COMMERCE

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SENATE FILE 545

BY HOLVECK

Passed Senate, Date _____ Passed House, Date _____

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

Approved _____

A BILL FOR

An Act relating to insurance, by providing for third-party payor liability for health care treatment decisions, prohibiting certain acts by third-party payors, and providing a statutory definition for medical necessity relating to the external review process for health care coverage decisions, and containing an applicability provision.

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

SF 545 COMMERCE

TLSB 1328XS 79

jj/cf/24

S.F. 545 H.F. _____

Section 1. Section 514J.2, Code 2001, is amended by adding the following new subsection:

NEW SUBSECTION. 5A. "Medically necessary" and "medical necessity" mean, with respect to a service or benefit, a service or benefit that is consistent with generally accepted principles of professional medical practice.

Sec. 2. Section 514J.5, subsection 1, paragraph b, Code 2001, is amended to read as follows:

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~~ is not medically necessary.

Sec. 3. NEW SECTION. 514L.1 TITLE.

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

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

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

1. "Appropriate and medically necessary" means with respect to a health care service, treatment decision, or benefit a health care service, treatment decision, or benefit that is consistent with generally accepted principles of professional practice.

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 service.

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. 5. 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 liable for damages for harm to an insured or enrollee proximately caused by the health care services treatment decision 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. In an action brought against a third-party payor pursuant to this section, any of the following shall be defenses:

a. 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 treatment decision.

b. 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. 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.

Sec. 6. NEW SECTION. 514L.4 THIRD-PARTY PAYOR PROHIBITIONS.

1. 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.

2. 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.

3. 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.

Sec. 7. NEW SECTION. 514L.5 EXCLUSIONS.

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

2. 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.

Sec. 8. APPLICABILITY. Sections 1 and 2 of this Act are applicable to all carriers and organized delivery systems, as those entities are defined in section 514J.2, whose policies, contracts, and plans are delivered, issued for delivery,

continued, or renewed in this state on or after January 1, 2002.

EXPLANATION

This bill creates new Code chapter 514L, the third-party payor liability Act, regarding third-party payor liability for health care treatment decisions, and prohibiting certain other acts by third-party payors, and also adds a definition of "medically necessary" to Code chapter 514J, which deals with external review of health care coverage decisions.

New Code section 514L.2 contains definitions for the new chapter. "Third-party payor" is defined as a health insurance carrier, health maintenance organization, managed care entity, or organized delivery system. "Appropriate and medically necessary" is defined as a health care service, treatment decision, or benefit that is consistent with generally accepted principles of professional practice. Code section 514L.2 also defines the terms "enrollee", "health care plan", "health care provider", "health care treatment decision", "health insurance carrier", "health maintenance organization", "insured", "managed care entity", "ordinary care", "organized delivery system", and "physician".

New Code section 514L.3 requires a third-party payor to exercise a duty of ordinary care when making health care treatment decisions, and imposes liability for damages proximately caused by the failure to exercise that duty of care. A third-party payor is also liable for damages proximately caused to an insured or enrollee because of treatment decisions made by an employee, agent, or representative of the third-party payor where the third-party payor's exercise of influence or control over such party has resulted in a failure to exercise ordinary care.

A third-party payor may assert the following as defenses to an action based on failure to exercise ordinary care: that the third-party payor did not influence, control, or participate in the health care treatment decision, or that the

third-party payor did not deny or delay payment for prescribed or recommended health care services. Code section 514L.3 also provides that the third-party payor may not assert as a defense that state law prohibits a third-party payor from practicing medicine.

New Code section 514L.4 provides that third-party payors may not remove or refuse to renew the participation of a health care provider for advocating appropriate and medically necessary health care services, and may not include an indemnification or hold-harmless clause for the acts of the third-party payor in its contract with a health care provider.

New Code section 514L.5 provides that the chapter does not apply to workers' compensation coverage, and does not create liability for employers who purchase or provide health care coverage.

The bill also adds a definition of "medically necessary" and "medical necessity" to Code chapter 514J, which deals with external review of health care coverage decisions. The defined terms are used in Code section 514J.1, which states the intent of the general assembly with regard to the chapter; Code section 514J.2, which provides the definition for "coverage decision"; Code section 514J.12, which provides the standard of review to be applied in evaluating a denial of coverage; and Code section 514J.5, which is also amended in this bill to make the use of the term "medical necessity" consistent with the new definition.

The bill also contains an applicability provision, providing that the changes are applicable to insurance policies, contracts, and plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2002.