HEALTH BENEFIT PLANS

CHAPTER 71*
SMALL GROUP HEALTH BENEFIT PLANS

191—71.1(513B) Purpose. This chapter is intended to implement the provisions of Iowa Code chapter 513B to provide for the guaranteed issue of all health insurance products in the small group market, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health insurance coverages; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of "basic" and "standard" health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; to improve the overall fairness and efficiency of the small group health insurance market and to promote broader spreading of risk in the small employer marketplace. Carriers and ODSs that provide basic and standard health benefit plans, as herein set forth, to small employers are intended to be subject to all provisions of Iowa Code chapter 513B and this chapter of rules.

71.1(1) Health insurance coverage subject to this chapter is available or renewable with respect to all eligible employees or their dependents, at the option of the employer, except for reasons set forth in Iowa Code section 513B.5.

71.1(2) A carrier or organized delivery system subject to this chapter is required to guarantee issue small employer plans except for reasons set forth in Iowa Code chapter 513B.

191—71.2(513B) Definitions. As used in this chapter:

"Associate member of an employee organization" means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. 1002(1)) that is a multiemployer plan (as defined in 29 U.S.C. 1002(37A)), other than the following:

1. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or
2. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan).

"Beneficiary" has the meaning given the term under Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which states, "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit" under the plan.

"Bona fide association" means, with respect to group health insurance coverage offered in Iowa, an association that meets the following conditions:

1. Has been actively in existence for at least five years.
2. Has been formed and maintained in good faith for purposes other than obtaining insurance.
3. Does not condition membership in the association on any health status-related factor relating to an individual including an employee of an employer or a dependent of any employee.
4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member.

*NOTE: In some instances, the numbering of this chapter does not adhere to the scheme developed for the Iowa Administrative Code.

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Continuation coverage" means coverage under a COBRA continuation provision or a similar state program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar state program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

"Creditable coverage" includes short-term limited duration insurance.

"Director" means the director of public health appointed pursuant to Iowa Code section 135.2.

"Employee" means any individual employed by an employer.

"Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

"Exhaustion of continuation coverage" means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted continuation coverage if:

1. Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or

2. When the individual no longer resides, lives, or works in a service area of an HMO or similar program, whether or not within the choice of the individual, and there is no other continuation coverage available to the individual.

"Health insurance coverage" does not include the following:

1. Flexible spending accounts.
2. Short-term limited duration insurance.
3. Stop loss insurance coverage.

"Health maintenance organization" or *"HMO"* means a federally qualified health maintenance organization as defined in Section 1301(a) of the Public Health Services Act or an organization licensed under Iowa Code section 514.5.

"Late enrollee" means an individual, other than one who enrolls during a special enrollment period, who enrolls under a health benefit plan or health insurance coverage in connection with which it is issued, other than during the first period in which the individual is eligible to enroll under terms of the health benefit plan or group health plan.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier.

"New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in health insurance coverage.

"Organized delivery system" or *"ODS"* means an organized delivery system licensed by the director.

"Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

1. The deductible/limit year used under the plan.
2. If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year.
3. If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year.

"Preexisting condition exclusion" means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

"Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

"Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

"Short-term limited duration insurance" means health insurance coverage provided under a contract with a carrier or ODS that has an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder without the carrier's or ODS's consent, that is, within 12 months of the date the contract becomes effective.

"Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

"Special enrollment period" means a period other than the first period in which an eligible employee or a dependent is eligible to enroll under the terms of group health insurance coverage in connection with which it is issued, without regard to other enrollment periods defined under the health insurance coverage.

"Waiting period" means, with respect to group health insurance coverage and an eligible employee or a dependent who is potentially eligible for coverage under the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

Other terms shall be defined pursuant to Iowa Code chapter 513B.

191—71.3(513B) Applicability and scope.

71.3(1) *a.* Except as provided herein, this chapter shall apply to any health insurance coverage, whether provided on a group or individual basis, which:

(1) Meets one or more of the conditions set forth in Iowa Code sections 513B.3(1) to 513B.3(3);

(2) Provides coverage to one or more employees of a small employer located in this state without regard to whether the policy or certificate was issued in this state; and

(3) Is in effect on or after July 1, 1991.

b. Except as specifically provided, the provisions of Iowa Code chapter 513B and this chapter shall not apply to health insurance coverages delivered or issued for delivery prior to the effective date of the Act.

71.3(2) *a.* A carrier or ODS that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier or ODS and subject to the provisions of Iowa Code chapter 513B and this chapter with respect to such policies if the small employer contributes, directly or indirectly, to the premiums for the policies and the carrier or ODS is aware, or should have been aware, of such contribution.

b. In the case of a carrier or ODS that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered an eligible small employer as defined in 513B.10 and the small employer carrier subject to 513B.10(1)*"b"*(2) if:

(1) The small employer has at least two employees;

(2) The small employer contributes, directly or indirectly, to the premiums charged by the carrier or ODS; and

(3) The carrier or ODS is aware, or should have been aware, of the contribution by the employer.

71.3(3) Iowa Code chapter 513B and this chapter shall apply to health insurance coverage provided to a small employer or to the employees of a small employer without regard to whether the health insurance coverage is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

71.3(4) An individual health insurance policy shall not be subject to 513B and this chapter solely because the policyholder elects a business expense deduction under Section 162(1) of the Internal Revenue Code, the health insurance coverage is treated as part of a plan or program for purposes of Section 125 of the Internal Revenue Code for which the employee makes all the contributions, the employer provides payroll deduction of health insurance premiums on behalf of an employee if the health insurance coverage covers employees where the employer has applied for group health benefits and has received written notification that the group did not meet the small group carrier's or ODS's minimum participation or contribution standards. The individual health insurance carrier or ODS shall maintain a copy of the employer's notification from the small group carrier for insurance division audit purposes.

71.3(5) *a.* If a small employer is issued health insurance coverage under the terms of 513B, the provisions of 513B and this chapter shall continue to apply to the health insurance coverage in the case that the small employer subsequently employs more than 50 eligible employees. A carrier or ODS providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 50 eligible employees but no later than the anniversary date of the employer's health insurance coverage, notify the employer that the protections provided under 513B and this chapter shall cease to apply to the employer if such employer fails to renew its current health insurance coverage or elects to enroll in different health insurance coverage. It is the responsibility of the employer to notify the carrier or ODS of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

b. (1) If health insurance coverage is issued to an employer that is not a small employer as defined, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of Iowa Code chapter 513B shall not apply to the health insurance coverage. The carrier or ODS providing health insurance coverage to such an employer shall not become a small employer carrier or ODS under the terms of Iowa Code chapter 513B solely because the carrier or ODS continues to provide coverage under the health insurance coverage to the employer.

(2) A carrier or ODS providing coverage to an employer described in subparagraph *"b"*(1) shall, within 60 days of becoming aware that the employer has 50 or fewer eligible employees, notify the employer of the options and protections available to the employer under 513B, including the employer's option to purchase a small employer health insurance coverage from any small employer carrier or ODS. It is the responsibility of the employer to notify the carrier of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

71.3(6) *a.* (1) If a small employer has employees in more than one state, Iowa Code chapter 513B and this chapter shall apply to health insurance coverage issued to the small employer if:

1. The majority of eligible employees of such small employer are employed in this state; or

2. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(2) In determining whether the laws of this state or another state apply to health insurance coverage issued to a small employer described in subparagraph (1), the provisions of the paragraph shall be applied as of the date the health insurance coverage was issued to the small employer for the period that the health insurance coverage remains in effect.

b. If health insurance coverage is subject to Iowa Code chapter 513B and this chapter, the provisions of 513B and those set forth herein shall apply to all individuals covered under the health insurance coverage whether they reside in this state or in another state.

71.3(7) A carrier or ODS that is not operating as a small employer carrier or ODS in this state shall not become subject to the provisions of the Act and this regulation solely because a small employer that was issued health insurance coverage in another state by that carrier or ODS moves to this state.

191—71.4(513B) Establishment of classes of business.

71.4(1) A small employer carrier or ODS that establishes more than one class of business as defined in Iowa Code section 513B.2 shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

a. A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

b. A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons as set forth in the definition of "class of business" in Iowa Code section 513B.2;

c. A statement disclosing which, if any, health insurance coverages are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

71.4(2) A carrier or ODS may not directly or indirectly use group size as a criterion for establishing eligibility for health insurance coverage or for a class of business.

191—71.5(513B) Transition for assumptions of business from another carrier.

71.5(1) ***a.*** A small employer carrier or ODS shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless:

(1) The transaction has been approved by the commissioner of the state of domicile of the assuming carrier or ODS;

(2) The transaction has been approved by the commissioner of the state of domicile of the ceding carrier or ODS; and

(3) The transaction otherwise meets the requirements of this rule and 513B.3(4)"*c.*"

b. A carrier or ODS domiciled in this state that proposes to assume or cede the entire insurance obligation or risk of one or more small employer health benefit plans from another carrier or ODS shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health insurance coverages to be transferred and is consistent with the purposes of Iowa Code chapter 513B and this chapter. The commissioner shall not approve the transaction until at least 30 days after the date of the filing except that, if the ceding carrier or ODS is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems reasonable after the filing.

c. (1) The filing required under paragraph 71.5(1)*"b"* shall:

1. Describe the class of business (including any eligibility requirements) of the ceding carrier or ODS from which the health insurance coverage will be ceded;

2. Describe whether the assuming carrier or ODS will maintain the assumed health insurance coverage as a separate class of business (pursuant to 71.5(3)) or will incorporate them into an existing class of business (pursuant to 71.5(4)). If the assumed health insurance coverage will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier or ODS into which the health insurance coverages will be incorporated;

3. Describe whether the health insurance coverages being assumed are currently available for purchase by small employers;

4. Describe the potential effect of the assumption (if any) on the benefits provided by the health insurance coverages to be assumed;

5. Describe the potential effect of the assumption (if any) on the premiums for the health insurance coverages to be assumed;

6. Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health insurance coverages to be assumed; and

7. Include any other information required by the commissioner.

(2) A small employer carrier or ODS required to make a filing under 71.5(1)*"b"* shall also make an informational filing with the commissioner of each state in which there are small employer health insurance coverages that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under 71.5(1)*"b"* and shall include at least the information specified in 71.5(1)*"c"*(1) for the small employer health insurance coverages in that state.

d. A small employer carrier or ODS shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless it complies with the following provisions:

(1) The carrier or ODS has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in 71.5(1)*"c"* for the health insurance coverages covering small employers in this state.

(2) If the assumption of a class of business would result in the assuming small employer carrier or ODS being out of compliance with the limitations related to premium rates contained in Iowa Code section 513B.4(1)*"a,"* the assuming carrier or ODS shall make a filing with the commissioner pursuant to Iowa Code section 513B.17 seeking suspension of the application of 513B.4(1)*"a."*

(3) An assuming carrier or ODS seeking suspension of the application of Iowa Code paragraph 513B.4(1)*"a"* shall not complete the assumption of health insurance coverages covering small employers in this state unless the commissioner grants the suspension requested pursuant to 71.5(1)*"d"*(2).

(4) Unless a different period is approved by the commissioner, a suspension of the application of 513B.4(1)*"a"* shall, with respect to an assumed class of business, be for no more than 15 months and, with respect to each individual small employer, last only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the class of business).

71.5(2) *a.* Except as provided in paragraph 71.5(1)*"b,"* a small employer carrier or ODS shall not cede or assume the entire insurance obligation or risk for small employer health insurance coverage unless the transaction includes ceding to the assuming carrier or ODS the entire class of business that includes such health insurance coverage.

b. A small employer carrier or ODS may cede less than an entire class of business to an assuming carrier if:

(1) One or more small employers in the class have exercised their right under contract or state law to reject (either directly or by implication) the ceding of their health insurance coverage to another carrier or ODS. In that instance, the transaction shall include each health insurance coverage in the class of business except those health insurance coverages for which a small employer has rejected the proposed cession; or

(2) After a written request from the transferring carrier, the commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business.

71.5(3) Except as provided in 71.5(4), a small employer carrier or ODS that assumes one or more health insurance coverages from another carrier or ODS shall maintain such health insurance coverages as a separate class of business.

71.5(4) A small employer carrier or ODS that assumes one or more health insurance coverages from another carrier or ODS may exceed the limitation contained in Iowa Code section 513B.2 (relating to the maximum number of classes of business a carrier or ODS may establish) due solely to such assumption for a period of up to 15 months after the date of the assumption, provided that the carrier or ODS complies with the following provisions:

a. Upon assumption of the health insurance coverages, such health insurance coverages shall be maintained as a separate class of business. During the 15-month period following the assumption, each of the assumed small employer health insurance coverages shall be transferred by the assuming small employer carrier or ODS into a single class of business operated by the assuming small employer carrier or ODS. The assuming small employer carrier or ODS shall select the class of business into which the assumed health insurance coverages will be transferred in a manner that results in the least possible change to the coverages and rating method of the assumed health insurance coverages.

b. The transfers authorized in paragraph *"a"* shall occur, with respect to each small employer, on the anniversary date of the small employer's coverage, except that an individual small employer period may be extended beyond the first anniversary date up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the class of business.

c. A small employer carrier or ODS making a transfer pursuant to paragraph *"a"* may alter the benefits of the assumed health insurance coverages to conform to the benefits currently offered by the carrier in the class of business into which the health insurance coverages have been transferred.

d. The premium rate for an assumed small employer health insurance coverage shall not be modified by the assuming small employer carrier or ODS until the health insurance coverage is transferred pursuant to paragraph *"a."* Upon transfer, the assuming small employer carrier or ODS shall calculate a new premium rate for the health insurance coverage from the rate manual established for the class of business into which the health insurance coverage is transferred. In making such calculation, the risk load applied to the health insurance coverage shall be no higher than the risk load applicable to such health insurance coverage prior to the assumption.

e. During the 15-month period provided in this subrule, the transfer of small employer health insurance coverages from the assumed class of business in accordance with this subrule shall not be considered a violation of the first sentence of Iowa Code section 513B.4(4).

71.5(5) An assuming carrier or ODS may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health insurance coverage (or with respect to any health insurance coverage subsequently offered to a small employer covered by such an assumed health insurance coverage) that are more stringent than the requirements applicable to such health insurance coverage prior to the assumption.

71.5(6) The commissioner may approve a longer period of transition upon application of a small employer carrier or ODS. The application shall be made within 60 days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

71.5(7) Nothing in this rule or in Iowa Code chapter 513B is intended to:

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier or ODS related to the transaction;

b. Authorize a carrier or ODS that is not admitted to transact the business of insurance in this state to offer health insurance coverages in this state; or

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Iowa Code chapters 521 and 521B or otherwise provided by law.

191—71.6(513B) Restrictions relating to premium rates.

71.6(1) *a.* A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this rule. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

b. (1) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this paragraph. The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purpose of Iowa Code chapter 513B and this chapter.

(2) A carrier may modify the rating method for a class of business only with prior approval of the commissioner. A carrier requesting to change the rating method for a class of business shall make a filing with the commissioner at least 30 days prior to the proposed date of the change. The filing shall contain at least the following information:

1. The reasons the change in rating method is being requested;
2. A complete description of each of the proposed modifications to the rating method;
3. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than 10 percent due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in health insurance coverage);
4. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and
5. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Iowa Code section 513B.4.

(3) For the purpose of this rule a change in rating method shall mean:

1. A change in the number of case characteristics used by a small employer carrier or ODS to determine premium rates for health insurance coverages in a class of business;

2. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health insurance coverages in a class of business;

3. A change in the method of allocating expenses among health insurance coverages in a class of business; or

4. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10 percent.

For the purpose of subparagraph (3), paragraph "1" above, a change in a rating factor shall mean the cumulative change, with respect to such factor, considered over a 12-month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12-month period, the carrier shall consider the cumulative effect of all such changes in applying the 10 percent test under paragraph "1." A filing which has not previously been approved, denied, or questioned is deemed approved on or after 30 days from receipt by the division.

71.6(2) *a.* The rate manual developed pursuant to 71.6(1) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

b. A small employer carrier may not use case characteristics other than those specified in 513B.4(2) without the prior approval of the commissioner. A small employer carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under 71.6(1)*"b."*

c. A small employer carrier or ODS shall use the same case characteristics in establishing premium rates for each health insurance coverage in a class of business and shall apply them in the same manner in establishing premium rates for each health insurance coverage. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

d. The rate manual developed pursuant to 71.6(1) shall clearly illustrate the relationship among the base premium rates charged for each health insurance coverage in the class of business. If the new business premium rate is different than the base premium rate for a health insurance coverage, the rate manual shall illustrate the difference.

e. Differences among base premium rates for health insurance coverages shall be based solely on the reasonable and objective differences in the design and benefits of the health insurance coverages and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage. A small employer carrier or ODS shall apply case characteristics and rate factors within a class of business in a manner that ensures that premium differences among health insurance coverages for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health insurance coverages and are not due to the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage.

f. The rate manual developed pursuant to 71.6(1) shall provide for premium rates to be developed in a two-step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Iowa Code section 513B.4, to reflect the risk characteristics of the group.

g. (1) Except as provided in subparagraph (2), a premium charged to a small employer for a health insurance coverage shall not include a separate application fee, underwriting fee or any other separate fee or charge.

(2) A carrier or ODS may charge a separate fee with respect to a health insurance coverage (but only one fee with respect to such plan) provided the fee is no more than $5 per month per employee and is applied in a uniform manner to each health insurance coverage in a class of business.

h. A small employer carrier or ODS shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable a basis than expenses are allocated to other health insurance coverages in the class of business. The rate manual developed pursuant to 71.6(1) shall describe the method of allocating administrative expenses to the health insurance coverages in the class of business for which the manual was developed.

i. Each rate manual developed pursuant to 71.6(1) shall be maintained by the carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.

j. The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the commissioner.

71.6(3) If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than 20 percent.

71.6(4) The restrictions related to changes in premium rates in 513B.4(1)*"c"* and 513B.4(1)*"d"* shall be applied as follows:

a. A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

b. (1) If, for any health insurance coverage with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed the change in the base premium rate for the purposes of 513B.4(1)*"c"* and 513B.4(1)*"d."*

(2) If, for any health insurance coverages with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health insurance coverage shall be considered health insurance coverage into which the small employer carrier or ODS is no longer enrolling new small employers for the purposes of 513B.4(1)*"c"* and 513B.4(1)*"d."*

c. If, for any rating period, the change in the new business premium rate for health insurance coverage differs from the change in the new business premium rate for any other health insurance coverage in the same class of business by more than 20 percent, the carrier or ODS shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within 30 days of the beginning of the rating period.

d. A small employer carrier or ODS shall keep on file, for a period of at least six years, the calculations used to determine the change in base premium rates and new business premium rates for each health insurance coverage for each rating period.

71.6(5) *a.* Except as provided in paragraphs *"b"* through *"d,"* a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) The base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

(2) One plus the sum of:

1. The risk load applicable to the small employer during the previous rating period, and
2. Fifteen percent (prorated for periods of less than one year).

b. In the case of health insurance coverage into which a small employer carrier or ODS is no longer enrolling new small employers, a change in a premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) The base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by

(2) One plus the lesser of:

1. The change in the base rate or

2. The percentage change in the new business premium for the most similar health insurance coverage into which the small employer carrier or ODS is enrolling new small employers, multiplied by

(3) One plus the sum of:

1. The risk load applicable to the small employer during the previous rating period and

2. Fifteen percent (prorated for periods of less than one year).

c. In the case of health insurance coverage described in Iowa Code section 513B.4(2), if the current premium rate for the health insurance coverage exceeds the ranges set forth in 513B.4(1), the formulae set forth in paragraphs *"a"* and *"b"* will be applied as if the 15 percent adjustment provided in 71.6(5)*"a"*(2)"2" and 71.6(5)*"b"*(3)"2" were a zero percent adjustment.

d. Notwithstanding the provisions of paragraphs *"a"* and *"b,"* a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in 513B.4(1)*"b."*

71.6(6) *a.* A representative of a Taft Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the commissioner a request for the waiver of application of the provisions of 513B.4 with respect to such trust.

b. A request made under paragraph *"a"* shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provisions would:

(1) Adversely affect the participants and beneficiaries of the trust; and

(2) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

c. A waiver granted under 513B.4A shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.

191—71.7(513B) Requirement to insure entire groups.

71.7(1) *a.* A small employer carrier or ODS that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. The small employer carrier or ODS shall provide the same health insurance coverage to each employee and dependent.

b. Except as provided in Iowa Code section 513B.10(4) (with respect to exclusions for preexisting conditions), the choice among insurance coverages may not be limited, restricted or conditioned upon the risk characteristics of the employees or their dependents.

71.7(2) *a.* Except as provided in this subrule, a small employer carrier or ODS may not issue health insurance coverage to a small employer unless the health insurance coverage covers all eligible employees and all dependents of eligible employees.

b. A small employer carrier or ODS may issue health insurance coverage to a small employer that excludes an eligible employee or the dependent of an eligible employee only if:

(1) The excluded individual has coverage under health insurance coverage or other health coverage arrangement, including that set forth in Iowa Code chapter 514E, that provides coverage similar to or exceeding benefits provided under the basic health insurance coverage;

(2) The excluded individual does not have a risk characteristic or other attribute that would cause the carrier to make a decision with respect to premiums or eligibility for health insurance coverage that is adverse to the small employer;

(3) The excluded individual states in a signed waiver that the individual has had coverage under health insurance coverage or other health arrangement, including that set forth in Iowa Code chapter 514E, within the previous six months and reasonably expects to have coverage within the succeeding six months under health insurance coverage or other health arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

c. A small employer carrier or ODS shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees. The small employer carrier or ODS shall require the small employer to provide appropriate supporting documentation in the form of a W-2 Summary Wage and Tax Form and federal or state quarterly withholding statements for the current year and the year immediately preceding the year of application for coverage.

(1) A small employer carrier or ODS shall secure a waiver, with respect to each eligible employee and each dependent of an eligible employee, declining an offer of coverage under health insurance coverage provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health insurance coverage. The waiver form shall require that the reason for declining coverage is stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier or ODS for a period of six years.

(2) A small employer carrier or ODS shall obtain, with respect to each individual who submits a waiver under 71.7(2)*"c"*(1), information sufficient to establish that the waiver is permitted under 71.7(2)*"b."*

d. (1) A small employer carrier or ODS shall not issue coverage to a small employer if the carrier is unable to obtain the list required under 71.7(2)*"c,"* a waiver required under 71.7(2)*"c"*(1) or the information required under 71.7(2)*"c"*(2) in circumstances set forth in this subrule.

(2) 1. A small employer carrier or ODS shall not offer coverage to a small employer if the carrier or ODS, or a producer for such carrier or ODS, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

2. A producer shall notify a small employer carrier or ODS, prior to submitting an application for coverage with the carrier or ODS on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

71.7(3) *a.* New entrants to a small employer group shall be offered an opportunity to enroll in the health insurance coverage currently held by such group. A new entrant that does not exercise the opportunity to enroll in the health insurance coverage within the period provided by the small employer carrier or ODS may be treated as a late enrollee by the carrier or ODS, provided that the period provided to enroll in the health insurance coverage extends at least 30 days after the date the new entrant is notified of the opportunity to enroll. If a small employer carrier or ODS has offered more than one health insurance coverage to a small employer group pursuant to 71.7(1)*"b,"* the new entrant shall be offered the same choice of health insurance coverages as the other members of the group.

b. A small employer carrier or ODS shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with Iowa Code section 513B.10(4)), with respect to a new entrant that is longer than 60 days. This subrule does not affect an employer's ability to determine an employee's probationary period of work prior to the commencement of benefits.

c. New entrants to a group shall be accepted for coverage by the small employer carrier or ODS without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents except that a carrier may exclude coverage for preexisting medical conditions consistent with the provisions provided in 513B.10.

d. A small employer carrier or ODS may assess a risk load to the premium rate associated with a new entrant consistent with the requirements of Iowa Code section 513B.4. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

71.7(4) *a.* (1) In the case of an eligible employee (or dependent of an eligible employee) who, prior to July 1, 1993, was excluded from coverage or denied coverage by a small employer carrier or ODS in the process of providing health insurance coverage to an eligible small employer (as defined in Iowa Code section 513B.2(16)), the small employer carrier or ODS shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in health insurance coverage currently held by the small employer.

(2) A small employer carrier or ODS may require an individual who requests enrollment under this subrule to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual.

The opportunity to enroll shall meet the following requirements:

b. (1) The opportunity to enroll shall begin October 1, 1993, and extend for a period of at least three months.

(2) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subrule shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with 71.7(3).

(3) The terms of coverage offered to an individual described in subparagraph *"a"*(1) may exclude coverage for preexisting medical conditions if the health insurance coverage currently held by the small employer contains such an exclusion, provided that the exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this subrule.

(4) A small employer carrier or ODS shall provide written notice at least 45 days prior to the opportunity to enroll provided in 71.7(4)*"a"*(1) to each small employer insured under health insurance coverage offered by such carrier or ODS. The notice shall clearly describe the rights granted under this subrule to employees and dependents previously excluded or denied coverage and the process for enrollment of such individuals in the employer's health insurance coverage.

191—71.8(513B) Case characteristics.

71.8(1) A small employer carrier may use age, geographic area, family composition, and group size in establishing premium rates, subject to Iowa Code section 513B.4(2).

71.8(2) Additional rating factors are not allowed without the prior approval of the commissioner.

191—71.9(513B) Application to reenter state.

71.9(1) A carrier or ODS prohibited from writing coverage for small employers in this state pursuant to Iowa Code section 513B.5(2) may not resume offering health insurance coverage to small employers in this state until the carrier or ODS has made a petition to the commissioner or director to be reinstated as a small employer carrier or ODS and the petition has been approved by the commissioner or director. In reviewing a petition, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

71.9(2) In the case of a small employer carrier or ODS doing business in only one established geographic service area of the state, if the small employer carrier or ODS elects to nonrenew health insurance coverage under 513B.5, the small employer carrier or ODS shall be prohibited from offering health insurance coverages to small employers in any other geographic area of the state without the prior approval of the commissioner or director. In considering whether to grant approval, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

191—71.10(513B) Creditable coverage. For purposes of this chapter, creditable coverage shall have the same definition as 1997 Iowa Acts, House File 701, section 10.

191—71.11(513B) Rules related to fair marketing.

71.11(1) *a.* A small employer carrier or ODS shall actively market health insurance coverages including one basic and one standard health benefit plan to small employers in this state. A small employer carrier or ODS may not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier or ODS has good cause and has received the prior approval of the commissioner or director.

b. In marketing the basic and standard health benefit plans to small employers, a small employer carrier or ODS shall use at least the same sources and methods of distribution that it uses to market other health insurance coverages to small employers.

71.11(2) *a.* A small employer carrier or ODS, in accordance with the provisions of Iowa Code section 513B.10, shall accept every small employer that applies for health insurance coverage from the small employer carrier or ODS and shall accept every eligible individual who applies for enrollment. The offer shall be in writing and shall include at least the following information:

(1) A general description of the benefits contained in the basic and standard health benefit plans and any other health insurance coverage being offered to the small employer, and

(2) Information describing how the small employer may enroll in the plans.

The offer may be provided directly to the small employer or delivered through a producer.

b. (1) A small employer carrier or ODS shall provide a price quote to a small employer (directly or through an authorized producer) within ten working days of receiving a request for a quote and other information as necessary to provide the quote. A small employer carrier or ODS shall notify a small employer (directly or through an authorized producer) of any additional information needed by the small employer carrier or ODS to provide the quote within five working days of receiving a request for a price quote.

(2) A small employer carrier or ODS shall not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than applied for other health insurance coverage offered by the carrier or ODS.

c. Rescinded IAB 7/16/97, effective 7/1/97.

71.11(3) A small employer carrier or ODS shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health insurance coverages in this state. The service shall provide information to callers regarding application for coverage from the carrier or ODS. The information may include the names and telephone numbers of producers located in geographic proximity to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

71.11(4) The small group carrier or ODS shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier or ODS except, if membership in an association or other group is a requirement for accepting a small employer into health insurance coverage, a small employer carrier or ODS may apply such requirement.

71.11(5) A small employer carrier or ODS may not require, as a condition to the offer or sale of health insurance coverage to a small employer, that the small employer purchase or qualify for any other insurance product or service.

71.11(6) *a.* Carriers offering individual and group health insurance coverages in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513B and this chapter. Carriers or ODSs shall elicit the following information from applicants for such plans at the time of application:

(1) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(2) Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health insurance coverage as part of a plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106 of the United States Internal Revenue Code.

b. If a small employer carrier or ODS fails to comply with paragraph *"a,"* the small employer carrier or ODS shall be deemed on notice regarding any information that could reasonably have been attained if the small employer carrier had complied with paragraph *"a."*

71.11(7) *a.* A small employer carrier or ODS shall annually file the following information with the commissioner related to health insurance coverages issued by the small employer carrier or ODS to small employers in this state:

(1) The number of small employers that were issued health insurance coverages in the previous calendar year (separated as to newly issued plans and renewals);

(2) The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year (separated as to newly issued plans and renewals and as to class of business);

(3) The number of small employer health insurance coverages in force in each county (or by ZIP code) of the state as of December 31 of the previous calendar year;

(4) The number of small employer health insurance coverages that were voluntarily not renewed by small employers in the previous calendar year;

(5) The number of small employer health insurance coverages that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and

(6) The number of small employer health insurance coverages that were issued to small employers that were uninsured for at least the three months prior to issue.

b. The information described in paragraph *"a"* shall be filed no later than March 15 of each year.

71.11(8) A small group carrier shall not price the basic and standard benefit plans nor set the commissions in such a way to make the plans unattractive for a producer to market. A small employer carrier shall provide reasonable compensation, as provided in the plan of operation, to a producer, if any, for the sale of a basic or standard health benefit plan.

71.11(9) A small employer carrier shall establish commission payments for the sale of basic and standard health benefit plans within each class of business at no less than 75 percent of the level of commission payments assessed on other small group health products.

191—71.12(513B) Status of carriers as small employer carriers.

71.12(1) Subject to 71.12(2), a carrier or ODS shall not offer health insurance coverages to small employers or continue to provide coverage under health insurance coverages previously issued to small employers in this state unless the carrier or ODS has made a filing with the commissioner or director that the carrier or ODS intends to operate as a small employer carrier or ODS in this state under the terms of this chapter.

71.12(2) *a.* If a carrier or ODS does not intend to operate as a small employer carrier or ODS in this state, the carrier or ODS may continue to provide coverage under health insurance coverages previously issued to small employers in this state only if the carrier or ODS complies with the following provisions:

(1) The carrier or ODS complies with the requirements of Iowa Code chapter 513B (other than sections 513B.11 to 513B.13) with respect to each of the health insurance coverages previously issued to small employers by the carrier or ODS.

(2) The carrier or ODS provides coverage to each new entrant to health insurance coverage previously issued to a small employer by the carrier or ODS. The provisions of Iowa Code chapter 513B (other than sections 513B.11 to 513B.13) and this chapter shall apply to the coverage issued new entrants.

(3) The carrier or ODS complies with the requirements of 513B.17A, and rule 71.13(513B), as they apply to small employers whose coverage has been terminated by the carrier or ODS, and to individuals and small employers whose coverage has been limited or restricted by the carrier or ODS.

b. A carrier or ODS that continues to provide coverage pursuant to this subrule shall not be eligible to participate in the reinsurance program established under Iowa Code section 513B.11.

71.12(3) If a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in 71.12(2)) for a period of five years from the date of this chapter. Upon a written request from such a carrier, the commissioner may reduce the period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state.

191—71.13(513B) Restoration of coverage.

71.13(1) *a.* Except as provided in 71.13(1)*"b,"* a small employer carrier or ODS shall, as a condition of continuing to transact business in this state with small employers, offer to provide health insurance coverage as described in 71.13(3) to any small employer carrier or ODS after January 1, 1993, unless the carrier's or ODS's termination is pursuant to Iowa Code section 513B.5.

b. The offer required under 71.13(1)*"a"* shall not be required with respect to health insurance coverage that was not renewed if:

(1) The health insurance coverage was not renewed for reasons permitted in Iowa Code section 513B.5(1), or

(2) The nonrenewal was a result of the small employer voluntarily electing coverage under different health insurance coverage.

71.13(2) The offer made under 71.13(1) shall occur not later than 60 days after July 2, 1993. A small employer shall be given at least 60 days to accept an offer made pursuant to 71.13(1).

71.13(3) A health insurance coverage provided to a terminated small employer pursuant to 71.13(1) shall meet the following conditions:

a. The health insurance coverage shall contain benefits that are identical to the benefits in the health insurance coverage that was terminated or nonrenewed.

b. The health insurance coverage shall not be subject to any waiting periods (including exclusion periods for preexisting conditions) or other limitations on coverage that exceed those contained in the health insurance coverage that was terminated or nonrenewed. In applying such exclusions or limitations, the health insurance coverage shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to 71.13(513B).

c. The health insurance coverage shall not be subject to any provisions that restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

d. The health insurance coverage shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier or ODS shall offer coverage to each dependent of such eligible employees.

e. The premium rate for the health insurance coverage shall be no more than the premium rate charged to the small employer on the date the health insurance coverage was terminated or nonrenewed provided that, if the number or case characteristics of the eligible employees (or their dependents) of the small employer has changed between the date the health insurance coverage was terminated or nonrenewed and the date that it is restored, the carrier or ODS may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier or ODS has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may be further adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health insurance coverage may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date the health insurance coverage is restored. Any such increase shall be subject to the provisions of Iowa Code section 513B.4.

f. The health insurance coverage shall not be eligible to be reinsured under the provisions of Iowa Code section 513B.12, except that the carrier or ODS may reinsure new entrants to the health insurance coverage who enroll after the restoration of coverage.

191—71.14(513B) Basic health benefit plan and standard health plan policy forms.

71.14(1) The form and level of coverage of the basic health benefit plan and the standard health benefit plan are contained in this rule. This rule provides the minimum benefit levels allowed and does not prevent carriers from voluntarily providing additional services to the basic health benefit plan or the standard health benefit plan.

71.14(2) The matrix and acceptable exclusions following this chapter are a guideline for the minimum benefit levels in a basic and standard health policy form.

71.14(3) Termination of pregnancy is to be covered in both policy forms when performed for therapeutic reasons. Elective termination of pregnancy is not to be covered in either the basic or standard form.

71.14(4) A provision shall be made in the basic health benefit plan and the standard health benefit plan covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis and treatment provided by a chiropractor licensed under Iowa Code chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor's license.

71.14(5) Prosthetic devices are covered when medically necessary.

71.14(6) Oral contraceptives are to be covered in both policy forms. Coverage for alternative forms of contraception is to be reviewed based on medical necessity.

71.14(7) Both policy forms shall cover well baby care consistent with Iowa Administrative Code 191—Chapter 80.

71.14(8) The division has available "safe harbor" policy forms for the basic and standard health insurance plans required pursuant to Iowa Code chapter 513B. These are model forms approved by the division as meeting the minimum requirements of a basic and a standard policy.

SMALL EMPLOYER PRODUCTS

	MANDATED INDEMNITY		MANDATED HMOs	
	BASIC	STANDARD	BASIC	STANDARD
Calendar Year Deductibles (S/F)	$500 x 3	$500 x 2		
E.R. Copayment	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)
Coinsurance	60%	80%	60%	80%
Out-of-pocket per insured/family maximum	$4,800/$14,400	$2,000/$4,000	$4,000/$8,000 (excludes deductibles and copays)	$2,000/$4,000
Annual Maximum				
Lifetime Maximum	$250,000	$1,000,000	$250,000	$1,000,000
Pre-Existing	513B.10(3)	513B.10(3)	513B.10(3)	513B.10(3)
Late Entrant	513B.2(12)	513B.2(12)	513B.2(12)	513B.2(12)
Wellness	100% first $100 60% over $100	100% first $150 80% over $150	100% after $20 copay per visit	100% after $15 copay per visit
Maternity	60% Enrollee or Spouse Only	80% Enrollee or Spouse	60%	80%
PHYSICIAN SERVICES				
Office Visits	60%(1)	80%(2)	$20 copay per office visit	$15 copay per office visit
Urgent Care	60%	80%	60%	80%
Inpatient	60%	80%	60%	80%
Outpatient	60%(1)	80%(2)	60%	80%
Vision Screening				
Vision Examinations				
Immunizations	60%(1)	80%(2)	60%	80%
Well Child	60%(1) (Deductible does not apply)	80%(2) (Deductible does not apply)	100% after $20 copay/visit	100% after $15 copay/visit
Pre-Natal/Post-Natal Outpatient Visits	60%(1)	80%(2)	100% after $50 copay/pregnancy	100% after $50 copay/pregnancy

(1)For wellness services, covered 100% first $100 and 60% over $100

(2)For wellness services, covered 100% first $150 and 80% over $150

HOSPITAL SERVICES	MANDATED INDEMNITY		MANDATED HMOs	
	BASIC	STANDARD	BASIC HMO	STANDARD HMO
Inpatient	60%	80%	60% of $400/admit	80% $200/admit
Prostheses	60%	80%	60%	80%
DME—including medical supplies	60%	80%	60%	80%
Ambulance-Emergency	60%	80%	60%	80%
Hospice	60%	80%	60%	80%
Home Health and Physician House Calls	60%	80%	60%	80%
ALCOHOLISM/ SUBSTANCE ABUSE				
Inpatient		80%(3)		80%(3)
Outpatient		80%(3) ($50 max. eligible fee)		80%(3)
MENTAL HEALTH				
Inpatient		80%(3)		80%(3)
Outpatient		80%(3) ($50 max. eligible fee)		80%(3)
RX	60%	80%	Copayment greater of $15 or 25%	Copayment greater of $10 or 25%
Transplants		80% $100,000 Lifetime Max.		80% $100,000 Lifetime Max.

(3)$50,000 lifetime max.

ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

Except as specifically provided for, no benefits will be provided for services, supplies or charges:

1. Which are not prescribed by, performed by, or upon the direction of a provider;

2. Which are not medically necessary;

3. Rendered by other than a hospital or a provider;

4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;

5. For any condition, disease, illness, or bodily injury which occurs in the course of employment if benefits or compensation is carried or required, in whole or in part, under the provisions of any legislation or governmental unit. This exclusion applies whether or not the insured claims the benefits or compensation;

6. To the extent benefits are provided by any governmental unit except as required by federal law for the treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions;

7. For any illness or injury suffered as a result of any act of war or while in the military service;

8. For which the insured would have no legal obligation to pay in the absence of this or any similar coverage;

9. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

10. Surgery and any related services intended solely to improve appearance including but not limited to the restoration of hair and appearance of skin. This does not include those services or surgeries that restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies of a newborn;

11. Rendered by a provider that is a member of the insured's immediate family;

12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;

13. Incurred after the date of termination of the insured's coverage;

14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;

15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;

16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;

17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;

18. For custodial care, domiciliary care or rest cures;

19. For treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence; (c) custodial care; (d) the aged; (e) the care or treatment of alcoholism or drug addiction; (f) rehabilitation; or (g) training, schooling or occupational therapy;

20. For screening examinations including X-ray examinations made without film;

21. For sterilization or reversal of sterilizations, or both;

22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;

23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, callouses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;

24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);

25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;

26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;

27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;

28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;

29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;

30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;

31. For travel whether or not recommended by a physician;

32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;

33. For maternity care of dependent children except for complications of pregnancy which is covered as any other illness;

34. For services to the extent that those services are covered by Medicare;

35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);

36. For or related to the transplantation of animal or artificial organs or tissues;

37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;

38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;

39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;

40. For the purchase of wigs or cranial prosthesis;

41. For weekend admission charges, except for emergencies and nonscheduled maternity admissions;

42. For orthomolecular therapy including nutrients, vitamins and food supplements;

43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.

71.14(9) All carriers shall provide benefits in the standard health benefit plan for the cost associated with equipment, supplies, and education for the treatment of diabetes pursuant to Iowa Code section 514C.14.

191—71.15(513B) Methods of counting creditable coverage.

71.15(1) For purposes of reducing any preexisting condition exclusion period, a group health plan, a carrier, or ODS offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in subrule 71.15(2), except that the plan, carrier, or ODS may use the alternative method under subrule 71.15(3) with respect to any or all of the categories of benefits described under paragraph 71.15(3)*"b."*

71.15(2) Under the standard method, a group health plan, a health insurance carrier, and an ODS offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

a. For purposes of reducing the preexisting condition exclusion period, a group health plan, a health insurance carrier, or ODS offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

b. Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

c. Notwithstanding any other provision of paragraph 71.15(2)*"b,"* for purposes of reducing a preexisting condition exclusion period, a group health plan, a health insurance carrier, and an ODS offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in paragraph 71.15(2)*"b."*

71.15(3) Under the alternative method, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in subparagraph 71.15(3)*"b"*(2) and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph 71.15(3)*"a."*

a. A plan, carrier, or ODS using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

b. The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

(1) Mental health.

(2) Substance abuse treatment.

(3) Prescription drugs.

(4) Dental care.

(5) Vision care.

c. If the alternative method is used, the plan is required to:

(1) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan;

(2) Include in these statements a description of the effect of using the alternative method, including an identification of the category's uses; and

(3) Under the alternative method, the group health plan, carrier, or ODS counts creditable coverage within a category if any level of benefits is provided within the category.

191—71.16(513B) Certificates of creditable coverage.

71.16(1) Group health plans, carriers, and ODSs shall issue certificates of creditable coverage to persons losing coverage. A group health plan, carrier, or ODS required to provide a certificate under this rule for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

a. Automatically upon the termination of an individual's group coverage;

b. Automatically upon the termination of COBRA coverage;

c. Upon request within 24 months after coverage ends.

71.16(2) Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

a. The individual requesting the certificate is not entitled to receive a certificate;

b. The individual requests that the certificate be sent to another plan or carrier or ODS;

c. The plan, carrier, or ODS receiving the certificate agrees to accept the information through means other than a written certificate;

d. The plan, carrier, or ODS receiving the certificate receives the certificate within a reasonable amount of time.

71.16(3) Required information. The certificate shall include the following information:

a. The date the certificate is issued;

b. The name of the group plan providing coverage;

c. The name of the employee or dependent to whom the certificate applies, other relevant identifying information, and the name of the employee if the certificate is for a dependent;

d. The plan administrator's name, address and telephone number;

e. A telephone number to call for further information if different from above;

f. Either a statement that the person has at least 18 months' creditable coverage without a significant break of coverage or the date any waiting period and creditable coverage began;

g. The date creditable coverage ended or an indication that the coverage is in force.

71.16(4) Family information. Information for families may be combined on one certificate. Any differences in creditable coverages shall be clearly delineated.

71.16(5) Dependent coverage transition rule. A group health plan or carrier or ODS that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

71.16(6) Delivering certificates. The certificate shall be given to the individual, plan or carrier or ODS requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

71.16(7) A group health plan, carrier, or ODS shall establish a procedure for individuals to request and receive certificates.

71.16(8) A certificate is not required to be furnished until the group health plan, carrier, or ODS knows or should have known that dependent's coverage terminated.

71.16(9) Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health plan, carrier, or ODS shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

191—71.17(513B) Notification requirements.

71.17(1) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents of:

a. The existence of any preexisting condition exclusions.

b. The length of time to which the exclusions will apply.

c. The right of the employee or dependent to appeal a decision to impose a preexisting condition exclusion.

d. The right of the person to demonstrate creditable coverage including:

(1) The right of the person to request a certificate from a prior group health plan, carrier, or ODS;

(2) A statement that the current group health plan, carrier, or ODS will assist in obtaining the certificate;

(3) That the group health plan, carrier, or ODS will use the alternative method of counting creditable coverage; and

(4) Special enrollment rights when an employee declines coverage for the employee or dependents.

71.17(2) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents of the modification of a prior creditable coverage decision when the group health plan, carrier, or ODS subsequently determines either no or less creditable coverage existed provided that the group health plan, carrier, or ODS acts according to its initial determination until the final determination is made.

191—71.18(513B) Special enrollments.

71.18(1) A carrier or organized delivery system shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health plan, if an eligible employee requests enrollment or, if the group health plan makes coverage available to dependents, on behalf of dependent who is eligible but not enrolled under the group health plan, during the special enrollment period, which shall be 30 days following an event described in subrules 71.18(2) and 71.18(3) with respect to the individual for whom enrollment is requested. A carrier or organized delivery system may impose enrollment requirements that are otherwise applicable under terms of the group health plan to individuals requesting immediate enrollment.

71.18(2) An individual, who previously had other coverage for medical care and for whom an eligible employee declined coverage under the group health plan, may be enrolled during a special enrollment period if the individual has lost the other coverage for medical care and:

a. If required by the group health plan, the eligible employee stated in writing when declining the coverage, after being given a notice of the requirement form, and the consequences of failure to submit a written statement that coverage was declined because the individual had coverage for medical care under another group health plan or otherwise; and

b. When enrollment was declined for the individual:

(1) The individual had coverage other than under a COBRA continuation provision and the coverage has been exhausted; or

(2) The individual had coverage other than under a COBRA continuation provision and the coverage has been terminated due to loss of eligibility for the coverage, including loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing, or termination of employer contributions toward the other coverage.

c. For purposes of this subparagraph 71.18(2)*"b"*(2):

(1) Loss of eligibility for the coverages does not include loss of eligibility due to the eligible employee's or dependent's failure to make timely premium payments or termination of coverage for cause such as making a fraudulent claim or intentional misrepresentation of material fact in connection with the group health plan; and

(2) Employer contributions include contributions by any current or former employer of the individual or another person that was contributing to coverage for the individual.

(3) Exhaustion of COBRA continuation coverage means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted COBRA continuation coverage if the coverage ceases.

71.18(3) If the eligible employee has previously declined enrollment under the group health plan but acquires a dependent through marriage, birth, adoption or placement for adoption, the eligible employee or dependent may be enrolled during the special enrollment period with respect to the individual.

71.18(4) Enrollment of the eligible employee or dependent is effective not later than the first day of the calendar month or, for a newborn or adopted child, on the date of birth, adoption, or placement for adoption.

191—71.19(513B) Disclosure requirements. All carriers and ODSs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier or ODS offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers and ODSs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—71.20(514C) Treatment options.

71.20(1) A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

71.20(2) A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

191—71.21(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

71.21(1) The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

71.21(2) The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

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

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

71.21(3) Reimbursement to a provider of "emergency services" shall not be denied by any carrier or ODS without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—71.22(514C) Provider access. A carrier shall allow a female enrollee direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

These rules are intended to implement Iowa Code chapters 513B and 514C and 1999 Iowa Acts, Senate File 276.

191—71.23(513B) Reconstructive surgery.

71.23(1) A carrier or organized delivery system that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

71.23(2) The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

71.23(3) Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

71.23(4) A carrier or organized delivery system shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier or organized delivery system shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

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