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SENATE FILE 2222

BY COMMITTEE ON HUMAN RESOURCES

(P.581) 3.14.94 House - Human Resources

(SUCCESSOR TO SSB 2201)

(p.636)

Passed Senate, Date 3-10-94

Passed House, Date \_\_\_\_\_

Vote: Ayes 26 Nays 24

Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_

Approved \_\_\_\_\_

A BILL FOR

1 An Act relating to health care reform, regulation of insurance  
2 and health care plan providers, income tax credits for certain  
3 individuals, establishing certain employer and individual  
4 requirements, establishing fees, and providing effective dates  
5 and applicability provisions.

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

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SF 2222

1 Section 1. INTENT AND FINDINGS. It is the intent of the  
2 general assembly that any significant health care reform must  
3 recognize the essential requirement that rural Iowa must have  
4 access to the benefits of affordable, accessible, and quality  
5 health care. Reform of the health care system in Iowa is not  
6 complete unless there is developed a strategy to address the  
7 needs of rural Iowa with subsequent implementation of a  
8 comprehensive system to meet those needs. Rural Iowans must  
9 be provided the same access to the best quality medical care  
10 available as Iowans residing in urban areas. The ability of  
11 hospitals and rural health clinics to access the state's fiber  
12 optic network is imperative. The complete use of the skills  
13 of all health care providers is essential to address the lack  
14 of access to primary care. New innovative initiatives for the  
15 delivery of care by rural hospitals and clinics must be  
16 encouraged.

17 The general assembly finds that given the rural bias  
18 inherent in the medicare system for hospital inpatient  
19 reimbursement, and the shortage of a number of important  
20 primary care providers, the challenges for health care reform  
21 in rural Iowa are significant. However, the general assembly  
22 believes that efforts to reform health care in Iowa coupled  
23 with the initiatives from the federal level offer a new  
24 opportunity to provide quality health care to rural Iowa. The  
25 general assembly finds that policymakers must seize this  
26 opportunity to ensure that rural Iowans will receive all the  
27 benefits of health care reform.

28 Sec. 2. Section 8.6, Code 1993, is amended by adding the  
29 following new subsection:

30 NEW SUBSECTION. 16. HEALTH ACCOUNTING SYSTEM. To  
31 establish a statewide health accounting system in coordination  
32 with the department of public health, the department of human  
33 services, the department of elder affairs, the department of  
34 employment services, and the insurance division of the  
35 department of commerce. The department of management shall

1 have access to all data, as deemed by the department to be  
2 necessary, in electronic format from the community health  
3 management information system established in chapter 144C.

4 Sec. 3. Section 18.133, subsection 2, Code Supplement  
5 1993, is amended to read as follows:

6 2. "Private agency" means an accredited nonpublic schools  
7 and school, nonprofit institutions institution of higher  
8 education eligible for tuition grants, hospital licensed  
9 pursuant to chapter 135B, rural health clinic defined pursuant  
10 to 42 U.S.C. § 1395(x), or physician clinic.

11 Sec. 4. Section 18.136, Code Supplement 1993, is amended  
12 by adding the following new subsection:

13 NEW SUBSECTION. 13A. Hospitals licensed pursuant to  
14 chapter 135B, rural health clinics defined pursuant to 42  
15 U.S.C. § 1395(x), and physician clinics shall be offered  
16 access to the network for diagnostic, clinical, consultative,  
17 data, and educational services for the purpose of developing a  
18 comprehensive, statewide telemedicine network.

19 Sec. 5. NEW SECTION. 135.110 ACCOUNTABLE HEALTH PLAN  
20 DEFINED.

21 An accountable health plan is an entity which does all of  
22 the following:

23 1. Pays for and provides health care services.

24 2. Is responsible for delivering the full range of health  
25 care services covered under a standard health benefit plan as  
26 established in chapter 513B.

27 3. Meets established solvency standards and complies with  
28 established underwriting standards, including modified  
29 community rating methods, for all beneficiaries served.

30 4. Is accountable to the public for the cost, quality, and  
31 access of the services which the accountable health plan  
32 provides and for the effects of its services on the health of  
33 those who are provided such services.

34 5. Is eligible for operation based on financial, quality  
35 of care, and structural qualifications.

1 6. Satisfies data reporting and collection standards.

2 Sec. 6. NEW SECTION. 135.111 RULES.

3 1. The director shall adopt rules relating to the  
4 establishment and regulation of accountable health plans. The  
5 rules shall allow significant flexibility in the structure and  
6 organization of an accountable health plan, including the  
7 flexibility to permit alternative structures for accountable  
8 health plans developed in rural areas of the state in response  
9 to the needs, preferences, and conditions of rural  
10 communities. Such plans shall utilize, to the greatest extent  
11 possible, existing health care providers and hospitals.

12 2. Rules adopted pursuant to this section shall include,  
13 at a minimum, all of the following:

14 a. Procedures for licensing accountable health plans as  
15 provided in section 135.112.

16 b. Procedures to sanction cooperative arrangements  
17 involving health care providers or purchasers in forming an  
18 accountable health plan, upon a finding by the director that  
19 the arrangement will improve quality, access, or affordability  
20 of health care, but which arrangement might be a violation of  
21 antitrust laws if undertaken without government direction and  
22 approval.

23 c. Procedures to assure ongoing supervision of  
24 arrangements sanctioned under paragraph "b" in order to assure  
25 that the arrangements do in fact improve the quality, access,  
26 or affordability of health care. The sanctioning of any  
27 arrangement by the director may be withdrawn on a prospective  
28 basis at the discretion of the director if necessary to  
29 enforce the intent to improve quality, access, or  
30 affordability.

31 d. Standards applicable to the plan of operation of an  
32 accountable health plan and which must be met for licensure of  
33 the plan. Such standards shall include standards related to  
34 the quality of health care provided.

35 e. A requirement that a plan of operation include

1 guaranteed access and rating practices no more restrictive  
2 than those required in the applicable state-regulated  
3 insurance market segment.

4 f. Procedures to collect information, directly or by other  
5 means as determined by the department, from the accountable  
6 health plan for purposes of monitoring quality, cost, and  
7 access standards. The department may access data collected  
8 through the community health management information system for  
9 purposes of implementing this chapter at a cost not to exceed  
10 the actual costs of reproducing the information for the  
11 division.

12 g. A method or methods to facilitate and encourage the  
13 appropriate provision of services by midlevel health care  
14 practitioners and allied health care practitioners.

15 h. Procedures to assure that all health carriers,  
16 including health maintenance organizations, insurers, and  
17 nonprofit health service plan corporations are subject to the  
18 same rules, to the extent the health carrier is operating an  
19 accountable health plan or is a participating entity in an  
20 accountable health plan.

21 i. Solvency standards to assure an accountable health  
22 plan's ability to deliver required services. The director may  
23 enter into an agreement with the insurance division of the  
24 department of commerce to conduct such solvency oversight.  
25 The insurance division shall assess the costs of a solvency  
26 examination against the entity being examined in the same  
27 manner and on the same terms as provided for insurance  
28 companies under section 505.7.

29 j. Publication and dissemination of statewide and  
30 localized expenditure targets relevant to each accountable  
31 health plan, as appropriate.

32 k. Provide for the identification of essential community  
33 providers within the service area of each accountable health  
34 plan. "Essential community providers" means those health care  
35 providing organizations which the director deems to be vital

1 to a local health care delivery system to ensure that all  
2 citizens of this state have reasonable access to health care.  
3 Accountable health plans must establish working relationships  
4 with essential community providers and include them within the  
5 plan's plan of operation in delivering health care within the  
6 plan's service area. This paragraph is repealed effective  
7 July 1, 1999.

8 1. Provisions for the identification of market areas to be  
9 serviced by each accountable health plan. Rules developed  
10 pursuant to this paragraph shall promote expansion of  
11 accountable health plans into all geographic areas of the  
12 state.

13 m. The director shall make, or cause to be made,  
14 inspections as the director deems necessary in order to  
15 determine compliance with section 135.110, this section, and  
16 sections 135.112 and 135.113, and applicable rules.

17 3. This section and rules adopted pursuant to this section  
18 are intended to provide immunity from federal antitrust law  
19 under the state action doctrine exemption.

20 Sec. 7. NEW SECTION. 135.112 LICENSING REQUIRED.

21 1. An accountable health plan shall not operate unless the  
22 plan is licensed by the department. The director shall adopt  
23 rules as provided in section 135.111 establishing a licensing  
24 procedure. A license shall not be issued by the department  
25 unless the director finds that the accountable health plan  
26 satisfies, at a minimum, all of the following:

27 a. The ability to be responsible for the full continuum of  
28 required health care and related costs for the defined  
29 population that the accountable health plan will serve.

30 b. Financial solvency.

31 c. The ability to satisfy established standards related to  
32 the quality of care provided.

33 d. The ability to fully comply with the provisions of this  
34 section and all applicable rules.

35 2. The department shall establish by rule a reasonable

1 filing fee to be submitted with a license application and each  
2 renewal application. A license shall be renewed annually. A  
3 license issued pursuant to this section expires on December 31  
4 of the calendar year for which the license was granted. Fees  
5 received by the department shall be retained by the department  
6 to offset costs associated with the administration of this  
7 chapter.

8 3. An accountable health plan may be organized and  
9 licensed as a nonprofit or for-profit plan.

10 Sec. 8. NEW SECTION. 135.113 DEFINITIONS.

11 For purposes of sections 135.110 through 135.112, unless  
12 the context otherwise requires:

13 1. "Hospital" means as defined in section 135B.1.

14 2. "Health care provider" or "provider" or "practitioner"  
15 means a person licensed or certified pursuant to chapter 147,  
16 148, 148A, 148C, 149, 150, 150A, 151, 152, 153, 154, 154B, or  
17 155A, to provide professional health care services in this  
18 state to an individual during the individual's medical care,  
19 treatment, or confinement.

20 Sec. 9. Section 422.7, Code Supplement 1993, is amended by  
21 adding the following new subsection:

22 NEW SUBSECTION. 29. Subtract, to the extent not otherwise  
23 deducted in computing adjusted gross income, the amounts paid  
24 by the taxpayer for the purchase of health insurance for the  
25 taxpayer or taxpayer's spouse or dependent.

26 Sec. 10. Section 422.7, Code Supplement 1993, is amended  
27 by adding the following new subsection:

28 NEW SUBSECTION. 30. Subtract, to the extent included, the  
29 amount of contributions made on behalf of the taxpayer to a  
30 medical care savings account and interest earned on moneys in  
31 the account if not otherwise withdrawn.

32 Sec. 11. Section 505.7, subsection 1, Code Supplement  
33 1993, is amended to read as follows:

34 1. All fees and charges which are required by law to be  
35 paid by insurance companies, and associations, and other

1 regulated entities shall be payable to the commissioner of the  
2 insurance division of the department of commerce or department  
3 of revenue and finance, as provided by law, whose duty it  
4 shall be to account for and pay over the same to the treasurer  
5 of state at the time and in the manner provided by law for  
6 deposit in the general fund of the state.

7 Sec. 12. Section 505.7, Code Supplement 1993, is amended  
8 by adding the following new subsection:

9 NEW SUBSECTION. 8. The commissioner may assess the costs  
10 of an audit or examination to a health insurance purchasing  
11 cooperative authorized under section 514I.1, in the same  
12 manner as provided for insurance companies under sections  
13 507.7 through 507.9, and may establish by rule reasonable  
14 filing fees to fund the cost of regulatory oversight.

15 Sec. 13. Section 505.8, Code 1993, is amended by adding  
16 the following new subsection:

17 NEW SUBSECTION. 6. The commissioner shall supervise all  
18 health insurance purchasing cooperatives providing services or  
19 operating within the state and the organization of domestic  
20 cooperatives. The commissioner may admit nondomestic health  
21 insurance purchasing cooperatives under the same standards as  
22 domestic cooperatives. Health insurance purchasing  
23 cooperatives are subject to rules adopted by the commissioner  
24 pursuant to section 514I.1.

25 Sec. 14. Section 509A.6, Code 1993, is amended by adding  
26 the following new unnumbered paragraph:

27 NEW UNNUMBERED PARAGRAPH. The governing body may also  
28 enroll in and contract with a health insurance purchasing  
29 cooperative authorized pursuant to section 514I.1.

30 Sec. 15. NEW SECTION. 509A.16 USE OF STATE GROUP  
31 INSURANCE RESERVES.

32 1. Notwithstanding section 509A.5, the director of the  
33 department of management may approve expenditures of up to  
34 three hundred thousand dollars per fiscal year, from that  
35 portion of the employer share of the state group insurance

1 reserves which consists of moneys appropriated from the  
2 general fund of the state but which is not needed to fund  
3 incentive programs, for the purposes of health reform  
4 activities.

5 2. This section is repealed effective July 1, 1996.

6 Sec. 16. Section 513B.2, subsection 16, Code Supplement  
7 1993, is amended to read as follows:

8 16. "Small employer" means a person actively engaged in  
9 business who, on at least fifty percent of the employer's  
10 working days during the preceding year, employed not less than  
11 two and not more than ~~twenty-five~~ fifty full-time equivalent  
12 eligible employees. In determining the number of eligible  
13 employees, companies which are affiliated companies or which  
14 are eligible to file a combined tax return for purposes of  
15 state taxation are considered one employer.

16 Sec. 17. Section 513B.4, Code Supplement 1993, is amended  
17 by adding the following new subsection:

18 NEW SUBSECTION. 1A. Notwithstanding subsection 1, there  
19 shall be no variance in premium rates for a basic or standard  
20 benefit plan offered pursuant to this chapter for any of the  
21 factors as provided for in subsection 1.

22 Sec. 18. Section 513B.4, subsection 2, unnumbered  
23 paragraph 2, Code Supplement 1993, is amended by striking the  
24 paragraph and inserting in lieu thereof the following:

25 Case characteristics other than age, geographic area,  
26 family composition, and group size shall not be used by a  
27 small employer carrier without the prior approval of the  
28 commissioner.

29 Sec. 19. Section 513B.4, Code Supplement 1993, is amended  
30 by adding the following new subsection:

31 NEW SUBSECTION. 5. Notwithstanding subsection 1, the  
32 commissioner may by order reduce or eliminate the allowed  
33 rating bands provided under subsection 1, paragraphs "a", "b",  
34 and "c", or otherwise limit or eliminate the use of experience  
35 rating.

1 Sec. 20. Section 513B.37, subsection 1, paragraph a, Code  
2 Supplement 1993, is amended to read as follows:

3 a. What benefits or direct pay requirements must be  
4 minimally included in a basic or standard benefit coverage  
5 policy or subscription contract.

6 Sec. 21. Section 513B.38, Code Supplement 1993, is amended  
7 by adding the following new subsections:

8 NEW SUBSECTION. 4. Upon the determination of the  
9 commissioner pursuant to section 513B.37, subsection 1,  
10 paragraph "a", to include expanded preventative care services  
11 and mental health and substance abuse treatment coverage as  
12 recommended by the Iowa health reform council, the  
13 commissioner shall do all of the following:

14 a. Adopt by rule, with all due diligence, requirements for  
15 the provision of expanded coverage for benefits for expanded  
16 preventative care services.

17 b. Adopt by rule, with all due diligence, requirements for  
18 the provision of limited coverage for benefits for mental  
19 health and substance abuse services.

20 NEW SUBSECTION. 5. A policy of accident and sickness  
21 insurance, a health maintenance organization contract, an  
22 accountable health plan contract, or other policy of health  
23 insurance shall not provide a lifetime maximum limit of  
24 coverage.

25 Sec. 22. NEW SECTION. 513C.1 SHORT TITLE.

26 This chapter shall be known and may be cited as the  
27 "Individual Health Insurance Market Reform Act".

28 Sec. 23. NEW SECTION. 513C.2 PURPOSE.

29 The purpose and intent of this chapter is to promote the  
30 availability of health insurance coverage to individuals  
31 regardless of their health status or claims experience, to  
32 prevent abusive rating practices, to require disclosure of  
33 rating practices to purchasers, to establish rules regarding  
34 the renewal of coverage, to establish limitations on the use  
35 of preexisting condition exclusions, to provide for the

1 development of a core group of basic or standard health  
2 benefits to be offered to all individuals, and to improve the  
3 overall fairness and efficiency of the individual health  
4 insurance market.

5 Sec. 24. NEW SECTION. 513C.3 DEFINITIONS.

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

8 1. "Actuarial certification" means a written statement by  
9 a member of the American academy of actuaries or other  
10 individual acceptable to the commissioner that an individual  
11 carrier is in compliance with the provision of section 513C.5  
12 which is based upon the actuary's or individual's examination,  
13 including a review of the appropriate records and the  
14 actuarial assumptions and methods used by the carrier in  
15 establishing premium rates for applicable individual health  
16 benefit plans.

17 2. "Affiliate" or "affiliated" means any entity or person  
18 who directly or indirectly through one or more intermediaries,  
19 controls or is controlled by, or is under common control with,  
20 a specified entity or person.

21 3. "Basic or standard health benefit plan" means the core  
22 group of health benefits developed pursuant to section 513C.8.

23 4. "Block of business" means all the individuals insured  
24 under the same individual health benefit plan.

25 5. "Carrier" means any entity that provides individual  
26 health benefit plans in this state. For purposes of this  
27 chapter, carrier includes an insurance company, a group  
28 hospital or medical service corporation, a fraternal benefit  
29 society, a health maintenance organization, an accountable  
30 health plan, and any other entity providing an individual plan  
31 of health insurance or health benefits subject to state  
32 insurance regulation.

33 6. "Commissioner" means the commissioner of insurance.

34 7. "Eligible individual" means an individual who is a  
35 resident of this state and who either has qualifying existing

1 coverage or has had qualifying existing coverage within the  
2 immediately preceding thirty days, or an individual who has  
3 had a qualifying event occur within the immediately preceding  
4 thirty days.

5 8. "Established service area" means a geographic area, as  
6 approved by the commissioner and based upon the carrier's  
7 certificate of authority to transact insurance in this state,  
8 within which the carrier is authorized to provide coverage.

9 9. "Filed rate" means, for a rating period related to each  
10 block of business, the rate charged to all individuals with  
11 similar rating characteristics for individual health benefit  
12 plans.

13 10. "Individual health benefit plan" means any hospital or  
14 medical expense incurred policy or certificate, hospital or  
15 medical service plan, or health maintenance organization  
16 subscriber contract sold to an individual, or any  
17 discretionary group trust or association policy providing  
18 hospital or medical expense incurred coverage to individuals.  
19 Individual health benefit plan does not include a self-insured  
20 group health plan, a self-insured multiple employer group  
21 health plan, a group conversion plan, an insured group health  
22 plan, accident-only, specified disease, short-term hospital or  
23 medical, hospital confinement indemnity, credit, dental,  
24 vision, medicare supplement, long-term care, or disability  
25 income insurance coverage, coverage issued as a supplement to  
26 liability insurance, workers' compensation or similar  
27 insurance, or automobile medical payment insurance.

28 11. "Premium" means all moneys paid by an individual and  
29 eligible dependents as a condition of receiving coverage from  
30 a carrier, including any fees or other contributions  
31 associated with an individual health benefit plan.

32 12. "Qualifying event" means any of the following:

33 a. Loss of eligibility for medical assistance provided  
34 pursuant to chapter 249A or medicare coverage provided  
35 pursuant to Title XVIII of the federal Social Security Act.

1     b. Loss or change of dependent status under qualifying  
2 previous coverage.

3     c. The attainment by an individual of the age of majority.

4     13. "Qualifying existing coverage" or "qualifying previous  
5 coverage" means benefits or coverage provided under either of  
6 the following:

7     a. Any group health insurance that provides benefits  
8 similar to or exceeding benefits provided under the standard  
9 health benefit plan, provided that such policy has been in  
10 effect for a period of at least one year.

11    b. An individual health insurance benefit plan, including  
12 coverage provided under a health maintenance organization  
13 contract, a hospital or medical service plan contract, or a  
14 fraternal benefit society contract, that provides benefits  
15 similar to or exceeding the benefits provided under the  
16 standard health benefit plan, provided that such policy has  
17 been in effect for a period of at least one year.

18    14. "Rating characteristics" means demographic or other  
19 objective characteristics of individuals which are considered  
20 by the carrier in the determination of premium rates for the  
21 individuals and which are approved by the commissioner.

22    15. "Rating period" means the period for which premium  
23 rates established by a carrier are in effect.

24    16. "Restricted network provision" means a provision of an  
25 individual health benefit plan that conditions the payment of  
26 benefits, in whole or in part, on the use of health care  
27 providers that have entered into a contractual arrangement  
28 with the carrier to provide health care services to covered  
29 individuals.

30    Sec. 25. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

31    This chapter applies to an individual health benefit plan  
32 delivered or issued for delivery to residents of this state on  
33 or after July 1, 1994.

34    1. Except as provided in subsection 2, for purposes of  
35 this chapter, carriers that are affiliated companies or that

1 are eligible to file a consolidated tax return shall be  
2 treated as one carrier and any restrictions or limitations  
3 imposed by this chapter shall apply as if all individual  
4 health benefit plans delivered or issued for delivery to  
5 residents of this state by such affiliated carriers were  
6 issued by one carrier.

7 2. An affiliated carrier that is a health maintenance  
8 organization having a certificate of authority under section  
9 513C.5 shall be considered to be a separate carrier for the  
10 purposes of this chapter.

11 Sec. 26. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO  
12 PREMIUM RATES.

13 1. Premium rates for any block of individual health  
14 benefit plan business issued on or after July 1, 1994, by a  
15 carrier subject to this chapter are subject to the composite  
16 effect of all of the following:

17 a. After making actuarial adjustments based upon benefit  
18 design, rating characteristics, and health choice factors, the  
19 filed rate for any block of business shall not exceed the  
20 filed rate for any other block of business by more than twenty  
21 percent.

22 b. The filed rate for any block of business shall not  
23 exceed the filed rate for any other block of business by more  
24 than thirty percent due to factors relating to rating  
25 characteristics.

26 c. The filed rate for any block of business shall not  
27 exceed the filed rate for any other block of business by more  
28 than thirty percent due to factors relating to health choices.

29 d. The carrier shall not apply gender or industry  
30 classification rating characteristics.

31 e. Experience rating characteristics other than age,  
32 geographic area, family composition, and group size shall not  
33 be used by a carrier without the prior approval of the  
34 commissioner.

35 f. Premium rates for individual health benefit plans shall

1 comply with the requirements of this section notwithstanding  
2 any assessments paid or payable by the carrier pursuant to any  
3 reinsurance program or risk adjustment mechanism.

4 g. An adjustment, not to exceed fifteen percent annually  
5 due to the claim experience or health status of a block of  
6 business.

7 h. For purposes of this subsection, an individual health  
8 benefit plan that contains a restricted network provision  
9 shall not be considered similar coverage to an individual  
10 health benefit plan that does not contain such a provision,  
11 provided that the differential in payments made to network  
12 providers results in substantial differences in claim costs.

13 2. Notwithstanding subsection 1, the commissioner may by  
14 order reduce or eliminate the allowed rating bands provided  
15 under subsection 1, paragraphs "a", "b", "c", and "g", or  
16 otherwise limit or eliminate the use of experience rating.

17 3. A carrier shall not transfer an individual  
18 involuntarily into or out of a block of business.

19 4. The commissioner may suspend for a specified period the  
20 application of subsection 1, paragraph "a", as to the premium  
21 rates applicable to one or more blocks of business of a  
22 carrier for one or more rating periods upon a filing by the  
23 carrier requesting the suspension and a finding by the  
24 commissioner that the suspension is reasonable in light of the  
25 financial condition of the carrier.

26 5. A carrier shall make a reasonable disclosure at the  
27 time of the offering for sale of any individual health benefit  
28 plan of all of the following:

29 a. The extent to which premium rates for a specified  
30 individual are established or adjusted based upon rating  
31 characteristics.

32 b. The carrier's right to change premium rates, and the  
33 factors, other than claim experience, that affect changes in  
34 premium rates.

35 c. The provisions relating to the renewal of policies and

1 contracts.

2 d. Any provisions relating to any preexisting condition.

3 e. All plans offered by the carrier, the prices of such  
4 plans, and the availability of such plans to the individual.

5 6. A carrier shall maintain at its principal place of  
6 business a complete and detailed description of its rating  
7 practices, including information and documentation that  
8 demonstrate that its rating methods and practices are based  
9 upon commonly accepted actuarial assumptions and are in  
10 accordance with sound actuarial principles.

11 7. A carrier shall file with the commissioner annually on  
12 or before March 15, an actuarial certification certifying that  
13 the carrier is in compliance with this chapter and that the  
14 rating methods of the carrier are actuarially sound. The  
15 certification shall be in a form and manner and shall contain  
16 information as specified by the commissioner. A copy of the  
17 certification shall be retained by the carrier at its  
18 principal place of business. Rate adjustments made in order  
19 to comply with this section are exempt from loss ratio  
20 requirements.

21 8. A carrier shall make the information and documentation  
22 maintained pursuant to subsection 5 available to the  
23 commissioner upon request. The information and documentation  
24 shall be considered proprietary and trade secret information  
25 and shall not be subject to disclosure by the commissioner to  
26 persons outside of the division except as agreed to by the  
27 carrier or as ordered by a court of competent jurisdiction.

28 Sec. 27. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

29 1. An individual health benefit plan is renewable at the  
30 option of the individual, except in any of the following  
31 cases:

32 a. Nonpayment of the required premiums.

33 b. Fraud or misrepresentation.

34 c. The insured individual becomes eligible for medicare  
35 coverage under Title XVIII of the federal Social Security Act.

1 d. The carrier elects not to renew all of its individual  
2 health benefit plans in the state. In such case, the carrier  
3 shall provide notice of the decision not to renew coverage to  
4 all affected individuals and to the commissioner in each state  
5 in which an affected insured individual is known to reside at  
6 least ninety days prior to the nonrenewal of the health  
7 benefit plan by the carrier. Notice to the commissioner under  
8 the paragraph shall be provided at least three working days  
9 prior to the notice to the affected individuals.

10 e. The commissioner finds that the continuation of the  
11 coverage would not be in the best interests of the  
12 policyholders or certificate holders, or would impair the  
13 carrier's ability to meet its contractual obligations.

14 2. A carrier that elects not to renew all of its  
15 individual health benefit plans in this state shall be  
16 prohibited from writing new individual health benefit plans in  
17 this state for a period of five years from the date of the  
18 notice to the commissioner.

19 3. With respect to a carrier doing business in an  
20 established geographic service area of the state, this section  
21 applies only to the carrier's operations in the service area.

22 Sec. 28. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

23 1. A carrier issuing an individual health benefit plan in  
24 this state shall issue a basic or standard health benefit plan  
25 to an eligible individual who applies for a plan and agrees to  
26 make the required premium payments and to satisfy other  
27 reasonable provisions of the basic or standard health benefit  
28 plan. An insurer is not required to issue a basic or standard  
29 health benefit plan to an individual who meets any of the  
30 following criteria:

31 a. The individual is covered or is eligible for coverage  
32 under a health benefit plan provided by the individual's  
33 employer.

34 b. An eligible individual who does not apply for a basic  
35 or standard health benefit plan within thirty days of a

1 qualifying event or within thirty days upon becoming  
2 ineligible for qualifying existing coverage.

3 c. The individual is covered or is eligible for any  
4 continued group coverage under section 4980b of the Internal  
5 Revenue Code, sections 601 through 608 of the federal Employee  
6 Retirement Income Security Act of 1974, sections 2201 through  
7 2208 of the federal Public Health Service Act, or any state-  
8 required continued group coverage. For purposes of this  
9 subsection, an individual who would have been eligible for  
10 such continuation of coverage, but is not eligible solely  
11 because the individual or other responsible party failed to  
12 make the required coverage election during the applicable time  
13 period, is deemed to be eligible for such group coverage until  
14 the date on which the individual's continuing group coverage  
15 would have expired had an election been made.

16 2. A carrier shall issue the basic or standard health  
17 insurance benefit plan to an individual currently covered by  
18 an underwritten benefit plan issued by that carrier at the  
19 option of the individual. This option must be exercised  
20 within thirty days of notification of a premium rate increase  
21 applicable to the underwritten benefit plan.

22 3. A carrier shall file with the commissioner, in a form  
23 and manner prescribed by the commissioner, the basic or  
24 standard health benefit plan to be used by the carrier. A  
25 basic or standard health benefit plan filed pursuant to this  
26 subsection may be used by a carrier beginning thirty days  
27 after it is filed unless the commissioner disapproves of its  
28 use.

29 The commissioner may at any time, after providing notice  
30 and an opportunity for a hearing to the carrier, disapprove  
31 the continued use by a carrier of a basic or standard health  
32 benefit plan on the grounds that the plan does not meet the  
33 requirements of this chapter.

34 4. a. The individual basic or standard health benefit  
35 plan shall not deny, exclude, or limit benefits for a covered

1 individual for losses incurred more than twelve months  
2 following the effective date of the individual's coverage due  
3 to a preexisting condition. A preexisting condition shall not  
4 be defined more restrictively than any of the following:

5 (1) A condition that would cause an ordinarily prudent  
6 person to seek medical advice, diagnosis, care, or treatment  
7 during the twelve months immediately preceding the effective  
8 date of coverage.

9 (2) A condition for which medical advice, diagnosis, care,  
10 or treatment was recommended or received during the twelve  
11 months immediately preceding the effective date of coverage.

12 (3) A pregnancy existing on the effective date of  
13 coverage.

14 b. A carrier shall waive any time period applicable to a  
15 preexisting condition exclusion or limitation period with  
16 respect to particular services in an individual health benefit  
17 plan for the period of time an individual was previously  
18 covered by qualifying previous coverage that provided benefits  
19 with respect to such services, provided that the qualifying  
20 previous coverage was continuous to a date not more than  
21 thirty days prior to the effective date of the new coverage.

22 5. A carrier is required to offer coverage or accept  
23 applications pursuant to subsection 1 from any individual  
24 residing in the carrier's established geographic access area.

25 6. A carrier shall not modify a basic or standard health  
26 benefit plan with respect to an individual or dependent  
27 through riders, endorsements, or other means to restrict or  
28 exclude coverage for certain diseases or medical conditions  
29 otherwise covered by the health benefit plan.

30 Sec. 29. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN  
31 STANDARDS.

32 The commissioner shall adopt by rule the form and level of  
33 coverage of the basic health benefit plan and the standard  
34 health benefit plan for the individual market which shall be  
35 the same as provided for under chapter 513B with respect to

1 small group coverage.

2 Sec. 30. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR  
3 MARKETING.

4 1. A carrier issuing individual health benefit plans in  
5 this state shall make available the basic or standard health  
6 benefit plan to residents of this state. If a carrier denies  
7 other individual health benefit plan coverage to an eligible  
8 individual on the basis of the health status or claims  
9 experience of the eligible individual, or the individual's  
10 dependents, the carrier shall offer the individual the  
11 opportunity to purchase a basic or standard health benefit  
12 plan.

13 2. A carrier or an agent shall not do either of the  
14 following:

15 a. Encourage or direct individuals to refrain from filing  
16 an application for coverage with the carrier because of the  
17 health status, claims experience, industry occupation, or  
18 geographic location of the individuals.

19 b. Encourage or direct individuals to seek coverage from  
20 another carrier because of the health status, claims  
21 experience, industry occupation, or geographic location of the  
22 individuals.

23 3. Subsection 2, paragraph "a", shall not apply with  
24 respect to information provided by a carrier or an agent to an  
25 individual regarding the established geographic service area  
26 of the carrier or the restricted network provision of the  
27 carrier.

28 4. A carrier shall not, directly or indirectly, enter into  
29 any contract, agreement, or arrangement with an agent that  
30 provides for, or results in, the compensation paid to an agent  
31 for a sale of a basic or standard health benefit plan to vary  
32 because of the health status or permitted rating  
33 characteristics of the individual or the individual's  
34 dependents.

35 5. Subsection 4 does not apply with respect to the

1 compensation paid to an agent on the basis of percentage of  
2 premium, provided that the percentage shall not vary because  
3 of the health status or other permitted rating characteristics  
4 of the individual or the individual's dependents.

5 6. Denial by a carrier of an application for coverage from  
6 an individual shall be in writing and shall state the reason  
7 or reasons for the denial.

8 7. A violation of this section by a carrier or an agent is  
9 an unfair trade practice under chapter 507B.

10 8. If a carrier enters into a contract, agreement, or  
11 other arrangement with a third-party administrator to provide  
12 administrative, marketing, or other services related to the  
13 offering of individual health benefit plans in this state, the  
14 third-party administrator is subject to this section as if it  
15 were a carrier.

16 Sec 31. NEW SECTION. 513D.1 EMPLOYER REQUIRED TO  
17 PROVIDE ACCESS TO HEALTH CARE COVERAGE -- PENALTIES.

18 1. An employer doing business within this state shall  
19 offer each employee, at a minimum, access to health insurance.  
20 The requirement contained in this section may be satisfied by  
21 offering any of the following:

22 a. Health care coverage through an insurer or health  
23 maintenance organization authorized to do business in this  
24 state.

25 b. Access to health benefits through a health benefits  
26 plan qualified under the federal Employee Retirement Income  
27 Security Act of 1974.

28 c. Enrollment in an Iowa-licensed health insurance  
29 purchasing cooperative. A cooperative may require payroll  
30 deduction of employee contributions and direct deposit of  
31 premium payments to the account of the cooperative.

32 2. An employer is not required to financially contribute  
33 toward the employee's health plan.

34 3. A violation of this section may be reported to the  
35 consumer and legal affairs bureau in the insurance division.

1 The division may issue, upon a finding that an employer has  
2 failed to offer an employee access to health insurance, any of  
3 the following:

4 a. A cease and desist order instructing the employer to  
5 cure the failure and desist from future violations of this  
6 section.

7 b. An order requiring an employer who has previously been  
8 the subject of a cease and desist order to pay an employee's  
9 reasonable health insurance premiums necessary to prevent or  
10 cure a lapse in health care coverage arising out of the  
11 employer's failure to offer as required.

12 c. An order upon the employer assessing the reasonable  
13 costs of the division's investigation and enforcement action.

14 Sec. 32. NEW SECTION. 514C.8 PROVIDER ACCESS UNDER  
15 MANAGED CARE HEALTH PLAN OR INDEMNITY PLAN WITH LIMITED  
16 PROVIDER NETWORK.

17 A managed care health plan or indemnity plan with a limited  
18 provider network shall provide patients direct access to  
19 providers licensed under chapter 147, 148, 148A, 148C, 149,  
20 150, 150A, 151, 152, 153, 154, 154B, or 155A. Access to such  
21 provider shall not be made conditional upon a referral by a  
22 provider licensed under another chapter. Referral to a  
23 specialist may be conditioned upon referral by a primary care  
24 provider licensed under the same chapter. Access to a class  
25 of providers licensed under one chapter shall not be subject  
26 to a copayment, deductible, or premium rate different than  
27 provided for access to a class of providers licensed under  
28 another chapter. Access to a specialist may be subject to a  
29 different copayment or deductible than access to a primary  
30 care provider. Access to a nonparticipating provider may be  
31 restricted, or may be subject to different copayments,  
32 deductibles, or premium rates.

33 For purposes of this section, "managed care health plan or  
34 indemnity plan with a limited provider network" means a health  
35 maintenance organization, accountable health plan, preferred

1 provider organization, exclusive provider organization, point  
2 of service plan, or similar health plan.

3 This section does not apply if an employer offers employees  
4 a choice of health plans, either directly or indirectly  
5 through a health insurance purchasing cooperative, provided  
6 that the offered choices include at least one indemnity plan  
7 with unrestricted choice of provider, or at least one managed  
8 care health plan or indemnity plan with a limited provider  
9 network which provides access as defined in this section.

10 Sec. 33. NEW SECTION. 514I.1 HEALTH INSURANCE PURCHASING  
11 COOPERATIVES.

12 1. The commissioner of insurance shall adopt rules and a  
13 licensing procedure for authorizing the establishment of a  
14 health insurance purchasing cooperative. The rules shall  
15 include, at a minimum, all of the following:

16 a. Procedures to sanction voluntary agreements between  
17 competitors within the service region of a health insurance  
18 purchasing cooperative, upon a finding by the commissioner  
19 that the agreement will improve the quality of, access to, or  
20 affordability of health care, but which agreement might be a  
21 violation of antitrust laws if undertaken without government  
22 direction and approval.

23 b. Procedures to assure ongoing supervision of contracts  
24 sanctioned under this subsection, in order to assure that the  
25 contracts do in fact improve health care quality, access, or  
26 affordability. Approval may be withdrawn on a prospective  
27 basis at the discretion of the commissioner if necessary to  
28 improve health care quality, access, and affordability.

29 c. A requirement to review the plan of operation of a  
30 health insurance purchasing cooperative, and standards for  
31 approval or disapproval of a plan.

32 d. A requirement that a plan of operation include  
33 guaranteed access and rating practices no more restrictive  
34 than those required of competitors within a market segment,  
35 such as small group health insurers regulated under chapter

1 513B, or individual or large group insurers regulated under  
2 chapter 514A or 514D. The commissioner shall regulate all  
3 health plans and health insurance purchasing cooperatives to  
4 assure that to the greatest extent possible all health  
5 insurance or health benefit marketing channels within a market  
6 segment are subject to the same rules of access, underwriting,  
7 risk spreading, and rate regulation.

8 e. An annual report to be submitted to the general  
9 assembly no later than February 1, describing the operations  
10 of all health insurance purchasing cooperatives, and  
11 permitting review of the success of health insurance  
12 purchasing cooperatives in furthering the goals of improved  
13 health care quality, access, or affordability. The report  
14 shall include any recommendations on whether additional health  
15 insurance purchasing cooperatives should be established.

16 2. This section does not prevent the development of any  
17 other health insurance or pooled purchasing arrangements  
18 otherwise permitted by law.

19 3. This section and rules adopted pursuant to this section  
20 are intended to provide immunity from federal antitrust law  
21 under the state action doctrine exemption.

22 Sec. 34. RURAL PRIMARY CARE INITIATIVE -- PHYSICIAN  
23 RESPITE PROGRAM. The Iowa department of public health, in  
24 cooperation with the university of Iowa college of medicine  
25 and the university of osteopathic medicine and health  
26 sciences, shall develop and establish a rural primary care  
27 initiative. The rural primary care initiative shall, at a  
28 minimum, focus on the expansion of the family practice  
29 residency program and training of rural physicians, physician  
30 assistants, and advanced registered nurse practitioner health  
31 care teams, and the development of a physician, physician  
32 assistant, and advanced registered nurse practitioner respite  
33 programs in the rural areas of Iowa. The department shall  
34 submit a written report to the general assembly no later than  
35 January 9, 1995, concerning the status of the development of

1 the rural primary care initiative, and include any legislative  
2 recommendations necessary to complete implementation of the  
3 initiative.

4     Sec. 35. HEALTH INSURANCE COST DEDUCTION -- CONTINGENT  
5 EFFECT. Section 5 of this Act, which amends section 422.7 by  
6 adding a new subsection 29, is effective upon the enactment of  
7 a federal individual income tax provision authorizing the  
8 deduction in computing federal adjusted gross income of one  
9 hundred percent of the cost of the purchase of health  
10 insurance. Section 5 of this Act applies to tax years  
11 designated in the federal enactment of the health insurance  
12 cost deduction.

13     Sec. 36. MEDICAL CARE SAVINGS ACCOUNT CONTRIBUTIONS --  
14 CONTINGENT EFFECT. Section 6 of this Act, which amends  
15 section 422.7 by adding a new subsection 30, is effective upon  
16 the enactment of a federal individual income tax provision  
17 authorizing the deduction or exclusion in computing federal  
18 adjusted gross income of contributions made on behalf of the  
19 taxpayer to a medical care savings account. Section 6 of this  
20 Act applies to tax years designated in the federal enactment  
21 related to contributions to a medical care savings account.

22     Sec. 37. NOTICE OF EFFECTIVENESS. The director of revenue  
23 and finance shall notify the governor, the chairpersons and  
24 ranking members of the senate and house ways and means  
25 committees, the Iowa Code editor, and the legislative fiscal  
26 bureau when section 5 or section 6, which amend section 422.7,  
27 of this Act becomes effective.

28     Sec. 38. FINANCING STUDY -- ANNUAL REPORT TO GENERAL  
29 ASSEMBLY. It is the intent of the general assembly that  
30 health care coverage be obtained by all Iowans on a voluntary  
31 basis. If the state has not achieved a level of individuals  
32 without health care coverage of less than three percent of  
33 total population through voluntary means by January 1, 1997,  
34 the general assembly shall impose a financing mechanism to  
35 provide guaranteed coverage to all citizens of this state.

1 The division shall annually provide a written report to the  
2 governor and general assembly no later than the third Monday  
3 of each regular session of the general assembly indicating the  
4 percentage of individuals in this state who do not have any  
5 health care coverage, and summarizing progress toward the goal  
6 of three percent.

7 Sec. 39. ALTERNATIVE MEDICAL MALPRACTICE DISPUTE  
8 RESOLUTION PROCEDURES -- MEDICAL SCREENING PANELS -- STUDY.

9 The supreme court, in cooperation with the department of  
10 public health and the insurance division, shall initiate a  
11 study concerning the development and use of alternative  
12 medical malpractice dispute resolution procedures and medical  
13 screening panels. The study shall include, at a minimum, a  
14 review of existing alternative dispute resolution procedures  
15 and medical screening panels and provide for a comprehensive  
16 review of existing statutes and court decisions in an effort  
17 to maximize the benefits of alternative medical malpractice  
18 dispute resolution procedures that have been successful while  
19 assuring procedural protections and fair access to the court  
20 system. Additionally, the study shall include a review of the  
21 availability of occurrence form of medical malpractice  
22 insurance for obstetricians and other physicians whose  
23 practice involves providing care services related to the birth  
24 of a child, the development of recommendations related to  
25 providing all individuals claiming injury resulting from an  
26 act of alleged malpractice reasonable and affordable access to  
27 alternative medical malpractice dispute resolution procedures,  
28 and a closed claim survey which shall include the frequency  
29 and severity of outcomes related to claims involving alleged  
30 malpractice by health care providers. The study shall also  
31 include any recommendations on implementing alternative  
32 medical malpractice dispute resolution procedures and medical  
33 screening panels in the state along with a corresponding cost  
34 benefit analysis related to each recommendation.

35 Sec. 40. INSURANCE DIVISION STUDIES.

1 1. The insurance division shall review, develop, and  
2 submit a plan for the establishment of an individual health  
3 coverage reinsurance program. The division shall submit a  
4 written report to the general assembly no later than January  
5 9, 1995, including the division's plan.

6 2. The insurance division shall review, study, and make  
7 recommendations to the general assembly concerning the Iowa  
8 comprehensive health insurance association established under  
9 chapter 514E, with the intent to merge the Iowa comprehensive  
10 health insurance program with an individual health reinsurance  
11 program. The division shall submit a written report to the  
12 general assembly no later than January 9, 1995, including the  
13 division's findings and recommendations.

14 Sec. 41. RURAL HEALTH CARE DELIVERY MODELS. It is the  
15 intent of the general assembly that the department of  
16 inspections and appeals, through the hospital licensure board,  
17 in conjunction with the department of public health and other  
18 appropriate health care provider licensure boards, as  
19 identified by the departments, review the California  
20 alternative rural hospital model and the community  
21 hospital/rural primary care hospital demonstration project  
22 sponsored by the health care financing administration. The  
23 review shall include an examination of existing provider  
24 licensure statutes and administrative rules that inhibit or  
25 preclude implementation of either alternative rural health  
26 care delivery model and shall include specific legislative and  
27 regulatory strategy proposals for the removal of such  
28 identified barriers. This written report shall be delivered  
29 by the department of inspections and appeals to the general  
30 assembly on or before January 1, 1995.

31 Sec. 42. APPLICABILITY. Notwithstanding the provisions of  
32 sections 513C.4 and 513C.5, chapter 513C, as enacted in this  
33 Act, is not applicable to an individual health benefit plan  
34 delivered or issued for delivery in this state or to a block  
35 of individual health benefit plan business until such time as

1 rules implementing the chapter have been adopted by the  
2 insurance division pursuant to chapter 17A.

3 Sec. 43. EFFECTIVE DATE. Section 31 of this Act, which  
4 creates new section 513D.1, is effective January 1, 1995.

5 EXPLANATION

6 Section 8.6 is amended and authorizes the director of the  
7 department of management to establish a statewide health  
8 accounting system in coordination with the department of  
9 public health, the department of human services, the  
10 department of elder affairs, the department of employment  
11 services, and the insurance division of the department of  
12 commerce. The department of management is granted access to  
13 all information necessary from the community health management  
14 information system created in chapter 144C.

15 Sections 18.133 and 18.136 are amended to provide that  
16 hospitals licensed pursuant to chapter 135B, rural health  
17 clinics defined pursuant to 42 U.S.C. § 1395(x), and physician  
18 clinics are to be offered access to the Iowa communications  
19 network for diagnostic, clinical, consultative, data, and  
20 educational services for the purpose of developing a  
21 comprehensive, statewide telemedicine network.

22 New sections 135.110 through 135.113 are created and relate  
23 to establishing and licensing accountable health plans in this  
24 state.

25 New section 135.110 is created which defines an accountable  
26 health plan as an entity which pays for and provides for the  
27 delivery of health services within a defined area, and is  
28 accountable to the public for the cost and quality of such  
29 services.

30 New section 135.111 is created and directs the director of  
31 public health to adopt rules relating to the establishment,  
32 licensure, and regulation of accountable health plans. The  
33 rules are to allow flexibility in the structure of such plans  
34 to permit the development of alternative structures in rural  
35 areas of the state in response to the needs, preferences, and

1 conditions of rural communities.

2 New section 135.112 is created and establishes licensing  
3 requirements for accountable health plans.

4 New section 135.113 defines terms used in sections 135.110  
5 through 135.112.

6 Section 422.7 is amended to implement the tax credit for  
7 individual medical savings accounts. This bill allows the  
8 deduction of 100 percent of health insurance costs from  
9 adjusted gross income in computing state individual income tax  
10 and allows a deduction for amounts of contributions to a  
11 medical care savings account. In addition, the bill allows a  
12 deduction from adjusted gross income for the interest earned  
13 on a medical care savings account to the extent not withdrawn.

14 Section 505.7 is amended to grant the insurance  
15 commissioner authority to assess a health insurance purchasing  
16 cooperative audit and examination costs.

17 Section 505.7 is also amended by adding a new subsection  
18 which provides that the commissioner may assess the costs of  
19 an audit or examination to a health insurance purchasing  
20 cooperative in the same manner as provided for insurance  
21 companies under sections 507.7 through 507.9.

22 Section 505.8 is amended to provide that the commissioner  
23 is given jurisdiction to supervise all health insurance  
24 purchasing cooperatives.

25 Section 509A.6, which relates to group insurance for public  
26 employees, is amended to provide that a governing body may  
27 enroll in and contract with a health insurance purchasing  
28 cooperative.

29 Section 509A.16 is amended to provide that the director of  
30 the department of management may approve expenditures of up to  
31 \$300,000 per fiscal year, from the surplus portion of the  
32 general fund portion of the employer share of the state group  
33 insurance reserves not needed to fund incentive programs, for  
34 the purposes of health reform activities. This section is  
35 repealed July 1, 1996.

1 Section 513B.2 is amended to provide that a small employer  
2 is a person who employs not less than two and not more than 50  
3 full-time employees. Currently, a small employer is defined  
4 as a person who employs not less than two and not more than 25  
5 full-time employees.

6 Section 513B.4 is amended to add a new subsection providing  
7 that the premium adjustment factors contained in subsection 1  
8 do not apply to a standard or basic health benefit plan.

9 Section 513B.4, subsection 2, is amended by striking  
10 language related to the case characteristics which may be used  
11 to adjust health insurance premiums for small groups and  
12 inserting language that case characteristics other than family  
13 composition and group size are not to be used by a small  
14 employer carrier without the prior approval of the  
15 commissioner.

16 Section 513B.4 is amended to add a new subsection providing  
17 that the commissioner may by order reduce or eliminate allowed  
18 rating bonds as provided in subsection 1 of that section.

19 Section 513B.37 is amended to provide that the commissioner  
20 is to determine what benefits or direct pay requirements must  
21 be minimally included in a standard health benefit plan.

22 Section 513B.38 is amended to provide that the commissioner  
23 may extend standard benefits to include preventative care  
24 services and mental health and substance abuse treatment  
25 coverage.

26 New chapter 513C is created relating to individual health  
27 coverage. New section 513C.1 provides the title, the  
28 Individual Health Insurance Market Reform Act.

29 New section 513C.2 states the purpose of the chapter.

30 New section 513C.3 establishes the definitions of key terms  
31 used in the chapter.

32 New section 513C.4 provides that the chapter applies to an  
33 individual health benefit plan delivered or issued for  
34 delivery to residents in this state on or after July 1, 1994.

35 New section 513C.5 establishes restrictions relating to

1 premium rates for individual health benefit plans. Among  
2 those factors, the carrier is not to apply gender or industry  
3 classification rating characteristics, and experience rating  
4 characteristics only apply when an individual who is obtaining  
5 health coverage does not currently have qualifying coverage,  
6 as defined in the chapter. Certain other restrictions apply  
7 relating to the transfer of an individual into and out of a  
8 block of business, and required disclosures relating to the  
9 coverage are enumerated.

10 New section 513C.6 relates to the renewal of an individual  
11 health benefit plan. Such plan is renewable at the option of  
12 the individual, except under certain enumerated circumstances.  
13 The section also provides that a carrier that elects not to  
14 renew all of its individual health benefit plans in this state  
15 shall be prohibited from writing new individual health benefit  
16 plans in this state for a period of five years from the date  
17 of the notice required to be provided to the commissioner of  
18 such election.

19 New section 513C.7 provides that a carrier issuing  
20 individual health benefit plans must issue such plan to an  
21 individual applying for the plan except under certain defined  
22 circumstances.

23 New section 513C.8 provides that the commissioner is to  
24 adopt rules relating to the form and level of coverage of the  
25 basic and standard health benefit plan for the individual  
26 market.

27 New section 513C.9 establishes standards to assure fair  
28 marketing of individual basic and standard health benefit  
29 plans. Restrictions are also established relating to carrier  
30 and the agent concerning the marketing of such plans.

31 New section 513D.1 is created which establishes a  
32 requirement that an employer provide an employee access to  
33 group health insurance. The employer is not required to  
34 financially contribute toward such insurance. The insurance  
35 division is given enforcement authority with respect to this

1 requirement, which includes monetary penalties necessary to  
2 cure the failure to offer access to group coverage, as well as  
3 charging enforcement costs to the offending employer.

4 New section 514C.8 is created which provides that a managed  
5 care health plan or indemnity plan with a limited provider  
6 network must provide patients direct access to providers  
7 licensed under chapter 147, 148, 148A, 148C, 149, 150, 150A,  
8 151, 152, 153, 154, 154B, or 155A. The section does not apply  
9 if an employer offers employees a choice of health plans,  
10 either directly or indirectly through a health insurance  
11 purchasing cooperative, provided that the offered choices  
12 include at least one indemnity plan with unrestricted choice  
13 of provider, or at least one managed care health plan or  
14 indemnity plan with a limited provider network which provides  
15 access as defined in this section.

16 New section 514I.1 is created which codifies a substantial  
17 portion of 1993 Iowa Acts, chapter 158, section 2, which  
18 directs the insurance commissioner to adopt rules and a  
19 licensing procedure for establishing a health insurance  
20 purchasing cooperative.

21 The bill directs the department of public health, in  
22 cooperation with the university of Iowa medical school and the  
23 university of osteopathic medicine and health sciences, to  
24 develop and establish a rural primary care initiative. The  
25 department is required to submit a written report to the  
26 general assembly no later than January 9, 1995, concerning the  
27 status of the development of the rural primary care  
28 initiative.

29 The bill provides that the tax deductions established in  
30 chapter 422 are effective on the date that similar federal  
31 legislation is enacted and made effective for federal  
32 individual income tax purposes.

33 The bill provides that it is the intent of the general  
34 assembly that health care coverage be obtained by all Iowans  
35 on a voluntary basis. The insurance division is directed to

1 report annually on the percent of individuals in this state  
2 who do not have health care coverage.

3 The bill directs the supreme court, in cooperation with the  
4 department of health and the insurance division, to initiate a  
5 study concerning medical malpractice and the development and  
6 use of alternative medical malpractice dispute resolution  
7 procedures and medical screening panels.

8 The bill directs the insurance division to review, develop,  
9 and submit a plan for the establishment of an individual  
10 health coverage reinsurance program. The division is also to  
11 review, study, and make recommendations concerning the Iowa  
12 comprehensive health insurance association established in  
13 chapter 514E.

14 The bill provides that new section 513D.1 is effective  
15 January 1, 1995.

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## SENATE FILE 2222

S-5136

1 Amend Senate File 2222 as follows:

2 1. Page 4, line 7, by inserting after the word  
3 "standards." the following: "Access standards shall  
4 include the assessment of prohibited referrals as  
5 provided in section 135L.1."

6 2. Page 6, by striking lines 15 through 17 and  
7 inserting the following: "means a person licensed or  
8 certified pursuant to chapters 147 through 154, and  
9 chapters 154B and 155A, to provide professional health  
10 care services in this".

11 3. Page 6, line 18, by striking the word  
12 "medical" and inserting the following: "health".

13 4. Page 6, by inserting after line 19 the  
14 following:

15 "Sec. \_\_\_\_ . NEW SECTION. 135L.1 PROHIBITED  
16 REFERRALS AND CLAIMS FOR PAYMENT.

17 1. A health care provider shall not refer a  
18 patient for the provision of designated health  
19 services to an entity in which the health care  
20 provider is an investor or has an investment interest.

21 2. A health care provider shall not refer a  
22 patient for the provision of any other health care  
23 item or service to an entity in which the health care  
24 provider is an investor unless either of the following  
25 applies:

26 a. The provider's investment interest is in  
27 registered securities purchased on a national exchange  
28 or over-the-counter market and issued by a publicly  
29 held corporation, whose shares are traded on a  
30 national exchange or on the over-the-counter market  
31 and whose total assets at the end of the corporation's  
32 most recent fiscal quarter exceeded fifty million  
33 dollars.

34 b. With respect to an entity other than a publicly  
35 held corporation described in paragraph "a", and a  
36 referring provider's investment interest in the  
37 entity, all of the following requirements arise:

38 (1) Not more than fifty percent of the value of  
39 the investment interests are held by investors who are  
40 in a position to make referrals to the entity.

41 (2) The terms under which an investment interest  
42 is offered to an investor, who is in a position to  
43 make referrals to the entity, are no different from  
44 the terms offered to investors who are not in a  
45 position to make referrals.

46 (3) The terms under which an investment interest  
47 is offered to an investor, who is in a position to  
48 make referrals to the entity, are not related to the  
49 previous or expected volume of referrals from the  
50 investor to the entity.

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1 (4) There is no requirement that an investor make  
2 referrals or be in a position to make referrals to the  
3 entity as a condition for becoming or remaining an  
4 investor.

5 3. Except as provided under subsection 2, the  
6 entity or corporation shall not loan funds to or  
7 guarantee a loan for an investor who is in a position  
8 to make referrals to the entity or corporation. The  
9 investor shall not use any part of a loan obtained  
10 through an entity or corporation to obtain the  
11 investment interest.

12 4. Except as provided under subsection 2, the  
13 amount distributed to an investor representing a  
14 return on the investment interest shall be directly  
15 proportional to the amount of the capital investment,  
16 made by the investor in the entity or corporation,  
17 including the fair market value of any preoperational  
18 services rendered.

19 5. A claim for payment shall not be presented by  
20 an entity to any individual, third-party payor, or  
21 other entity for a service furnished pursuant to a  
22 referral prohibited under this section.

23 6. If an entity collects an amount that was billed  
24 in violation of this section, the entity shall refund  
25 the amount and any interest or late fee assessed on a  
26 timely basis to the payor or individual as applicable.

27 7. Any person that presents or causes to be  
28 presented a bill or a claim for service that the  
29 person knows or should know is for a service for which  
30 payment may not be made under subsection 5, or for  
31 which a refund has not been made under subsection 6,  
32 is subject to a civil penalty of not more than fifteen  
33 thousand dollars for each service, to be imposed and  
34 collected by the appropriate board.

35 8. Any health care provider or other entity that  
36 enters into an arrangement or scheme, such as a cross-  
37 referral arrangement, which the physician or entity  
38 knows or should know has a principal purpose of  
39 assuring referrals by the physician to a particular  
40 entity which, if the physician directly made referrals  
41 to the entity, would be in violation of this section,  
42 is subject to a civil penalty of not more than one  
43 hundred thousand dollars for each circumvention  
44 arrangement or scheme, to be imposed and collected by  
45 the appropriate board or boards.

46 9. A health care provider or any provider of  
47 health care services shall not offer, pay, solicit, or  
48 receive a kickback, directly or indirectly, overtly or  
49 covertly, in the form of cash, consulting fees, wages,  
50 or in kind, for referring or soliciting patients.

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1 10. A violation of this section by a health care  
 2 provider constitutes grounds for disciplinary action  
 3 to be taken by the applicable board.  
 4 11. A health care professional licensed pursuant  
 5 to chapters 147 through 154, and chapters 154B and  
 6 155A, is subject to suspension or revocation of  
 7 license if the person engages directly or indirectly  
 8 in the division, transferring, assigning, rebating, or  
 9 refunding of fees received for professional services  
 10 or profits by means of a credit or other valuable  
 11 consideration such as wages, an unearned commission,  
 12 discount or gratuity with a person who referred a  
 13 patient, or with any relative or business associate of  
 14 the referring person. Nothing in this paragraph shall  
 15 be construed as prohibiting the members of any legally  
 16 organized business entity recognized by law and  
 17 comprised of health care professionals licensed  
 18 pursuant to chapters 147 through 154, and chapters  
 19 154B and 155A, from making any division of their total  
 20 fees among the health care professionals determined by  
 21 contract necessary to defray their joint operating  
 22 costs.  
 23 12. In addition to any other penalty or  
 24 disciplinary action taken under this section, a health  
 25 care provider who violates this section shall divest  
 26 any investment interest which has resulted in the  
 27 violation of this section.  
 28 13. This section shall not apply to a health care  
 29 provider or other provider of health care services  
 30 located in rural areas of the state as defined by the  
 31 department of public health."  
 32 5. By renumbering as necessary.

By JIM RIORDAN

S-5136 FILED MARCH 9, 1994

*out of order 3-10-94*

SENATE FILE 2222

S-5120

1 Amend Senate File 2222 as follows:  
 2 1. Page 24, line 5, by striking the figure "5"  
 3 and inserting the following: "9".  
 4 2. Page 24, line 10, by striking the figure "5"  
 5 and inserting the following: "9".  
 6 3. Page 24, line 14, by striking the figure "6"  
 7 and inserting the following: "10".  
 8 4. Page 24, line 19, by striking the figure "6"  
 9 and inserting the following: "10".  
 10 5. Page 24, line 26, by striking the words and  
 11 figures "5 or section 6" and inserting the following:  
 12 "9 or section 10".

By ELAINE SZYMONIAK

S-5120 FILED MARCH 9, 1994

*out of order 3-10-94 (p. 633)*

SENATE FILE 2222

S-5068

Amend Senate File 2222 as follows:

1. Page 9, line 7, by striking the word
- 3 "subsections" and inserting the following:
- 4 "subsection".
- 5 2. Page 9, by striking lines 20 through 24.

By ELAINE SZYMONIAK

*out of order*  
S-5068 FILED MARCH 3, 1994

SENATE FILE 2222

S-5086

1 Amend Senate File 2222 as follows:

- 2 1. Page 6, line 17, by inserting after the figure
- 3 "155A," the following: "or a home care services
- 4 program certified under Title XVIII or XIX of the
- 5 federal Social Security Act or a home care services
- 6 program under contract with the department of public
- 7 health,".

By ELAINE SZYMONIAK

*out of order*  
S-5086 FILED MARCH 7, 1994

SENATE FILE 2222

S-5087

1 Amend Senate File 2222 as follows:

- 2 1. Page 2, by inserting after line 18 the
- 3 following:
- 4 "Sec. \_\_\_\_ . NEW SECTION. 135.63A EXEMPTION FROM
- 5 CERTIFICATE OF NEED.
- 6 This division does not apply to a health care
- 7 provider or an institutional health facility which
- 8 receives fifty percent or more of its revenue under a
- 9 capitated payment system."
- 10 2. By renumbering as necessary.

By ELAINE SZYMONIAK

S-5087 FILED MARCH 7, 1994

*out of order*

## SENATE FILE 2222

S-5157

1 Amend the amendment, S-5152, to Senate File 2222,  
2 as follows:

3 1. Page 17, by inserting after line 48 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 514C.9 SERVICES PROVIDED  
6 BY LICENSED PHYSICIAN ASSISTANTS, ADVANCED REGISTERED  
7 NURSE PRACTITIONERS, AND PODIATRISTS.

8 A policy, contract, or plan providing for third-  
9 party payment or prepayment of health or medical  
10 expenses shall include a provision for the payment of  
11 necessary medical or surgical care and treatment  
12 provided by a physician assistant licensed pursuant to  
13 chapter 148C, an advanced registered nurse  
14 practitioner licensed pursuant to chapter 152, or a  
15 podiatrist licensed pursuant to chapter 149, if  
16 performed within the scope of the physician  
17 assistant's license, the advanced registered nurse  
18 practitioner's license, or the podiatrist's license  
19 and the policy, contract, or plan would pay for the  
20 care and treatment if the care and treatment were  
21 provided by a person engaged in the practice of  
22 medicine or surgery as licensed under chapter 148 or  
23 150A. The policy, contract, or plan shall provide  
24 that insureds or enrollees under the policy, contract,  
25 or plan may reject the coverage for services which may  
26 be provided by a licensed physician assistant,  
27 licensed advanced registered nurse practitioner, or  
28 licensed podiatrist if the coverage is rejected for  
29 all providers of similar services. The terms and  
30 conditions under which physician assistant, advanced  
31 nurse practitioner, or podiatrist services are  
32 compensated shall not contain practice or supervision  
33 restrictions in addition to those already imposed by  
34 law. This section applies to services provided under  
35 a policy, contract, or plan issued on or after July 1,  
36 1994, and to an existing group policy, contract, or  
37 plan on the policy's, contract's, or plan's  
38 anniversary or renewal date, or upon the expiration of  
39 the applicable collective bargaining contract, if any,  
40 whichever is later. Notwithstanding section 514C.6,  
41 this section does not apply to enrollees eligible for  
42 coverage under Title XVIII of the Social Security Act  
43 or any other similar coverage under a state or federal  
44 government plan."

45 2. By renumbering as necessary.

By JIM RIORDAN  
ROBERT E. DVORSKY

PATTY JUDGE  
JOHN W. JENSEN

S-5157 FILED MARCH 10, 1994

LOST

## SENATE FILE 2222

S-5159

1 Amend the amendment, S-5152, to Senate File 2222 as  
2 follows:

3 1. Page 7, line 6, by inserting after the word  
4 "shall" the following: ", with the concurrence of the  
5 board of the Iowa small employer health reinsurance  
6 program established in section 513B.13,".

7 2. Page 11, line 33, by inserting after the word  
8 "shall" the following: ", with the concurrence of the  
9 board of the Iowa individual health benefit  
10 reinsurance association established in section  
11 513C.10,".

12 3. Page 18, by striking line 47 and inserting the  
13 following: "conduct all meetings of the board  
14 pursuant to chapter 21."

By MICHAEL E. GRONSTAL

S-5159 FILED MARCH 10, 1994  
ADOPTED

## SENATE FILE 2222

S-5160

1 Amend the amendment, S-5152, to Senate File 2222 as  
2 follows:

3 1. Page 19, by striking lines 39 through 48 and  
4 inserting the following:

5 "Sec. \_\_\_\_ . HEALTH INSURANCE COST DEDUCTION.  
6 Section 7 of this Act takes effect upon enactment and  
7 applies retroactively to January 1, 1994, for tax  
8 years beginning on or after that date."

By BERL E. PRIEBE  
H. KAY HEDGE  
EMIL J. HUSAK

JIM RIORDAN  
JOHN P. KIBBIE

S-5160 FILED MARCH 10, 1994  
ADOPTED

## SENATE FILE 2222

S-5152

1 Amend Senate File 2222 as follows:

2 1. By striking everything after the enacting  
3 clause and inserting the following:

4 "Section 1. INTENT AND FINDINGS. It is the intent  
5 of the general assembly that any significant health  
6 care reform must recognize the essential requirement  
7 that rural Iowa must have access to the benefits of  
8 affordable, accessible, and quality health care.  
9 Reform of the health care system in Iowa is not  
10 complete unless there is developed a strategy to  
11 address the needs of rural Iowa with subsequent  
12 implementation of a comprehensive system to meet those  
13 needs. Rural Iowans must be provided the same access  
14 to the best quality medical care available as Iowans  
15 residing in urban areas. The ability of hospitals and  
16 rural health clinics to access the state's fiber optic  
17 network is imperative. The complete use of the skills  
18 of all health care providers is essential to address  
19 the lack of access to primary care. New innovative  
20 initiatives for the delivery of care by rural  
21 hospitals and clinics must be encouraged.

22 The general assembly finds that given the rural  
23 bias inherent in the medicare system for hospital  
24 inpatient reimbursement, and the shortage of a number  
25 of important primary care providers, the challenges  
26 for health care reform in rural Iowa are significant.  
27 However, the general assembly believes that efforts to  
28 reform health care in Iowa coupled with the  
29 initiatives from the federal level offer a new  
30 opportunity to provide quality health care to rural  
31 Iowa. The general assembly finds that policymakers  
32 must seize this opportunity to ensure that rural  
33 Iowans will receive all the benefits of health care  
34 reform.

35 Sec. 2. Section 8.6, Code 1993, is amended by  
36 adding the following new subsection:

37 NEW SUBSECTION. 16. HEALTH ACCOUNTING SYSTEM. To  
38 establish a statewide health accounting system in  
39 coordination with the department of public health, the  
40 department of human services, the department of elder  
41 affairs, the department of employment services, and  
42 the insurance division of the department of commerce.  
43 The department of management shall have access to all  
44 data, as deemed by the department to be necessary, in  
45 electronic format from the community health management  
46 information system established in chapter 144C.

47 Sec. 3. NEW SECTION. 135.110 ACCOUNTABLE HEALTH  
48 PLAN DEFINED.

49 An accountable health plan is an entity which does  
50 all of the following:

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1 1. Pays for and provides health care services.

2 2. Is responsible for delivering the full range of  
3 health care services covered under a standard health  
4 benefit plan as established in chapter 513B.

5 3. Meets established solvency standards and  
6 complies with established underwriting standards,  
7 including modified community rating methods, for all  
8 beneficiaries served.

9 4. Is accountable to the public for the cost,  
10 quality, and access of the services which the  
11 accountable health plan provides and for the effects  
12 of its services on the health of those who are  
13 provided such services.

14 5. Is eligible for operation based on financial,  
15 quality of care, and structural qualifications.

16 6. Satisfies data reporting and collection  
17 standards.

18 Sec. 4. NEW SECTION. 135.111 RULES.

19 1. The director shall adopt rules relating to the  
20 establishment and regulation of accountable health  
21 plans. The rules shall allow significant flexibility  
22 in the structure and organization of an accountable  
23 health plan, including the flexibility to permit  
24 alternative structures for accountable health plans  
25 developed in rural areas of the state in response to  
26 the needs, preferences, and conditions of rural  
27 communities. Such plans shall utilize, to the  
28 greatest extent possible, existing health care  
29 providers and hospitals.

30 2. Rules adopted pursuant to this section shall  
31 include, at a minimum, all of the following:

32 a. Procedures for licensing accountable health  
33 plans as provided in section 135.112.

34 b. Procedures to sanction cooperative arrangements  
35 involving health care providers or purchasers in  
36 forming an accountable health plan, upon a finding by  
37 the director that the arrangement will improve  
38 quality, access, or affordability of health care, but  
39 which arrangement might be a violation of antitrust  
40 laws if undertaken without government direction and  
41 approval.

42 c. Procedures to assure ongoing supervision of  
43 arrangements sanctioned under paragraph "b" in order  
44 to assure that the arrangements do in fact improve the  
45 quality, access, or affordability of health care. The  
46 sanctioning of any arrangement by the director may be  
47 withdrawn on a prospective basis at the discretion of  
48 the director if necessary to enforce the intent to  
49 improve quality, access, or affordability.

50 d. Standards applicable to the plan of operation

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1 of an accountable health plan and which must be met  
2 for licensure of the plan. Such standards shall  
3 include standards related to the quality of health  
4 care provided.

5 e. A requirement that a plan of operation include  
6 guaranteed access and rating practices no more  
7 restrictive than those required in the applicable  
8 state-regulated insurance market segment.

9 f. Procedures to collect information, directly or  
10 by other means as determined by the department, from  
11 the accountable health plan for purposes of monitoring  
12 quality, cost, and access standards. The department  
13 may access data collected through the community health  
14 management information system for purposes of  
15 implementing this chapter at a cost not to exceed the  
16 actual costs of reproducing the information for the  
17 division.

18 g. A method or methods to facilitate and encourage  
19 the appropriate provision of services by midlevel  
20 health care practitioners and allied health care  
21 practitioners.

22 h. Procedures to assure that all health carriers,  
23 including health maintenance organizations, insurers,  
24 and nonprofit health service plan corporations are  
25 subject to the same rules, to the extent the health  
26 carrier is operating an accountable health plan or is  
27 a participating entity in an accountable health plan.

28 i. Solvency standards to assure an accountable  
29 health plan's ability to deliver required services.  
30 The director may enter into an agreement with the  
31 insurance division of the department of commerce to  
32 conduct such solvency oversight. The insurance  
33 division shall assess the costs of a solvency  
34 examination against the entity being examined in the  
35 same manner and on the same terms as provided for  
36 insurance companies under section 505.7.

37 j. Publication and dissemination of statewide and  
38 localized expenditure targets relevant to each  
39 accountable health plan, as appropriate.

40 k. Provide for the identification of essential  
41 community providers within the service area of each  
42 accountable health plan. "Essential community  
43 providers" means those health care providing  
44 organizations which the director deems to be vital to  
45 a local health care delivery system to ensure that all  
46 citizens of this state have reasonable access to  
47 health care. Accountable health plans must establish  
48 working relationships with essential community  
49 providers and include them within the plan's plan of  
50 operation in delivering health care within the plan's

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1 service area. This paragraph is repealed effective  
2 July 1, 1999.

3 1. Provisions for the identification of market  
4 areas to be serviced by each accountable health plan.  
5 Rules developed pursuant to this paragraph shall  
6 promote expansion of accountable health plans into all  
7 geographic areas of the state.

8 m. The director shall make, or cause to be made,  
9 inspections as the director deems necessary in order  
10 to determine compliance with section 135.110, this  
11 section, and sections 135.112 and 135.113, and  
12 applicable rules.

13 3. This section and rules adopted pursuant to this  
14 section are intended to provide immunity from federal  
15 antitrust law under the state action doctrine  
16 exemption.

17 Sec. 5. NEW SECTION. 135.112 LICENSING REQUIRED.

18 1. An accountable health plan shall not operate  
19 unless the plan is licensed by the department. The  
20 director shall adopt rules as provided in section  
21 135.111 establishing a licensing procedure. A license  
22 shall not be issued by the department unless the  
23 director finds that the accountable health plan  
24 satisfies, at a minimum, all of the following:

25 a. The ability to be responsible for the full  
26 continuum of required health care and related costs  
27 for the defined population that the accountable health  
28 plan will serve.

29 b. Financial solvency.

30 c. The ability to satisfy established standards  
31 related to the quality of care provided.

32 d. The ability to fully comply with the provisions  
33 of this section and all applicable rules.

34 2. The department shall establish by rule a  
35 reasonable filing fee to be submitted with a license  
36 application and each renewal application. A license  
37 shall be renewed annually. A license issued pursuant  
38 to this section expires on December 31 of the calendar  
39 year for which the license was granted. Fees received  
40 by the department shall be retained by the department  
41 to offset costs associated with the administration of  
42 this chapter.

43 3. An accountable health plan may be organized and  
44 licensed as a nonprofit or for-profit plan.

45 Sec. 6. NEW SECTION. 135.113 DEFINITIONS.

46 For purposes of sections 135.110 through 135.112,  
47 unless the context otherwise requires:

48 1. "Hospital" means as defined in section 135B.1.

49 2. "Health care provider" or "provider" or  
50 "practitioner" means a person licensed or certified

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1 pursuant to chapter 148, 148A, 148B, 148C, 149, 150,  
2 150A, 151, 152, 152A, 153, 154, 154B, or 155A, to  
3 provide professional health care services in this  
4 state to an individual during the individual's medical  
5 care, treatment, or confinement.

6 Sec. 7. Section 422.7, Code Supplement 1993, is  
7 amended by adding the following new subsection:

8 NEW SUBSECTION. 29. Subtract, to the extent not  
9 otherwise deducted in computing adjusted gross income,  
10 the amounts paid by the taxpayer for the purchase of  
11 health insurance for the taxpayer or taxpayer's spouse  
12 or dependent.

13 Sec. 8. Section 505.7, subsection 1, Code  
14 Supplement 1993, is amended to read as follows:

15 1. All fees and charges which are required by law  
16 to be paid by insurance companies, and associations,  
17 and other regulated entities shall be payable to the  
18 commissioner of the insurance division of the  
19 department of commerce or department of revenue and  
20 finance, as provided by law, whose duty it shall be to  
21 account for and pay over the same to the treasurer of  
22 state at the time and in the manner provided by law  
23 for deposit in the general fund of the state.

24 Sec. 9. Section 505.7, Code Supplement 1993, is  
25 amended by adding the following new subsection:

26 NEW SUBSECTION. 8. The commissioner may assess  
27 the costs of an audit or examination to a health  
28 insurance purchasing cooperative authorized under  
29 section 514I.1, in the same manner as provided for  
30 insurance companies under sections 507.7 through  
31 507.9, and may establish by rule reasonable filing  
32 fees to fund the cost of regulatory oversight.

33 Sec. 10. Section 505.8, Code 1993, is amended by  
34 adding the following new subsection:

35 NEW SUBSECTION. 6. The commissioner shall  
36 supervise all health insurance purchasing cooperatives  
37 providing services or operating within the state and  
38 the organization of domestic cooperatives. The  
39 commissioner may admit nondomestic health insurance  
40 purchasing cooperatives under the same standards as  
41 domestic cooperatives. Health insurance purchasing  
42 cooperatives are subject to rules adopted by the  
43 commissioner pursuant to section 514I.1.

44 Sec. 11. Section 509A.6, Code 1993, is amended by  
45 adding the following new unnumbered paragraph:

46 NEW UNNUMBERED PARAGRAPH. The governing body may  
47 also enroll in and contract with a health insurance  
48 purchasing cooperative authorized pursuant to section  
49 514I.1.

50 Sec. 12. Section 513B.2, subsection 12, unnumbered

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1 paragraph 1, Code Supplement 1993, is amended to read  
2 as follows:

3 "Late enrollee" means an eligible employee or  
4 dependent who requests enrollment in a health benefit  
5 plan of a small employer following the initial  
6 enrollment period for which such individual is  
7 entitled to enroll under the terms of the health  
8 benefit plan, provided the initial enrollment period  
9 is a period of at least thirty one hundred eighty  
10 days. An eligible employee or dependent shall not be  
11 considered a late enrollee if any of the following  
12 apply:

13 Sec. 13. Section 513B.2, subsection 12, paragraph  
14 a, subparagraph (3), Code Supplement 1993, is amended  
15 to read as follows:

16 (3) The individual requests enrollment within  
17 thirty one hundred eighty days after termination of  
18 the qualifying previous coverage.

19 Sec. 14. Section 513B.2, subsection 12, paragraph  
20 c, Code Supplement 1993, is amended to read as  
21 follows:

22 c. A court has ordered that coverage be provided  
23 for a spouse or minor or dependent child under a  
24 covered employee's health benefit plan and the request  
25 for enrollment is made within thirty one hundred  
26 eighty days after issuance of the court order.

27 Sec. 15. Section 513B.2, subsection 16, Code  
28 Supplement 1993, is amended to read as follows:

29 16. "Small employer" means a person actively  
30 engaged in business who, on at least fifty percent of  
31 the employer's working days during the preceding year,  
32 employed not less than two and not more than twenty-  
33 five fifty full-time equivalent eligible employees.  
34 In determining the number of eligible employees,  
35 companies which are affiliated companies or which are  
36 eligible to file a combined tax return for purposes of  
37 state taxation are considered one employer.

38 Sec. 16. Section 513B.4, Code Supplement 1993, is  
39 amended by adding the following new subsection:

40 NEW SUBSECTION. 1A. Notwithstanding subsection 1,  
41 there shall be no variance in premium rates for a  
42 basic or standard benefit plan offered pursuant to  
43 this chapter for any of the factors as provided for in  
44 subsection 1.

45 Sec. 17. Section 513B.4, subsection 2, unnumbered  
46 paragraph 2, Code Supplement 1993, is amended by  
47 striking the paragraph and inserting in lieu thereof  
48 the following:

49 Case characteristics other than family composition  
50 and group size shall not be used by a small employer

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1 carrier without the prior approval of the  
2 commissioner.

3 Sec. 18. Section 513B.4, Code Supplement 1993, is  
4 amended by adding the following new subsection:

5 NEW SUBSECTION. 5. Notwithstanding subsection 1,  
6 the commissioner shall by order reduce or eliminate  
7 the allowed rating bands provided under subsection 1,  
8 paragraphs "a", "b", and "c", or otherwise limit or  
9 eliminate the use of experience rating.

10 Sec. 19. Section 513B.10, subsection 3, paragraph  
11 a, unnumbered paragraph 1, Code Supplement 1993, is  
12 amended to read as follows:

13 The plan shall not deny, exclude, or limit  
14 benefits for a covered individual for losses incurred  
15 more than ~~twelve~~ six months following the effective  
16 date of the individual's coverage due to a preexisting  
17 condition. A health benefit plan shall not define a  
18 preexisting condition more restrictively than the  
19 following:

20 Sec. 20. Section 513B.37, subsection 1, paragraph  
21 a, Code Supplement 1993, is amended to read as  
22 follows:

23 a. What benefits or direct pay requirements must  
24 be minimally included in a basic or standard benefit  
25 coverage policy or subscription contract.

26 Sec. 21. Section 513B.38, Code Supplement 1993, is  
27 amended by adding the following new subsections:

28 NEW SUBSECTION. 4. Upon the determination of the  
29 commissioner pursuant to section 513B.37, subsection  
30 1, paragraph "a", to include expanded preventative  
31 care services and mental health and substance abuse  
32 treatment coverage, the commissioner shall do all of  
33 the following:

34 a. Adopt by rule, with all due diligence,  
35 requirements for the provision of expanded coverage  
36 for benefits for expanded preventative care services.

37 b. Adopt by rule, with all due diligence,  
38 requirements for the provision of coverage for  
39 benefits for mental health and substance abuse  
40 services, which shall be on the same terms and  
41 conditions as such coverage is provided for other  
42 illnesses and diseases.

43 NEW SUBSECTION. 5. A policy of accident and  
44 sickness insurance, a health maintenance organization  
45 contract, an accountable health plan contract, or  
46 other policy of health insurance shall not provide a  
47 lifetime maximum limit of coverage.

48 Sec. 22. NEW SECTION. 513C.1 SHORT TITLE.

49 This chapter shall be known and may be cited as the  
50 "Individual Health Insurance Market Reform Act".

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1 Sec. 23. NEW SECTION. 513C.2 PURPOSE.

2 The purpose and intent of this chapter is to  
3 promote the availability of health insurance coverage  
4 to individuals regardless of their health status or  
5 claims experience, to prevent abusive rating  
6 practices, to require disclosure of rating practices  
7 to purchasers, to establish rules regarding the  
8 renewal of coverage, to establish limitations on the  
9 use of preexisting condition exclusions, to provide  
10 for the development of a core group of basic or  
11 standard health benefits to be offered to all  
12 individuals, and to improve the overall fairness and  
13 efficiency of the individual health insurance market.

14 Sec. 24. NEW SECTION. 513C.3 DEFINITIONS.

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

17 1. "Actuarial certification" means a written  
18 statement by a member of the American academy of  
19 actuaries or other individual acceptable to the  
20 commissioner that an individual carrier is in  
21 compliance with the provision of section 513C.5 which  
22 is based upon the actuary's or individual's  
23 examination, including a review of the appropriate  
24 records and the actuarial assumptions and methods used  
25 by the carrier in establishing premium rates for  
26 applicable individual health benefit plans.

27 2. "Affiliate" or "affiliated" means any entity or  
28 person who directly or indirectly through one or more  
29 intermediaries, controls or is controlled by, or is  
30 under common control with, a specified entity or  
31 person.

32 3. "Basic or standard health benefit plan" means  
33 the core group of health benefits developed pursuant  
34 to section 513C.8.

35 4. "Block of business" means all the individuals  
36 insured under the same individual health benefit plan.

37 5. "Carrier" means any entity that provides  
38 individual health benefit plans in this state. For  
39 purposes of this chapter, carrier includes an  
40 insurance company, a group hospital or medical service  
41 corporation, a fraternal benefit society, a health  
42 maintenance organization, an accountable health plan,  
43 and any other entity providing an individual plan of  
44 health insurance or health benefits subject to state  
45 insurance regulation.

46 6. "Commissioner" means the commissioner of  
47 insurance.

48 7. "Eligible individual" means an individual who  
49 is a resident of this state and who either has  
50 qualifying existing coverage or has had qualifying

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1 existing coverage within the immediately preceding one  
2 hundred eighty days, or an individual who has had a  
3 qualifying event occur within the immediately  
4 preceding one hundred eighty days.

5 8. "Established service area" means a geographic  
6 area, as approved by the commissioner and based upon  
7 the carrier's certificate of authority to transact  
8 insurance in this state, within which the carrier is  
9 authorized to provide coverage.

10 9. "Filed rate" means, for a rating period related  
11 to each block of business, the rate charged to all  
12 individuals with similar rating characteristics for  
13 individual health benefit plans.

14 10. "Individual health benefit plan" means any  
15 hospital or medical expense incurred policy or  
16 certificate, hospital or medical service plan, or  
17 health maintenance organization subscriber contract  
18 sold to an individual, or any discretionary group  
19 trust or association policy providing hospital or  
20 medical expense incurred coverage to individuals.  
21 Individual health benefit plan does not include a  
22 self-insured group health plan, a self-insured  
23 multiple employer group health plan, a group  
24 conversion plan, an insured group health plan,  
25 accident-only, specified disease, short-term hospital  
26 or medical, hospital confinement indemnity, credit,  
27 dental, vision, medicare supplement, long-term care,  
28 or disability income insurance coverage, coverage  
29 issued as a supplement to liability insurance,  
30 workers' compensation or similar insurance, or  
31 automobile medical payment insurance.

32 11. "Premium" means all moneys paid by an  
33 individual and eligible dependents as a condition of  
34 receiving coverage from a carrier, including any fees  
35 or other contributions associated with an individual  
36 health benefit plan.

37 12. "Qualifying event" means any of the following:

38 a. Loss of eligibility for medical assistance  
39 provided pursuant to chapter 249A or medicare coverage  
40 provided pursuant to Title XVIII of the federal Social  
41 Security Act.

42 b. Loss or change of dependent status under  
43 qualifying previous coverage.

44 c. The attainment by an individual of the age of  
45 majority.

46 13. "Qualifying existing coverage" or "qualifying  
47 previous coverage" means benefits or coverage provided  
48 under either of the following:

49 a. Any group health insurance that provides  
50 benefits similar to or exceeding benefits provided

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1 under the standard health benefit plan, provided that  
2 such policy has been in effect for a period of at  
3 least one year.

4 b. An individual health insurance benefit plan,  
5 including coverage provided under a health maintenance  
6 organization contract, a hospital or medical service  
7 plan contract, or a fraternal benefit society  
8 contract, that provides benefits similar to or  
9 exceeding the benefits provided under the standard  
10 health benefit plan, provided that such policy has  
11 been in effect for a period of at least one year.

12 14. "Rating characteristics" means demographic or  
13 other objective characteristics of individuals which  
14 are considered by the carrier in the determination of  
15 premium rates for the individuals and which are  
16 approved by the commissioner.

17 15. "Rating period" means the period for which  
18 premium rates established by a carrier are in effect.

19 16. "Restricted network provision" means a  
20 provision of an individual health benefit plan that  
21 conditions the payment of benefits, in whole or in  
22 part, on the use of health care providers that have  
23 entered into a contractual arrangement with the  
24 carrier to provide health care services to covered  
25 individuals.

26 Sec. 25. NEW SECTION. 513C.4 APPLICABILITY AND  
27 SCOPE.

28 This chapter applies to an individual health  
29 benefit plan delivered or issued for delivery to  
30 residents of this state on or after July 1, 1994.

31 1. Except as provided in subsection 2, for  
32 purposes of this chapter, carriers that are affiliated  
33 companies or that are eligible to file a consolidated  
34 tax return shall be treated as one carrier and any  
35 restrictions or limitations imposed by this chapter  
36 shall apply as if all individual health benefit plans  
37 delivered or issued for delivery to residents of this  
38 state by such affiliated carriers were issued by one  
39 carrier.

40 2. An affiliated carrier that is a health  
41 maintenance organization having a certificate of  
42 authority under section 513C.5 shall be considered to  
43 be a separate carrier for the purposes of this  
44 chapter.

45 Sec. 26. NEW SECTION. 513C.5 RESTRICTIONS  
46 RELATING TO PREMIUM RATES.

47 1. Premium rates for any block of individual  
48 health benefit plan business issued on or after July  
49 1, 1994, by a carrier subject to this chapter are  
50 subject to the composite effect of all of the

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1 following:

2 a. After making actuarial adjustments based upon  
3 benefit design and rating characteristics, the filed  
4 rate for any block of business shall not exceed the  
5 filed rate for any other block of business by more  
6 than twenty percent.

7 b. The filed rate for any block of business shall  
8 not exceed the filed rate for any other block of  
9 business by more than thirty percent due to factors  
10 relating to rating characteristics.

11 c. The carrier shall not apply gender or industry  
12 classification rating characteristics.

13 d. Experience rating characteristics other than  
14 family composition and group size shall not be used by  
15 a carrier without the prior approval of the  
16 commissioner.

17 e. Premium rates for individual health benefit  
18 plans shall comply with the requirements of this  
19 section notwithstanding any assessments paid or  
20 payable by the carrier pursuant to any reinsurance  
21 program or risk adjustment mechanism.

22 f. An adjustment, not to exceed fifteen percent  
23 annually due to the claim experience or health status  
24 of a block of business.

25 g. For purposes of this subsection, an individual  
26 health benefit plan that contains a restricted network  
27 provision shall not be considered similar coverage to  
28 an individual health benefit plan that does not  
29 contain such a provision, provided that the  
30 differential in payments made to network providers  
31 results in substantial differences in claim costs.

32 2. Notwithstanding subsection 1, the commissioner  
33 shall by order reduce or eliminate the allowed rating  
34 bands provided under subsection 1, paragraphs "a",  
35 "b", "c", and "g", or otherwise limit or eliminate the  
36 use of experience rating.

37 3. A carrier shall not transfer an individual  
38 involuntarily into or out of a block of business.

39 4. The commissioner may suspend for a specified  
40 period the application of subsection 1, paragraph "a",  
41 as to the premium rates applicable to one or more  
42 blocks of business of a carrier for one or more rating  
43 periods upon a filing by the carrier requesting the  
44 suspension and a finding by the commissioner that the  
45 suspension is reasonable in light of the financial  
46 condition of the carrier.

47 5. A carrier shall make a reasonable disclosure at  
48 the time of the offering for sale of any individual  
49 health benefit plan of all of the following:

50 a. The extent to which premium rates for a

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1 specified individual are established or adjusted based  
2 upon rating characteristics.

3 b. The carrier's right to change premium rates,  
4 and the factors, other than claim experience, that  
5 affect changes in premium rates.

6 c. The provisions relating to the renewal of  
7 policies and contracts.

8 d. Any provisions relating to any preexisting  
9 condition.

10 e. All plans offered by the carrier, the prices of  
11 such plans, and the availability of such plans to the  
12 individual.

13 6. A carrier shall maintain at its principal place  
14 of business a complete and detailed description of its  
15 rating practices, including information and  
16 documentation that demonstrate that its rating methods  
17 and practices are based upon commonly accepted  
18 actuarial assumptions and are in accordance with sound  
19 actuarial principles.

20 7. A carrier shall file with the commissioner  
21 annually on or before March 15, an actuarial  
22 certification certifying that the carrier is in  
23 compliance with this chapter and that the rating  
24 methods of the carrier are actuarially sound. The  
25 certification shall be in a form and manner and shall  
26 contain information as specified by the commissioner.  
27 A copy of the certification shall be retained by the  
28 carrier at its principal place of business. Rate  
29 adjustments made in order to comply with this section  
30 are exempt from loss ratio requirements.

31 8. A carrier shall make the information and  
32 documentation maintained pursuant to subsection 5  
33 available to the commissioner upon request. The  
34 information and documentation shall be considered  
35 proprietary and trade secret information and shall not  
36 be subject to disclosure by the commissioner to  
37 persons outside of the division except as agreed to by  
38 the carrier or as ordered by a court of competent  
39 jurisdiction.

40 Sec. 27. NEW SECTION. 513C.6 RENEWAL OF  
41 COVERAGE.

42 1. An individual health benefit plan is renewable  
43 at the option of the individual, except in any of the  
44 following cases:

45 a. Nonpayment of the required premiums.

46 b. Fraud or misrepresentation.

47 c. The insured individual becomes eligible for  
48 medicare coverage under Title XVIII of the federal  
49 Social Security Act.

50 d. The carrier elects not to renew all of its

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1 individual health benefit plans in the state. In such  
2 case, the carrier shall provide notice of the decision  
3 not to renew coverage to all affected individuals and  
4 to the commissioner in each state in which an affected  
5 insured individual is known to reside at least ninety  
6 days prior to the nonrenewal of the health benefit  
7 plan by the carrier. Notice to the commissioner under  
8 the paragraph shall be provided at least three working  
9 days prior to the notice to the affected individuals.

10 e. The commissioner finds that the continuation of  
11 the coverage would not be in the best interests of the  
12 policyholders or certificate holders, or would impair  
13 the carrier's ability to meet its contractual  
14 obligations.

15 2. A carrier that elects not to renew all of its  
16 individual health benefit plans in this state shall be  
17 prohibited from writing new individual health benefit  
18 plans in this state for a period of five years from  
19 the date of the notice to the commissioner.

20 3. With respect to a carrier doing business in an  
21 established geographic service area of the state, this  
22 section applies only to the carrier's operations in  
23 the service area.

24 Sec. 28. NEW SECTION. 513C.7 AVAILABILITY OF  
25 COVERAGE.

26 1. A carrier issuing an individual health benefit  
27 plan in this state shall issue a basic or standard  
28 health benefit plan to an eligible individual who  
29 applies for a plan and agrees to make the required  
30 premium payments and to satisfy other reasonable  
31 provisions of the basic or standard health benefit  
32 plan. An insurer is not required to issue a basic or  
33 standard health benefit plan to an individual who  
34 meets any of the following criteria:

35 a. The individual is covered or is eligible for  
36 coverage under a health benefit plan provided by the  
37 individual's employer.

38 b. An eligible individual who does not apply for a  
39 basic or standard health benefit plan within one  
40 hundred eighty days of a qualifying event or within  
41 one hundred eighty days upon becoming ineligible for  
42 qualifying existing coverage.

43 c. The individual is covered or is eligible for  
44 any continued group coverage under section 4980b of  
45 the Internal Revenue Code, sections 601 through 608 of  
46 the federal Employee Retirement Income Security Act of  
47 1974, sections 2201 through 2208 of the federal Public  
48 Health Service Act, or any state-required continued  
49 group coverage. For purposes of this subsection, an  
50 individual who would have been eligible for such

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1 continuation of coverage, but is not eligible solely  
2 because the individual or other responsible party  
3 failed to make the required coverage election during  
4 the applicable time period, is deemed to be eligible  
5 for such group coverage until the date on which the  
6 individual's continuing group coverage would have  
7 expired had an election been made.

8 2. A carrier shall issue the basic or standard  
9 health insurance benefit plan to an individual  
10 currently covered by an underwritten benefit plan  
11 issued by that carrier at the option of the  
12 individual. This option must be exercised within one  
13 hundred eighty days of notification of a premium rate  
14 increase applicable to the underwritten benefit plan.

15 3. A carrier shall file with the commissioner, in  
16 a form and manner prescribed by the commissioner, the  
17 basic or standard health benefit plan to be used by  
18 the carrier. A basic or standard health benefit plan  
19 filed pursuant to this subsection may be used by a  
20 carrier beginning thirty days after it is filed unless  
21 the commissioner disapproves of its use.

22 The commissioner may at any time, after providing  
23 notice and an opportunity for a hearing to the  
24 carrier, disapprove the continued use by a carrier of  
25 a basic or standard health benefit plan on the grounds  
26 that the plan does not meet the requirements of this  
27 chapter.

28 4. a. The individual basic or standard health  
29 benefit plan shall not deny, exclude, or limit  
30 benefits for a covered individual for losses incurred  
31 more than six months following the effective date of  
32 the individual's coverage due to a preexisting  
33 condition. A preexisting condition shall not be  
34 defined more restrictively than any of the following:

35 (1) A condition that would cause an ordinarily  
36 prudent person to seek medical advice, diagnosis,  
37 care, or treatment during the six months immediately  
38 preceding the effective date of coverage.

39 (2) A condition for which medical advice,  
40 diagnosis, care, or treatment was recommended or  
41 received during the six months immediately preceding  
42 the effective date of coverage.

43 (3) A pregnancy existing on the effective date of  
44 coverage.

45 b. A carrier shall waive any time period  
46 applicable to a preexisting condition exclusion or  
47 limitation period with respect to particular services  
48 in an individual health benefit plan for the period of  
49 time an individual was previously covered by  
50 qualifying previous coverage that provided benefits

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1 with respect to such services, provided that the  
2 qualifying previous coverage was continuous to a date  
3 not more than one hundred eighty days prior to the  
4 effective date of the new coverage.

5 5. A carrier is required to offer coverage or  
6 accept applications pursuant to subsection 1 from any  
7 individual residing in the carrier's established  
8 geographic access area.

9 6. A carrier shall not modify a basic or standard  
10 health benefit plan with respect to an individual or  
11 dependent through riders, endorsements, or other means  
12 to restrict or exclude coverage for certain diseases  
13 or medical conditions otherwise covered by the health  
14 benefit plan.

15 Sec. 29. NEW SECTION. 513C.8 HEALTH BENEFIT  
16 PLAN STANDARDS.

17 The commissioner shall adopt by rule the form and  
18 level of coverage of the basic health benefit plan and  
19 the standard health benefit plan for the individual  
20 market which shall be the same as provided for under  
21 chapter 513B with respect to small group coverage.

22 Sec. 30. NEW SECTION. 513C.9 STANDARDS TO ASSURE  
23 FAIR MARKETING.

24 1. A carrier issuing individual health benefit  
25 plans in this state shall make available the basic or  
26 standard health benefit plan to residents of this  
27 state. If a carrier denies other individual health  
28 benefit plan coverage to an eligible individual on the  
29 basis of the health status or claims experience of the  
30 eligible individual, or the individual's dependents,  
31 the carrier shall offer the individual the opportunity  
32 to purchase a basic or standard health benefit plan.

33 2. A carrier or an agent shall not do either of  
34 the following:

35 a. Encourage or direct individuals to refrain from  
36 filing an application for coverage with the carrier  
37 because of the health status, claims experience,  
38 industry occupation, or geographic location of the  
39 individuals.

40 b. Encourage or direct individuals to seek  
41 coverage from another carrier because of the health  
42 status, claims experience, industry occupation, or  
43 geographic location of the individuals.

44 3. Subsection 2, paragraph "a", shall not apply  
45 with respect to information provided by a carrier or  
46 an agent to an individual regarding the established  
47 geographic service area of the carrier or the  
48 restricted network provision of the carrier.

49 4. A carrier shall not, directly or indirectly,  
50 enter into any contract, agreement, or arrangement

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1 with an agent that provides for, or results in, the  
2 compensation paid to an agent for a sale of a basic or  
3 standard health benefit plan to vary because of the  
4 health status or permitted rating characteristics of  
5 the individual or the individual's dependents.

6 5. Subsection 4 does not apply with respect to the  
7 compensation paid to an agent on the basis of  
8 percentage of premium, provided that the percentage  
9 shall not vary because of the health status or other  
10 permitted rating characteristics of the individual or  
11 the individual's dependents.

12 6. Denial by a carrier of an application for  
13 coverage from an individual shall be in writing and  
14 shall state the reason or reasons for the denial.

15 7. A violation of this section by a carrier or an  
16 agent is an unfair trade practice under chapter 507B.

17 8. If a carrier enters into a contract, agreement,  
18 or other arrangement with a third-party administrator  
19 to provide administrative, marketing, or other  
20 services related to the offering of individual health  
21 benefit plans in this state, the third-party  
22 administrator is subject to this section as if it were  
23 a carrier.

24 Sec. 31. NEW SECTION. 513D.1 EMPLOYER REQUIRED  
25 TO PROVIDE ACCESS TO HEALTH CARE COVERAGE --PENALTIES.

26 1. An employer doing business within this state  
27 shall offer each employee, at a minimum, meaningful  
28 access to health insurance. The requirement contained  
29 in this section may be satisfied by offering the  
30 following:

31 a. Health care coverage through an insurer or  
32 health maintenance organization authorized to do  
33 business in this state.

34 b. Enrollment in an Iowa-licensed health insurance  
35 purchasing cooperative. A cooperative may require  
36 payroll deduction of employee contributions and direct  
37 deposit of premium payments to the account of the  
38 cooperative.

39 c. Access to health benefits through a health  
40 benefits plan qualified under the federal Employee  
41 Retirement Income Security Act of 1974, if the  
42 employer is self-insured.

43 2. An employer is not required to financially  
44 contribute toward the employee's health plan.

45 3. A violation of this section may be reported to  
46 the consumer and legal affairs bureau in the insurance  
47 division. The division may issue, upon a finding that  
48 an employer has failed to offer an employee access to  
49 health insurance, any of the following:

50 a. A cease and desist order instructing the

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1 employer to cure the failure and desist from future  
2 violations of this section.

3 b. An order requiring an employer who has  
4 previously been the subject of a cease and desist  
5 order to pay an employee's reasonable health insurance  
6 premiums necessary to prevent or cure a lapse in  
7 health care coverage arising out of the employer's  
8 failure to offer as required.

9 c. An order upon the employer assessing the  
10 reasonable costs of the division's investigation and  
11 enforcement action.

12 Sec. 32. NEW SECTION. 514C.8 PROVIDER ACCESS  
13 UNDER MANAGED CARE HEALTH PLAN OR INDEMNITY PLAN WITH  
14 LIMITED PROVIDER NETWORK.

15 A managed care health plan or indemnity plan with a  
16 limited provider network shall provide patients direct  
17 access to providers licensed under chapter 148, 148A,  
18 148B, 148C, 149, 150, 150A, 151, 152, 152A, 153, 154,  
19 154B, or 155A. Access to such provider shall not be  
20 made conditional upon a referral by a provider  
21 licensed under another chapter. Referral to a  
22 specialist may be conditioned upon referral by a  
23 primary care provider licensed under the same chapter.  
24 Access to a class of providers licensed under one  
25 chapter shall not be subject to a copayment,  
26 deductible, or premium rate different than provided  
27 for access to a class of providers licensed under  
28 another chapter. Access to a specialist may be  
29 subject to a different copayment or deductible than  
30 access to a primary care provider. Access to a  
31 nonparticipating provider may be restricted, or may be  
32 subject to different copayments, deductibles, or  
33 premium rates.

34 For purposes of this section, "managed care health  
35 plan or indemnity plan with a limited provider  
36 network" means a health maintenance organization,  
37 accountable health plan, preferred provider  
38 organization, exclusive provider organization, point  
39 of service plan, or similar health plan.

40 This section does not apply if an employer offers  
41 employees a choice of health plans, either directly or  
42 indirectly through a health insurance purchasing  
43 cooperative, provided that the offered choices include  
44 at least one indemnity plan with unrestricted choice  
45 of provider, or at least one managed care health plan  
46 or indemnity plan with a limited provider network  
47 which provides access as defined in this section.

48 Sec. 33. NEW SECTION. 514I.1 NONPROFIT HEALTH  
49 INSURANCE PURCHASING COOPERATIVES.

50 1. The commissioner of insurance shall adopt rules

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1 and a licensing procedure for authorizing the  
2 establishment of a nonprofit health insurance  
3 purchasing cooperative. The rules shall include, at a  
4 minimum, all of the following:

5 a. Procedures to sanction voluntary agreements  
6 between competitors within the service region of a  
7 nonprofit health insurance purchasing cooperative,  
8 upon a finding by the commissioner that the agreement  
9 will improve the quality of, access to, or  
10 affordability of health care, but which agreement  
11 might be a violation of antitrust laws if undertaken  
12 without government direction and approval.

13 b. Procedures to assure ongoing supervision of  
14 contracts sanctioned under this subsection, in order  
15 to assure that the contracts do in fact improve health  
16 care quality, access, or affordability. Approval may  
17 be withdrawn on a prospective basis at the discretion  
18 of the commissioner if necessary to improve health  
19 care quality, access, and affordability.

20 c. A requirement to review the plan of operation  
21 of a nonprofit health insurance purchasing  
22 cooperative, and standards for approval or disapproval  
23 of a plan.

24 d. A requirement that a plan of operation include  
25 guaranteed access and rating practices no more  
26 restrictive than those required of competitors within  
27 a market segment, such as small group health insurers  
28 regulated under chapter 513B, or individual or large  
29 group insurers regulated under chapter 514A or 514D.  
30 The commissioner shall regulate all health plans and  
31 nonprofit health insurance purchasing cooperatives to  
32 assure that to the greatest extent possible all health  
33 insurance or health benefit marketing channels within  
34 a market segment are subject to the same rules of  
35 access, underwriting, risk spreading, and rate  
36 regulation.

37 e. A requirement that the nonprofit health  
38 insurance purchasing cooperative be governed by a  
39 board of directors consisting of twelve members,  
40 including seven members who are consumers.

41 f. A requirement that the members of the board of  
42 directors be free of conflicts of interest and that  
43 the members of the board file an annual financial  
44 disclosure report with the commissioner.

45 g. A requirement that the board of directors  
46 conduct all official business during open meetings.

47 h. A requirement that the nonprofit health  
48 insurance purchasing cooperative shall have a consumer  
49 ombudsman whose exclusive duties shall be to assist  
50 and advocate for subscribers enrolled in the

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1 cooperative.

2 i. An annual report to be submitted to the general  
3 assembly no later than February 1, describing the  
4 operations of all nonprofit health insurance  
5 purchasing cooperatives, and permitting review of the  
6 success of nonprofit health insurance purchasing  
7 cooperatives in furthering the goals of improved  
8 health care quality, access, or affordability. The  
9 report shall include any recommendations on whether  
10 additional nonprofit health insurance purchasing  
11 cooperatives should be established.

12 2. This section does not prevent the development  
13 of any other health insurance or pooled purchasing  
14 arrangements otherwise permitted by law.

15 3. This section and rules adopted pursuant to this  
16 section are intended to provide immunity from federal  
17 antitrust law under the state action doctrine  
18 exemption.

19 Sec. 34. RURAL PRIMARY CARE INITIATIVE --PHYSICIAN  
20 RESPITE PROGRAM. The Iowa department of public  
21 health, in cooperation with the university of Iowa  
22 college of medicine and the university of osteopathic  
23 medicine and health sciences, shall develop and  
24 establish a rural primary care initiative. The rural  
25 primary care initiative shall, at a minimum, focus on  
26 the expansion of the family practice residency program  
27 and training of rural physicians, physician  
28 assistants, and advanced registered nurse practitioner  
29 health care teams, and the development of a physician,  
30 physician assistant, and advanced registered nurse  
31 practitioner respite programs in the rural areas of  
32 Iowa. The department shall submit a written report to  
33 the general assembly no later than January 9, 1995,  
34 concerning the status of the development of the rural  
35 primary care initiative, and include any legislative  
36 recommendations necessary to complete implementation  
37 of the initiative.

38 Sec. 35. HEALTH INSURANCE COST DEDUCTION --  
39 CONTINGENT EFFECT. Section 7 of this Act, which  
40 amends section 422.7 by adding a new subsection 29, is  
41 effective upon the enactment of a federal individual  
42 income tax provision authorizing the deduction in  
43 computing federal adjusted gross income of one hundred  
44 percent of the cost of the purchase of health  
45 insurance. Section 7 of this Act applies to tax years  
46 designated in the federal enactment of the health  
47 insurance cost deduction.

48 Sec. 36. NOTICE OF EFFECTIVENESS. The director of  
49 revenue and finance shall notify the governor, the  
50 chairpersons and ranking members of the senate and

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1 house ways and means committees, the Iowa Code editor,  
2 and the legislative fiscal bureau when section 7,  
3 which amends section 422.7, of this Act becomes  
4 effective.

5 Sec. 37. UNIVERSAL COVERAGE -- TASK FORCE  
6 ESTABLISHED.

7 1. The state shall provide for universal health  
8 care benefit coverage by no later than January 1,  
9 1998.

10 2. A task force is created to do all of the  
11 following:

12 a. (1) Recommend a comprehensive set of  
13 guaranteed benefits for every Iowan and determine the  
14 cost of providing such benefits. The task force shall  
15 include in guaranteed benefits, at a minimum, all of  
16 the following:

17 (a) Preventative health services.

18 (b) Hospital services.

19 (c) Physician services.

20 (d) Services provided by other licensed providers,  
21 including essential community providers.

22 (e) Long-term care, including home care aide  
23 services and community-based services.

24 (f) Prescriptions and biologicals.

25 (g) Dental.

26 (h) Mental health and substance abuse services,  
27 which shall be provided the same as benefits for  
28 physical illness.

29 (2) Provide a written report to the general  
30 assembly no later than January 9, 1995, including the  
31 comprehensive set of guaranteed benefits recommended  
32 by the task force, and any other recommendations as  
33 deemed necessary by the task force. The general  
34 assembly shall review the report and take action  
35 during the 1995 Regular Session of the general  
36 assembly on such recommendations, as appropriate.

37 b. Make recommendations related to the containment  
38 of health care costs. The task force shall do all of  
39 the following:

40 (1) Develop budget and expenditure targets for  
41 health care spending.

42 (2) Establish limits on insurance administrative  
43 costs.

44 (3) Review single payor, managed competition, and  
45 other structures for administering health benefit  
46 coverages.

47 (4) Develop other health cost containment  
48 mechanisms that ensure accessibility to quality,  
49 affordable health care by all Iowans.

50 Additionally, the task force shall examine and

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1 evaluate, as part of the study of health care cost  
2 containment, the benefits of establishing a single  
3 mandatory, nonprofit health insurance purchasing  
4 cooperative for all Iowans, granted the authority to  
5 negotiate premium limits with insurers and managed  
6 care plans.

7 The task force shall provide a written report to  
8 the general assembly no later than January 8, 1996,  
9 including the cost containment recommendations of the  
10 task force, and any other recommendations as deemed  
11 necessary by the task force. The general assembly  
12 shall review the report and take action during the  
13 1996 Regular Session of the general assembly on such  
14 recommendations, as appropriate.

15 c. Recommend a fair and appropriate financing  
16 mechanism for providing the comprehensive set of  
17 guaranteed benefits recommended pursuant to paragraph  
18 "a", which shall include a level of contribution by  
19 each employer, and the identification of additional  
20 funding sources sufficient to allow for the  
21 development of sliding scale subsidies for businesses  
22 with low-wage workers, self-employed individuals, and  
23 other persons as recommended by the task force and  
24 approved by the general assembly. The task force  
25 shall provide a written report to the general assembly  
26 no later than January 13, 1997, including the  
27 financing mechanism and funding sources recommended by  
28 the task force, and any other recommendations as  
29 deemed necessary by the task force. The general  
30 assembly shall review the report and take action  
31 during the 1997 Regular Session of the general  
32 assembly on such recommendations, as appropriate.

33 3. The task force shall consist of eleven members  
34 to be appointed by the legislative council, of which  
35 at least six members shall be consumers. Members of  
36 the task force shall be reimbursed for all actual and  
37 necessary expenses incurred in the performance of  
38 duties as members. Members of the task force shall  
39 elect a chairperson and vice chairperson and other  
40 officers as they determine. Meetings of the task  
41 force shall be held at the call of the chairperson of  
42 the task force or on written request of four members.

43 Sec. 38. ALTERNATIVE MEDICAL MALPRACTICE DISPUTE  
44 RESOLUTION PROCEDURES -- MEDICAL SCREENING PANELS --  
45 STUDY. The supreme court, in cooperation with the  
46 department of public health and the insurance  
47 division, shall initiate a study concerning the  
48 development and use of alternative medical malpractice  
49 dispute resolution procedures and medical screening  
50 panels. The study shall include, at a minimum, a

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1 review of existing alternative dispute resolution  
2 procedures and medical screening panels and provide  
3 for a comprehensive review of existing statutes and  
4 court decisions in an effort to maximize the benefits  
5 of alternative medical malpractice dispute resolution  
6 procedures that have been successful while assuring  
7 procedural protections and fair access to the court  
8 system. Additionally, the study shall include a  
9 review of the availability of occurrence form of  
10 medical malpractice insurance for obstetricians and  
11 other physicians whose practice involves providing  
12 care services related to the birth of a child, the  
13 development of recommendations related to providing  
14 all individuals claiming injury resulting from an act  
15 of alleged malpractice reasonable and affordable  
16 access to alternative medical malpractice dispute  
17 resolution procedures, and a closed claim survey which  
18 shall include the frequency and severity of outcomes  
19 related to claims involving alleged malpractice by  
20 health care providers. The study shall also include  
21 any recommendations on implementing alternative  
22 medical malpractice dispute resolution procedures and  
23 medical screening panels in the state along with a  
24 corresponding cost benefit analysis related to each  
25 recommendation.

26 Sec. 39. INSURANCE DIVISION STUDIES.

27 1. The insurance division shall review, develop,  
28 and submit a plan for the establishment of an  
29 individual health coverage reinsurance program. The  
30 division shall submit a written report to the general  
31 assembly no later than January 9, 1995, including the  
32 division's plan.

33 2. The insurance division shall review, study, and  
34 make recommendations to the general assembly  
35 concerning the Iowa comprehensive health insurance  
36 association established under chapter 514E, with the  
37 intent to merge the Iowa comprehensive health  
38 insurance program with an individual health  
39 reinsurance program. The division shall submit a  
40 written report to the general assembly no later than  
41 January 9, 1995, including the division's findings and  
42 recommendations.

43 Sec. 40. RURAL HEALTH CARE DELIVERY MODELS. It is  
44 the intent of the general assembly that the department  
45 of inspections and appeals, through the hospital  
46 licensure board, in conjunction with the department of  
47 public health and other appropriate health care  
48 provider licensure boards, as identified by the  
49 departments, review the California alternative rural  
50 hospital model and the community hospital/rural

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1 primary care hospital demonstration project sponsored  
2 by the health care financing administration. The  
3 review shall include an examination of existing  
4 provider licensure statutes and administrative rules  
5 that inhibit or preclude implementation of either  
6 alternative rural health care delivery model and shall  
7 include specific legislative and regulatory strategy  
8 proposals for the removal of such identified barriers.  
9 This written report shall be delivered by the  
10 department of inspections and appeals to the general  
11 assembly on or before January 1, 1995.

12 Sec. 41. APPLICABILITY. Notwithstanding the  
13 provisions of sections 513C.4 and 513C.5, chapter  
14 513C, as enacted in this Act, is not applicable to an  
15 individual health benefit plan delivered or issued for  
16 delivery in this state or to a block of individual  
17 health benefit plan business until such time as rules  
18 implementing the chapter have been adopted by the  
19 insurance division pursuant to chapter 17A.

20 Sec. 42. EFFECTIVE DATE. Section 30 of this Act,  
21 which creates new section 513D.1, is effective January  
22 1, 1995."

By TOM VILSACK

MICHAEL E. GRONSTAL

PATTY JUDGE

MIKE CONNOLLY

JEAN LLOYD-JONES

JIM RIORDAN

BILL FINK

ROBERT E. DVORSKY

RALPH ROSENBERG

S-5152 FILED MARCH 10, 1994

ADOPTED

## SENATE FILE 2222

S-5153

1 Amend the amendment, S-5152, to Senate File 2222 as  
2 follows:

3 1. Page 6, lines 43 and 44, by striking the words  
4 "any of the factors as provided for in subsection 1"  
5 and inserting the following: "health status or claim  
6 experience".

7 2. Page 7, line 27, by striking the word  
8 "subsections" and inserting the following:  
9 "subsection".

10 3. Page 7, by striking lines 43 through 47.

11 4. Page 11, by striking lines 11 and 12.

12 5. Page 11, line 13, by striking the words  
13 "Experiencing rating" and inserting the following:  
14 "Rating".

15 6. Page 15, line 20, by striking the words "the  
16 same as" and inserting the following: "substantially  
17 similar to those".

18 7. By renumbering as necessary.

By ELAINE SZYMONIAK

S-5153 FILED MARCH 10, 1994

ADOPTED, MOTION TO RECONSIDER WITHDRAWN

## SENATE FILE 2222

S-5154

1 Amend the amendment, S-5152, to Senate File 2222,  
2 as follows:  
3 1. Page 16, by inserting after line 23 the  
4 following:  
5 "Sec. . NEW SECTION. 513C.10 IOWA INDIVIDUAL  
6 HEALTH BENEFIT REINSURANCE ASSOCIATION.  
7 1. A nonprofit corporation is established to be  
8 known as the Iowa individual health benefit  
9 reinsurance association. All persons that provide  
10 health benefit plans in this state including insurers  
11 providing accident and sickness insurance under  
12 chapter 509, 514, or 514A; fraternal benefit societies  
13 providing hospital, medical, or nursing benefits under  
14 chapter 512B; health maintenance organizations,  
15 accountable health plans, and all other entities  
16 providing health insurance or health benefits subject  
17 to state insurance regulation shall be members of this  
18 association. The association shall be incorporated  
19 under chapter 504A, shall operate under a plan of  
20 operation established and approved pursuant to chapter  
21 504A, and shall exercise its powers through a board of  
22 directors established under this section.  
23 2. The initial board of directors of the  
24 association shall consist of seven members as follows:  
25 a. Four members shall be representatives of the  
26 four largest carriers of individual health insurance  
27 in the state, excluding medicare supplement coverage  
28 premiums, as of the calendar year ending December 31,  
29 1993.  
30 b. Three members shall be representatives of the  
31 three largest writers of health insurance in the state  
32 which are not otherwise represented.  
33 After an initial term, board members shall be  
34 nominated and elected by the members of the  
35 association.  
36 Members of the board may be reimbursed from the  
37 funds of the association for expenses incurred by them  
38 as members, but shall not otherwise be compensated by  
39 the association for their services.  
40 3. The association shall submit to the  
41 commissioner a plan of operation for the association  
42 and any amendments to the association's articles of  
43 incorporation necessary and appropriate to assure the  
44 fair, reasonable, and equitable administration of the  
45 association. The plan shall provide for the sharing  
46 of losses related to basic and standard plans, if any,  
47 on an equitable and proportional basis among the  
48 members of the association. If the association fails  
49 to submit a suitable plan of operation within one  
50 hundred eighty days after the appointment of the board

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1 of directors, the commissioner shall adopt rules  
2 necessary to implement this section. The rules shall  
3 continue in force until modified by the commissioner  
4 or superseded by a plan submitted by the association  
5 and approved by the commissioner. In addition to  
6 other requirements, the plan of operation shall  
7 provide for all of the following:

8 a. The handling and accounting of assets and funds  
9 of the association.

10 b. The amount of and method for reimbursing the  
11 expenses of board members.

12 c. Regular times and places for meetings of the  
13 board of directors.

14 d. Records to be kept relating to all financial  
15 transactions, and annual fiscal reporting to the  
16 commissioner.

17 e. Procedures for selecting the board of  
18 directors.

19 f. Additional provisions necessary or proper for  
20 the execution of the powers and duties of the  
21 association.

22 4. The plan of operation may provide that the  
23 powers and duties of the association may be delegated  
24 to a person who will perform functions similar to  
25 those of the association. A delegation under this  
26 section takes effect only upon the approval of the  
27 board of directors.

28 5. The association has the general powers and  
29 authority enumerated by this section and executed in  
30 accordance with the plan of operation approved by the  
31 commissioner under subsection 3. In addition, the  
32 association may do any of the following:

33 a. Enter into contracts as necessary or proper to  
34 administer this chapter.

35 b. Sue or be sued, including taking any legal  
36 action necessary or proper for recovery of any  
37 assessments for, on behalf of, or against  
38 participating carriers.

39 c. Appoint from among members appropriate legal,  
40 actuarial, and other committees as necessary to  
41 provide technical assistance in the operation of the  
42 association, including the hiring of independent  
43 consultants as necessary.

44 d. Perform any other functions within the  
45 authority of the association.

46 6. Rates for basic and standard coverages as  
47 provided in this chapter shall be determined by each  
48 individual health insurance carrier as the average of  
49 the lowest rate available for issuance by that carrier  
50 adjusted for rate characteristics and benefits and the

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1 maximum rate allowable by law after adjustments for  
2 rate characteristics and benefits.

3 7. Following the close of each calendar year, the  
4 association, in conjunction with the commissioner,  
5 shall require each individual health insurance carrier  
6 to report the amount of earned premiums and the  
7 associated paid losses for all basic and standard  
8 plans issued by the individual health insurance  
9 carrier. The reporting of these amounts must be  
10 certified by an officer of the carrier.

11 8. The board shall determine the amount of loss,  
12 if any, from all basic and standard plans issued in  
13 the state by all individual health insurance carriers  
14 by aggregating the data reported in subsection 7. A  
15 loss shall be equal to ninety percent of earned  
16 premiums minus total paid claims.

17 9. The loss plus necessary operating expenses for  
18 the association, plus any additional expenses as  
19 provided by law, shall be assessed by the association  
20 to all members in proportion to their respective  
21 shares of total health insurance premiums or payments  
22 for subscriber contracts received in Iowa during the  
23 second preceding calendar year, or with paid losses in  
24 the year, coinciding with or ending during the  
25 calendar year, or on any other equitable basis as  
26 provided in the plan of operation. In sharing losses,  
27 the association may abate or defer in any part the  
28 assessment of a member, if, in the opinion of the  
29 board, payment of the assessment would endanger the  
30 ability of the member to fulfill its contractual  
31 obligations. The association may also provide for an  
32 initial or interim assessment against members of the  
33 association if necessary to assure the financial  
34 viability of the association to meet the operating  
35 expenses of the association until the next calendar  
36 year is completed.

37 10. The collected assessments shall be disbursed  
38 to an individual health insurance carrier in  
39 proportion to the loss that carrier represented of the  
40 aggregate loss as determined in subsection 8.

41 11. An individual health insurance carrier may  
42 petition the association board to seek remedy from  
43 writing a significantly disproportionate share of  
44 basic and standard policies in relation to total  
45 individual health insurance premiums written in the  
46 state. Upon a finding that a company has written a  
47 disproportionate share, the board may agree to  
48 compensate the carrier either by paying to the company  
49 an additional fee not to exceed two percent of earned  
50 premiums from basic and standard policies for that

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1 company or by petitioning the commissioner for remedy.  
2 12. The commissioner, upon a finding that the  
3 acceptance of the offer of basic and standard coverage  
4 by individuals pursuant to this chapter would place  
5 the individual health insurance carrier in a  
6 financially impaired condition, shall not require the  
7 carrier to offer coverage or accept applications for  
8 any period of time the financial impairment is deemed  
9 to exist."

10 2. Page 22, by striking lines 28 through 33.

11 3. Page 22, line 34, by striking the figure "2."

12 4. By renumbering as necessary.

By ELAINE SZYMONIAK

S-5154 FILED MARCH 10, 1994

ADOPTED

SENATE FILE 2222

S-5155

1 Amend the amendment, S-5152, to Senate File 2222 as  
2 follows:

3 1. Page 2, line 49, by inserting after the word  
4 "affordability." the following: "One of the standards  
5 for access to surgical services shall be that  
6 procedures for minors shall only be provided with the  
7 consent of at least one parent or guardian except  
8 where the life of the minor is in jeopardy."

By WILLIAM W. DIELEMAN

S-5155 FILED MARCH 10, 1994

RULED OUT OF ORDER

## SENATE FILE 2222

S-5156

1 Amend the amendment, S-5152, to Senate File 2222 as  
2 follows:

3 1. Page 3, line 12, by inserting after the word  
4 "standards." the following: "Access standards shall  
5 include the assessment of prohibited referrals as  
6 provided in section 135L.1."

7 2. Page 5, by striking lines 1 through 3 and  
8 inserting the following: "pursuant to chapters 147  
9 through 154, and chapters 154B and 155A, to provide  
10 professional health care services in this".

11 3. Page 5, line 4, by striking the word "medical"  
12 and inserting the following: "health".

13 4. Page 5, by inserting before line 6 the  
14 following:

15 "Sec. \_\_\_\_ . NEW SECTION. 135L.1 PROHIBITED  
16 REFERRALS AND CLAIMS FOR PAYMENT.

17 1. A health care provider shall not refer a  
18 patient for the provision of designated health  
19 services to an entity in which the health care  
20 provider is an investor or has an investment interest,  
21 except where the entity is the sole provider of health  
22 services in a county with a population density of no  
23 greater than one hundred persons per square mile.

24 2. A health care provider shall not refer a  
25 patient for the provision of any other health care  
26 item or service to an entity in which the health care  
27 provider is an investor unless either of the following  
28 applies:

29 a. The provider's investment interest is in  
30 registered securities purchased on a national exchange  
31 or over-the-counter market and issued by a publicly  
32 held corporation, whose shares are traded on a  
33 national exchange or on the over-the-counter market  
34 and whose total assets at the end of the corporation's  
35 most recent fiscal quarter exceeded fifty million  
36 dollars.

37 b. With respect to an entity other than a publicly  
38 held corporation described in paragraph "a", and a  
39 referring provider's investment interest in the  
40 entity, all of the following requirements arise:

41 (1) Not more than fifty percent of the value of  
42 the investment interests are held by investors who are  
43 in a position to make referrals to the entity.

44 (2) The terms under which an investment interest  
45 is offered to an investor, who is in a position to  
46 make referrals to the entity, are no different from  
47 the terms offered to investors who are not in a  
48 position to make referrals.

49 (3) The terms under which an investment interest  
50 is offered to an investor, who is in a position to

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1 make referrals to the entity, are not related to the  
2 previous or expected volume of referrals from the  
3 investor to the entity.

4 (4) There is no requirement that an investor make  
5 referrals or be in a position to make referrals to the  
6 entity as a condition for becoming or remaining an  
7 investor.

8 3. Except as provided under subsection 2, the  
9 entity or corporation shall not loan funds to or  
10 guarantee a loan for an investor who is in a position  
11 to make referrals to the entity or corporation. The  
12 investor shall not use any part of a loan obtained  
13 through an entity or corporation to obtain the  
14 investment interest.

15 4. Except as provided under subsection 2, the  
16 amount distributed to an investor representing a  
17 return on the investment interest shall be directly  
18 proportional to the amount of the capital investment,  
19 made by the investor in the entity or corporation,  
20 including the fair market value of any preoperational  
21 services rendered.

22 5. A claim for payment shall not be presented by  
23 an entity to any individual, third-party payor, or  
24 other entity for a service furnished pursuant to a  
25 referral prohibited under this section.

26 6. If an entity collects an amount that was billed  
27 in violation of this section, the entity shall refund  
28 the amount and any interest or late fee assessed on a  
29 timely basis to the payor or individual as applicable.

30 7. Any person that presents or causes to be  
31 presented a bill or a claim for service that the  
32 person knows or should know is for a service for which  
33 payment may not be made under subsection 5, or for  
34 which a refund has not been made under subsection 6,  
35 is subject to a civil penalty of not more than fifteen  
36 thousand dollars for each service, to be imposed and  
37 collected by the appropriate board.

38 8. Any health care provider or other entity that  
39 enters into an arrangement or scheme, such as a cross-  
40 referral arrangement, which the physician or entity  
41 knows or should know has a principal purpose of  
42 assuring referrals by the physician to a particular  
43 entity which, if the physician directly made referrals  
44 to the entity, would be in violation of this section,  
45 is subject to a civil penalty of not more than one  
46 hundred thousand dollars for each circumvention  
47 arrangement or scheme, to be imposed and collected by  
48 the appropriate board or boards.

49 9. A health care provider or any provider of  
50 health care services shall not offer, pay, solicit, or

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1 receive a kickback, directly or indirectly, overtly or  
2 covertly, in the form of cash, consulting fees, wages,  
3 or in kind, for referring or soliciting patients.

4 10. A violation of this section by a health care  
5 provider constitutes grounds for disciplinary action  
6 to be taken by the applicable board.

7 11. A health care professional licensed pursuant  
8 to chapters 147 through 154, and chapters 154B and  
9 155A, is subject to suspension or revocation of  
10 license if the person engages directly or indirectly  
11 in the division, transferring, assigning, rebating, or  
12 refunding of fees received for professional services  
13 or profits by means of a credit or other valuable  
14 consideration such as wages, an unearned commission,  
15 discount or gratuity with a person who referred a  
16 patient, or with any relative or business associate of  
17 the referring person. Nothing in this paragraph shall  
18 be construed as prohibiting the members of any legally  
19 organized business entity recognized by law and  
20 comprised of health care professionals licensed  
21 pursuant to chapters 147 through 154, and chapters  
22 154B and 155A, from making any division of their total  
23 fees among the health care professionals determined by  
24 contract necessary to defray their joint operating  
25 costs.

26 12. In addition to any other penalty or  
27 disciplinary action taken under this section, a health  
28 care provider who violates this section shall divest  
29 any investment interest which has resulted in the  
30 violation of this section."

31 5. By renumbering as necessary.

By JIM RIORDAN  
JEAN LLOYD-JONES

S-5156 FILED MARCH 10, 1994  
LOST

## SENATE FILE 2222

S-5149

1 Amend Senate File 2222 as follows:

2 1. Page 6, line 25, by inserting after the word  
3 "dependent." the following: "This deduction does not  
4 apply to the extent the amounts paid are from a  
5 medical care savings account for which the taxpayer  
6 received tax benefits."

7 2. Page 6, by striking lines 27 through 31 and  
8 inserting the following: "by adding the following new  
9 subsections:

10 NEW SUBSECTION. 30. Subtract, to the extent  
11 included, up to three thousand dollars contributed by  
12 the individual in the aggregate to a medical care  
13 savings account for the individual, the individual's  
14 spouse, or the individual's dependent. The deduction  
15 for contributions to a medical care savings account  
16 are allowed subject to the following conditions:

17 a. The net income is forty thousand dollars or  
18 less in the case of a married individual, an unmarried  
19 head of household, or a surviving spouse or the net  
20 income is thirty thousand dollars or less in the case  
21 of all other persons. In the case of a married  
22 individual, the combined net income of both spouses  
23 shall be considered.

24 b. The individual or the individual's spouse is a  
25 self-employed individual as defined in section 401(c)  
26 of the Internal Revenue Code.

27 NEW SUBSECTION. 31. Subtract to the extent  
28 included, interest earned in the tax year on a medical  
29 care savings account unless the interest is withdrawn  
30 and not used for any of the approved purposes  
31 described in section 514B.2, subsection 6.

32 NEW SUBSECTION. 32. Add to the extent not  
33 included, amounts withdrawn from a medical care  
34 savings account which were not used for any of the  
35 approved purposes described in section 514B.2,  
36 subsection 6, and which represent tax benefits  
37 previously taken by the individual."

38 3. Page 23, by inserting after line 21 the  
39 following:

40 "Sec. 130. NEW SECTION. 541B.1 DEFINITIONS.

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

43 1. "Account holder" means an individual for whose  
44 benefit a medical care savings account is established.

45 2. "Department" means the department of revenue  
46 and finance.

47 3. "Dependent" means the same as defined in  
48 section 152 of the Internal Revenue Code.

49 4. "Financial institution" means a financial  
50 institution or insurance company approved by the

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1 department as an investment mechanism for medical care  
2 savings accounts.

3 5. "Internal Revenue Code" means the same as  
4 defined in section 422.3.

5 Sec. 131. NEW SECTION. 514B.2 MEDICAL CARE  
6 SAVINGS ACCOUNTS.

7 A financial instrument known as the medical care  
8 savings account is established. A medical care  
9 savings account shall have all of the following  
10 characteristics:

11 1. The account is kept in the name of the  
12 individual, the individual's spouse, or the  
13 individual's dependent.

14 2. Deposits of up to three thousand dollars can be  
15 made to the medical care savings accounts in the year.

16 3. The account earns income or interest.

17 4. In the case of death of an individual with a  
18 medical care savings account, the balance can be  
19 transferred to the account of the spouse or dependent  
20 or an account can be set up for the spouse or  
21 dependent. The balance of an individual's medical  
22 care savings account that transfers to the spouse or  
23 dependent at the time of death is not subject to the  
24 state inheritance tax.

25 5. The total amount of principal in a medical care  
26 savings account shall not exceed fifty thousand  
27 dollars.

28 6. Amounts withdrawn for any of the following  
29 approved purposes do not result in income to the  
30 holder of a medical care savings account:

31 Payment of health insurance premiums and payment of  
32 the costs of all medical services for the individual,  
33 the individual's spouse, and the individual's  
34 dependent to the extent that the expenditures qualify  
35 for the deduction for medical care under section  
36 213(a) of the Internal Revenue Code without regard to  
37 whether the expenditures exceed seven and one-half  
38 percent of the individual's federal adjusted gross  
39 income. However, any expenditure for medical care  
40 which is paid from the medical care savings account  
41 may not be deducted as a medical expense under section  
42 422.9, subsection 2, or as health insurance costs of  
43 self-employed individuals under section 162(i) of the  
44 Internal Revenue Code.

45 7. A financial institution holding a medical care  
46 savings account shall make an annual report to the  
47 department on contributions and withdrawals to the  
48 account in the year pursuant to rules of the  
49 department.

50 8. A financial institution holding a medical care

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1 savings account may charge a reasonable fee for  
2 administration of the account.

3 9. An individual who makes a withdrawal from the  
4 individual's medical care savings account in the tax  
5 year and the withdrawal is not for one of the purposes  
6 described in subsection 6, a civil penalty of ten  
7 percent shall be imposed on the amount withdrawn  
8 pursuant to rules of the department."

9 4. Page 24, by striking lines 14 through 21 and  
10 inserting the following: "Sections 6, 130, and 131 of  
11 this Act are effective January 1, 1995, for tax years  
12 beginning on or after that date."

By MARY E. KRAMER  
MARY LOU FREEMAN

S-5149 FILED MARCH 10, 1994  
RULED OUT OF ORDER

## SENATE FILE 2222

S-5146

- 1 Amend Senate File 2222 as follows:  
2 1. By striking page 1, line 28, through page 2,  
3 line 3.  
4 2. Page 4, by striking lines 4 through 7 and  
5 inserting the following:  
6 "f. Procedures for departmental access to data  
7 collected".  
8 3. By striking page 4, line 29, through page 5,  
9 line 12.  
10 4. Page 6, by inserting before line 20 the  
11 following:  
12 "Sec. \_\_\_\_ . NEW SECTION. 144D.1 HEALTH ACCOUNTING  
13 SYSTEM.  
14 A statewide health accounting system shall be  
15 established in conjunction with the community health  
16 management information system established in chapter  
17 144C, if enacted by the Seventy-fifth General  
18 Assembly. The community health management information  
19 system board shall propose accounting standards for  
20 cost and quality to the commissioner of insurance for  
21 approval. The commissioner, upon review and approval  
22 of such standards, shall enforce the standards in  
23 conjunction with the community health management  
24 information system board."  
25 2. Renumber as necessary.

By ELAINE SZYMONIAK  
MARY E. KRAMER

S-5146 FILED MARCH 10, 1994  
RULED OUT OF ORDER

## SENATE FILE 2222

S-5137

1 Amend Senate File 2222 as follows:

2 1. Page 4, line 14, by inserting after the word  
3 "practitioners." the following: "The plan of  
4 operation and annual report shall describe the extent  
5 and method of direct consumer access to health care  
6 practitioners including, but not limited to, health  
7 care practitioners licensed under chapter 148, 148A,  
8 148C, 149, 150, 150A, 151, 152, 153, 154, 154B, or  
9 155A. If access is restricted, the plan of operation  
10 shall indicate the business or professional reason  
11 that supports the restriction. The director may  
12 disapprove or require amendment of an arbitrary or  
13 capricious restriction. Consumer complaints  
14 concerning unreasonable restrictions on access to  
15 practitioners may be filed with the insurance  
16 division, and the director of public health may  
17 consider complaints against a health plan and the  
18 division's findings in evaluating a plan of operation  
19 or subsequent amendments. The plan of operation shall  
20 detail consumer access to participating health care  
21 practitioners and assure fair consumer access to  
22 participating practitioners. The plan of operation  
23 shall provide a point of service option to permit  
24 consumers direct access to participating  
25 practitioners, but may require a different copayment  
26 or deductible to access a participating practitioner  
27 or class of practitioners without prior approval or  
28 referral."

29 2. By striking page 21, line 14 through page 22,  
30 line 9.

31 3. Page 23, by inserting after line 7 the  
32 following:

33 "\_\_\_\_. Minimum standards for evaluation of a health  
34 plan's relative access to health care practitioners,  
35 including but not limited to health care practitioners  
36 licensed under chapter 148, 148A, 148C, 149, 150,  
37 150A, 151, 152, 153, 154, 154B, or 155A. The report  
38 card shall be prepared by a health insurance  
39 purchasing cooperative and shall also evaluate  
40 consumer satisfaction with access."

41 4. By renumbering as necessary.

By MERLIN E. BARTZ

S-5137 FILED MARCH 10, 1994  
RULED OUT OF ORDER

## SENATE FILE 2222

S-5142

- 1 Amend Senate File 2222 as follows:  
2 1. Page 8, lines 20 and 21, by striking the words  
3 "any of the factors as provided for in subsection 1"  
4 and inserting the following: "health status or claim  
5 experience".  
6 2. Page 9, line 7, by striking the word  
7 "subsections" and inserting the following:  
8 "subsection".  
9 3. Page 9, by striking lines 20 through 24.  
10 4. Page 13, by striking lines 29 and 30.  
11 5. Page 13, line 31, by striking the words  
12 "Experiencing rating" and inserting the following:  
13 "Rating".  
14 6. Page 18, line 35, by striking the words "the  
15 same as" and inserting the following: "substantially  
16 similar to those".  
17 7. By renumbering as necessary.

By ELAINE SZYMONIAK  
MARY E. KRAMER

S-5142 FILED MARCH 10, 1994  
RULED OUT OF ORDER

## SENATE FILE 2222

S-5143

- 1 Amend Senate File 2222 as follows:  
2 1. Page 2, line 15, by inserting after the figure  
3 "1395(x)," the following: "nonprofit health care  
4 provider organizations,".

By ELAINE SZYMONIAK

S-5143 FILED MARCH 10, 1994  
RULED OUT OF ORDER

SENATE FILE 2222  
FISCAL NOTE

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A fiscal note for Senate File 2222 is hereby submitted pursuant to Joint Rule 17. Data used in developing this fiscal note is available from the Legislative Fiscal Bureau to members of the Legislature upon request.

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Senate File 2222 modifies health insurance regulation and implements health care reform provisions. Sections with potential fiscal impact include:

Section 2 - Establishes a Statewide Health Accounting System in coordination with the Departments of Public Health (DPH), Human Services (DHS), Elder Affairs (DEA), Employment Services (DES), and the Insurance Division of the Department of Commerce.

Section 3 - Changes the definition of private agency for the purpose of allowing hospitals and rural health clinics access to the Iowa Communications Network (ICN).

Sections 6 and 7 - Allows the DPH to establish a filing fee and licensing requirements for Accountable Health Plans (AHPs).

Sections 9 and 10 - Allows the tax deductibility of insurance premiums paid for individual, spouse, or dependent in computing adjusted gross income. Also allows the deduction of the amount of contribution made on behalf of the taxpayer, and interest earned on a medical savings account. Section 9 is contingent upon the enactment of a federal deduction of 100.0% of the cost of purchasing health insurance. Section 10 is contingent upon federal enactment of an exclusion in computing gross income of contributions to a medical care savings account.

Section 11 - Adds "other regulated entities" to definition of those responsible to pay nonexamination revenues.

Section 15 - Allows the Department of Management (DOM) to expend up to \$300,000 per year for coordination of the Transition Team and State health care purchasing professional and scientific services. This Section is repealed effective July 1, 1996.

Section 34 - Requires the DPH, with the University of Iowa College of Medicine and the University of Osteopathic Medicine and Health Sciences to develop and establish a rural primary care initiative.

Section 38 - Requires if by January 1, 1997, 97.0% of Iowans are not covered by voluntary means then the General Assembly is required to implement a financing mechanism to provide guaranteed coverage to all citizens of the State.

Sections 39 to 41 - Required studies on the use of alternative medical malpractice dispute resolution procedures, alternative rural hospital models, and the merger of the Iowa Comprehensive Health Insurance Program with an

-2-

Individual Health Reinsurance Program.

Assumptions:

1. Existing staff will be utilized in completing required activities, studies, and reports, except as noted.
2. Federal deductibility of health insurance premiums and interest from medical savings accounts will not occur during FY 1995 or FY 1996.

Fiscal Impact:

The fiscal impact of SF 2222 is a net FY 1995 General Fund cost of \$243,000 and 3.0 FTE positions. Other fund net costs of SF 2222 are estimated to be \$300,000 and 2.0 FTE positions for FY 1995.

General Fund Impact:

General Fund costs accrue from Sections 34 and 6. Section 34 requires the DPH to develop and establish a rural primary care initiative. The estimated cost of this initiative is \$143,000 and 3.0 FTE positions.

Costs from Section 6 include \$100,000 which, according to the DPH, will be required for analyzing the status of the health care industry, including ongoing review of the rules and regulatory requirements.

Revenues from the Section 3 (use of the ICN) are unknown due to the uncertainty over the extent to which the hospitals will use the network. The hospitals would be charged the same \$5 per hour fee that other users of the ICN are charged.

Costs for Sections 9 and 10 are not estimatable at this time. These Sections would only be enacted after federal enactment of similar provisions.

Other Funds Impact:

Section 15 has up to a \$300,000 cost per year in FY 1995 and FY 1996. This Section allows the DOM to utilize up to \$300,000 each year for transition team costs and State health care purchasing professional and scientific services.

Section 11 is estimated to cost \$100,000 per year for Insurance Division HIPC regulation activities which will be offset by \$100,000 from licensing fees paid by the HIPCs.

Section 7 is estimated to cost \$104,000 per year and 2.0 FTE positions for DPH regulation activities which will be offset by \$104,000 from licensing fees paid by the AHPs. The additional staff are needed to provide regulatory oversight, including initial licensure, ongoing supervision, and anti-trust exemption oversight.

PAGE 3 , FISCAL NOTE, SENATE FILE 2222

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The analysis does not take into account any additional costs from potential impacts upon insurance costs of State employees or the costs associated with Section 38 which requires the General Assembly to implement a financing mechanism for guaranteed coverage if 97.0% of Iowans are not covered by January 1, 1997

Sources: Department of Management  
Insurance Division

(LSB 4150SV, LCS)

FILED MARCH 8, 1994

BY DENNIS PROUTY, FISCAL DIRECTOR

(p. 962) 3/29/94 Motion to Withdraw from  
Committee failed

SENATE FILE **2222**  
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SSB 2201)

(AS AMENDED AND PASSED BY THE SENATE MARCH 10, 1994)

ALL New Language by the Senate

Passed Senate, Date \_\_\_\_\_ Passed House, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

**A BILL FOR**

1 An Act relating to health care reform, regulation of insurance  
2 and health care plan providers, income tax credits for certain  
3 individuals, establishing certain employer and individual  
4 requirements, establishing fees, and providing effective dates  
5 and applicability provisions.

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

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S.F. 2222

1 Section 1. INTENT AND FINDINGS. It is the intent of the  
2 general assembly that any significant health care reform must  
3 recognize the essential requirement that rural Iowa must have  
4 access to the benefits of affordable, accessible, and quality  
5 health care. Reform of the health care system in Iowa is not  
6 complete unless there is developed a strategy to address the  
7 needs of rural Iowa with subsequent implementation of a  
8 comprehensive system to meet those needs. Rural Iowans must  
9 be provided the same access to the best quality medical care  
10 available as Iowans residing in urban areas. The ability of  
11 hospitals and rural health clinics to access the state's fiber  
12 optic network is imperative. The complete use of the skills  
13 of all health care providers is essential to address the lack  
14 of access to primary care. New innovative initiatives for the  
15 delivery of care by rural hospitals and clinics must be  
16 encouraged.

17 The general assembly finds that given the rural bias  
18 inherent in the medicare system for hospital inpatient  
19 reimbursement, and the shortage of a number of important  
20 primary care providers, the challenges for health care reform  
21 in rural Iowa are significant. However, the general assembly  
22 believes that efforts to reform health care in Iowa coupled  
23 with the initiatives from the federal level offer a new  
24 opportunity to provide quality health care to rural Iowa. The  
25 general assembly finds that policymakers must seize this  
26 opportunity to ensure that rural Iowans will receive all the  
27 benefits of health care reform.

28 Sec. 2. Section 8.6, Code 1993, is amended by adding the  
29 following new subsection:

30 NEW SUBSECTION. 16. HEALTH ACCOUNTING SYSTEM. To  
31 establish a statewide health accounting system in coordination  
32 with the department of public health, the department of human  
33 services, the department of elder affairs, the department of  
34 employment services, and the insurance division of the  
35 department of commerce. The department of management shall

1 have access to all data, as deemed by the department to be  
2 necessary, in electronic format from the community health  
3 management information system established in chapter 144C.

4 Sec. 3. NEW SECTION. 135.110 ACCOUNTABLE HEALTH PLAN  
5 DEFINED.

6 An accountable health plan is an entity which does all of  
7 the following:

8 1. Pays for and provides health care services.

9 2. Is responsible for delivering the full range of health  
10 care services covered under a standard health benefit plan as  
11 established in chapter 513B.

12 3. Meets established solvency standards and complies with  
13 established underwriting standards, including modified  
14 community rating methods, for all beneficiaries served.

15 4. Is accountable to the public for the cost, quality, and  
16 access of the services which the accountable health plan  
17 provides and for the effects of its services on the health of  
18 those who are provided such services.

19 5. Is eligible for operation based on financial, quality  
20 of care, and structural qualifications.

21 6. Satisfies data reporting and collection standards.

22 Sec. 4. NEW SECTION. 135.111 RULES.

23 1. The director shall adopt rules relating to the  
24 establishment and regulation of accountable health plans. The  
25 rules shall allow significant flexibility in the structure and  
26 organization of an accountable health plan, including the  
27 flexibility to permit alternative structures for accountable  
28 health plans developed in rural areas of the state in response  
29 to the needs, preferences, and conditions of rural  
30 communities. Such plans shall utilize, to the greatest extent  
31 possible, existing health care providers and hospitals.

32 2. Rules adopted pursuant to this section shall include,  
33 at a minimum, all of the following:

34 a. Procedures for licensing accountable health plans as  
35 provided in section 135.112.

1 b. Procedures to sanction cooperative arrangements  
2 involving health care providers or purchasers in forming an  
3 accountable health plan, upon a finding by the director that  
4 the arrangement will improve quality, access, or affordability  
5 of health care, but which arrangement might be a violation of  
6 antitrust laws if undertaken without government direction and  
7 approval.

8 c. Procedures to assure ongoing supervision of  
9 arrangements sanctioned under paragraph "b" in order to assure  
10 that the arrangements do in fact improve the quality, access,  
11 or affordability of health care. The sanctioning of any  
12 arrangement by the director may be withdrawn on a prospective  
13 basis at the discretion of the director if necessary to  
14 enforce the intent to improve quality, access, or  
15 affordability.

16 d. Standards applicable to the plan of operation of an  
17 accountable health plan and which must be met for licensure of  
18 the plan. Such standards shall include standards related to  
19 the quality of health care provided.

20 e. A requirement that a plan of operation include  
21 guaranteed access and rating practices no more restrictive  
22 than those required in the applicable state-regulated  
23 insurance market segment.

24 f. Procedures to collect information, directly or by other  
25 means as determined by the department, from the accountable  
26 health plan for purposes of monitoring quality, cost, and  
27 access standards. The department may access data collected  
28 through the community health management information system for  
29 purposes of implementing this chapter at a cost not to exceed  
30 the actual costs of reproducing the information for the  
31 division.

32 g. A method or methods to facilitate and encourage the  
33 appropriate provision of services by midlevel health care  
34 practitioners and allied health care practitioners.

35 h. Procedures to assure that all health carriers,

1 including health maintenance organizations, insurers, and  
2 nonprofit health service plan corporations are subject to the  
3 same rules, to the extent the health carrier is operating an  
4 accountable health plan or is a participating entity in an  
5 accountable health plan.

6 i. Solvency standards to assure an accountable health  
7 plan's ability to deliver required services. The director may  
8 enter into an agreement with the insurance division of the  
9 department of commerce to conduct such solvency oversight.  
10 The insurance division shall assess the costs of a solvency  
11 examination against the entity being examined in the same  
12 manner and on the same terms as provided for insurance  
13 companies under section 505.7.

14 j. Publication and dissemination of statewide and  
15 localized expenditure targets relevant to each accountable  
16 health plan, as appropriate.

17 k. Provide for the identification of essential community  
18 providers within the service area of each accountable health  
19 plan. "Essential community providers" means those health care  
20 providing organizations which the director deems to be vital  
21 to a local health care delivery system to ensure that all  
22 citizens of this state have reasonable access to health care.  
23 Accountable health plans must establish working relationships  
24 with essential community providers and include them within the  
25 plan's plan of operation in delivering health care within the  
26 plan's service area. This paragraph is repealed effective  
27 July 1, 1999.

28 l. Provisions for the identification of market areas to be  
29 serviced by each accountable health plan. Rules developed  
30 pursuant to this paragraph shall promote expansion of  
31 accountable health plans into all geographic areas of the  
32 state.

33 m. The director shall make, or cause to be made,  
34 inspections as the director deems necessary in order to  
35 determine compliance with section 135.110, this section, and

1 sections 135.112 and 135.113, and applicable rules.

2 3. This section and rules adopted pursuant to this section  
3 are intended to provide immunity from federal antitrust law  
4 under the state action doctrine exemption.

5 Sec. 5. NEW SECTION. 135.112 LICENSING REQUIRED.

6 1. An accountable health plan shall not operate unless the  
7 plan is licensed by the department. The director shall adopt  
8 rules as provided in section 135.111 establishing a licensing  
9 procedure. A license shall not be issued by the department  
10 unless the director finds that the accountable health plan  
11 satisfies, at a minimum, all of the following:

12 a. The ability to be responsible for the full continuum of  
13 required health care and related costs for the defined  
14 population that the accountable health plan will serve.

15 b. Financial solvency.

16 c. The ability to satisfy established standards related to  
17 the quality of care provided.

18 d. The ability to fully comply with the provisions of this  
19 section and all applicable rules.

20 2. The department shall establish by rule a reasonable  
21 filing fee to be submitted with a license application and each  
22 renewal application. A license shall be renewed annually. A  
23 license issued pursuant to this section expires on December 31  
24 of the calendar year for which the license was granted. Fees  
25 received by the department shall be retained by the department  
26 to offset costs associated with the administration of this  
27 chapter.

28 3. An accountable health plan may be organized and  
29 licensed as a nonprofit or for-profit plan.

30 Sec. 6. NEW SECTION. 135.113 DEFINITIONS.

31 For purposes of sections 135.110 through 135.112, unless  
32 the context otherwise requires:

33 1. "Hospital" means as defined in section 135B.1.

34 2. "Health care provider" or "provider" or "practitioner"  
35 means a person licensed or certified pursuant to chapter 148,

1 148A, 148B, 148C, 149, 150, 150A, 151, 152, 152A, 153, 154,  
2 154B, or 155A, to provide professional health care services in  
3 this state to an individual during the individual's medical  
4 care, treatment, or confinement.

5 Sec. 7. Section 422.7, Code Supplement 1993, is amended by  
6 adding the following new subsection:

7 NEW SUBSECTION. 29. Subtract, to the extent not otherwise  
8 deducted in computing adjusted gross income, the amounts paid  
9 by the taxpayer for the purchase of health insurance for the  
10 taxpayer or taxpayer's spouse or dependent.

11 Sec. 8. Section 505.7, subsection 1, Code Supplement 1993,  
12 is amended to read as follows:

13 1. All fees and charges which are required by law to be  
14 paid by insurance companies, and associations, and other  
15 regulated entities shall be payable to the commissioner of the  
16 insurance division of the department of commerce or department  
17 of revenue and finance, as provided by law, whose duty it  
18 shall be to account for and pay over the same to the treasurer  
19 of state at the time and in the manner provided by law for  
20 deposit in the general fund of the state.

21 Sec. 9. Section 505.7, Code Supplement 1993, is amended by  
22 adding the following new subsection:

23 NEW SUBSECTION. 8. The commissioner may assess the costs  
24 of an audit or examination to a health insurance purchasing  
25 cooperative authorized under section 514I.1, in the same  
26 manner as provided for insurance companies under sections  
27 507.7 through 507.9, and may establish by rule reasonable  
28 filing fees to fund the cost of regulatory oversight.

29 Sec. 10. Section 505.8, Code 1993, is amended by adding  
30 the following new subsection:

31 NEW SUBSECTION. 6. The commissioner shall supervise all  
32 health insurance purchasing cooperatives providing services or  
33 operating within the state and the organization of domestic  
34 cooperatives. The commissioner may admit nondomestic health  
35 insurance purchasing cooperatives under the same standards as

1 domestic cooperatives. Health insurance purchasing  
2 cooperatives are subject to rules adopted by the commissioner  
3 pursuant to section 514I.1.

4 Sec. 11. Section 509A.6, Code 1993, is amended by adding  
5 the following new unnumbered paragraph:

6 NEW UNNUMBERED PARAGRAPH. The governing body may also  
7 enroll in and contract with a health insurance purchasing  
8 cooperative authorized pursuant to section 514I.1.

9 Sec. 12. Section 513B.2, subsection 12, unnumbered  
10 paragraph 1, Code Supplement 1993, is amended to read as  
11 follows:

12 "Late enrollee" means an eligible employee or dependent who  
13 requests enrollment in a health benefit plan of a small  
14 employer following the initial enrollment period for which  
15 such individual is entitled to enroll under the terms of the  
16 health benefit plan, provided the initial enrollment period is  
17 a period of at least thirty one hundred eighty days. An  
18 eligible employee or dependent shall not be considered a late  
19 enrollee if any of the following apply:

20 Sec. 13. Section 513B.2, subsection 12, paragraph a,  
21 subparagraph (3), Code Supplement 1993, is amended to read as  
22 follows:

23 (3) The individual requests enrollment within thirty one  
24 hundred eighty days after termination of the qualifying  
25 previous coverage.

26 Sec. 14. Section 513B.2, subsection 12, paragraph c, Code  
27 Supplement 1993, is amended to read as follows:

28 c. A court has ordered that coverage be provided for a  
29 spouse or minor or dependent child under a covered employee's  
30 health benefit plan and the request for enrollment is made  
31 within thirty one hundred eighty days after issuance of the  
32 court order.

33 Sec. 15. Section 513B.2, subsection 16, Code Supplement  
34 1993, is amended to read as follows:

35 16. "Small employer" means a person actively engaged in

1 business who, on at least fifty percent of the employer's  
2 working days during the preceding year, employed not less than  
3 two and not more than ~~twenty-five~~ fifty full-time equivalent  
4 eligible employees. In determining the number of eligible  
5 employees, companies which are affiliated companies or which  
6 are eligible to file a combined tax return for purposes of  
7 state taxation are considered one employer.

8 Sec. 16. Section 513B.4, Code Supplement 1993, is amended  
9 by adding the following new subsection:

10 NEW SUBSECTION. 1A. Notwithstanding subsection 1, there  
11 shall be no variance in premium rates for a basic or standard  
12 benefit plan offered pursuant to this chapter for health  
13 status or claim experience.

14 Sec. 17. Section 513B.4, subsection 2, unnumbered  
15 paragraph 2, Code Supplement 1993, is amended by striking the  
16 paragraph and inserting in lieu thereof the following:

17 Case characteristics other than family composition and  
18 group size shall not be used by a small employer carrier  
19 without the prior approval of the commissioner.

20 Sec. 18. Section 513B.4, Code Supplement 1993, is amended  
21 by adding the following new subsection:

22 NEW SUBSECTION. 5. Notwithstanding subsection 1, the  
23 commissioner shall, with the concurrence of the board of the  
24 Iowa small employer health reinsurance program established in  
25 section 513B.13, by order reduce or eliminate the allowed  
26 rating bands provided under subsection 1, paragraphs "a", "b",  
27 and "c", or otherwise limit or eliminate the use of experience  
28 rating.

29 Sec. 19. Section 513B.10, subsection 3, paragraph a,  
30 unnumbered paragraph 1, Code Supplement 1993, is amended to  
31 read as follows:

32 The plan shall not deny, exclude, or limit  
33 benefits for a covered individual for losses incurred more  
34 than ~~twelve~~ six months following the effective date of the  
35 individual's coverage due to a preexisting condition. A

1 health benefit plan shall not define a preexisting condition  
2 more restrictively than the following:

3 Sec. 20. Section 513B.37, subsection 1, paragraph a, Code  
4 Supplement 1993, is amended to read as follows:

5 a. What benefits or direct pay requirements must be  
6 minimally included in a basic or standard benefit coverage  
7 policy or subscription contract.

8 Sec. 21. Section 513B.38, Code Supplement 1993, is amended  
9 by adding the following new subsection:

10 NEW SUBSECTION. 4. Upon the determination of the  
11 commissioner pursuant to section 513B.37, subsection 1,  
12 paragraph "a", to include expanded preventative care services  
13 and mental health and substance abuse treatment coverage, the  
14 commissioner shall do all of the following:

15 a. Adopt by rule, with all due diligence, requirements for  
16 the provision of expanded coverage for benefits for expanded  
17 preventative care services.

18 b. Adopt by rule, with all due diligence, requirements for  
19 the provision of coverage for benefits for mental health and  
20 substance abuse services, which shall be on the same terms and  
21 conditions as such coverage is provided for other illnesses  
22 and diseases.

23 Sec. 22. NEW SECTION. 513C.1 SHORT TITLE.

24 This chapter shall be known and may be cited as the  
25 "Individual Health Insurance Market Reform Act".

26 Sec. 23. NEW SECTION. 513C.2 PURPOSE.

27 The purpose and intent of this chapter is to promote the  
28 availability of health insurance coverage to individuals  
29 regardless of their health status or claims experience, to  
30 prevent abusive rating practices, to require disclosure of  
31 rating practices to purchasers, to establish rules regarding  
32 the renewal of coverage, to establish limitations on the use  
33 of preexisting condition exclusions, to provide for the  
34 development of a core group of basic or standard health  
35 benefits to be offered to all individuals, and to improve the

1 overall fairness and efficiency of the individual health  
2 insurance market.

3 Sec. 24. NEW SECTION. 513C.3 DEFINITIONS.

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

6 1. "Actuarial certification" means a written statement by  
7 a member of the American academy of actuaries or other  
8 individual acceptable to the commissioner that an individual  
9 carrier is in compliance with the provision of section 513C.5  
10 which is based upon the actuary's or individual's examination,  
11 including a review of the appropriate records and the  
12 actuarial assumptions and methods used by the carrier in  
13 establishing premium rates for applicable individual health  
14 benefit plans.

15 2. "Affiliate" or "affiliated" means any entity or person  
16 who directly or indirectly through one or more intermediaries,  
17 controls or is controlled by, or is under common control with,  
18 a specified entity or person.

19 3. "Basic or standard health benefit plan" means the core  
20 group of health benefits developed pursuant to section 513C.8.

21 4. "Block of business" means all the individuals insured  
22 under the same individual health benefit plan.

23 5. "Carrier" means any entity that provides individual  
24 health benefit plans in this state. For purposes of this  
25 chapter, carrier includes an insurance company, a group  
26 hospital or medical service corporation, a fraternal benefit  
27 society, a health maintenance organization, an accountable  
28 health plan, and any other entity providing an individual plan  
29 of health insurance or health benefits subject to state  
30 insurance regulation.

31 6. "Commissioner" means the commissioner of insurance.

32 7. "Eligible individual" means an individual who is a  
33 resident of this state and who either has qualifying existing  
34 coverage or has had qualifying existing coverage within the  
35 immediately preceding one hundred eighty days, or an

1 individual who has had a qualifying event occur within the  
2 immediately preceding one hundred eighty days.

3 8. "Established service area" means a geographic area, as  
4 approved by the commissioner and based upon the carrier's  
5 certificate of authority to transact insurance in this state,  
6 within which the carrier is authorized to provide coverage.

7 9. "Filed rate" means, for a rating period related to each  
8 block of business, the rate charged to all individuals with  
9 similar rating characteristics for individual health benefit  
10 plans.

11 10. "Individual health benefit plan" means any hospital or  
12 medical expense incurred policy or certificate, hospital or  
13 medical service plan, or health maintenance organization  
14 subscriber contract sold to an individual, or any  
15 discretionary group trust or association policy providing  
16 hospital or medical expense incurred coverage to individuals.  
17 Individual health benefit plan does not include a self-insured  
18 group health plan, a self-insured multiple employer group  
19 health plan, a group conversion plan, an insured group health  
20 plan, accident-only, specified disease, short-term hospital or  
21 medical, hospital confinement indemnity, credit, dental,  
22 vision, medicare supplement, long-term care, or disability  
23 income insurance coverage, coverage issued as a supplement to  
24 liability insurance, workers' compensation or similar  
25 insurance, or automobile medical payment insurance.

26 11. "Premium" means all moneys paid by an individual and  
27 eligible dependents as a condition of receiving coverage from  
28 a carrier, including any fees or other contributions  
29 associated with an individual health benefit plan.

30 12. "Qualifying event" means any of the following:

31 a. Loss of eligibility for medical assistance provided  
32 pursuant to chapter 249A or medicare coverage provided  
33 pursuant to Title XVIII of the federal Social Security Act.

34 b. Loss or change of dependent status under qualifying  
35 previous coverage.

1 c. The attainment by an individual of the age of majority.  
2 13. "Qualifying existing coverage" or "qualifying previous  
3 coverage" means benefits or coverage provided under either of  
4 the following:

5 a. Any group health insurance that provides benefits  
6 similar to or exceeding benefits provided under the standard  
7 health benefit plan, provided that such policy has been in  
8 effect for a period of at least one year.

9 b. An individual health insurance benefit plan, including  
10 coverage provided under a health maintenance organization  
11 contract, a hospital or medical service plan contract, or a  
12 fraternal benefit society contract, that provides benefits  
13 similar to or exceeding the benefits provided under the  
14 standard health benefit plan, provided that such policy has  
15 been in effect for a period of at least one year.

16 14. "Rating characteristics" means demographic or other  
17 objective characteristics of individuals which are considered  
18 by the carrier in the determination of premium rates for the  
19 individuals and which are approved by the commissioner.

20 15. "Rating period" means the period for which premium  
21 rates established by a carrier are in effect.

22 16. "Restricted network provision" means a provision of an  
23 individual health benefit plan that conditions the payment of  
24 benefits, in whole or in part, on the use of health care  
25 providers that have entered into a contractual arrangement  
26 with the carrier to provide health care services to covered  
27 individuals.

28 Sec. 25. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

29 This chapter applies to an individual health benefit plan  
30 delivered or issued for delivery to residents of this state on  
31 or after July 1, 1994.

32 1. Except as provided in subsection 2, for purposes of  
33 this chapter, carriers that are affiliated companies or that  
34 are eligible to file a consolidated tax return shall be  
35 treated as one carrier and any restrictions or limitations

1 imposed by this chapter shall apply as if all individual  
2 health benefit plans delivered or issued for delivery to  
3 residents of this state by such affiliated carriers were  
4 issued by one carrier.

5 2. An affiliated carrier that is a health maintenance  
6 organization having a certificate of authority under section  
7 513C.5 shall be considered to be a separate carrier for the  
8 purposes of this chapter.

9 Sec. 26. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO  
10 PREMIUM RATES.

11 1. Premium rates for any block of individual health  
12 benefit plan business issued on or after July 1, 1994, by a  
13 carrier subject to this chapter are subject to the composite  
14 effect of all of the following:

15 a. After making actuarial adjustments based upon benefit  
16 design and rating characteristics, the filed rate for any  
17 block of business shall not exceed the filed rate for any  
18 other block of business by more than twenty percent.

19 b. The filed rate for any block of business shall not  
20 exceed the filed rate for any other block of business by more  
21 than thirty percent due to factors relating to rating  
22 characteristics.

23 c. Rating characteristics other than family composition  
24 and group size shall not be used by a carrier without the  
25 prior approval of the commissioner.

26 d. Premium rates for individual health benefit plans shall  
27 comply with the requirements of this section notwithstanding  
28 any assessments paid or payable by the carrier pursuant to any  
29 reinsurance program or risk adjustment mechanism.

30 e. An adjustment, not to exceed fifteen percent annually  
31 due to the claim experience or health status of a block of  
32 business.

33 f. For purposes of this subsection, an individual health  
34 benefit plan that contains a restricted network provision  
35 shall not be considered similar coverage to an individual

1 health benefit plan that does not contain such a provision,  
2 provided that the differential in payments made to network  
3 providers results in substantial differences in claim costs.

4 2. Notwithstanding subsection 1, the commissioner shall,  
5 with the concurrence of the board of the Iowa individual  
6 health benefit reinsurance association established in section  
7 513C.10, by order reduce or eliminate the allowed rating bands  
8 provided under subsection 1, paragraphs "a", "b", "c", and  
9 "g", or otherwise limit or eliminate the use of experience  
10 rating.

11 3. A carrier shall not transfer an individual  
12 involuntarily into or out of a block of business.

13 4. The commissioner may suspend for a specified period the  
14 application of subsection 1, paragraph "a", as to the premium  
15 rates applicable to one or more blocks of business of a  
16 carrier for one or more rating periods upon a filing by the  
17 carrier requesting the suspension and a finding by the  
18 commissioner that the suspension is reasonable in light of the  
19 financial condition of the carrier.

20 5. A carrier shall make a reasonable disclosure at the  
21 time of the offering for sale of any individual health benefit  
22 plan of all of the following:

23 a. The extent to which premium rates for a specified  
24 individual are established or adjusted based upon rating  
25 characteristics.

26 b. The carrier's right to change premium rates, and the  
27 factors, other than claim experience, that affect changes in  
28 premium rates.

29 c. The provisions relating to the renewal of policies and  
30 contracts.

31 d. Any provisions relating to any preexisting condition.

32 e. All plans offered by the carrier, the prices of such  
33 plans, and the availability of such plans to the individual.

34 6. A carrier shall maintain at its principal place of  
35 business a complete and detailed description of its rating

1 practices, including information and documentation that  
2 demonstrate that its rating methods and practices are based  
3 upon commonly accepted actuarial assumptions and are in  
4 accordance with sound actuarial principles.

5 7. A carrier shall file with the commissioner annually on  
6 or before March 15, an actuarial certification certifying that  
7 the carrier is in compliance with this chapter and that the  
8 rating methods of the carrier are actuarially sound. The  
9 certification shall be in a form and manner and shall contain  
10 information as specified by the commissioner. A copy of the  
11 certification shall be retained by the carrier at its  
12 principal place of business. Rate adjustments made in order  
13 to comply with this section are exempt from loss ratio  
14 requirements.

15 8. A carrier shall make the information and documentation  
16 maintained pursuant to subsection 5 available to the  
17 commissioner upon request. The information and documentation  
18 shall be considered proprietary and trade secret information  
19 and shall not be subject to disclosure by the commissioner to  
20 persons outside of the division except as agreed to by the  
21 carrier or as ordered by a court of competent jurisdiction.

22 Sec. 27. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

23 1. An individual health benefit plan is renewable at the  
24 option of the individual, except in any of the following  
25 cases:

- 26 a. Nonpayment of the required premiums.
- 27 b. Fraud or misrepresentation.
- 28 c. The insured individual becomes eligible for medicare  
29 coverage under Title XVIII of the federal Social Security Act.
- 30 d. The carrier elects not to renew all of its individual  
31 health benefit plans in the state. In such case, the carrier  
32 shall provide notice of the decision not to renew coverage to  
33 all affected individuals and to the commissioner in each state  
34 in which an affected insured individual is known to reside at  
35 least ninety days prior to the nonrenewal of the health

1 benefit plan by the carrier. Notice to the commissioner under  
2 the paragraph shall be provided at least three working days  
3 prior to the notice to the affected individuals.

4 e. The commissioner finds that the continuation of the  
5 coverage would not be in the best interests of the  
6 policyholders or certificate holders, or would impair the  
7 carrier's ability to meet its contractual obligations.

8 2. A carrier that elects not to renew all of its  
9 individual health benefit plans in this state shall be  
10 prohibited from writing new individual health benefit plans in  
11 this state for a period of five years from the date of the  
12 notice to the commissioner.

13 3. With respect to a carrier doing business in an  
14 established geographic service area of the state, this section  
15 applies only to the carrier's operations in the service area.

16 Sec. 28. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

17 1. A carrier issuing an individual health benefit plan in  
18 this state shall issue a basic or standard health benefit plan  
19 to an eligible individual who applies for a plan and agrees to  
20 make the required premium payments and to satisfy other  
21 reasonable provisions of the basic or standard health benefit  
22 plan. An insurer is not required to issue a basic or standard  
23 health benefit plan to an individual who meets any of the  
24 following criteria:

25 a. The individual is covered or is eligible for coverage  
26 under a health benefit plan provided by the individual's  
27 employer.

28 b. An eligible individual who does not apply for a basic  
29 or standard health benefit plan within one hundred eighty days  
30 of a qualifying event or within one hundred eighty days upon  
31 becoming ineligible for qualifying existing coverage.

32 c. The individual is covered or is eligible for any  
33 continued group coverage under section 4980b of the Internal  
34 Revenue Code, sections 601 through 608 of the federal Employee  
35 Retirement Income Security Act of 1974, sections 2201 through

1 2208 of the federal Public Health Service Act, or any state-  
2 required continued group coverage. For purposes of this  
3 subsection, an individual who would have been eligible for  
4 such continuation of coverage, but is not eligible solely  
5 because the individual or other responsible party failed to  
6 make the required coverage election during the applicable time  
7 period, is deemed to be eligible for such group coverage until  
8 the date on which the individual's continuing group coverage  
9 would have expired had an election been made.

10 2. A carrier shall issue the basic or standard health  
11 insurance benefit plan to an individual currently covered by  
12 an underwritten benefit plan issued by that carrier at the  
13 option of the individual. This option must be exercised  
14 within one hundred eighty days of notification of a premium  
15 rate increase applicable to the underwritten benefit plan.

16 3. A carrier shall file with the commissioner, in a form  
17 and manner prescribed by the commissioner, the basic or  
18 standard health benefit plan to be used by the carrier. A  
19 basic or standard health benefit plan filed pursuant to this  
20 subsection may be used by a carrier beginning thirty days  
21 after it is filed unless the commissioner disapproves of its  
22 use.

23 The commissioner may at any time, after providing notice  
24 and an opportunity for a hearing to the carrier, disapprove  
25 the continued use by a carrier of a basic or standard health  
26 benefit plan on the grounds that the plan does not meet the  
27 requirements of this chapter.

28 4. a. The individual basic or standard health benefit  
29 plan shall not deny, exclude, or limit benefits for a covered  
30 individual for losses incurred more than six months following  
31 the effective date of the individual's coverage due to a  
32 preexisting condition. A preexisting condition shall not be  
33 defined more restrictively than any of the following:

34 (1) A condition that would cause an ordinarily prudent  
35 person to seek medical advice, diagnosis, care, or treatment

1 during the six months immediately preceding the effective date  
2 of coverage.

3 (2) A condition for which medical advice, diagnosis, care,  
4 or treatment was recommended or received during the six months  
5 immediately preceding the effective date of coverage.

6 (3) A pregnancy existing on the effective date of  
7 coverage.

8 b. A carrier shall waive any time period applicable to a  
9 preexisting condition exclusion or limitation period with  
10 respect to particular services in an individual health benefit  
11 plan for the period of time an individual was previously  
12 covered by qualifying previous coverage that provided benefits  
13 with respect to such services, provided that the qualifying  
14 previous coverage was continuous to a date not more than one  
15 hundred eighty days prior to the effective date of the new  
16 coverage.

17 5. A carrier is required to offer coverage or accept  
18 applications pursuant to subsection 1 from any individual  
19 residing in the carrier's established geographic access area.

20 6. A carrier shall not modify a basic or standard health  
21 benefit plan with respect to an individual or dependent  
22 through riders, endorsements, or other means to restrict or  
23 exclude coverage for certain diseases or medical conditions  
24 otherwise covered by the health benefit plan.

25 Sec. 29. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN  
26 STANDARDS.

27 The commissioner shall adopt by rule the form and level of  
28 coverage of the basic health benefit plan and the standard  
29 health benefit plan for the individual market which shall be  
30 substantially similar to those provided for under chapter 513B  
31 with respect to small group coverage.

32 Sec. 30. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR  
33 MARKETING.

34 1. A carrier issuing individual health benefit plans in  
35 this state shall make available the basic or standard health

1 benefit plan to residents of this state. If a carrier denies  
2 other individual health benefit plan coverage to an eligible  
3 individual on the basis of the health status or claims  
4 experience of the eligible individual, or the individual's  
5 dependents, the carrier shall offer the individual the  
6 opportunity to purchase a basic or standard health benefit  
7 plan.

8 2. A carrier or an agent shall not do either of the  
9 following:

10 a. Encourage or direct individuals to refrain from filing  
11 an application for coverage with the carrier because of the  
12 health status, claims experience, industry occupation, or  
13 geographic location of the individuals.

14 b. Encourage or direct individuals to seek coverage from  
15 another carrier because of the health status, claims  
16 experience, industry occupation, or geographic location of the  
17 individuals.

18 3. Subsection 2, paragraph "a", shall not apply with  
19 respect to information provided by a carrier or an agent to an  
20 individual regarding the established geographic service area  
21 of the carrier or the restricted network provision of the  
22 carrier.

23 4. A carrier shall not, directly or indirectly, enter into  
24 any contract, agreement, or arrangement with an agent that  
25 provides for, or results in, the compensation paid to an agent  
26 for a sale of a basic or standard health benefit plan to vary  
27 because of the health status or permitted rating  
28 characteristics of the individual or the individual's  
29 dependents.

30 5. Subsection 4 does not apply with respect to the  
31 compensation paid to an agent on the basis of percentage of  
32 premium, provided that the percentage shall not vary because  
33 of the health status or other permitted rating characteristics  
34 of the individual or the individual's dependents.

35 6. Denial by a carrier of an application for coverage from

1 an individual shall be in writing and shall state the reason  
2 or reasons for the denial.

3 7. A violation of this section by a carrier or an agent is  
4 an unfair trade practice under chapter 507B.

5 8. If a carrier enters into a contract, agreement, or  
6 other arrangement with a third-party administrator to provide  
7 administrative, marketing, or other services related to the  
8 offering of individual health benefit plans in this state, the  
9 third-party administrator is subject to this section as if it  
10 were a carrier.

11 Sec. 31. NEW SECTION. 513C.10 IOWA INDIVIDUAL HEALTH  
12 BENEFIT REINSURANCE ASSOCIATION.

13 1. A nonprofit corporation is established to be known as  
14 the Iowa individual health benefit reinsurance association.  
15 All persons that provide health benefit plans in this state  
16 including insurers providing accident and sickness insurance  
17 under chapter 509, 514, or 514A; fraternal benefit societies  
18 providing hospital, medical, or nursing benefits under chapter  
19 512B; health maintenance organizations, accountable health  
20 plans, and all other entities providing health insurance or  
21 health benefits subject to state insurance regulation shall be  
22 members of this association. The association shall be  
23 incorporated under chapter 504A, shall operate under a plan of  
24 operation established and approved pursuant to chapter 504A,  
25 and shall exercise its powers through a board of directors  
26 established under this section.

27 2. The initial board of directors of the association shall  
28 consist of seven members as follows:

29 a. Four members shall be representatives of the four  
30 largest carriers of individual health insurance in the state,  
31 excluding medicare supplement coverage premiums, as of the  
32 calendar year ending December 31, 1993.

33 b. Three members shall be representatives of the three  
34 largest writers of health insurance in the state which are not  
35 otherwise represented.

1 After an initial term, board members shall be nominated and  
2 elected by the members of the association.

3 Members of the board may be reimbursed from the funds of  
4 the association for expenses incurred by them as members, but  
5 shall not otherwise be compensated by the association for  
6 their services.

7 3. The association shall submit to the commissioner a plan  
8 of operation for the association and any amendments to the  
9 association's articles of incorporation necessary and  
10 appropriate to assure the fair, reasonable, and equitable  
11 administration of the association. The plan shall provide for  
12 the sharing of losses related to basic and standard plans, if  
13 any, on an equitable and proportional basis among the members  
14 of the association. If the association fails to submit a  
15 suitable plan of operation within one hundred eighty days  
16 after the appointment of the board of directors, the  
17 commissioner shall adopt rules necessary to implement this  
18 section. The rules shall continue in force until modified by  
19 the commissioner or superseded by a plan submitted by the  
20 association and approved by the commissioner. In addition to  
21 other requirements, the plan of operation shall provide for  
22 all of the following:

23 a. The handling and accounting of assets and funds of the  
24 association.

25 b. The amount of and method for reimbursing the expenses  
26 of board members.

27 c. Regular times and places for meetings of the board of  
28 directors.

29 d. Records to be kept relating to all financial  
30 transactions, and annual fiscal reporting to the commissioner.

31 e. Procedures for selecting the board of directors.

32 f. Additional provisions necessary or proper for the  
33 execution of the powers and duties of the association.

34 4. The plan of operation may provide that the powers and  
35 duties of the association may be delegated to a person who

1 will perform functions similar to those of the association. A  
2 delegation under this section takes effect only upon the  
3 approval of the board of directors.

4 5. The association has the general powers and authority  
5 enumerated by this section and executed in accordance with the  
6 plan of operation approved by the commissioner under  
7 subsection 3. In addition, the association may do any of the  
8 following:

9 a. Enter into contracts as necessary or proper to  
10 administer this chapter.

11 b. Sue or be sued, including taking any legal action  
12 necessary or proper for recovery of any assessments for, on  
13 behalf of, or against participating carriers.

14 c. Appoint from among members appropriate legal,  
15 actuarial, and other committees as necessary to provide  
16 technical assistance in the operation of the association,  
17 including the hiring of independent consultants as necessary.

18 d. Perform any other functions within the authority of the  
19 association.

20 6. Rates for basic and standard coverages as provided in  
21 this chapter shall be determined by each individual health  
22 insurance carrier as the average of the lowest rate available  
23 for issuance by that carrier adjusted for rate characteristics  
24 and benefits and the maximum rate allowable by law after  
25 adjustments for rate characteristics and benefits.

26 7. Following the close of each calendar year, the  
27 association, in conjunction with the commissioner, shall  
28 require each individual health insurance carrier to report the  
29 amount of earned premiums and the associated paid losses for  
30 all basic and standard plans issued by the individual health  
31 insurance carrier. The reporting of these amounts must be  
32 certified by an officer of the carrier.

33 8. The board shall determine the amount of loss, if any,  
34 from all basic and standard plans issued in the state by all  
35 individual health insurance carriers by aggregating the data

1 reported in subsection 7. A loss shall be equal to ninety  
2 percent of earned premiums minus total paid claims.

3 9. The loss plus necessary operating expenses for the  
4 association, plus any additional expenses as provided by law,  
5 shall be assessed by the association to all members in  
6 proportion to their respective shares of total health  
7 insurance premiums or payments for subscriber contracts  
8 received in Iowa during the second preceding calendar year, or  
9 with paid losses in the year, coinciding with or ending during  
10 the calendar year, or on any other equitable basis as provided  
11 in the plan of operation. In sharing losses, the association  
12 may abate or defer in any part the assessment of a member, if,  
13 in the opinion of the board, payment of the assessment would  
14 endanger the ability of the member to fulfill its contractual  
15 obligations. The association may also provide for an initial  
16 or interim assessment against members of the association if  
17 necessary to assure the financial viability of the association  
18 to meet the operating expenses of the association until the  
19 next calendar year is completed.

20 10. The collected assessments shall be disbursed to an  
21 individual health insurance carrier in proportion to the loss  
22 that carrier represented of the aggregate loss as determined  
23 in subsection 8.

24 11. An individual health insurance carrier may petition  
25 the association board to seek remedy from writing a  
26 significantly disproportionate share of basic and standard  
27 policies in relation to total individual health insurance  
28 premiums written in the state. Upon a finding that a company  
29 has written a disproportionate share, the board may agree to  
30 compensate the carrier either by paying to the company an  
31 additional fee not to exceed two percent of earned premiums  
32 from basic and standard policies for that company or by  
33 petitioning the commissioner for remedy.

34 12. The commissioner, upon a finding that the acceptance  
35 of the offer of basic and standard coverage by individuals

1 pursuant to this chapter would place the individual health  
2 insurance carrier in a financially impaired condition, shall  
3 not require the carrier to offer coverage or accept  
4 applications for any period of time the financial impairment  
5 is deemed to exist.

6 Sec. 32. NEW SECTION. 513D.1 EMPLOYER REQUIRED TO  
7 PROVIDE ACCESS TO HEALTH CARE COVERAGE --PENALTIES.

8 1. An employer doing business within this state shall  
9 offer each employee, at a minimum, meaningful access to health  
10 insurance. The requirement contained in this section may be  
11 satisfied by offering the following:

12 a. Health care coverage through an insurer or health  
13 maintenance organization authorized to do business in this  
14 state.

15 b. Enrollment in an Iowa-licensed health insurance  
16 purchasing cooperative. A cooperative may require payroll  
17 deduction of employee contributions and direct deposit of  
18 premium payments to the account of the cooperative.

19 c. Access to health benefits through a health benefits  
20 plan qualified under the federal Employee Retirement Income  
21 Security Act of 1974, if the employer is self-insured.

22 2. An employer is not required to financially contribute  
23 toward the employee's health plan.

24 3. A violation of this section may be reported to the  
25 consumer and legal affairs bureau in the insurance division.  
26 The division may issue, upon a finding that an employer has  
27 failed to offer an employee access to health insurance, any of  
28 the following:

29 a. A cease and desist order instructing the employer to  
30 cure the failure and desist from future violations of this  
31 section.

32 b. An order requiring an employer who has previously been  
33 the subject of a cease and desist order to pay an employee's  
34 reasonable health insurance premiums necessary to prevent or  
35 cure a lapse in health care coverage arising out of the

1 employer's failure to offer as required.

2 c. An order upon the employer assessing the reasonable  
3 costs of the division's investigation and enforcement action.

4 Sec. 33. NEW SECTION. 514C.8 PROVIDER ACCESS UNDER  
5 MANAGED CARE HEALTH PLAN OR INDEMNITY PLAN WITH LIMITED  
6 PROVIDER NETWORK.

7 A managed care health plan or indemnity plan with a limited  
8 provider network shall provide patients direct access to  
9 providers licensed under chapter 148, 148A, 148B, 148C, 149,  
10 150, 150A, 151, 152, 152A, 153, 154, 154B, or 155A. Access to  
11 such provider shall not be made conditional upon a referral by  
12 a provider licensed under another chapter. Referral to a  
13 specialist may be conditioned upon referral by a primary care  
14 provider licensed under the same chapter. Access to a class  
15 of providers licensed under one chapter shall not be subject  
16 to a copayment, deductible, or premium rate different than  
17 provided for access to a class of providers licensed under  
18 another chapter. Access to a specialist may be subject to a  
19 different copayment or deductible than access to a primary  
20 care provider. Access to a nonparticipating provider may be  
21 restricted, or may be subject to different copayments,  
22 deductibles, or premium rates.

23 For purposes of this section, "managed care health plan or  
24 indemnity plan with a limited provider network" means a health  
25 maintenance organization, accountable health plan, preferred  
26 provider organization, exclusive provider organization, point  
27 of service plan, or similar health plan.

28 This section does not apply if an employer offers employees  
29 a choice of health plans, either directly or indirectly  
30 through a health insurance purchasing cooperative, provided  
31 that the offered choices include at least one indemnity plan  
32 with unrestricted choice of provider, or at least one managed  
33 care health plan or indemnity plan with a limited provider  
34 network which provides access as defined in this section.

35 Sec. 34. NEW SECTION. 514I.1 NONPROFIT HEALTH INSURANCE

1 PURCHASING COOPERATIVES.

2 1. The commissioner of insurance shall adopt rules and a  
3 licensing procedure for authorizing the establishment of a  
4 nonprofit health insurance purchasing cooperative. The rules  
5 shall include, at a minimum, all of the following:

6 a. Procedures to sanction voluntary agreements between  
7 competitors within the service region of a nonprofit health  
8 insurance purchasing cooperative, upon a finding by the  
9 commissioner that the agreement will improve the quality of,  
10 access to, or affordability of health care, but which  
11 agreement might be a violation of antitrust laws if undertaken  
12 without government direction and approval.

13 b. Procedures to assure ongoing supervision of contracts  
14 sanctioned under this subsection, in order to assure that the  
15 contracts do in fact improve health care quality, access, or  
16 affordability. Approval may be withdrawn on a prospective  
17 basis at the discretion of the commissioner if necessary to  
18 improve health care quality, access, and affordability.

19 c. A requirement to review the plan of operation of a  
20 nonprofit health insurance purchasing cooperative, and  
21 standards for approval or disapproval of a plan.

22 d. A requirement that a plan of operation include  
23 guaranteed access and rating practices no more restrictive  
24 than those required of competitors within a market segment,  
25 such as small group health insurers regulated under chapter  
26 513B, or individual or large group insurers regulated under  
27 chapter 514A or 514D. The commissioner shall regulate all  
28 health plans and nonprofit health insurance purchasing  
29 cooperatives to assure that to the greatest extent possible  
30 all health insurance or health benefit marketing channels  
31 within a market segment are subject to the same rules of  
32 access, underwriting, risk spreading, and rate regulation.

33 e. A requirement that the nonprofit health insurance  
34 purchasing cooperative be governed by a board of directors  
35 consisting of twelve members, including seven members who are

1 consumers.

2 f. A requirement that the members of the board of  
3 directors be free of conflicts of interest and that the  
4 members of the board file an annual financial disclosure  
5 report with the commissioner.

6 g. A requirement that the board of directors conduct all  
7 meetings of the board pursuant to chapter 21.

8 h. A requirement that the nonprofit health insurance  
9 purchasing cooperative shall have a consumer ombudsman whose  
10 exclusive duties shall be to assist and advocate for  
11 subscribers enrolled in the cooperative.

12 i. An annual report to be submitted to the general  
13 assembly no later than February 1, describing the operations  
14 of all nonprofit health insurance purchasing cooperatives, and  
15 permitting review of the success of nonprofit health insurance  
16 purchasing cooperatives in furthering the goals of improved  
17 health care quality, access, or affordability. The report  
18 shall include any recommendations on whether additional  
19 nonprofit health insurance purchasing cooperatives should be  
20 established.

21 2. This section does not prevent the development of any  
22 other health insurance or pooled purchasing arrangements  
23 otherwise permitted by law.

24 3. This section and rules adopted pursuant to this section  
25 are intended to provide immunity from federal antitrust law  
26 under the state action doctrine exemption.

27 Sec. 35. RURAL PRIMARY CARE INITIATIVE --PHYSICIAN RESPITE  
28 PROGRAM. The Iowa department of public health, in cooperation  
29 with the university of Iowa college of medicine and the  
30 university of osteopathic medicine and health sciences, shall  
31 develop and establish a rural primary care initiative. The  
32 rural primary care initiative shall, at a minimum, focus on  
33 the expansion of the family practice residency program and  
34 training of rural physicians, physician assistants, and  
35 advanced registered nurse practitioner health care teams, and

1 the development of a physician, physician assistant, and  
2 advanced registered nurse practitioner respite programs in the  
3 rural areas of Iowa. The department shall submit a written  
4 report to the general assembly no later than January 9, 1995,  
5 concerning the status of the development of the rural primary  
6 care initiative, and include any legislative recommendations  
7 necessary to complete implementation of the initiative.

8 Sec. 36. HEALTH INSURANCE COST DEDUCTION. Section 7 of  
9 this Act takes effect upon enactment and applies retroactively  
10 to January 1, 1994, for tax years beginning on or after that  
11 date.

12 Sec. 37. NOTICE OF EFFECTIVENESS. The director of revenue  
13 and finance shall notify the governor, the chairpersons and  
14 ranking members of the senate and house ways and means  
15 committees, the Iowa Code editor, and the legislative fiscal  
16 bureau when section 7, which amends section 422.7, of this Act  
17 becomes effective.

18 Sec. 38. UNIVERSAL COVERAGE -- TASK FORCE ESTABLISHED.

19 1. The state shall provide for universal health care  
20 benefit coverage by no later than January 1, 1998.

21 2. A task force is created to do all of the following:

22 a. (1) Recommend a comprehensive set of guaranteed  
23 benefits for every Iowan and determine the cost of providing  
24 such benefits. The task force shall include in guaranteed  
25 benefits, at a minimum, all of the following:

26 (a) Preventative health services.

27 (b) Hospital services.

28 (c) Physician services.

29 (d) Services provided by other licensed providers,  
30 including essential community providers.

31 (e) Long-term care, including home care aide services and  
32 community-based services.

33 (f) Prescriptions and biologicals.

34 (g) Dental.

35 (h) Mental health and substance abuse services, which

1 shall be provided the same as benefits for physical illness.

2 (2) Provide a written report to the general assembly no  
3 later than January 9, 1995, including the comprehensive set of  
4 guaranteed benefits recommended by the task force, and any  
5 other recommendations as deemed necessary by the task force.  
6 The general assembly shall review the report and take action  
7 during the 1995 Regular Session of the general assembly on  
8 such recommendations, as appropriate.

9 b. Make recommendations related to the containment of  
10 health care costs. The task force shall do all of the  
11 following:

12 (1) Develop budget and expenditure targets for health care  
13 spending.

14 (2) Establish limits on insurance administrative costs.

15 (3) Review single payor, managed competition, and other  
16 structures for administering health benefit coverages.

17 (4) Develop other health cost containment mechanisms that  
18 ensure accessibility to quality, affordable health care by all  
19 Iowans.

20 Additionally, the task force shall examine and evaluate, as  
21 part of the study of health care cost containment, the  
22 benefits of establishing a single mandatory, nonprofit health  
23 insurance purchasing cooperative for all Iowans, granted the  
24 authority to negotiate premium limits with insurers and  
25 managed care plans.

26 The task force shall provide a written report to the  
27 general assembly no later than January 8, 1996, including the  
28 cost containment recommendations of the task force, and any  
29 other recommendations as deemed necessary by the task force.  
30 The general assembly shall review the report and take action  
31 during the 1996 Regular Session of the general assembly on  
32 such recommendations, as appropriate.

33 c. Recommend a fair and appropriate financing mechanism  
34 for providing the comprehensive set of guaranteed benefits  
35 recommended pursuant to paragraph "a", which shall include a

1 level of contribution by each employer, and the identification  
2 of additional funding sources sufficient to allow for the  
3 development of sliding scale subsidies for businesses with  
4 low-wage workers, self-employed individuals, and other persons  
5 as recommended by the task force and approved by the general  
6 assembly. The task force shall provide a written report to  
7 the general assembly no later than January 13, 1997, including  
8 the financing mechanism and funding sources recommended by the  
9 task force, and any other recommendations as deemed necessary  
10 by the task force. The general assembly shall review the  
11 report and take action during the 1997 Regular Session of the  
12 general assembly on such recommendations, as appropriate.

13 3. The task force shall consist of eleven members to be  
14 appointed by the legislative council, of which at least six  
15 members shall be consumers. Members of the task force shall  
16 be reimbursed for all actual and necessary expenses incurred  
17 in the performance of duties as members. Members of the task  
18 force shall elect a chairperson and vice chairperson and other  
19 officers as they determine. Meetings of the task force shall  
20 be held at the call of the chairperson of the task force or on  
21 written request of four members.

22 Sec. 39. ALTERNATIVE MEDICAL MALPRACTICE DISPUTE

23 RESOLUTION PROCEDURES -- MEDICAL SCREENING PANELS --STUDY.

24 The supreme court, in cooperation with the department of  
25 public health and the insurance division, shall initiate a  
26 study concerning the development and use of alternative  
27 medical malpractice dispute resolution procedures and medical  
28 screening panels. The study shall include, at a minimum, a  
29 review of existing alternative dispute resolution procedures  
30 and medical screening panels and provide for a comprehensive  
31 review of existing statutes and court decisions in an effort  
32 to maximize the benefits of alternative medical malpractice  
33 dispute resolution procedures that have been successful while  
34 assuring procedural protections and fair access to the court  
35 system. Additionally, the study shall include a review of the

1 availability of occurrence form of medical malpractice  
2 insurance for obstetricians and other physicians whose  
3 practice involves providing care services related to the birth  
4 of a child, the development of recommendations related to  
5 providing all individuals claiming injury resulting from an  
6 act of alleged malpractice reasonable and affordable access to  
7 alternative medical malpractice dispute resolution procedures,  
8 and a closed claim survey which shall include the frequency  
9 and severity of outcomes related to claims involving alleged  
10 malpractice by health care providers. The study shall also  
11 include any recommendations on implementing alternative  
12 medical malpractice dispute resolution procedures and medical  
13 screening panels in the state along with a corresponding cost  
14 benefit analysis related to each recommendation.

15 Sec. 40. INSURANCE DIVISION STUDIES.

16 The insurance division shall review, study, and make  
17 recommendations to the general assembly concerning the Iowa  
18 comprehensive health insurance association established under  
19 chapter 514E, with the intent to merge the Iowa comprehensive  
20 health insurance program with an individual health reinsurance  
21 program. The division shall submit a written report to the  
22 general assembly no later than January 9, 1995, including the  
23 division's findings and recommendations.

24 Sec. 41. RURAL HEALTH CARE DELIVERY MODELS. It is the  
25 intent of the general assembly that the department of  
26 inspections and appeals, through the hospital licensure board,  
27 in conjunction with the department of public health and other  
28 appropriate health care provider licensure boards, as  
29 identified by the departments, review the California  
30 alternative rural hospital model and the community  
31 hospital/rural primary care hospital demonstration project  
32 sponsored by the health care financing administration. The  
33 review shall include an examination of existing provider  
34 licensure statutes and administrative rules that inhibit or  
35 preclude implementation of either alternative rural health

1 care delivery model and shall include specific legislative and  
2 regulatory strategy proposals for the removal of such  
3 identified barriers. This written report shall be delivered  
4 by the department of inspections and appeals to the general  
5 assembly on or before January 1, 1995.

6 Sec. 42. APPLICABILITY. Notwithstanding the provisions of  
7 sections 513C.4 and 513C.5, chapter 513C, as enacted in this  
8 Act, is not applicable to an individual health benefit plan  
9 delivered or issued for delivery in this state or to a block  
10 of individual health benefit plan business until such time as  
11 rules implementing the chapter have been adopted by the  
12 insurance division pursuant to chapter 17A.

13 Sec. 43. EFFECTIVE DATE. Section 32 of this Act, which  
14 creates new section 513D.1, is effective January 1, 1995.

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## SENATE FILE 2222

H-5573

1 Amend Senate File 2222, as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 6, by inserting after line 4 the  
4 following:  
5 "Sec. \_\_\_\_ . Section 142B.1, subsection 3, Code  
6 1993, is amended to read as follows:  
7 3. "Public place" means any enclosed indoor area  
8 used by the general public or serving as a place of  
9 work containing ~~two-hundred-fifty-or-more-square-feet~~  
10 ~~of-floor-space~~, including, but not limited to, all  
11 ~~restaurants with-a-seating-capacity-greater-than~~  
12 ~~fifty~~, all retail stores, lobbies and malls, offices,  
13 including waiting rooms, and other commercial  
14 establishments; public conveyances with departures,  
15 travel, and destination entirely within this state;  
16 educational facilities; hospitals, clinics, nursing  
17 homes, and other health care and medical facilities;  
18 child care centers, as defined in section 237A.1; and  
19 auditoriums, elevators, theaters, libraries, art  
20 museums, concert halls, indoor arenas, and meeting  
21 rooms. "Public place" does not include a retail store  
22 at which fifty percent or more of the sales result  
23 from the sale of tobacco or tobacco products, the  
24 portion of a retail store where tobacco or tobacco  
25 products are sold, a private, enclosed office occupied  
26 exclusively by smokers even though the office may be  
27 visited by nonsmokers, a room used primarily as the  
28 residence of students or other persons at an  
29 educational facility, a sleeping room in a motel or  
30 hotel, or each resident's room in a health care  
31 facility. The person in custody or control of the  
32 facility shall provide a sufficient number of rooms in  
33 which smoking is not permitted to accommodate all  
34 persons who desire such rooms.

35 Sec. \_\_\_\_ . Section 142B.2, subsection 3, unnumbered  
36 paragraph 1, Code 1993, is amended to read as follows:

37 ~~Where-smoking-areas-are-designated,-existing~~  
38 ~~physical-barriers-and-existing-ventilation-systems~~  
39 ~~shall-be-used-to-minimize-the-toxic-effect-of-smoke-in~~  
40 ~~adjacent-nonsmoking-areas.--in-the-case-of-public~~  
41 ~~places-consisting-of-a-single-room,-the-provisions-of~~  
42 ~~this-law-shall-be-considered-met-if-one-side-of-the~~  
43 ~~room-is-reserved-and-posted-as-a-no-smoking-area. A~~  
44 smoking area shall only be designated if transmission  
45 of environmental tobacco smoke to adjacent areas can  
46 be eliminated. No public place other than a bar shall  
47 be designated as a smoking area in its entirety.--if a  
48 bar has within its premises a nonsmoking area, this  
49 designation shall be posted on all entrances normally  
50 used by the public.

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Page 2

1 Sec. \_\_\_\_\_. Section 142B.2, Code 1993, is amended  
2 by adding the following new subsection:  
3 NEW SUBSECTION. 5. The following conditions shall  
4 apply to restaurants, as applicable, in order to  
5 comply with this chapter:

6 a. A restaurant of any size or seating capacity  
7 which designates the restaurant as a no-smoking area  
8 in its entirety shall post signs in conspicuous areas  
9 both inside and on the exterior of the building which  
10 advise patrons of the no-smoking policy of the  
11 restaurant.

12 b. A restaurant of any size or seating capacity  
13 which offers both smoking and no-smoking areas in  
14 accordance with the application of this chapter to  
15 other public places shall comply with the requirements  
16 under this chapter for a public place.

17 c. A restaurant of any size but with a seating  
18 capacity of fewer than fifty seats may designate the  
19 restaurant as a smoking-permitted restaurant by  
20 designating the restaurant as a smoking area in its  
21 entirety. A smoking-permitted restaurant shall post  
22 signs, in conspicuous areas both inside and on the  
23 exterior of the building, which advise patrons of the  
24 smoking-permitted status of the restaurant. A  
25 restaurant which is designated as a smoking-permitted  
26 restaurant shall also issue a written health warning  
27 to prospective and current employees which states that  
28 due to the environment of the restaurant, the employee  
29 may be working in a hazardous environment.

30 d. A restaurant which is held out to be a bar or a  
31 bar may be designated as a smoking area in its  
32 entirety. If the bar has within its premises a  
33 nonsmoking area, the designation shall be posted on  
34 all entrances normally used by the public. If the bar  
35 is designated as a smoking area in its entirety, signs  
36 designating this status shall be posted both inside  
37 and on the exterior of the building. The bar shall  
38 also issue a written health warning to prospective and  
39 current employees which states that due to the  
40 environment of the bar, the employee may be working in  
41 a hazardous environment.

42 Sec. \_\_\_\_\_. Section 142B.4, Code 1993, is amended to  
43 read as follows:

44 142B.4 AREAS POSTED.

45 A person having custody or control of a public  
46 place or public meeting shall cause signs to be posted  
47 within the appropriate areas of the facility advising  
48 patrons of smoking and no-smoking areas. In addition  
49 the statement "Smoking prohibited except in designated  
50 areas" shall be conspicuously posted on all major

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Page 3

1 entrances to the public place or public meeting. In  
2 regard to restaurants, signs shall also be posted in  
3 accordance with section 142B.2, subsection 5.

4 Sec. \_\_\_\_\_. Section 142B.6, unnumbered paragraph 1,  
5 Code 1993, is amended to read as follows:

6 A person who ~~smokes-in-those-areas-prohibited-in~~  
7 ~~section-142B-2,-or-who~~ violates section 142B.2,  
8 142B.3, or 142B.4, shall pay a civil fine pursuant to  
9 section 805.8, subsection 11, for each violation.

10 Sec. \_\_\_\_\_. Section 142B.6, unnumbered paragraph 3,  
11 Code 1993, is amended by striking the unnumbered  
12 paragraph.

13 Sec. \_\_\_\_\_. NEW SECTION. 142B.7 ENFORCEMENT.

14 The Iowa department of public health shall adopt  
15 rules to enforce this chapter."

16 2. By renumbering as necessary.

By BRAMMER of Linn

H-5573 FILED MARCH 22, 1994

Szymoniak, Chair  
Judge  
Kramer

SSB 2201  
HUMAN RESOURCES

SENATE FILE 2222  
BY (PROPOSED COMMITTEE ON  
HUMAN RESOURCES BILL  
BY CHAIRPERSON SZYMONIAK)

Passed Senate, Date \_\_\_\_\_ Passed House, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

A BILL FOR

1 An Act relating to health care reform, legal process changes,  
2 regulation of insurance and health care plan providers, income  
3 tax credits for certain individuals, establishing certain  
4 employer and individual requirements, establishing fees, and  
5 providing effective dates and applicability provisions.

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

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1 Section 1. INTENT AND FINDINGS. It is the intent of the  
2 general assembly that any significant health care reform must  
3 recognize the essential requirement that rural Iowa must have  
4 access to the benefits of affordable, accessible, and quality  
5 health care. Reform of the health care system in Iowa is not  
6 complete unless there is developed a strategy to address the  
7 needs of rural Iowa with subsequent implementation of a  
8 comprehensive system to meet those needs. Rural Iowans must  
9 be provided the same access to the best quality medical care  
10 available as Iowans residing in urban areas. The ability of  
11 hospitals and rural health clinics to access the state's fiber  
12 optic network is imperative. The complete use of the skills  
13 of all health care providers is essential to address the lack  
14 of access to primary care. New innovative initiatives for the  
15 delivery of care by rural hospitals and clinics must be  
16 encouraged.

17 The general assembly finds that given the rural bias  
18 inherent in the medicare system for hospital inpatient  
19 reimbursement, and the shortage of a number of important  
20 primary care providers, the challenges for health care reform  
21 in rural Iowa are significant. However, the general assembly  
22 believes that efforts to reform health care in Iowa coupled  
23 with the initiatives from the federal level offer a new  
24 opportunity to provide quality health care to rural Iowa. The  
25 general assembly finds that policymakers must seize this  
26 opportunity to ensure that rural Iowans will receive all the  
27 benefits of health care reform.

28 Sec. 2. Section 8.6, Code 1993, is amended by adding the  
29 following new subsection:

30 NEW SUBSECTION. 16. HEALTH ACCOUNTING SYSTEM. To  
31 establish a statewide health accounting system in coordination  
32 with the department of public health, the department of human  
33 services, the department of elder affairs, the department of  
34 employment services, and the insurance division of the  
35 department of commerce. The department of management shall

1 have access to all data, as deemed by the department to be  
2 necessary, in electronic format from the community health  
3 management information system established in chapter 144C.

4 Sec. 3. Section 18.133, subsection 2, Code Supplement  
5 1993, is amended to read as follows:

6 2. "Private agency" means an accredited nonpublic schools  
7 and school, nonprofit institutions institution of higher  
8 education eligible for tuition grants, hospital licensed  
9 pursuant to chapter 135B, rural health clinic defined pursuant  
10 to 42 U.S.C. § 1395(x), or physician clinic.

11 Sec. 4. Section 18.136, Code Supplement 1993, is amended  
12 by adding the following new subsection:

13 NEW SUBSECTION. 13A. Hospitals licensed pursuant to  
14 chapter 135B, rural health clinics defined pursuant to 42  
15 U.S.C. § 1395(x), and physician clinics shall be offered  
16 access to the network for diagnostic, clinical, consultative,  
17 data, and educational services for the purpose of developing a  
18 comprehensive, statewide telemedicine network.

19 Sec. 5. Section 422.7, Code Supplement 1993, is amended by  
20 adding the following new subsection:

21 NEW SUBSECTION. 29. Subtract, to the extent not otherwise  
22 deducted in computing adjusted gross income, the amounts paid  
23 by the taxpayer for the purchase of health insurance for the  
24 taxpayer or taxpayer's spouse or dependent.

25 Sec. 6. Section 422.7, Code Supplement 1993, is amended by  
26 adding the following new subsection:

27 NEW SUBSECTION. 30. Subtract, to the extent included, the  
28 amount of contributions made on behalf of the taxpayer to a  
29 medical care savings account and interest earned on moneys in  
30 the account if not otherwise withdrawn.

31 Sec. 7. Section 505.7, subsection 1, Code Supplement 1993,  
32 is amended to read as follows:

33 1. All fees and charges which are required by law to be  
34 paid by insurance companies, and associations, and other  
35 regulated entities shall be payable to the commissioner of the

1 insurance division of the department of commerce or department  
2 of revenue and finance, as provided by law, whose duty it  
3 shall be to account for and pay over the same to the treasurer  
4 of state at the time and in the manner provided by law for  
5 deposit in the general fund of the state.

6 Sec. 8. Section 505.7, Code Supplement 1993, is amended by  
7 adding the following new subsection:

8 NEW SUBSECTION. 8. The commissioner may assess the costs  
9 of an audit or examination to a health insurance purchasing  
10 cooperative authorized under section 514I.1, in the same  
11 manner as provided for insurance companies under sections  
12 507.7 through 507.9, and may establish by rule reasonable  
13 filing fees to fund the cost of regulatory oversight.

14 Sec. 9. Section 505.8, Code 1993, is amended by adding the  
15 following new subsection:

16 NEW SUBSECTION. 6. The commissioner shall supervise all  
17 health insurance purchasing cooperatives providing services or  
18 operating within the state and the organization of domestic  
19 cooperatives. The commissioner may admit nondomestic health  
20 insurance purchasing cooperatives under the same standards as  
21 domestic cooperatives. Health insurance purchasing  
22 cooperatives are subject to rules adopted by the commissioner  
23 pursuant to section 514I.1.

24 Sec. 10. Section 509A.6, Code 1993, is amended by adding  
25 the following new unnumbered paragraph:

26 NEW UNNUMBERED PARAGRAPH. The governing body may also  
27 enroll in and contract with a health insurance purchasing  
28 cooperative authorized pursuant to section 514I.1.

29 Sec. 11. NEW SECTION. 509A.16 USE OF STATE GROUP  
30 INSURANCE RESERVES.

31 1. Notwithstanding section 509A.5, the director of the  
32 department of management may approve expenditures of up to  
33 three hundred thousand dollars per fiscal year, from that  
34 portion of the employer share of the state group insurance  
35 reserves which consists of moneys appropriated from the

1 general fund of the state but which is not needed to fund  
2 incentive programs, for the purposes of health reform  
3 activities.

4 2. This section is repealed effective July 1, 1996.

5 Sec. 12. Section 513B.2, subsection 16, Code Supplement  
6 1993, is amended to read as follows:

7 16. "Small employer" means a person actively engaged in  
8 business who, on at least fifty percent of the employer's  
9 working days during the preceding year, employed not less than  
10 two and not more than ~~twenty-five~~ fifty full-time equivalent  
11 eligible employees. In determining the number of eligible  
12 employees, companies which are affiliated companies or which  
13 are eligible to file a combined tax return for purposes of  
14 state taxation are considered one employer.

15 Sec. 13. Section 513B.4, Code Supplement 1993, is amended  
16 by adding the following new subsection:

17 NEW SUBSECTION. 1A. Notwithstanding subsection 1, there  
18 shall be no variance in premium rates for a basic or standard  
19 benefit plan offered pursuant to this chapter for any of the  
20 factors as provided for in subsection 1.

21 Sec. 14. Section 513B.4, subsection 2, unnumbered  
22 paragraph 2, Code Supplement 1993, is amended by striking the  
23 paragraph and inserting in lieu thereof the following:

24 Case characteristics other than family composition and  
25 group size shall not be used by a small employer carrier  
26 without the prior approval of the commissioner.

27 Sec. 15. Section 513B.4, Code Supplement 1993, is amended  
28 by adding the following new subsection:

29 NEW SUBSECTION. 5. Notwithstanding subsection 1, the  
30 commissioner may by order reduce or eliminate the allowed  
31 rating bands provided under subsection 1, paragraphs "a", "b",  
32 and "c", or otherwise limit or eliminate the use of experience  
33 rating.

34 Sec. 16. Section 513B.37, subsection 1, paragraph a, Code  
35 Supplement 1993, is amended to read as follows:

1 a. What benefits or direct pay requirements must be  
2 minimally included in a basic or standard benefit coverage  
3 policy or subscription contract.

4 Sec. 17. Section 513B.38, Code Supplement 1993, is amended  
5 by adding the following new subsections:

6 NEW SUBSECTION. 4. Upon the determination of the  
7 commissioner pursuant to section 513B.37, subsection 1,  
8 paragraph "a", to include expanded preventative care services  
9 and mental health and substance abuse treatment coverage as  
10 recommended by the Iowa health reform council, the  
11 commissioner shall do all of the following:

12 a. Adopt by rule, with all due diligence, requirements for  
13 the provision of expanded coverage for benefits for expanded  
14 preventative care services.

15 b. Adopt by rule, with all due diligence, requirements for  
16 the provision of limited coverage for benefits for mental  
17 health and substance abuse services.

18 NEW SUBSECTION. 5. A policy of accident and sickness  
19 insurance, a health maintenance organization contract, an  
20 accountable health plan contract, or other policy of health  
21 insurance shall not provide a lifetime maximum limit of  
22 coverage.

23 Sec. 18. NEW SECTION. 513C.1 SHORT TITLE.

24 This chapter shall be known and may be cited as the  
25 "Individual Health Insurance Market Reform Act".

26 Sec. 19. NEW SECTION. 513C.2 PURPOSE.

27 The purpose and intent of this chapter is to promote the  
28 availability of health insurance coverage to individuals  
29 regardless of their health status or claims experience, to  
30 prevent abusive rating practices, to require disclosure of  
31 rating practices to purchasers, to establish rules regarding  
32 the renewal of coverage, to establish limitations on the use  
33 of preexisting condition exclusions, to provide for the  
34 development of a core group of basic or standard health  
35 benefits to be offered to all individuals, and to improve the

1 overall fairness and efficiency of the individual health  
2 insurance market.

3 Sec. 20. NEW SECTION. 513C.3 DEFINITIONS.

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

6 1. "Actuarial certification" means a written statement by  
7 a member of the American academy of actuaries or other  
8 individual acceptable to the commissioner that an individual  
9 carrier is in compliance with the provision of section 513C.5  
10 which is based upon the actuary's or individual's examination,  
11 including a review of the appropriate records and the  
12 actuarial assumptions and methods used by the carrier in  
13 establishing premium rates for applicable individual health  
14 benefit plans.

15 2. "Affiliate" or "affiliated" means any entity or person  
16 who directly or indirectly through one or more intermediaries,  
17 controls or is controlled by, or is under common control with,  
18 a specified entity or person.

19 3. "Basic or standard health benefit plan" means the core  
20 group of health benefits developed pursuant to section 513C.8.

21 4. "Block of business" means all the individuals insured  
22 under the same individual health benefit plan.

23 5. "Carrier" means any entity that provides individual  
24 health benefit plans in this state. For purposes of this  
25 chapter, carrier includes an insurance company, a group  
26 hospital or medical service corporation, a fraternal benefit  
27 society, a health maintenance organization, an accountable  
28 health plan, and any other entity providing an individual plan  
29 of health insurance or health benefits subject to state  
30 insurance regulation.

31 6. "Commissioner" means the commissioner of insurance.

32 7. "Eligible individual" means an individual who is a  
33 resident of this state and who either has qualifying existing  
34 coverage or has had qualifying existing coverage within the  
35 immediately preceding thirty days, or an individual who has

1 had a qualifying event occur within the immediately preceding  
2 thirty days.

3 8. "Established service area" means a geographic area, as  
4 approved by the commissioner and based upon the carrier's  
5 certificate of authority to transact insurance in this state,  
6 within which the carrier is authorized to provide coverage.

7 9. "Filed rate" means, for a rating period related to each  
8 block of business, the rate charged to all individuals with  
9 similar rating characteristics for individual health benefit  
10 plans.

11 10. "Individual health benefit plan" means any hospital or  
12 medical expense incurred policy or certificate, hospital or  
13 medical service plan, or health maintenance organization  
14 subscriber contract sold to an individual, or any  
15 discretionary group trust or association policy providing  
16 hospital or medical expense incurred coverage to individuals.  
17 Individual health benefit plan does not include a self-insured  
18 group health plan, a self-insured multiple employer group  
19 health plan, a group conversion plan, an insured group health  
20 plan, accident-only, specified disease, short-term hospital or  
21 medical, hospital confinement indemnity, credit, dental,  
22 vision, medicare supplement, long-term care, or disability  
23 income insurance coverage, coverage issued as a supplement to  
24 liability insurance, workers' compensation or similar  
25 insurance, or automobile medical payment insurance.

26 11. "Premium" means all moneys paid by an individual and  
27 eligible dependents as a condition of receiving coverage from  
28 a carrier, including any fees or other contributions  
29 associated with an individual health benefit plan.

30 12. "Qualifying event" means any of the following:

31 a. Loss of eligibility for medical assistance provided  
32 pursuant to chapter 249A or medicare coverage provided  
33 pursuant to Title XVIII of the federal Social Security Act.

34 b. Loss or change of dependent status under qualifying  
35 previous coverage.

1 c. The attainment by an individual of the age of majority.

2 13. "Qualifying existing coverage" or "qualifying previous  
3 coverage" means benefits or coverage provided under either of  
4 the following:

5 a. Any group health insurance that provides benefits  
6 similar to or exceeding benefits provided under the standard  
7 health benefit plan, provided that such policy has been in  
8 effect for a period of at least one year.

9 b. An individual health insurance benefit plan, including  
10 coverage provided under a health maintenance organization  
11 contract, a hospital or medical service plan contract, or a  
12 fraternal benefit society contract, that provides benefits  
13 similar to or exceeding the benefits provided under the  
14 standard health benefit plan, provided that such policy has  
15 been in effect for a period of at least one year.

16 14. "Rating characteristics" means demographic or other  
17 objective characteristics of individuals which are considered  
18 by the carrier in the determination of premium rates for the  
19 individuals and which are approved by the commissioner.

20 15. "Rating period" means the period for which premium  
21 rates established by a carrier are in effect.

22 16. "Restricted network provision" means a provision of an  
23 individual health benefit plan that conditions the payment of  
24 benefits, in whole or in part, on the use of health care  
25 providers that have entered into a contractual arrangement  
26 with the carrier to provide health care services to covered  
27 individuals.

28 Sec. 21. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

29 This chapter applies to an individual health benefit plan  
30 delivered or issued for delivery to residents of this state on  
31 or after July 1, 1994.

32 1. Except as provided in subsection 2, for purposes of  
33 this chapter, carriers that are affiliated companies or that  
34 are eligible to file a consolidated tax return shall be  
35 treated as one carrier and any restrictions or limitations

1 imposed by this chapter shall apply as if all individual  
2 health benefit plans delivered or issued for delivery to  
3 residents of this state by such affiliated carriers were  
4 issued by one carrier.

5 2. An affiliated carrier that is a health maintenance  
6 organization having a certificate of authority under section  
7 513C.5 shall be considered to be a separate carrier for the  
8 purposes of this chapter.

9 Sec. 22. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO  
10 PREMIUM RATES.

11 1. Premium rates for any block of individual health  
12 benefit plan business issued on or after July 1, 1994, by a  
13 carrier subject to this chapter are subject to the composite  
14 effect of all of the following:

15 a. After making actuarial adjustments based upon benefit  
16 design, rating characteristics, and health choice factors, the  
17 filed rate for any block of business shall not exceed the  
18 filed rate for any other block of business by more than twenty  
19 percent.

20 b. The filed rate for any block of business shall not  
21 exceed the filed rate for any other block of business by more  
22 than thirty percent due to factors relating to rating  
23 characteristics.

24 c. The filed rate for any block of business shall not  
25 exceed the filed rate for any other block of business by more  
26 than thirty percent due to factors relating to health choices.

27 d. The carrier shall not apply gender or industry  
28 classification rating characteristics.

29 e. Experience rating characteristics other than family  
30 composition and group size shall not be used by a carrier  
31 without the prior approval of the commissioner.

32 f. Premium rates for individual health benefit plans shall  
33 comply with the requirements of this section notwithstanding  
34 any assessments paid or payable by the carrier pursuant to any  
35 reinsurance program or risk adjustment mechanism.

1 g. An adjustment, not to exceed fifteen percent annually  
2 due to the claim experience or health status of a block of  
3 business.

4 h. For purposes of this subsection, an individual health  
5 benefit plan that contains a restricted network provision  
6 shall not be considered similar coverage to an individual  
7 health benefit plan that does not contain such a provision,  
8 provided that the differential in payments made to network  
9 providers results in substantial differences in claim costs.

10 2. Notwithstanding subsection 1, the commissioner may by  
11 order reduce or eliminate the allowed rating bands provided  
12 under subsection 1, paragraphs "a", "b", "c", and "g", or  
13 otherwise limit or eliminate the use of experience rating.

14 3. A carrier shall not transfer an individual  
15 involuntarily into or out of a block of business.

16 4. The commissioner may suspend for a specified period the  
17 application of subsection 1, paragraph "a", as to the premium  
18 rates applicable to one or more blocks of business of a  
19 carrier for one or more rating periods upon a filing by the  
20 carrier requesting the suspension and a finding by the  
21 commissioner that the suspension is reasonable in light of the  
22 financial condition of the carrier.

23 5. A carrier shall make a reasonable disclosure at the  
24 time of the offering for sale of any individual health benefit  
25 plan of all of the following:

26 a. The extent to which premium rates for a specified  
27 individual are established or adjusted based upon rating  
28 characteristics.

29 b. The carrier's right to change premium rates, and the  
30 factors, other than claim experience, that affect changes in  
31 premium rates.

32 c. The provisions relating to the renewal of policies and  
33 contracts.

34 d. Any provisions relating to any preexisting condition.

35 e. All plans offered by the carrier, the prices of such

1 plans, and the availability of such plans to the individual.

2 6. A carrier shall maintain at its principal place of  
3 business a complete and detailed description of its rating  
4 practices, including information and documentation that  
5 demonstrate that its rating methods and practices are based  
6 upon commonly accepted actuarial assumptions and are in  
7 accordance with sound actuarial principles.

8 7. A carrier shall file with the commissioner annually on  
9 or before March 15, an actuarial certification certifying that  
10 the carrier is in compliance with this chapter and that the  
11 rating methods of the carrier are actuarially sound. The  
12 certification shall be in a form and manner and shall contain  
13 information as specified by the commissioner. A copy of the  
14 certification shall be retained by the carrier at its  
15 principal place of business. Rate adjustments made in order  
16 to comply with this section are exempt from loss ratio  
17 requirements.

18 8. A carrier shall make the information and documentation  
19 maintained pursuant to subsection 5 available to the  
20 commissioner upon request. The information and documentation  
21 shall be considered proprietary and trade secret information  
22 and shall not be subject to disclosure by the commissioner to  
23 persons outside of the division except as agreed to by the  
24 carrier or as ordered by a court of competent jurisdiction.

25 Sec. 23. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

26 1. An individual health benefit plan is renewable at the  
27 option of the individual, except in any of the following  
28 cases:

29 a. Nonpayment of the required premiums.

30 b. Fraud or misrepresentation.

31 c. The insured individual becomes eligible for medicare  
32 coverage under Title XVIII of the federal Social Security Act.

33 d. The carrier elects not to renew all of its individual  
34 health benefit plans in the state. In such case, the carrier  
35 shall provide notice of the decision not to renew coverage to

1 all affected individuals and to the commissioner in each state  
2 in which an affected insured individual is known to reside at  
3 least ninety days prior to the nonrenewal of the health  
4 benefit plan by the carrier. Notice to the commissioner under  
5 the paragraph shall be provided at least three working days  
6 prior to the notice to the affected individuals.

7 e. The commissioner finds that the continuation of the  
8 coverage would not be in the best interests of the  
9 policyholders or certificate holders, or would impair the  
10 carrier's ability to meet its contractual obligations.

11 2. A carrier that elects not to renew all of its  
12 individual health benefit plans in this state shall be  
13 prohibited from writing new individual health benefit plans in  
14 this state for a period of five years from the date of the  
15 notice to the commissioner.

16 3. With respect to a carrier doing business in an  
17 established geographic service area of the state, this section  
18 applies only to the carrier's operations in the service area.

19 Sec. 24. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

20 1. A carrier issuing an individual health benefit plan in  
21 this state shall issue a basic or standard health benefit plan  
22 to an eligible individual who applies for a plan and agrees to  
23 make the required premium payments and to satisfy other  
24 reasonable provisions of the basic or standard health benefit  
25 plan. An insurer is not required to issue a basic or standard  
26 health benefit plan to an individual who meets any of the  
27 following criteria:

28 a. The individual is covered or is eligible for coverage  
29 under a health benefit plan provided by the individual's  
30 employer.

31 b. An eligible individual who does not apply for a basic  
32 or standard health benefit plan within thirty days of a  
33 qualifying event or within thirty days upon becoming  
34 ineligible for qualifying existing coverage.

35 c. The individual is covered or is eligible for any

1 continued group coverage under section 4980b of the Internal  
2 Revenue Code, sections 601 through 608 of the federal Employee  
3 Retirement Income Security Act of 1974, sections 2201 through  
4 2208 of the federal Public Health Service Act, or any state-  
5 required continued group coverage. For purposes of this  
6 subsection, an individual who would have been eligible for  
7 such continuation of coverage, but is not eligible solely  
8 because the individual or other responsible party failed to  
9 make the required coverage election during the applicable time  
10 period, is deemed to be eligible for such group coverage until  
11 the date on which the individual's continuing group coverage  
12 would have expired had an election been made.

13 2. A carrier shall issue the basic or standard health  
14 insurance benefit plan to an individual currently covered by  
15 an underwritten benefit plan issued by that carrier at the  
16 option of the individual. This option must be exercised  
17 within thirty days of notification of a premium rate increase  
18 applicable to the underwritten benefit plan.

19 3. A carrier shall file with the commissioner, in a form  
20 and manner prescribed by the commissioner, the basic or  
21 standard health benefit plan to be used by the carrier. A  
22 basic or standard health benefit plan filed pursuant to this  
23 subsection may be used by a carrier beginning thirty days  
24 after it is filed unless the commissioner disapproves of its  
25 use.

26 The commissioner may at any time, after providing notice  
27 and an opportunity for a hearing to the carrier, disapprove  
28 the continued use by a carrier of a basic or standard health  
29 benefit plan on the grounds that the plan does not meet the  
30 requirements of this chapter.

31 4. a. The individual basic or standard health benefit  
32 plan shall not deny, exclude, or limit benefits for a covered  
33 individual for losses incurred more than twelve months  
34 following the effective date of the individual's coverage due  
35 to a preexisting condition. A preexisting condition shall not

1 be defined more restrictively than any of the following:

2 (1) A condition that would cause an ordinarily prudent  
3 person to seek medical advice, diagnosis, care, or treatment  
4 during the twelve months immediately preceding the effective  
5 date of coverage.

6 (2) A condition for which medical advice, diagnosis, care,  
7 or treatment was recommended or received during the twelve  
8 months immediately preceding the effective date of coverage.

9 (3) A pregnancy existing on the effective date of  
10 coverage.

11 b. A carrier shall waive any time period applicable to a  
12 preexisting condition exclusion or limitation period with  
13 respect to particular services in an individual health benefit  
14 plan for the period of time an individual was previously  
15 covered by qualifying previous coverage that provided benefits  
16 with respect to such services, provided that the qualifying  
17 previous coverage was continuous to a date not more than  
18 thirty days prior to the effective date of the new coverage.

19 5. A carrier is required to offer coverage or accept  
20 applications pursuant to subsection 1 from any individual  
21 residing in the carrier's established geographic access area.

22 6. A carrier shall not modify a basic or standard health  
23 benefit plan with respect to an individual or dependent  
24 through riders, endorsements, or other means to restrict or  
25 exclude coverage for certain diseases or medical conditions  
26 otherwise covered by the health benefit plan.

27 Sec. 25. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN  
28 STANDARDS.

29 The commissioner shall adopt by rule the form and level of  
30 coverage of the basic health benefit plan and the standard  
31 health benefit plan for the individual market which shall be  
32 the same as provided for under chapter 513B with respect to  
33 small group coverage.

34 Sec. 26. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR  
35 MARKETING.

1 1. A carrier issuing individual health benefit plans in  
2 this state shall make available the basic or standard health  
3 benefit plan to residents of this state. If a carrier denies  
4 other individual health benefit plan coverage to an eligible  
5 individual on the basis of the health status or claims  
6 experience of the eligible individual, or the individual's  
7 dependents, the carrier shall offer the individual the  
8 opportunity to purchase a basic or standard health benefit  
9 plan.

10 2. A carrier or an agent shall not do either of the  
11 following:

12 a. Encourage or direct individuals to refrain from filing  
13 an application for coverage with the carrier because of the  
14 health status, claims experience, industry occupation, or  
15 geographic location of the individuals.

16 b. Encourage or direct individuals to seek coverage from  
17 another carrier because of the health status, claims  
18 experience, industry occupation, or geographic location of the  
19 individuals.

20 3. Subsection 2, paragraph "a", shall not apply with  
21 respect to information provided by a carrier or an agent to an  
22 individual regarding the established geographic service area  
23 of the carrier or the restricted network provision of the  
24 carrier.

25 4. A carrier shall not, directly or indirectly, enter into  
26 any contract, agreement, or arrangement with an agent that  
27 provides for, or results in, the compensation paid to an agent  
28 for a sale of a basic or standard health benefit plan to vary  
29 because of the health status or permitted rating  
30 characteristics of the individual or the individual's  
31 dependents.

32 5. Subsection 4 does not apply with respect to the  
33 compensation paid to an agent on the basis of percentage of  
34 premium, provided that the percentage shall not vary because  
35 of the health status or other permitted rating characteristics

1 of the individual or the individual's dependents.

2 6. Denial by a carrier of an application for coverage from  
3 an individual shall be in writing and shall state the reason  
4 or reasons for the denial.

5 7. A violation of this section by a carrier or an agent is  
6 an unfair trade practice under chapter 507B.

7 8. If a carrier enters into a contract, agreement, or  
8 other arrangement with a third-party administrator to provide  
9 administrative, marketing, or other services related to the  
10 offering of individual health benefit plans in this state, the  
11 third-party administrator is subject to this section as if it  
12 were a carrier.

13 Sec. 27. NEW SECTION. 513D.1 EMPLOYER REQUIRED TO  
14 PROVIDE ACCESS TO HEALTH CARE COVERAGE -- PENALTIES.

15 1. An employer doing business within this state shall  
16 offer each employee, at a minimum, access to health insurance.  
17 The requirement contained in this section may be satisfied by  
18 offering any of the following:

19 a. Health care coverage through an insurer or health  
20 maintenance organization authorized to do business in this  
21 state.

22 b. Access to health benefits through a health benefits  
23 plan qualified under the federal Employee Retirement Income  
24 Security Act of 1974.

25 c. Enrollment in an Iowa-licensed health insurance  
26 purchasing cooperative. A cooperative may require payroll  
27 deduction of employee contributions and direct deposit of  
28 premium payments to the account of the cooperative.

29 2. An employer is not required to financially contribute  
30 toward the employee's health plan.

31 3. A violation of this section may be reported to the  
32 consumer and legal affairs bureau in the insurance division.  
33 The division may issue, upon a finding that an employer has  
34 failed to offer an employee access to health insurance, any of  
35 the following:

1 a. A cease and desist order instructing the employer to  
2 cure the failure and desist from future violations of this  
3 section.

4 b. An order requiring an employer who has previously been  
5 the subject of a cease and desist order to pay an employee's  
6 reasonable health insurance premiums necessary to prevent or  
7 cure a lapse in health care coverage arising out of the  
8 employer's failure to offer as required.

9 c. An order upon the employer assessing the reasonable  
10 costs of the division's investigation and enforcement action.

11 Sec. 28. NEW SECTION. 514C.8 PROVIDER ACCESS UNDER  
12 MANAGED CARE HEALTH PLAN OR INDEMNITY PLAN WITH LIMITED  
13 PROVIDER NETWORK.

14 A managed care health plan or indemnity plan with a limited  
15 provider network shall provide patients direct access to  
16 providers licensed under chapter 148, 150, or 150A. Access to  
17 such provider shall not be made conditional upon a referral by  
18 a provider licensed under another chapter. Referral to a  
19 specialist may be conditioned upon referral by a primary care  
20 provider licensed under the same chapter. Access to a class  
21 of providers licensed under one chapter shall not be subject  
22 to a copayment, deductible, or premium rate different than  
23 provided for access to a class of providers licensed under  
24 another chapter. Access to a specialist may be subject to a  
25 different copayment or deductible than access to a primary  
26 care provider. Access to a nonparticipating provider may be  
27 restricted; may be subject to different copayments,  
28 deductibles, or premium rates; or may be excluded.

29 For purposes of this section, "managed care health plan or  
30 indemnity plan with a limited provider network" means a health  
31 maintenance organization, accountable health plan, preferred  
32 provider organization, exclusive provider organization, point  
33 of service plan, or similar health plan.

34 This section does not apply if an employer offers employees  
35 a choice of health plans, either directly or indirectly

1 through a health insurance purchasing cooperative, provided  
2 that the offered choices include at least one indemnity plan  
3 with unrestricted choice of provider, or at least one managed  
4 care health plan or indemnity plan with a limited provider  
5 network which provides access as defined in this section.

6 Sec. 29. NEW SECTION. 514I.1 HEALTH INSURANCE PURCHASING  
7 COOPERATIVES.

8 1. The commissioner of insurance shall adopt rules and a  
9 licensing procedure for authorizing the establishment of a  
10 health insurance purchasing cooperative. The rules shall  
11 include, at a minimum, all of the following:

12 a. Procedures to sanction voluntary agreements between  
13 competitors within the service region of a health insurance  
14 purchasing cooperative, upon a finding by the commissioner  
15 that the agreement will improve the quality of, access to, or  
16 affordability of health care, but which agreement might be a  
17 violation of antitrust laws if undertaken without government  
18 direction and approval.

19 b. Procedures to assure ongoing supervision of contracts  
20 sanctioned under this subsection, in order to assure that the  
21 contracts do in fact improve health care quality, access, or  
22 affordability. Approval may be withdrawn on a prospective  
23 basis at the discretion of the commissioner if necessary to  
24 improve health care quality, access, and affordability.

25 c. A requirement to review the plan of operation of a  
26 health insurance purchasing cooperative, and standards for  
27 approval or disapproval of a plan.

28 d. A requirement that a plan of operation include  
29 guaranteed access and rating practices no more restrictive  
30 than those required of competitors within a market segment,  
31 such as small group health insurers regulated under chapter  
32 513B, or individual or large group insurers regulated under  
33 chapter 514A or 514D. The commissioner shall regulate all  
34 health plans and health insurance purchasing cooperatives to  
35 assure that to the greatest extent possible all health

1 insurance or health benefit marketing channels within a market  
2 segment are subject to the same rules of access, underwriting,  
3 risk spreading, and rate regulation.

4 e. An annual report to be submitted to the general  
5 assembly no later than February 1, describing the operations  
6 of all health insurance purchasing cooperatives, and  
7 permitting review of the success of health insurance  
8 purchasing cooperatives in furthering the goals of improved  
9 health care quality, access, or affordability. The report  
10 shall include any recommendations on whether additional health  
11 insurance purchasing cooperatives should be established.

12 2. This section does not prevent the development of any  
13 other health insurance or pooled purchasing arrangements  
14 otherwise permitted by law.

15 3. This section and rules adopted pursuant to this section  
16 are intended to provide immunity from federal antitrust law  
17 under the state action doctrine exemption.

18 Sec. 30. NEW SECTION. 514C.1 ACCOUNTABLE HEALTH PLAN  
19 DEFINED.

20 An accountable health plan is an entity which does all of  
21 the following:

22 1. Pays for and provides health care services.

23 2. Is responsible for delivering the full range of health  
24 care services covered under a standard health benefit plan as  
25 established in chapter 513B.

26 3. Meets established solvency standards and complies with  
27 established underwriting standards, including modified  
28 community rating methods, for all beneficiaries served.

29 4. Is accountable to the public for the cost, quality, and  
30 access of the services which the accountable health plan  
31 provides and for the effects of its services on the health of  
32 those who are provided such services.

33 5. Is eligible for operation based on financial, quality  
34 of care, and structural qualifications.

35 6. Satisfies data reporting and collection standards.

1     Sec. 31. NEW SECTION. 514J.2 RULES.

2     1. The commissioner shall adopt rules relating to the  
3 establishment and regulation of accountable health plans. The  
4 rules shall allow significant flexibility in the structure and  
5 organization of an accountable health plan, including the  
6 flexibility to permit alternative structures for accountable  
7 health plans developed in rural areas of the state in response  
8 to the needs, preferences, and conditions of rural  
9 communities. Such plans shall utilize, to the greatest extent  
10 possible, existing health care providers and hospitals.

11    2. Rules adopted pursuant to this section shall include,  
12 at a minimum, all of the following:

13    a. Procedures for licensing accountable health plans as  
14 provided in section 514J.3.

15    b. Procedures to sanction cooperative arrangements  
16 involving health care providers or purchasers in forming an  
17 accountable health plan, upon a finding by the commissioner  
18 that the arrangement will improve quality, access, or  
19 affordability of health care, but which arrangement might be a  
20 violation of antitrust laws if undertaken without government  
21 direction and approval.

22    c. Procedures to assure ongoing supervision of  
23 arrangements sanctioned under paragraph "b" in order to assure  
24 that the arrangements do in fact improve the quality, access,  
25 or affordability of health care. The sanctioning of any  
26 arrangement by the commissioner may be withdrawn on a  
27 prospective basis at the discretion of the commissioner if  
28 necessary to enforce the intent to improve quality, access, or  
29 affordability.

30    d. Standards applicable to the plan of operation of an  
31 accountable health plan and which must be met for licensure of  
32 the plan. Such standards shall include standards related to  
33 the quality of health care provided.

34    e. A requirement that a plan of operation include  
35 guaranteed access and rating practices no more restrictive

1 than those required in the applicable state-regulated  
2 insurance market segment.

3 f. Procedures to collect information, directly or by other  
4 means as determined by the division, from the accountable  
5 health plan for purposes of monitoring quality, cost, and  
6 access standards. The division may access data collected  
7 through the community health management information system for  
8 purposes of implementing this chapter at a cost not to exceed  
9 the actual costs of reproducing the information for the  
10 division.

11 g. A method or methods to facilitate and encourage the  
12 appropriate provision of services by midlevel health care  
13 practitioners and allied health care practitioners.

14 h. Procedures to assure that all health carriers,  
15 including health maintenance organizations, insurers, and  
16 nonprofit health service plan corporations are subject to the  
17 same rules, to the extent the health carrier is operating an  
18 accountable health plan or is a participating entity in an  
19 accountable health plan.

20 i. Solvency standards to assure an accountable health  
21 plan's ability to deliver required services. The division  
22 shall assess the costs of a solvency examination against the  
23 entity being examined in the same manner and on the same terms  
24 as provided for insurance companies under section 505.7.

25 j. Publication and dissemination of statewide and  
26 localized expenditure targets relevant to each accountable  
27 health plan, as appropriate.

28 k. Provide for the identification of essential community  
29 providers within the service area of each accountable health  
30 plan. "Essential community providers" means those health care  
31 providing organizations which the commissioner deems to be  
32 vital to a local health care delivery system to ensure that  
33 all citizens of this state have reasonable access to health  
34 care. Accountable health plans must establish working  
35 relationships with essential community providers and include

1 them within the plan's plan of operation in delivering health  
2 care within the plan's service area. This paragraph is  
3 repealed effective July 1, 1999.

4 1. Provisions for the identification of market areas to be  
5 serviced by each accountable health plan. Rules developed  
6 pursuant to this paragraph shall promote expansion of  
7 accountable health plans into all geographic areas of the  
8 state.

9 m. The commissioner shall make, or cause to be made,  
10 inspections as it deems necessary in order to determine  
11 compliance with section 514J.1, this section, and sections  
12 514J.3 and 514J.4, and applicable rules.

13 3. This section and rules adopted pursuant to this section  
14 are intended to provide immunity from federal antitrust law  
15 under the state action doctrine exemption.

16 Sec. 32. NEW SECTION. 514J.3 LICENSING REQUIRED.

17 1. An accountable health plan shall not operate unless the  
18 plan is licensed by the division. The commissioner shall  
19 adopt rules as provided in section 514J.2 establishing a  
20 licensing procedure. A license shall not be issued by the  
21 division unless the commissioner finds that the accountable  
22 health plan satisfies, at a minimum, all of the following:

23 a. The ability to be responsible for the full continuum of  
24 required health care and related costs for the defined  
25 population that the accountable health plan will serve.

26 b. Financial solvency.

27 c. The ability to satisfy established standards related to  
28 the quality of care provided.

29 d. The ability to fully comply with the provisions of this  
30 section and all applicable rules.

31 2. The division shall establish by rule a reasonable  
32 filing fee to be submitted with a license application and each  
33 renewal application. A license shall be renewed annually. A  
34 license issued pursuant to this section expires on December 31  
35 of the calendar year for which the license was granted. Fees

1 received by the division shall be retained by the division to  
2 offset costs associated with the administration of this  
3 chapter.

4 3. An accountable health plan may be organized and  
5 licensed as a nonprofit or for-profit plan.

6 Sec. 33. NEW SECTION. 514J.4 DEFINITIONS.

7 For purposes of this chapter, unless the context otherwise  
8 requires:

9 1. "Hospital" means as defined in section 135B.1.

10 2. "Health care provider" or "provider" or "practitioner"  
11 means a person licensed or certified pursuant to chapter 147,  
12 148, 148A, 148C, 149, 150, 150A, 151, 152, 153, 154, 154B, or  
13 155A, to provide professional health care services in this  
14 state to an individual during the individual's medical care,  
15 treatment, or confinement.

16 Sec. 34. Section 614.8, Code 1993, is amended to read as  
17 follows:

18 614.8 MINORS AND MENTALLY ILL PERSONS.

19 1. The Except as provided in subsection 2, the times  
20 limited for actions herein, except those brought for penalties  
21 and forfeitures, shall-be are extended in favor of minors and  
22 mentally ill persons, so that they shall have one year from  
23 and after the termination of such the disability within which  
24 to commence said an action.

25 2. The times limited for actions brought for medical  
26 malpractice are extended in favor of minors up to the day of  
27 their sixth birthday so that they have until their eighth  
28 birthday to commence an action.

29 Sec. 35. RURAL PRIMARY CARE INITIATIVE -- PHYSICIAN  
30 RESPITE PROGRAM. The Iowa department of public health, in  
31 cooperation with the university of Iowa college of medicine  
32 and the university of osteopathic medicine and health  
33 sciences, shall develop and establish a rural primary care  
34 initiative. The rural primary care initiative shall, at a  
35 minimum, focus on the expansion of the family practice

1 residency program and the development of a physician respite  
2 program in the rural areas of Iowa. The department shall  
3 submit a written report to the general assembly no later than  
4 January 9, 1995, concerning the status of the development of  
5 the rural primary care initiative, and include any legislative  
6 recommendations necessary to complete implementation of the  
7 initiative.

8     Sec. 36. HEALTH INSURANCE COST DEDUCTION -- CONTINGENT  
9 EFFECT. Section 5 of this Act, which amends section 422.7 by  
10 adding a new subsection 29, is effective upon the enactment of  
11 a federal individual income tax provision authorizing the  
12 deduction in computing federal adjusted gross income of one  
13 hundred percent of the cost of the purchase of health  
14 insurance. Section 5 of this Act applies to tax years  
15 designated in the federal enactment of the health insurance  
16 cost deduction.

17     Sec. 37. MEDICAL CARE SAVINGS ACCOUNT CONTRIBUTIONS --  
18 CONTINGENT EFFECT. Section 6 of this Act, which amends  
19 section 422.7 by adding a new subsection 30, is effective upon  
20 the enactment of a federal individual income tax provision  
21 authorizing the deduction or exclusion in computing federal  
22 adjusted gross income of contributions made on behalf of the  
23 taxpayer to a medical care savings account. Section 6 of this  
24 Act applies to tax years designated in the federal enactment  
25 related to contributions to a medical care savings account.

26     Sec. 38. NOTICE OF EFFECTIVENESS. The director of revenue  
27 and finance shall notify the governor, the chairpersons and  
28 ranking members of the senate and house ways and means  
29 committees, the Iowa Code editor, and the legislative fiscal  
30 bureau when section 5 or section 6, which amend section 422.7,  
31 of this Act becomes effective.

32     Sec. 39. FINANCING STUDY -- ANNUAL REPORT TO GENERAL  
33 ASSEMBLY. It is the intent of the general assembly that  
34 health care coverage be obtained by all Iowans on a voluntary  
35 basis. If the state has not achieved a level of individuals

1 without health care coverage of less than three percent of  
2 total population through voluntary means, it is the intent of  
3 the general assembly that the state shall consider the  
4 imposition of a financing mechanism to provide guaranteed  
5 coverage to all citizens of this state. The division shall  
6 annually provide a written report to the governor and general  
7 assembly no later than the third Monday of each regular  
8 session of the general assembly indicating the percentage of  
9 individuals in this state who do not have any health care  
10 coverage, and summarizing progress toward the goal of three  
11 percent.

12       Sec. 40. ALTERNATIVE MEDICAL MALPRACTICE DISPUTE  
13 RESOLUTION PROCEDURES -- MEDICAL SCREENING PANELS -- STUDY.

14 The supreme court, in cooperation with the department of  
15 public health and the insurance division, shall initiate a  
16 study concerning the development and use of alternative  
17 medical malpractice dispute resolution procedures and medical  
18 screening panels. The study shall include, at a minimum, a  
19 review of existing alternative dispute resolution procedures  
20 and medical screening panels and provide for a comprehensive  
21 review of existing statutes and court decisions in an effort  
22 to maximize the benefits of alternative medical malpractice  
23 dispute resolution procedures that have been successful while  
24 assuring procedural protections and fair access to the court  
25 system. The study shall also include any recommendations on  
26 implementing alternative medical malpractice dispute  
27 resolution procedures and medical screening panels in the  
28 state along with a corresponding cost benefit analysis related  
29 to each recommendation.

30       Sec. 41. INSURANCE DIVISION STUDIES.

31       1. The insurance division shall review, develop, and  
32 submit a plan for the establishment of an individual health  
33 coverage reinsurance program. The division shall submit a  
34 written report to the general assembly no later than January  
35 9, 1995, including the division's plan.

1       2. The insurance division shall review, study, and make  
2 recommendations to the general assembly concerning the Iowa  
3 comprehensive health insurance association established under  
4 chapter 514E, with the intent to merge the Iowa comprehensive  
5 health insurance program with an individual health reinsurance  
6 program. The division shall submit a written report to the  
7 general assembly no later than January 9, 1995, including the  
8 division's findings and recommendations.

9       Sec. 42. TORT LIABILITY REFORM ACTUARIAL REVIEW.

10      1. The commissioner of insurance shall commence no later  
11 than July 1, 1994, an actuarial review of the projected impact  
12 of section 34 of this Act as it amends section 614.8 upon  
13 medical liability claim experience and reserve requirements.  
14 The commissioner shall order appropriate rate adjustments con-  
15 sistent with the actuarial review effective upon the next  
16 filing or renewal of policy rates by licensed carriers.

17      2. The commissioner shall submit a written report to the  
18 general assembly no later than the third Monday of the 1995  
19 regular session which reviews and summarizes the results of  
20 the actuarial study and any rate adjustments.

21      Sec. 43. RURAL HEALTH CARE DELIVERY MODELS. It is the  
22 intent of the general assembly that the department of  
23 inspections and appeals, through the hospital licensure board,  
24 in conjunction with the department of public health and other  
25 appropriate health care provider licensure boards, as  
26 identified by the departments, review the California  
27 alternative rural hospital model and the community  
28 hospital/rural primary care hospital demonstration project  
29 sponsored by the health care financing administration. The  
30 review shall include an examination of existing provider  
31 licensure statutes and administrative rules that inhibit or  
32 preclude implementation of either alternative rural health  
33 care delivery model and shall include specific legislative and  
34 regulatory strategy proposals for the removal of such  
35 identified barriers. This written report shall be delivered

1 by the department of inspections and appeals to the general  
2 assembly on or before January 1, 1995.

3 Sec. 44. APPLICABILITY. Notwithstanding the provisions of  
4 sections 513C.4 and 513C.5, chapter 513C, as enacted in this  
5 Act, is not applicable to an individual health benefit plan  
6 delivered or issued for delivery in this state or to a block  
7 of individual health benefit plan business until such time as  
8 rules implementing the chapter have been adopted by the  
9 insurance division pursuant to chapter 17A.

10 Sec. 45. EFFECTIVE DATE. Section 27 of this Act, which  
11 creates new section 513D.1, is effective January 1, 1995.

12

#### EXPLANATION

13 Section 8.6 is amended and authorizes the director of the  
14 department of management to establish a statewide health  
15 accounting system in coordination with the department of  
16 public health, the department of human services, the  
17 department of elder affairs, the department of employment  
18 services, and the insurance division of the department of  
19 commerce. The department of management is granted access to  
20 all information necessary from the community health management  
21 information system created in chapter 144C.

22 Sections 18.133 and 18.136 are amended to provide that  
23 hospitals licensed pursuant to chapter 135B, rural health  
24 clinics defined pursuant to 42 U.S.C. § 1395(x), and physician  
25 clinics are to be offered access to the Iowa communications  
26 network for diagnostic, clinical, consultative, data, and  
27 educational services for the purpose of developing a  
28 comprehensive, statewide telemedicine network.

29 Section 422.7 is amended to implement the tax credit for  
30 individual medical savings accounts. This bill allows the  
31 deduction of 100 percent of health insurance costs from  
32 adjusted gross income in computing state individual income tax  
33 and allows a deduction for amounts of contributions to a  
34 medical care savings account. In addition, the bill allows a  
35 deduction from adjusted gross income for the interest earned

1 on a medical care savings account to the extent not withdrawn.

2 Section 505.7 is amended to grant the insurance  
3 commissioner authority to assess a health insurance purchasing  
4 cooperative audit and examination costs.

5 Section 505.7 is also amended by adding a new subsection  
6 which provides that the commissioner may assess the costs of  
7 an audit or examination to a health insurance purchasing  
8 cooperative in the same manner as provided for insurance  
9 companies under sections 507.7 through 507.9.

10 Section 505.8 is amended to provide that the commissioner  
11 is given jurisdiction to supervise all health insurance  
12 purchasing cooperatives.

13 Section 509A.6, which relates to group insurance for public  
14 employees, is amended to provide that a governing body may  
15 enroll in and contract with a health insurance purchasing  
16 cooperative.

17 Section 509A.16 is amended to provide that the director of  
18 the department of management may approve expenditures of up to  
19 \$300,000 per fiscal year, from the surplus portion of the  
20 general fund portion of the employer share of the state group  
21 insurance reserves not needed to fund incentive programs, for  
22 the purposes of health reform activities. This section is  
23 repealed July 1, 1996.

24 Section 513B.2 is amended to provide that a small employer  
25 is a person who employs not less than two and not more than 50  
26 full-time employees. Currently, a small employer is defined  
27 as a person who employs not less than two and not more than 25  
28 full-time employees.

29 Section 513B.4 is amended to add a new subsection providing  
30 that the premium adjustment factors contained in subsection 1  
31 do not apply to a standard or basic health benefit plan.

32 Section 513B.4, subsection 2, is amended by striking  
33 language related to the case characteristics which may be used  
34 to adjust health insurance premiums for small groups and  
35 inserting language that case characteristics other than family

1 composition and group size are not to be used by a small  
2 employer carrier without the prior approval of the  
3 commissioner.

4 Section 513B.4 is amended to add a new subsection providing  
5 that the commissioner may by order reduce or eliminate allowed  
6 rating bonds as provided in subsection 1 of that section.

7 Section 513B.37 is amended to provide that the commissioner  
8 is to determine what benefits or direct pay requirements must  
9 be minimally included in a standard health benefit plan.

10 Section 513B.38 is amended to provide that the commissioner  
11 may extend standard benefits to include preventative care  
12 services and mental health and substance abuse treatment  
13 coverage.

14 New chapter 513C is created relating to individual health  
15 coverage. New section 513C.1 provides the title, the  
16 Individual Health Insurance Market Reform Act.

17 New section 513C.2 states the purpose of the chapter.

18 New section 513C.3 establishes the definitions of key terms  
19 used in the chapter.

20 New section 513C.4 provides that the chapter applies to an  
21 individual health benefit plan delivered or issued for  
22 delivery to residents in this state on or after July 1, 1994.

23 New section 513C.5 establishes restrictions relating to  
24 premium rates for individual health benefit plans. Among  
25 those factors, the carrier is not to apply gender or industry  
26 classification rating characteristics, and experience rating  
27 characteristics only apply when an individual who is obtaining  
28 health coverage does not currently have qualifying coverage,  
29 as defined in the chapter. Certain other restrictions apply  
30 relating to the transfer of an individual into and out of a  
31 block of business, and required disclosures relating to the  
32 coverage are enumerated.

33 New section 513C.6 relates to the renewal of an individual  
34 health benefit plan. Such plan is renewable at the option of  
35 the individual, except under certain enumerated circumstances.

1 The section also provides that a carrier that elects not to  
2 renew all of its individual health benefit plans in this state  
3 shall be prohibited from writing new individual health benefit  
4 plans in this state for a period of five years from the date  
5 of the notice required to be provided to the commissioner of  
6 such election.

7 New section 513C.7 provides that a carrier issuing  
8 individual health benefit plans must issue such plan to an  
9 individual applying for the plan except under certain defined  
10 circumstances.

11 New section 513C.8 provides that the commissioner is to  
12 adopt rules relating to the form and level of coverage of the  
13 basic and standard health benefit plan for the individual  
14 market.

15 New section 513C.9 establishes standards to assure fair  
16 marketing of individual basic and standard health benefit  
17 plans. Restrictions are also established relating to carrier  
18 and the agent concerning the marketing of such plans.

19 New section 513D.1 is created which establishes a  
20 requirement that an employer provide an employee access to  
21 group health insurance. The employer is not required to  
22 financially contribute toward such insurance. The insurance  
23 division is given enforcement authority with respect to this  
24 requirement, which includes monetary penalties necessary to  
25 cure the failure to offer access to group coverage, as well as  
26 charging enforcement costs to the offending employer.

27 New section 514C.8 is created which provides that a managed  
28 care health plan or indemnity plan with a limited provider  
29 network must provide patients direct access to providers  
30 licensed under chapter 148, 150, or 150A. The section does  
31 not apply if an employer offers employees a choice of health  
32 plans, either directly or indirectly through a health  
33 insurance purchasing cooperative, provided that the offered  
34 choices include at least one indemnity plan with unrestricted  
35 choice of provider, or at least one managed care health plan

1 or indemnity plan with a limited provider network which  
2 provides access as defined in this section.

3 New section 514I.1 is created which codifies a substantial  
4 portion of 1993 Iowa Acts, chapter 158, section 2, which  
5 directs the insurance commissioner to adopt rules and a  
6 licensing procedure for establishing a health insurance  
7 purchasing cooperative.

8 New chapter 514J is created and relates to establishing and  
9 licensing accountable health plans in this state.

10 New section 514J.1 is created which defines an accountable  
11 health plan as an entity which pays for and provides for the  
12 delivery of health services within a defined area, and is  
13 accountable to the public for the cost and quality of such  
14 services.

15 New section 514J.2 is created and directs the insurance  
16 division to adopt rules relating to the establishment,  
17 licensure, and regulation of accountable health plans. The  
18 rules are to allow flexibility in the structure of such plans  
19 to permit the development of alternative structures in rural  
20 areas of the state in response to the needs, preferences, and  
21 conditions of rural communities.

22 New section 514J.3 is created and establishes licensing  
23 requirements for accountable health plans.

24 New section 514J.4 defines terms used in chapter 514J.

25 Section 614.8 is amended to provide that a minor up to age  
26 six has until the minor's eighth birthday to bring an action  
27 for medical malpractice.

28 The bill directs the department of public health, in  
29 cooperation with the university of Iowa medical school and the  
30 university of osteopathic medicine and health sciences, to  
31 develop and establish a rural primary care initiative. The  
32 department is required to submit a written report to the  
33 general assembly no later than January 9, 1995, concerning the  
34 status of the development of the rural primary care  
35 initiative.

1 The bill provides that the tax deductions established in  
2 chapter 422 are effective on the date that similar federal  
3 legislation is enacted and made effective for federal  
4 individual income tax purposes.

5 The bill provides that it is the intent of the general  
6 assembly that health care coverage be obtained by all Iowans  
7 on a voluntary basis. The insurance division is directed to  
8 report annually on the percent of individuals in this state  
9 who do not have health care coverage.

10 The bill directs the supreme court, in cooperation with the  
11 department of health and the insurance division, to initiate a  
12 study concerning the development and use of alternative  
13 medical malpractice dispute resolution procedures and medical  
14 screening panels.

15 The bill directs the insurance division to review, develop,  
16 and submit a plan for the establishment of an individual  
17 health coverage reinsurance program. The division is also to  
18 review, study, and make recommendations concerning the Iowa  
19 comprehensive health insurance association established in  
20 chapter 514E.

21 The bill also includes provisions regarding a tort  
22 liability reform actuarial review and a rural health care  
23 delivery model study.

24 The bill provides that new section 513D.1 is effective  
25 January 1, 1995.

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