Sec. 2. RETROACTIVE APPLICABILITY. This Act, being deemed of immediate importance, takes effect upon enactment and is retroactively applicable to July 1, 1994.

Approved February 20, 1995

CHAPTER 5

INDIVIDUAL HEALTH INSURANCE MARKET REFORM - TAXATION

S.F. 84

AN ACT relating to individual health insurance and individual health benefit plan reforms, and establishing an income tax credit for certain individuals.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. Section 422.7, Code 1995, is amended by adding the following new subsection:

NEW SUBSECTION. 32. Subtract, to the extent not otherwise deducted in computing adjusted gross income, the amounts paid by the taxpayer for the purchase of health benefits coverage or insurance for the taxpayer or taxpayer's spouse or dependent.

Sec. 2. Section 422.9, subsection 2, Code 1995, is amended by adding the following new paragraph:

NEW PARAGRAPH. i. If the taxpayer has a deduction for medical care expenses under section 213 of the Internal Revenue Code, the taxpayer shall recompute for the purposes of this subsection the amount of the deduction under section 213 by excluding from medical care, as defined in section 213, the amount subtracted under section 422.7, subsection 32.

Sec. 3. NEW SECTION. 513C.1 SHORT TITLE.

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

Sec. 4. NEW SECTION. 513C.2 PURPOSE.

The purpose and intent of this chapter is to promote the availability of health insurance coverage to individuals regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding the renewal of coverage, to establish limitations on the use of preexisting condition exclusions, to assure fair access to health plans, and to improve the overall fairness and efficiency of the individual health insurance market.

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

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

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

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

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

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

5. "Carrier" means any entity that provides individual health benefit plans in this state. For purposes of this chapter, carrier includes an insurance company, a group hospital or medical service corporation, a fraternal benefit society, a health maintenance organization, and any other entity providing an individual plan of health insurance or health benefits subject to state insurance regulation. "Carrier" does not include an organized delivery system.

6. "Commissioner" means the commissioner of insurance.

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

8. "Eligible individual" means an individual who is a resident of this state and who either has qualifying existing coverage or has had qualifying existing coverage within the immediately preceding thirty days, or an individual who has had a qualifying event occur within the immediately preceding thirty days.

9. "Established service area" means a geographic area, as approved by the commissioner and based upon the carrier's certificate of authority to transact business in this state, within which the carrier is authorized to provide coverage or a geographic area, as approved by the director and based upon the organized delivery system's license to transact business in this state, within which the organized delivery system is authorized to provide coverage.

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

11. "Individual health benefit plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan, or health maintenance organization subscriber contract sold to an individual, or any discretionary group trust or association policy, whether issued within or outside of the state, providing hospital or medical expense incurred coverage to individuals residing within this state. Individual health benefit plan does not include a self-insured group health plan, a self-insured multiple employer group health plan, a group conversion plan, an insured group health plan, accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

12. "Organized delivery system" means an organized delivery system licensed by the director.

13. "Premium" means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier or an organized delivery system, including any fees or other contributions associated with an individual health benefit plan.

14. "Qualifying event" means any of the following:

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

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

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

15. "Qualifying existing coverage" or "qualifying previous coverage" means benefits or coverage provided under any of the following:

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

b. An individual health insurance benefit plan, including coverage provided under a health maintenance organization contract, a hospital or medical service plan contract, or a

fraternal benefit society contract, that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, provided that such policy has been in effect for a period of at least one year.

c. An organized delivery system that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, provided that the benefits provided by the organized delivery system have been in effect for a period of at least one year.

16. "Rating characteristics" means demographic characteristics of individuals which are considered by the carrier in the determination of premium rates for the individuals and which are approved by the commissioner.

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

18. "Restricted network provision" means a provision of an individual health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier or the organized delivery system to provide health care services to covered individuals.

Sec. 6. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

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

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

Sec. 7. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO PREMIUM RATES.

1. Premium rates for any block of individual health benefit plan business issued on or after January 1, 1996, or the date rules are adopted by the commissioner of insurance and the director of public health and become effective, whichever date is later, by a carrier subject to this chapter shall be limited to the composite effect of allocating costs among the following:

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

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

c. The filed rate for any block of business shall not exceed the filed rate for any other block of business by more than thirty percent due to any other factors approved by the commissioner.

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

e. An adjustment applied to a single block of business shall not exceed the adjustment applied to all blocks of business by more than fifteen percent due to the claim experience or health status of that block of business.

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

2. Notwithstanding subsection 1, the commissioner, with the concurrence of the board of the Iowa individual health benefit reinsurance association established in section 513C.10, may by order reduce or eliminate the allowed rating bands provided under subsection 1,

*Section 514B.5 probably intended

paragraphs "a", "b", "c", and "e", or otherwise limit or eliminate the use of experience rating. The commissioner shall also develop a recommendation for the elimination of age as a rating characteristic, and shall submit such recommendation by January 8, 1996.

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

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

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

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

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

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

d. Any provisions relating to any preexisting condition.

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

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

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

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

Sec. 8. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

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

a. Nonpayment of the required premiums.

b. Fraud or misrepresentation.

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

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

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

*Subsection 6 probably intended

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

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

Sec. 9. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

1. A carrier or an organized delivery system, as a condition of issuing individual health benefit plans in this state, shall make available a basic or standard health benefit plan to an eligible individual who applies for a plan and agrees to make the required premium payments and to satisfy other reasonable provisions of the basic or standard health benefit plan. A carrier or an organized delivery system is not required to issue a basic or standard health benefit plan to an individual who meets any of the following criteria:

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

b. An eligible individual who does not apply for a basic or standard health benefit plan within thirty days of a qualifying event or within thirty days upon becoming ineligible for qualifying existing coverage.

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

2. A carrier or an organized delivery system shall issue the basic or standard health benefit plan to an individual currently covered by an underwritten benefit plan issued by that carrier or an organized delivery system at the option of the individual. This option must be exercised within thirty days of notification of a premium rate increase applicable to the underwritten benefit plan.

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

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

b. An organized delivery system shall file with the director, in a form and manner prescribed by the director, the basic or standard health benefit plan to be used by the organized delivery system. A basic or standard health benefit plan filed pursuant to this paragraph may be used by the organized delivery system beginning thirty days after it is filed unless the director disapproves of its use.

The director may at any time, after providing notice and an opportunity for a hearing to the organized delivery system, disapprove the continued use by an organized delivery system of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

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

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

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

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

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

5. A carrier or an organized delivery system is not required to offer coverage or accept applications pursuant to subsection 1 from any individual not residing in the carrier's or the organized delivery system's established geographic access area.

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

Sec. 10. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN STANDARDS.

The commissioner shall adopt by rule the form and level of coverage of the basic health benefit plan and the standard health benefit plan for the individual market which shall provide benefits substantially similar to those as provided for under chapter 513B with respect to small group coverage, but which shall be appropriately adjusted to reflect the individual market.

Sec. 11. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR MARKETING.

1. A carrier or an organized delivery system issuing individual health benefit plans in this state shall make available the basic or standard health benefit plan to residents of this state. If a carrier or an organized delivery system denies other individual health benefit plan coverage to an eligible individual on the basis of the health status or claims experience of the eligible individual, or the individual's dependents, the carrier or the organized delivery system shall offer the individual the opportunity to purchase a basic or standard health benefit plan.

2. A carrier, or an organized delivery system, or an agent shall not do either of the following:

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

b. Encourage or direct individuals to seek coverage from another carrier or another organized delivery system because of the health status, claims experience, industry, occupation, or geographic location of the individuals.

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

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

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

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

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

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

Sec. 12. NEW SECTION. 513C.10 IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE ASSOCIATION.

1. A nonprofit corporation is established to be known as the Iowa individual health benefit reinsurance association. All persons that provide health benefit plans in this state including insurers providing accident and sickness insurance under chapter 509, 514, or 514A; fraternal benefit societies providing hospital, medical, or nursing benefits under chapter 512B; health maintenance organizations, organized delivery systems, and all other entities providing health insurance or health benefits subject to state insurance regulation shall be members of this association. The association shall be incorporated under chapter 504A, shall operate under a plan of operation established and approved pursuant to chapter 504A, and shall exercise its powers through a board of directors established under this section.

2. The initial board of directors of the association shall consist of seven members appointed by the commissioner as follows:

a. Four members shall be representatives of the four largest domestic carriers of individual health insurance in the state as of the calendar year ending December 31, 1994.

b. Three members shall be representatives of the three largest carriers of health insurance in the state, excluding Medicare supplement coverage premiums, which are not otherwise represented. In the event a carrier to be represented pursuant to this paragraph does not appoint a representative, the board member shall be a representative of the next largest carrier which satisfies the criteria.

After an initial term, board members shall be nominated and elected by the members of the association.

Members of the board may be reimbursed from the funds of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

3. The association shall submit to the commissioner a plan of operation for the association and any amendments to the association's articles of incorporation necessary and appropriate to assure the fair, reasonable, and equitable administration of the association. The plan shall provide for the sharing of losses related to basic and standard plans, if any, on an equitable and proportional basis among the members of the association. If the association fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, the commissioner shall adopt rules necessary to implement this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

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

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

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

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

e. Procedures for selecting the board of directors.

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

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

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

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

b. Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments for, on behalf of, or against members of the association or other participating persons.

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

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

6. Rates for basic and standard coverages as provided in this chapter shall be determined by each carrier or organized delivery system as the average of the lowest rate available for issuance by that carrier or organized delivery system adjusted for rating characteristics and benefits and the maximum rate allowable by law after adjustments for rate characteristics and benefits.

7. Following the close of each calendar year, the association, in conjunction with the commissioner, shall require each carrier or organized delivery system to report the amount of earned premiums and the associated paid losses for all basic and standard plans issued by the carrier or organized delivery system. The reporting of these amounts must be certified by an officer of the carrier or organized delivery system.

8. The board shall develop procedures and make assessments and distributions as required to equalize the individual carrier and organized delivery system gains or losses so that each carrier or organized delivery system receives the same ratio of paid claims to ninety percent of earned premiums as the aggregate of all basic and standard plans insured by all carriers and organized delivery systems in the state.

9. If the statewide aggregate ratio of paid claims to ninety percent of earned premiums is greater than one, the dollar difference between ninety percent of earned premiums and the paid claims shall represent an assessable loss.

10. The assessable loss plus necessary operating expenses for the association, plus any additional expenses as provided by law, shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year, or on any other equitable basis as provided in the plan of operation. In sharing losses, the association may abate or defer any part of the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against the members of the association to meet the operating expenses of the association until the next calendar year is completed.

11. The board shall develop procedures for distributing the assessable loss assessments to each carrier and organized delivery system in proportion to the carrier's and organized delivery system's respective share of premium for basic and standard plans to the statewide total premium for all basic and standard plans.

12. The board shall ensure that procedures for collecting and distributing assessments are as efficient as possible for carriers and organized delivery systems. The board may establish procedures which combine, or offset, the assessment from, and the distribution due to, a carrier or organized delivery system.

13. A carrier or an organized delivery system may petition the association board to seek remedy from writing a significantly disproportionate share of basic and standard policies in relation to total premiums written in this state for health benefit plans. Upon a finding that a carrier or organized delivery system has written a disproportionate share, the board may agree to compensate the carrier or organized delivery system either by paying to the carrier or organized delivery system an additional fee not to exceed two percent of earned premiums from basic and standard policies for that carrier or organized delivery system or by petitioning the commissioner or director, as appropriate for remedy.

14. a. The commissioner, upon a finding that the acceptance of the offer of basic and standard coverage by individuals pursuant to this chapter would place the carrier in a financially impaired condition, shall not require the carrier to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.

b. The director, upon a finding that the acceptance of the offer of basic and standard coverage by individuals pursuant to this chapter would place the organized delivery system in a financially impaired condition, shall not required* the organized delivery system to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.

Sec. 13. NEW SECTION. 513C.11 SELF-FUNDED EMPLOYER-SPONSORED HEALTH BENEFIT PLAN PARTICIPATION IN IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE ASSOCIATION.

1. A self-funded employer-sponsored health benefit plan qualified under the federal Employee Retirement Income Security Act of 1974 may voluntarily elect to participate in the Iowa individual health benefit reinsurance association established in section 513C.10 in accordance with the plan of operation and subject to such terms and conditions adopted by the board of the association to provide portability and continuity to its covered employees and their covered spouses and dependents subject to the same terms and conditions as a participating insurer.

2. If the federal Employee Retirement Income Security Act of 1974 is amended such that the state may require the participation of a self-funded employer, the individual reinsurance requirements shall apply equally to such employers.

3. When and if the federal government imposes conditions of portability and continuity on self-funded employers qualified under the federal Employee Retirement Income Security Act of 1974 that the commissioner deems are substantially similar to those required of Iowa insurers, coverage under such qualified plan shall be deemed qualified prior coverage for purposes of chapters 513B and 513C.

Sec. 14. EFFECTIVE DATE. Sections 1 and 2 of this Act, which amend section 422.7 by adding a new subsection 32, and section 422.9, subsection 2, by adding a new paragraph "i", are effective January 1, 1996, for tax years beginning on or after that date.

Approved March 2, 1995

*According to enrolled Act