A BILL FOR

1 An Act related to health insurance coverage for the assessment
2 or diagnosis of a health condition, illness, or disease
3 related to COVID-19, and for the administration of COVID-19
4 vaccines, and including effective date and retroactive
5 applicability provisions.
6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
Section 1. NEW SECTION. 514C.36 COVID-19 — coverage.
1. As used in this section, unless the context otherwise requires:
   a. "Commissioner" means the commissioner of insurance.
   b. "Cost-sharing" means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense obligation imposed on a covered person by a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses.
   c. "Covered person" means a policyholder, subscriber, or other individual participating in a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses.
   d. "COVID-19" means a severe acute respiratory syndrome coronavirus 2 or the disease caused by severe acute respiratory syndrome coronavirus 2.
   e. "Facility" means the same as defined in section 514J.102.
   f. "Health care professional" means the same as defined in section 514J.102.
   g. "Health care provider" means a health care professional or a facility.
   h. "Health care services" means services for the assessment or diagnosis of a health condition, illness, or disease related to COVID-19.
   i. "Vaccines" means any vaccine for COVID-19 licensed by the United States food and drug administration, or for which the United States food and drug administration has issued an emergency use authorization, and that is administered pursuant to guidance issued by federal, state, or county public health officials.
2. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan that provides for third-party payment or prepayment of health or medical expenses shall comply with the following requirements:
   a. Waive all cost-sharing requirements for health care
services recommended by a covered person's health care provider.

b. Waive all costs, including administration fees and cost-sharing requirements, for the administration of vaccines.
c. Waive prior authorization requirements for all health care services recommended by a covered person's health care provider, and for the administration of vaccines.
d. Waive all requirements mandating a covered person receive health care services or vaccines from an in-network health care provider if the policy, contract, or plan is unable to provide timely and reasonable in-network access to health care services recommended by a covered person's health care provider, or to vaccines.

3. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan that provides for third-party payment or prepayment of health or medical expenses shall not retroactively deny reimbursement to a health care provider that provided health care services or that administered a vaccine to a covered person, based on any of the following:
a. The health care provider's network status.
b. The covered person receiving a diagnosis other than a diagnosis related to COVID-19.

4. All requirements pursuant to subsections 2 and 3 shall be communicated in writing in a policy, contract, or plan that provides for third-party payment or prepayment of health or medical expenses to all covered persons and to all health care providers that are contracted with the policy, contract, or plan.

5. This section applies to the following classes of third-party payment provider policies, contracts, or plans:
a. Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.
b. An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.
c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. A plan established pursuant to chapter 509A for public employees.

e. The medical assistance program established pursuant to chapter 249A, including a managed care organization acting pursuant to a contract with the department of human services to provide coverage to medical assistance program members.

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

7. The commissioner shall adopt rules pursuant to chapter 17A to administer this section. Such rules shall include the requirement that all policies, contracts, or plans that provide for third-party payment or prepayment of health or medical expenses adopt a uniform system of billing that allows health care providers to timely process billing codes related to health care services and vaccines provided pursuant to this section.

Sec. 2. EMERGENCY RULES. The commissioner may adopt emergency rules under section 17A.4, subsection 3, and section 17A.5, subsection 2, paragraph "b", to implement this Act and the rules shall be effective immediately upon filing unless a later date is specified in the rules. Any rules adopted in accordance with this section shall also be published as a notice of intended action as provided in section 17A.4.

Sec. 3. EFFECTIVE DATE. This Act, being deemed of immediate importance, takes effect upon enactment.

Sec. 4. RETROACTIVE APPLICABILITY. This Act applies retroactively to January 1, 2020, for policies, contracts, or
plans that are delivered, issued for delivery, continued, or renewed in this state on or after that date.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to health insurance coverage for the assessment or diagnosis of a health condition, illness, or disease related to COVID-19, and for the administration of COVID-19 vaccines. The bill requires policies, contracts, and plans (plans) that provide for third-party payment or prepayment of health or medical expenses to waive all cost-sharing requirements and prior authorization requirements for health care services recommended by a covered person's health care provider. The plans must also waive all costs, including administration fees and cost-sharing requirements, for the administration of vaccines. "Vaccines" is defined in the bill as any vaccine for COVID-19 licensed by the United States food and drug administration, or for which the United States food and drug administration has issued an emergency use authorization, and that is administered pursuant to guidance issued by federal, state, or county public health officials. In addition, the plans must waive all requirements mandating that a covered person receive health care services in-network if the plan is unable to provide timely and reasonable in-network access to health care services recommended by the covered person's health care provider, or to vaccines. "Health care services" is defined in the bill as services for the assessment or diagnosis of a health condition, illness, or disease related to COVID-19. The bill prohibits plans from retroactively denying reimbursement, based on a health care provider's network status or a covered person receiving a diagnosis other than a diagnosis related to COVID-19, to a health care provider that provided health care services or vaccines to a covered person. The bill requires plans to communicate these requirements in
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writing to all covered persons and to all health care providers that are contracted with the plan.

The bill specifies the types of specialized health-related insurance that are not subject to the bill. The commissioner of insurance is required to adopt rules to administer the bill and the rules must include the requirement that all plans adopt a uniform system of billing that allows health care providers to timely process billing codes related to health care services provided to covered persons. The commissioner may also adopt emergency rules as outlined in the bill.

The bill takes effect upon enactment and applies retroactively to plans that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2020, by the third-party payment providers enumerated in the bill.