

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

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

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

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

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

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

31 The external review process shall meet the following  
32 criteria:

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



1 following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 5     1. The number of external reviews requested.
- 6     2. The number of the external reviews certified by the  
7 commissioner.
- 8     3. The number of coverage decisions which were upheld by  
9 an independent review entity.

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

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

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

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

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

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

35    The review decision by the independent review entity

1 conducting the review is binding upon the carrier or organized  
2 delivery system. The enrollee or the enrollee's treating  
3 health care provider acting on behalf of the enrollee may  
4 appeal the review decision by the independent review entity  
5 conducting the review by filing a petition for judicial review  
6 either in Polk county district court or in the district court  
7 in the county in which the enrollee resides. The petition for  
8 judicial review must be filed within fifteen business days  
9 after the issuance of the review decision. The findings of  
10 fact by the independent review entity conducting the review  
11 are conclusive and binding on appeal. The carrier or  
12 organized delivery system shall follow and comply with the  
13 review decision of the independent review entity conducting  
14 the review, or the decision of the court on appeal. The  
15 carrier or organized delivery system and the enrollee's  
16 treating health care provider shall not be subject to any  
17 penalties, sanctions, or award of damages for following and  
18 complying in good faith with the review decision of the  
19 independent review entity conducting the review or decision of  
20 the court on appeal. The enrollee or the enrollee's treating  
21 health care provider may bring an action in Polk county  
22 district court or in the district court in the county in which  
23 the enrollee resides to enforce the review decision of the  
24 independent review entity conducting the review or the  
25 decision of the court on appeal.

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

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

29 EXPLANATION

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

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

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

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

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

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

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

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

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

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

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

1 medical payment insurance.

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

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

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

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

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

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

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

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

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

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

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



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

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

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## SENATE FILE 276

S-3053

1 Amend Senate File 276 as follows:

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

4 "Sec. \_\_\_\_ . NEW SECTION. 514C.17 CONTINUITY OF  
5 CARE -- TERMINAL ILLNESS.

6 1. Except as provided under subsection 2 or 3, if  
7 a carrier, as defined in section 513B.2, an organized  
8 delivery system, authorized under 1993 Iowa Acts,  
9 chapter 158, or a plan established pursuant to chapter  
10 509A for public employees, terminates its contract  
11 with a participating health care provider, a covered  
12 individual who is undergoing a specified course of  
13 treatment for a terminal illness or a related  
14 condition, with the recommendation of the covered  
15 individual's treating physician licensed under chapter  
16 148, 150, or 150A, may continue to receive coverage  
17 for treatment received from the covered individual's  
18 physician for the terminal illness or a related  
19 condition, for a period of up to ninety days. Payment  
20 for covered benefits and benefit level shall be  
21 according to the terms and conditions of the contract.

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

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

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

43 "Sec. \_\_\_\_ . NEW SECTION. 514F.5 EXPERIMENTAL  
44 TREATMENT REVIEW.

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

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Page 2

1 evaluate experimental medical treatments and shall  
2 submit a description of the procedure to the division  
3 of insurance. The procedure shall be in writing and  
4 must describe the process used to determine whether  
5 the carrier, organized delivery system, or chapter  
6 509A plan will provide coverage for new medical  
7 technologies and new uses of existing technologies.  
8 The procedure, at a minimum, shall require a review of  
9 information from appropriate government regulatory  
10 agencies and published scientific literature  
11 concerning new medical technologies, new uses of  
12 existing technologies, and the use of external experts  
13 in making decisions. A carrier, organized delivery  
14 system, or chapter 509A plan shall include  
15 appropriately licensed or qualified professionals in  
16 the evaluation process. The procedure shall provide a  
17 process for a person covered under a plan or contract  
18 to request a review of a denial of coverage because  
19 the proposed treatment is experimental. A review of a  
20 particular treatment need not be reviewed more than  
21 once a year.

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

27 3. By renumbering as necessary.

By JOHN REDWINE

S-3053 FILED MARCH 10, 1999  
ADOPTED

(p. 539)

## SENATE FILE 276

S-3050

1 Amend Senate File 276 as follows:

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

4 "Sec. \_\_\_\_ . NEW SECTION. 514K.1 HEALTH CARE PLAN  
5 DISCLOSURES -- INFORMATION TO ENROLLEES.

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

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

17 b. Enrollee cost-sharing requirements.

18 c. A list of participating providers.

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

22 e. An explanation for accessing emergency care  
23 services.

24 f. Any policies addressing investigational or  
25 experimental treatments.

26 g. The methodologies used to compensate providers.

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

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

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

36 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

1 Amend Senate File 276 as follows:

- 2 1. Page 5, line 26, by inserting after the word
- 3 "enrollee" the following: "in writing".
- 4 2. Page 6, line 31, by inserting after the word
- 5 "commissioner" the following: ", within two business
- 6 days,".
- 7 3. Page 7, line 4, by inserting after the word
- 8 "medical" the following: "and health care".
- 9 4. Page 7, line 5, by striking the words "both
- 10 of" and inserting the following: ", but are not
- 11 limited to,".
- 12 5. Page 7, line 18, by inserting after the word
- 13 "board." the following: "A health care professional
- 14 who is not a physician shall also hold a current
- 15 certification by such professional's respective
- 16 specialty board."
- 17 6. Page 9, line 29, by inserting after the word
- 18 "hours" the following: "of notification to the
- 19 commissioner".

By JOHN REDWINE

*adopted 3/10/99 (P.539)*

S-3048 FILED MARCH 9, 1999

SENATE FILE 276

S-3049

1 Amend Senate File 276 as follows:

- 2 1. Page 11, by inserting after line 28 the
- 3 following:
- 4 "Sec. \_\_\_\_ . EFFECTIVE DATE. Sections 5 through 18
- 5 of this Act, which create new chapter 514J, take
- 6 effect January 1, 2000."
- 7 2. Title page, line 5, by inserting after the
- 8 word "process" the following: ", and providing an
- 9 effective date".
- 10 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

1 Amend Senate File 276 as follows:

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

By JOHN REDWINE

S-3052 FILED MARCH 10, 1999

ADOPTED *(P. 539)*

SENATE FILE 276

3035

- 1 Amend Senate File 276 as follows:
- 2 1. Page 5, line 33, by inserting after the word
- 3 "decision." the following: "However, the enrollee's
- 4 treating health care provider does not have a duty to
- 5 request external review."

By JOHN REDWINE

S-3035 FILED MARCH 3, 1999

*Adopted 3/10/99*

*(P. 539)*

SENATE FILE 276

S-3039

- 1 Amend Senate File 276 as follows:
- 2 1. Page 2, line 18, by striking the words
- 3 "medically necessary".
- 4 2. Page 2, line 30, by striking the words ", the
- 5 onset of which is sudden,".

By JOHN REDWINE

S-3039 FILED MARCH 3, 1999

*Adopted*

*3/10/99 (P. 539)*

SENATE FILE

<sup>3-12-99</sup> H-Commerce & Reg.  
216

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

Passed Senate, Date <sup>(P. 1272)</sup> 4/14/99 Passed House, Date <sup>(P. 1272)</sup> 4/14/99  
Vote: Ayes 97 Nays 1 Vote: Ayes 97 Nays 1  
Approved April 21, 1999

**A BILL FOR**

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

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

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S.F. 276

SF 276

mj/cc/26

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

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

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

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

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

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



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

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

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

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

13 1. A carrier, as defined in section 513B.2; an organized  
14 delivery system authorized under 1993 Iowa Acts, chapter 158,  
15 and licensed by the director of public health; or a plan  
16 established pursuant to chapter 509A for public employees,

17 which provides coverage for emergency services, is responsible  
\*18 for charges for emergency services provided to a covered  
19 individual, including services furnished outside any  
20 contractual provider network or preferred provider network.  
21 Coverage for emergency services is subject to the terms and  
22 conditions of the health benefit plan or contract.

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

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

29 a. "Emergency medical condition" means a medical condition  
\*30 that manifests itself by symptoms of sufficient severity,  
31 including but not limited to severe pain, that an ordinarily  
32 prudent person, possessing average knowledge of medicine and  
33 health, could reasonably expect the absence of immediate  
34 medical attention to result in one of the following:

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

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

3 (2) Serious impairment to bodily function.

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

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

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

12 1. Except as provided under subsection 2 or 3, if a  
13 carrier, as defined in section 513B.2, an organized delivery  
14 system, authorized under 1993 Iowa Acts, chapter 158, or a  
15 plan established pursuant to chapter 509A for public  
16 employees, terminates its contract with a participating health  
17 care provider, a covered individual who is undergoing a  
18 specified course of treatment for a terminal illness or a  
19 related condition, with the recommendation of the covered  
20 individual's treating physician licensed under chapter 148,  
21 150, or 150A, may continue to receive coverage for treatment  
22 received from the covered individual's physician for the  
23 terminal illness or a related condition, for a period of up to  
24 ninety days. Payment for covered benefits and benefit level  
25 shall be according to the terms and conditions of the  
26 contract.

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

1 terms and conditions of the contract.

2 3. Notwithstanding subsections 1 and 2, a carrier,  
3 organized delivery system, or plan established under chapter  
4 509A which terminates the contract of a participating health  
5 care provider for cause shall not be required to cover health  
6 care services provided by the health care provider to a  
7 covered person following the date of termination.

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

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

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

22 a. Title XVIII of the federal Social Security Act.

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

25 c. Any other federal employee health benefit plan.

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

28 a. "Third-party payor" means:

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

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

31 (3) A health maintenance organization subject to chapter  
32 514B.

33 (4) A preferred provider arrangement.

34 (5) A multiple employer welfare arrangement.

35 (6) A third-party administrator.

1 (7) A fraternal benefit society.

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

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

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

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

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

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

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

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

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

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

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

29 2. "Commissioner" means the commissioner of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 following criteria are satisfied:

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

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

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

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

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

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

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

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

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

1 a. Medical peer review organizations.  
2 b. Nationally recognized health experts or institutions.  
3 3. The commissioner shall certify independent review  
4 entities to conduct external reviews. An individual who  
5 conducts an external review as or as part of a certified  
6 independent review entity shall be a health care professional  
7 and satisfy both of the following requirements:

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

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

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

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

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

27 The external review process shall meet the following  
28 criteria:

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 1. The number of external reviews requested.
- 2 2. The number of the external reviews certified by the
- 3 commissioner.
- 4 3. The number of coverage decisions which were upheld by
- 5 an independent review entity.
- 6 The commissioner shall prepare a report by January 31 of
- 7 each year.

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

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

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

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

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

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

1 conducting the review by filing a petition for judicial review  
2 either in Polk county district court or in the district court  
3 in the county in which the enrollee resides. The petition for  
4 judicial review must be filed within fifteen business days  
5 after the issuance of the review decision. The findings of  
6 fact by the independent review entity conducting the review  
7 are conclusive and binding on appeal. The carrier or  
8 organized delivery system shall follow and comply with the  
9 review decision of the independent review entity conducting  
10 the review, or the decision of the court on appeal. The  
11 carrier or organized delivery system and the enrollee's  
12 treating health care provider shall not be subject to any  
13 penalties, sanctions, or award of damages for following and  
14 complying in good faith with the review decision of the  
15 independent review entity conducting the review or decision of  
16 the court on appeal. The enrollee or the enrollee's treating  
17 health care provider may bring an action in Polk county  
18 district court or in the district court in the county in which  
19 the enrollee resides to enforce the review decision of the  
20 independent review entity conducting the review or the  
21 decision of the court on appeal.

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

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

25 Sec. 21. NEW SECTION. 514K.1 HEALTH CARE PLAN

26 DISCLOSURES -- INFORMATION TO ENROLLEES.

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

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

- 1 b. Enrollee cost-sharing requirements.
- 2 c. A list of participating providers.
- 3 d. Disclosure of the existence of any drug formularies
- 4 used and, upon request, information about the specific drugs
- 5 included in the formulary.
- 6 e. An explanation for accessing emergency care services.
- 7 f. Any policies addressing investigational or experimental
- 8 treatments.
- 9 g. The methodologies used to compensate providers.
- 10 h. Performance measures as determined by the commissioner
- 11 and the director.
- 12 i. Information on how to access internal and external
- 13 grievance procedures.
- 14 2. The commissioner and the director shall annually
- 15 publish a consumer guide providing a comparison by plan on
- 16 performance measures, network composition, and other key
- 17 information to enable consumers to better understand plan
- 18 differences.
- 19 Sec. 22. EFFECTIVE DATE. Sections 7 through 20 of this
- 20 Act, which create new chapter 514J, take effect January 1,
- 21 2000.

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## SENATE FILE 276

H-1530

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

4 1. Page 1, line 20, by striking the words "shall  
5 not have ever" and inserting the following: ", within  
6 the immediately preceding ten years, shall not have".

7 2. Page 1, line 22, by inserting after the word  
8 "year" the following: "within such ten-year period".

9 3. Page 2, line 7, by striking the word "ten-day"  
10 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

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

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

6 "\_\_\_\_. Page 12, by striking lines 19 and 20 and  
7 inserting the following: "necessary and consistent  
8 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

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

4 1. Page 1, by striking lines 3 through 11.

5 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

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.19 MANDATED  
 6 COVERAGE FOR DENTAL CARE -- ANESTHESIA AND CERTAIN  
 7 HOSPITAL CHARGES.  
 8 1. Notwithstanding section 514C.6, a policy or  
 9 contract providing for third-party payment or  
 10 prepayment of health or medical expenses shall provide  
 11 coverage for anesthesia and hospital charges related  
 12 to the provision of dental care services provided to  
 13 any of the following covered individuals:  
 14 a. A child under five years of age.  
 15 b. An individual who is severely disabled.  
 16 c. An individual who has a medical condition that  
 17 requires hospitalization or general anesthesia for  
 18 delivery of the dental care services.  
 19 2. A policy or contract providing for third-party  
 20 payment or prepayment of health or medical expenses  
 21 shall provide coverage for general anesthesia and  
 22 treatment rendered by a dentist for conditions covered  
 23 under such policy or contract, whether the services  
 24 are provided in a hospital or a dental office.  
 25 3. Prior authorization of hospitalization for  
 26 dental care procedures may be required in the same  
 27 manner that prior authorization is required for  
 28 hospitalization for other coverage under the contract  
 29 or policy.  
 30 4. This section applies to the following contracts  
 31 or policies delivered, issued for delivery, continued,  
 32 or renewed in this state on or after July 1, 1999:  
 33 a. Individual or group accident and sickness  
 34 insurance providing coverage on an expense-incurred  
 35 basis.  
 36 b. An individual or group hospital or medical  
 37 service contract issued pursuant to chapter 509, 514,  
 38 or 514A.  
 39 c. An individual or group health maintenance  
 40 organization contract regulated under chapter 514B.  
 41 d. An individual or group Medicare supplemental  
 42 policy, unless coverage pursuant to such policy is  
 43 preempted by federal law.  
 44 e. An organized delivery system licensed by the  
 45 director of public health."  
 46 2. Title page, line 2, by inserting after the  
 47 word "care," the following: "anesthesia and certain  
 48 hospital charges associated with dental care  
 49 services,".  
 50 3. By renumbering as necessary.

By FOEGE of Linn  
 RAECKER of Polk  
 HUSER of Polk

*Not Lermone 4/13/99 (p.1247)*

## SENATE FILE 276

H-1577

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

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

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

7 Sec. \_\_\_\_\_. Section 514.7, unnumbered paragraph 3,  
8 Code 1999, is amended by striking the unnumbered  
9 paragraph.

10 Sec. \_\_\_\_\_. Section 514B.1, subsection 5, paragraph  
11 c, Code 1999, is amended by striking the paragraph."

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

14 "Sec. \_\_\_\_\_. NEW SECTION. 514C.20 DIABETES  
15 COVERAGE.

16 1. Notwithstanding the uniformity of treatment  
17 requirements of section 514C.6, a policy or contract  
18 providing for third-party payment or prepayment of  
19 health or medical expenses shall provide coverage  
20 benefits for the cost associated with equipment,  
21 supplies, and self-management training and education  
22 for the treatment of all types of diabetes mellitus  
23 when prescribed by a physician licensed under chapter  
24 148, 150, or 150A. Coverage benefits shall include  
25 coverage for the cost associated with all of the  
26 following:

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

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

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

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

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

50 (i) A new onset of diabetes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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- 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

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

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

6 "\_\_\_\_. Page 1, by inserting before line 1 the  
7 following:

8 "Section 1. Section 509.3, subsection 6, Code  
9 1999, is amended by striking the subsection.

10 Sec. \_\_\_\_\_. Section 514.7, unnumbered paragraph 3,  
11 Code 1999, is amended by striking the unnumbered  
12 paragraph.

13 Sec. \_\_\_\_\_. Section 514B.1, subsection 5, paragraph  
14 c, Code 1999, is amended by striking the paragraph."

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

17 Sec. \_\_\_\_\_. NEW SECTION. 514C.19 MANDATED COVERAGE  
18 FOR DENTAL CARE -- ANESTHESIA AND CERTAIN HOSPITAL  
19 CHARGES.

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

26 a. A child under five years of age.

27 b. An individual who is severely disabled.

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

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

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

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

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

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

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

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

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

8 Sec. \_\_\_\_ . NEW SECTION. 514C.20 DIABETES  
9 COVERAGE.

10 1. Notwithstanding the uniformity of treatment  
11 requirements of section 514C.6, a policy or contract  
12 providing for third-party payment or prepayment of  
13 health or medical expenses shall provide coverage  
14 benefits for the cost associated with equipment,  
15 supplies, and self-management training and education  
16 for the treatment of all types of diabetes mellitus  
17 when prescribed by a physician licensed under chapter  
18 148, 150, or 150A. Coverage benefits shall include  
19 coverage for the cost associated with all of the  
20 following:

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

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

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

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

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

44 (i) A new onset of diabetes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

49 4. By renumbering as necessary.

By JOCHUM of Dubuque

H-1583 FILED APRIL 13, 1999

ADOPTED

(p. 1242)

SENATE FILE 276

H-1528

1 Amend Senate File 276, as amended, passed, and  
 2 reprinted by the Senate, as follows:  
 3 1. Page 1, by inserting before line 1 the  
 4 following:  
 5 "Section 1. Section 507B.4, Code 1999, is amended  
 6 by adding the following new subsection:  
 7 NEW SUBSECTION. 9A. UNAUTHORIZED DISCHARGE FROM  
 8 HOSPITAL. Communicating to a covered individual who  
 9 is hospitalized, either directly or through an  
 10 intermediary, that the covered individual's hospital  
 11 treatment or hospital stay is completed, without first  
 12 providing the covered individual with written  
 13 treatment status confirmation endorsed by the covered  
 14 individual's attending health care provider."  
 15 2. By renumbering as necessary.

By CONNORS of Polk

H-1528 FILED APRIL 8, 1999

*Mut Hermone*

*4/13/99 (P.1237)* SENATE FILE 276

H-1523

1 Amend the amendment, H-1285, to Senate File 276, as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:  
 4 1. Page 1, line 33, by striking the figure "1998"  
 5 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

1 Amend the amendment, H-1185, to Senate File 276, as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:  
 4 1. Page 1, line 5, by striking the words ", if  
 5 any,".  
 6 2. Page 1, by striking lines 7 through 11.  
 7 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

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

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

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

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

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

14 4. Page 10, by striking lines 12 through 22 and  
15 inserting the following: "independent review entity  
16 selected by the commissioner by notifying the  
17 commissioner within five business days of the receipt  
18 of notice from the commissioner. If the carrier or  
19 organized delivery system, the enrollee, or the  
20 enrollee's treating health care provider, objects to  
21 the independent review entity selected, the objecting  
22 party shall have an opportunity to recommend another  
23 independent review entity from the list certified by  
24 the commissioner within the five-day period for  
25 objection. If the parties agree to the independent  
26 review entity recommended by the objecting party, that  
27 independent review entity shall perform the external  
28 review. If the parties fail to agree to the  
29 independent review entity recommended by the objecting  
30 party, the independent review entity selected by the  
31 commissioner under paragraph "a" shall perform the  
32 external review. The parties may waive the five-day  
33 period for objection if all parties agree to the  
34 independent review entity selected by the commissioner  
35 and inform the commissioner of their agreement.

36 1A. The carrier or organized delivery system,  
37 within three days after the selection of the  
38 independent review entity that will be conducting the  
39 external review, shall do both of the following:

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

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

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

By CHAPMAN of Linn

H-1419 FILED APRIL 5, 1999

*Last* (P. 1266)  
4/14/99

## SENATE FILE 276

H-1285

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 SERVICES  
6 PROVIDED BY LICENSED MENTAL HEALTH COUNSELORS AND  
7 MARITAL AND FAMILY THERAPISTS.

8 Notwithstanding section 514C.6, a policy or  
9 contract providing for third-party payment or  
10 prepayment of health or medical expenses shall include  
11 a provision for the payment of necessary mental health  
12 services provided by a mental health counselor or a  
13 marital and family therapist licensed pursuant to  
14 chapters 147 and 154D and performed within the scope  
15 of the license of the licensed mental health counselor  
16 or marital and family therapist if the policy or  
17 contract would pay for the care and treatment if the  
18 services were provided by a person engaged in the  
19 practice of medicine and surgery or osteopathic  
20 medicine and surgery under chapter 148 or 150A. The  
21 policy or contract shall provide that policyholders  
22 and subscribers under the policy or contract may  
23 reject the coverage for services which may be provided  
24 by a licensed mental health counselor or a marital and  
25 family therapist if the coverage is rejected for all  
26 providers of similar services. A policy or contract  
27 subject to this section shall not impose a practice or  
28 supervision restriction which is inconsistent with or  
29 more restrictive than the restriction already imposed  
30 by law. This section applies to services provided  
31 under a policy or contract delivered, issued for  
32 delivery, continued, or renewed in this state on or  
33 after July 1, 1998, and to an existing policy or  
34 contract, on the policy's or contract's anniversary or  
35 renewal date, or upon the expiration of the applicable  
36 collective bargaining contract, if any, whichever is  
37 later. This section does not apply to policyholders  
38 or subscribers eligible for coverage under Title XVIII  
39 of the federal Social Security Act or any similar  
40 coverage under a state or federal government plan.  
41 For the purposes of this section, third-party payment  
42 or prepayment includes an individual or group policy  
43 of accident or health insurance or individual or group  
44 hospital or health care service contract issued  
45 pursuant to chapter 509, 514, or 514A, an individual  
46 or group health maintenance organization contract  
47 issued and regulated under chapter 514B, an organized  
48 delivery system contract regulated under rules adopted  
49 by the director of public health, or a preferred  
50 provider organization contract regulated pursuant to

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1 chapter 514F. Nothing in this section shall be  
2 interpreted to require an individual or group health  
3 maintenance organization, an organized delivery  
4 system, or a preferred provider organization or  
5 arrangement to provide payment or prepayment for  
6 services provided by a licensed mental health  
7 counselor or licensed marital and family therapist  
8 unless the licensed mental health counselor or  
9 licensed marital and family therapist has entered into  
10 a contract or other agreement to provide services with  
11 the individual or group health maintenance  
12 organization, the organized delivery system, or the  
13 preferred provider organization or arrangement."  
14 2. By renumbering as necessary.

By FREVERT of Palo Alto

H-1285 FILED MARCH 29, 1999

*Pat Henne*  
4/13/99  
(p.1245)

## SENATE FILE 276

H-1185

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

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

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

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

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

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

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

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

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

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

40 "1A. The carrier or organized delivery system,  
41 within three business days of notification of an  
42 independent review, shall do the following:

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

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

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

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

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- 1 "entity" the following: ", unless good cause can be  
2 shown for the failure to provide the information  
3 within the ten-day period".  
4 11. Page 11, line 11, by inserting after the word  
5 "entity" the following: ", unless good cause can be  
6 shown for the failure to provide the information  
7 within the ten-day period".  
8 12. Page 11, line 24, by inserting after the word  
9 "conducted" the following: ", and a decision  
10 submitted,".  
11 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

- 1 Amend Senate File 276, as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 13, by inserting after line 21 the  
4 following:  
5 "Sec. \_\_\_\_ . NEW SECTION. 514J.13A CIVIL PENALTY.  
6 The commissioner may impose a civil penalty upon a  
7 carrier or organized delivery system not to exceed ten  
8 thousand dollars for each occurrence of a denial of  
9 coverage to an enrollee if such carrier or organized  
10 delivery system is found to be engaging in a pattern  
11 of conduct to circumvent the purposes of this chapter.  
12 Evidence that a carrier or organized delivery system  
13 has lost sixty percent or more of its external appeals  
14 under this chapter shall be considered prima facie  
15 evidence of an attempt to circumvent the purposes of  
16 this chapter."  
17 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

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 MENTAL HEALTH  
6 AND SUBSTANCE ABUSE TREATMENT COVERAGE.

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

16 b. Coverage required under this section includes  
17 the following:

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

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

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

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

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

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

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

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

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

50 3. For purposes of this section, unless the

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- 1 context otherwise requires:
- 2 a. "Mental health or substance abuse condition"
- 3 means a condition or disorder involving mental illness
- 4 or substance abuse or other addictive disorder which
- 5 is included in the diagnostic categories listed in the
- 6 mental disorders section of the international
- 7 classification of disease, as periodically revised.
- 8 b. "Rates, terms, and conditions" means lifetime
- 9 payment limits, deductibles, copayments, coinsurance,
- 10 and any other cost-sharing requirements, out-of-pocket
- 11 limits, visit limitations, and any other financial
- 12 component of benefits coverage that affects the
- 13 covered individual."
- 14 2. Title page, line 2, by inserting after the
- 15 word "care," the following: "mental health and
- 16 substance abuse treatment coverage,".
- 17 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 Done*  
 4-13-99  
 (p.1242)

SENATE FILE 276

H-1182

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

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

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

8 1. For the purposes of this section:

9 a. "Health care provider" means a person licensed  
10 to practice medicine and surgery pursuant to chapter  
11 148, physical therapy pursuant to chapter 148A,  
12 occupational therapy pursuant to chapter 148B,  
13 acupuncture pursuant to chapter 148E, podiatry  
14 pursuant to chapter 149, osteopathy pursuant to  
15 chapter 150, osteopathic medicine and surgery pursuant  
16 to chapter 150A, chiropractic pursuant to chapter 151,  
17 nursing pursuant to chapter 152, dietetics pursuant to  
18 chapter 152A, respiratory care pursuant to chapter  
19 152B, massage therapy pursuant to chapter 152C,  
20 dentistry pursuant to chapter 153, optometry pursuant  
21 to chapter 154, psychology pursuant to chapter 154B,  
22 social work pursuant to chapter 154C, behavioral  
23 science pursuant to chapter 154D, or licensed as a  
24 physician assistant pursuant to chapter 148C, a  
25 hospital licensed pursuant to chapter 135B, and a  
26 health care facility licensed pursuant to chapter  
27 135C.

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

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

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

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

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

By JOCHUM of Dubuque

H-1182 FILED MARCH 23, 1999

*Not Vermon  
4/13/99  
(P. 1236)*

## SENATE FILE 276

H-1181

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

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

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

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

12 "\_\_\_\_\_. "Medically necessary or appropriate" means,  
13 with respect to a service or benefit, a service or  
14 benefit which is consistent with generally accepted  
15 principles of professional medical practice."

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

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

22 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

- 1 Amend Senate File 276, as amended, passed, and
- 2 reprinted by the Senate, as follows:
- 3 1. Page 3, line 5, by striking the word
- 4 "covered".

By OSTERHAUS of Jackson

H-1178 FILED MARCH 23, 1999

*W/O*  
*4/13/99 (p. 1238)*

## SENATE FILE 276

H-1179

- 1 Amend Senate File 276, as amended, passed, and
- 2 reprinted by the Senate, as follows:
- 3 1. Page 2, line 11, by inserting after the word
- 4 "plan" the following: ", or advocating on behalf of a
- 5 covered individual as provided in chapter 514J".

By CHAPMAN of Linn

H-1179 FILED MARCH 23, 1999

*Last*  
*4-13-99*  
*(p. 1238)*

## SENATE FILE 276

H-1180

- 1 Amend Senate File 276, as amended, passed, and
- 2 reprinted by the Senate, as follows:
- 3 1. Page 6, by inserting after line 19 the
- 4 following:
- 5 "\_\_\_\_. "Appropriate and medically necessary" means
- 6 the standard for health care services as determined by
- 7 a physician or health care provider consistent with
- 8 accepted practices and standards of care provided by
- 9 the medical profession in the community."
- 10 2. Page 8, by striking lines 8 and 9 and
- 11 inserting the following: "of appropriate and
- 12 medically necessary."
- 13 3. By renumbering as necessary.

By OSTERHAUS of Jackson

H-1180 FILED MARCH 23, 1999

*Last*  
*4/13/99*  
*(p. 1251)*

## SENATE FILE 276

H-1176

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

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

5 "Sec. \_\_\_\_ . NEW SECTION. 514K.1 TITLE.

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

8 Sec. \_\_\_\_ . NEW SECTION. 514K.2 DEFINITIONS.

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

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

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

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

22 4. "Health care provider" means a person licensed  
23 or certified under chapter 147, 148, 148A, 148C, 149,  
24 150, 150A, 151, 152, 153, 154, 154B, or 155A to  
25 provide in this state professional health care  
26 services to an individual during that individual's  
27 medical care, treatment, or confinement.

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

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

46 7. "Health maintenance organization" means a  
47 health maintenance organization as defined in section  
48 514B.1.

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

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1 carrier.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40 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

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

3 1. Page 1, line 5, by inserting after the figure  
4 "158," the following: "and licensed by the director  
5 of public health".

By CHAPMAN of Linn

H-1177 FILED MARCH 23, 1999

*lost  
4/13/99  
(P. 1237)*

## SENATE FILE 276

H-1172

1 Amend Senate File 276, as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 13, by inserting after line 21 the  
4 following:  
5 "In addition to an action to enforce the review  
6 decision, or the decision of the court on appeal, the  
7 enrollee shall have a cause of action against the  
8 carrier or organized delivery system for any further  
9 harm incurred after the rendering of the external  
10 review decision or decision of the court on appeal,  
11 and caused by any substantial noncompliance with the  
12 external review decision or court decision by the  
13 carrier or organized delivery system. The carrier or  
14 organized delivery system's failure to substantially  
15 comply with an external review decision, or decision  
16 of the court on appeal, within twenty-four hours of  
17 the decision, shall be prima facie evidence of bad  
18 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

1 Amend Senate File 276, as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 11, by inserting after line 22 the  
4 following:  
5 "6. An enrollee's treating health care provider  
6 may apply for and shall receive reasonable  
7 compensation from the carrier or organized delivery  
8 system for time spent by the health care provider to  
9 supply information in support of an enrollee's request  
10 for external review under this chapter."

By OSTERHAUS of Jackson  
CHAPMAN of Linn

H-1173 FILED MARCH 23, 1999

*Lost* (P.1267)  
*4/14/99*

## SENATE FILE 276

H-1170

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

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

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

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

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

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

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

19 a. The individual basic or standard health benefit  
20 plan shall not deny, exclude, or limit benefits for a  
21 covered individual for losses incurred more than  
22 ~~twelve~~ six months following the effective date of the  
23 individual's coverage due to a preexisting condition.

24 A preexisting condition shall not be defined more  
25 restrictively than any of the following:

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

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

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

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

39 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

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

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

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

8 a. Arrive at a correct diagnosis.

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

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

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

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

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

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

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

37 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

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

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

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

7 Sec. \_\_\_\_\_. Section 514.7, unnumbered paragraph 3,  
8 Code 1999, is amended by striking the unnumbered  
9 paragraph.

10 Sec. \_\_\_\_\_. Section 514B.1, subsection 5, paragraph  
11 c, Code 1999, is amended by striking the paragraph."

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

14 "Sec. \_\_\_\_\_. NEW SECTION. 514C.18 COMPARABLE  
15 COVERAGE FOR MENTAL HEALTH TREATMENT.

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

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

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

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

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

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

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

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

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1 subject to the jurisdiction of the commissioner.

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

4 Sec. \_\_\_\_\_. NEW SECTION. 514C.19 MANDATED COVERAGE  
5 FOR DENTAL CARE -- ANESTHESIA AND CERTAIN HOSPITAL  
6 CHARGES.

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

13 a. A child under five years of age.

14 b. An individual who is severely disabled.

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

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

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

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

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

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

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

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

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

45 Sec. \_\_\_\_\_. NEW SECTION. 514C.20 DIABETES  
46 COVERAGE.

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

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1 benefits for the cost associated with equipment,  
2 supplies, and self-management training and education  
3 for the treatment of all types of diabetes mellitus  
4 when prescribed by a physician licensed under chapter  
5 148, 150, or 150A. Coverage benefits shall include  
6 coverage for the cost associated with all of the  
7 following:

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

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

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

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

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

31 (i) A new onset of diabetes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 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/19  
4/13/99  
(P. 1232)*

## 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.

1. 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.

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MARY E. KRAMER  
President of the Senate

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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.

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MICHAEL E. MARSHALL  
Secretary of the Senate

Approved April 26, 1999

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THOMAS J. VILSACK  
Governor