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COMMERCE AND REGULATION

HOUSE FILE 650
BY JOCHUM

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

## A BILL FOR

An Act relating to health care including inspection and duplication of health care records, requirements relating to health care services policies and contracts, and the third-party payor liability.

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

TLSB 1578HH 79
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S.F. _____ H.F. 650

Section 1. NEW SECTION. 135.29A HEALTH CARE PROVIDER RECORDS -- DUPLICATION FOR PROVISION TO PATIENT.

1. For the purposes of this section:

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

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

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

3. A health care provider may withhold the record from the patient if the provider reasonably determines that the information is detrimental to the physical or mental health of the patient or is likely to cause the patient to harm the patient or another person. If a record is withheld from the patient under this subsection, the health care provider may

provide access to the record or a duplicate of the record to the patient's attorney or personal physician upon request of the patient.

4. The department shall adopt rules pursuant to chapter 17A prescribing uniform fees, based upon the actual cost of duplication, that a health care provider may charge for duplication of health care records requested by a patient under this section. The rules may provide for an additional fee based upon the actual costs for postage or other means of delivery and may provide for an annual increase based upon the annual rate of inflation for the preceding calendar year as determined by the consumer price index published by the bureau of labor statistics of the United States department of labor.

Sec. 2. NEW SECTION. 514C.21 HEALTH CARE SERVICES POLICY OR CONTRACT -- PRIMARY CARE PROVIDER -- OBSTETRICIAN -- GYNECOLOGIST.

Notwithstanding section 514C.6, a person who provides an individual or group policy of accident or health insurance or an individual or group hospital or health care services contract issued pursuant to chapter 509, 509A, 514, or 514A, or an individual or group health maintenance organization contract issued and regulated under chapter 514B, which is delivered, amended, or renewed on or after July 1, 2001, and which requires, in the policy or contract, that an insured, subscriber, or enrollee use, or which creates incentives for an insured, subscriber, or enrollee to use, a provider who is under contract with or who is managed, owned, or employed by the entity providing the contract or policy, shall provide that a female insured, subscriber, or enrollee may select an obstetrician or gynecologist as the insured's, subscriber's, or enrollee's primary care provider.

Sec. 3. NEW SECTION. 514C.22 HEALTH CARE SERVICES POLICY OR CONTRACT -- PRIMARY CARE PROVIDER -- SPECIALIST.

Notwithstanding section 514C.6, a person who provides an individual or group policy of accident or health insurance or

an individual or group hospital or health care services contract issued pursuant to chapter 509, 509A, 514, or 514A, or an individual or group health maintenance organization contract issued and regulated under chapter 514B, which is delivered, amended, or renewed on or after July 1, 2001, and which requires, in the policy or contract, that an insured, subscriber, or enrollee use, or which creates incentives for an insured, subscriber, or enrollee to use, a provider who is under contract with or who is managed, owned, or employed by the entity providing the contract or policy, shall provide that an insured, a subscriber, or an enrollee who has a serious illness or disability may select a specialist as the insured's, subscriber's, or enrollee's primary care provider.

Sec. 4. NEW SECTION. 514C.23 HEALTH CARE SERVICES POLICY OR CONTRACT -- STANDING REFERRALS.

Notwithstanding section 514C.6, a person who provides an individual or group policy of accident or health insurance or an individual or group hospital or health care services contract issued pursuant to chapter 509, 509A, 514, 514A, or an individual or group health maintenance organization contract issued and regulated under chapter 514B, which is delivered, amended, or renewed on or after July 1, 2001, and which requires, in the policy or contract, that an insured, subscriber, or enrollee use, or which creates incentives for an insured, subscriber, or enrollee to use, a provider who is under contract with or who is managed, owned, or employed by the entity providing the contract or policy, shall provide a procedure by which an insured, subscriber, or enrollee who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to the specialist for the treatment of the special condition. For the purposes of this section, "special condition" means a condition or disease that is life-threatening, degenerative, or disabling, and that requires specialized medical care over an ongoing period of time.

Sec. 5. NEW SECTION 514C.24 HEALTH CARE SERVICES POLICY OR CONTRACT -- PRESCRIPTION DRUG FORMULARY -- EXCEPTIONS.

Notwithstanding section 514C.6, a person who provides an individual or group policy of accident or health insurance or individual or group hospital or health care services contract issued pursuant to chapter 509, 509A, 514, 514A, or an individual or group health maintenance organization contract issued and regulated under chapter 514B, which is delivered, amended, or renewed on or after July 1, 2001, that provides coverage for prescription drugs on an outpatient basis and that applies a formulary to the prescription drug benefits provided, shall establish and maintain an expeditious process and procedure that allows an insured, subscriber, or enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the insured's, subscriber's, or enrollee's covered benefits, coverage for a specific, medically necessary and appropriate nonformulary prescription drug, as determined by the provider, without prior approval.

Sec. 6. NEW SECTION. 514C.25 HEALTH CARE SERVICES POLICY OR CONTRACT -- PROHIBITIONS -- FINANCIAL INCENTIVES.

The commissioner shall issue rules to establish standards that prohibit inappropriate financial incentives that result in the denial or reduction of necessary health care services for individual or group policies of accident or health insurance or individual or group hospital or health care services contracts issued pursuant to chapter 509, 509A, 514, or 514A, or an individual or group health maintenance organization contract issued and regulated under chapter 514B.

Sec. 7. NEW SECTION. 514L.1 TITLE.

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

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

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

1. "Appropriate and medically necessary" means the

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

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

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

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

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

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

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

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

9. "Managed care entity" means an entity that provides a health care plan that selects and contracts with health care

providers; manages and coordinates health care services delivery; monitors necessity, appropriateness, and quality of health care services delivered by health care providers; and performs utilization review and cost control.

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

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

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

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

Sec. 9. NEW SECTION. 514L.3 THIRD-PARTY PAYOR DUTY TO EXERCISE ORDINARY CARE -- LIABILITY.

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

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

results in the failure to exercise ordinary care.

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

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

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

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

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

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

9. In an action against a third-party payor, a finding that a health care provider is an employee, agent, or

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

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

EXPLANATION

This bill relates to health care including inspection and duplication of health care records, the requiring of certain provisions under health care services policies or contracts, and third-party payors.

The bill requires a health care provider to allow a patient to inspect the patient's health care record and to provide the patient with a duplicate of the patient's health care record upon written request of the patient. The bill provides that if the health care provider reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to harm the patient or another person, the health care provider may withhold the record and instead may provide the record to the patient's attorney or personal physician upon the request of the patient. The bill requires the Iowa department of public health to adopt rules to establish a uniform fee which may be charged for duplication of the records.

The bill requires a provider of an individual or group policy of accident or health insurance, hospital or health care services contract, or health maintenance organization contract, which is delivered, amended, or renewed on or after July 1, 2001, to provide in the policy or contract that a female insured, subscriber, or enrollee may choose an obstetrician or gynecologist as the insured's, subscriber's, or enrollee's primary care provider if the policy or contract requires or creates incentives for the insured, subscriber, or enrollee to use a provider who is managed, owned, or employed by or under contract with the entity.

The bill also requires a provider of an individual or group policy of accident or health insurance, hospital or health care services contract or health maintenance organization contract, which is delivered, amended, or renewed on or after July 1, 2001, to provide in the policy or contract that an insured, subscriber, or enrollee who has a serious illness or disability may select a specialist as the insured's, subscriber's, or enrollee's primary care provider if the policy or contract requires or creates incentives for the insured, subscriber, or enrollee to use a provider who is managed, owned, or employed by or under contract with the entity.

The bill also requires a provider of an individual or group policy of accident or health insurance, hospital or health care services contract, or health maintenance organization contract, which is delivered, amended, or renewed on or after July 1, 2001, to provide in the policy or contract a procedure by which an insured, subscriber, or enrollee who has an ongoing special condition that requires ongoing care from a specialist to receive a standing referral to the specialist for the treatment of the special condition, if the policy or contract requires or creates incentives for the insured, subscriber, or enrollee to use a provider who is managed, owned, or employed by or under contract with the entity.

The bill also requires a provider of an individual or group policy of accident or health insurance, hospital or health care services contract, or health maintenance organization contract, which is delivered, amended, or renewed on or after July 1, 2001, that provides coverage for prescription drugs on an outpatient basis and that applies a formulary to the prescription drug benefits provided, to establish and maintain an expeditious process and procedure that allows an insured, subscriber, or enrollee to obtain, without penalty or additional cost-sharing coverage for a specific, medically necessary and appropriate nonformulary prescription drug, as

determined by the provider, without prior approval.

The bill directs the commissioner of insurance to issue rules to establish standards that prohibit inappropriate financial incentives that result in the denial or reduction of necessary health care services for individual or group policies of accident or health insurance, or individual or group hospital or health care services contracts, or an individual or group health maintenance organization contract.

The bill creates new Code chapter 514L. The bill provides that a third-party payor has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care. The bill establishes certain defenses to such an action for failure to use ordinary care and provides that the duty to exercise ordinary care does not create an obligation on the part of the third-party payor to provide health care services to an insured or enrollee which are not covered by the health care plan offered by the third-party payor. The bill defines "third-party payor" as a health insurance carrier, health maintenance organization, managed care entity, or organized delivery system.