CHAPTER 1167

SMALL GROUP HEALTH BENEFIT PLANS

H.F. 2370

AN ACT relating to health insurance availability to employees of small employers and providing for certain assessments.

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

Section 1. Section 513B.2, Code Supplement 1991, is amended by adding the following new subsections:

NEW SUBSECTION. 2A. "Basic health benefit plan" means a plan which is offered pursuant to section 513B.7E.

NEW SUBSECTION. 7A. "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, or substitute basis.

NEW SUBSECTION. 9A. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided the initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if any of the following apply:

a. The individual meets all of the following:

(1) The individual was covered under qualifying previous coverage at the time of the initial enrollment.

(2) The individual lost coverage under qualifying previous coverage as a result of termination of the individual's employment or eligibility, the involuntary termination of the qualifying previous coverage, death of the individual's spouse, or the individual's divorce.

(3) The individual requests enrollment within thirty days after termination of the qualifying previous coverage.

b. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

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

NEW SUBSECTION. 10A. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under any of the following:

a. Medicaid pursuant to Title XIX of the Social Security Act, medicare pursuant to Title XVIII of the Social Security Act, or coverage pursuant to the person's service as a member of a branch of the armed forces of the United States.

b. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a basic health benefit plan.

c. An individual health insurance policy or contract issued by a carrier which provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided the policy or contract has been in effect for a period of at least one year.

NEW SUBSECTION. 14. "Standard health benefit plan" means a plan which is offered pursuant to section 513B.7E.

Sec. 2. Section 513B.3, Code Supplement 1991, is amended by striking the section and inserting in lieu thereof the following:

513B.3 APPLICABILITY AND SCOPE.

This chapter applies to a health benefit plan providing coverage to the employees of a small employer in this state if any of the following apply:

1. Any portion of the premium or benefits is paid by or on behalf of the small employer.

2. An eligible employee or dependent is reimbursed in any manner by or on behalf of the small employer for any portion of the premium or benefits.

3. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code as defined in section 422.3.

4. a. Except as provided in paragraph "b", 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 health benefit plans delivered or issued for delivery to small employers in this state by such carriers were issued by one carrier.

b. An affiliated carrier which is a health maintenance organization possessing a certificate of authority issued pursuant to chapter 514B shall be considered to be a separate carrier for the purposes of this chapter.

c. Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if the arrangements would result in less than fifty percent of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier.

Sec. 3. Section 513B.4, subsection 1, paragraph c, subparagraph (1), Code Supplement 1991, is amended to read as follows:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new insureds who are small employers.

Sec. 4. Section 513B.4, subsection 1, paragraph d, Code Supplement 1991, is amended to read as follows:

d. In the case of health benefit plans issued prior to July 1, 1991, a premium rate for a rating period may exceed the ranges described in subsection 1, paragraph "a" or "b" ~~of this section~~, for a period of ~~five~~ three years following July 1, ~~1991~~ 1992. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new insureds who are small employers.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

Sec. 5. Section 513B.4, subsection 1, paragraph e, Code Supplement 1991, is amended by striking the paragraph and inserting in lieu thereof the following:

e. Any adjustment in rates for claims experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

Sec. 6. Section 513B.4, subsection 2, Code Supplement 1991, is amended by adding the following new unnumbered paragraphs:

NEW UNNUMBERED PARAGRAPH. For purposes of this subsection, case characteristics may include industry classification, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent. However, case characteristics other than age, industry classification, geographic area, family composition, and group size shall not be used by a small employer carrier without the prior approval of the commissioner. Gender may be used by a small employer carrier as a case characteristic provided the insurance division has conducted an independent actuarial study that determined the use of gender to be actuarially justified and, therefore, an allowed case characteristic. The study shall be based upon Iowa data to the extent the data is statistically valid or actuarially sound. The commissioner may assess the cost of the study to health insurance carriers admitted to this state pursuant to the procedures established for the assessment of fees and charges against certain insurers under section 507D.4. The commissioner, upon receipt of the findings of the study, shall adopt rules prohibiting or permitting the use of gender as an allowed case characteristic as determined by the study.

NEW UNNUMBERED PARAGRAPH. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

Sec. 7. Section 513B.4, Code Supplement 1991, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. For purposes of this section, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

Sec. 8. Section 513B.5, subsection 1, Code Supplement 1991, is amended by adding the following new paragraphs:

NEW PARAGRAPH. f. Repeated misuse of a provider network provision.

NEW PARAGRAPH. g. The commissioner finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's ability to meet its contractual obligations. If nonrenewal occurs as a result of findings pursuant to this paragraph, the commissioner shall assist affected small employers in finding replacement coverage.

Sec. 9. Section 513B.5, subsection 2, unnumbered paragraph 1, Code Supplement 1991, is amended to read as follows:

A small employer carrier may cease to renew all plans under a class of business, or all classes of business in a defined geographic region if the carrier is a health maintenance organization. The small employer carrier shall provide notice at least ~~ninety~~ one hundred eighty days prior to termination of coverage to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside. A small employer carrier which exercises its right to cease to renew all plans in a class of business shall not do either or both of the following:

Sec. 10. Section 513B.6, subsection 3, Code Supplement 1991, is amended by striking the subsection and inserting in lieu thereof the following:

3. The provisions relating to any preexisting condition provision.

Sec. 11. NEW SECTION. 513B.7A AVAILABILITY OF COVERAGE.

1. a. A small employer carrier, as a condition of transacting business in this state with small employers, shall actively offer to small employers at least two health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan.

b. (1) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to an eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter.

(2) A small employer carrier establishing more than one class of business shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer provided all of the following apply:

(a) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan.

(b) The criteria are not related to the health status or claims experience of the small employer.

(c) The criteria are applied consistently to all small employers applying for coverage in the class of business.

(d) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subparagraph do not apply to a class of business into which the small employer carrier is no longer enrolling new insureds who are small employers.

(3) For purposes of this lettered paragraph, a small employer is eligible if it employed at least two or more eligible employees within this state on at least fifty percent of its days of operation during the preceding calendar quarter. The provisions of this lettered paragraph shall be effective one hundred eighty days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan.

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

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

3. A health benefit plan providing coverage for small employers shall satisfy all of the following:

a. The 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 health benefit plan shall not define a preexisting condition more restrictively than the following:

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

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

b. The plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such service, provided that the qualifying previous coverage was continuous to a date not less than thirty days prior to the effective date of the new coverage. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

c. The plan may exclude coverage for late enrollees for the greater of eighteen months or an eighteen-month preexisting condition period, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.

d. (1) Except as provided in subparagraph (3), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) Except as provided in this subparagraph, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met under the applicable minimum participation requirements. However, with respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer when applying minimum participation requirements.

(4) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage. For any plan issued prior to July 1, 1992, a carrier may, upon approval of the commissioner, increase a minimum employee participation requirement or a minimum employer contribution requirement consistent with chapter 509.

e. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of the small employer and the employees' dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except as permitted with regard to late enrollees.

(2) A small employer carrier shall not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee 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.

4. a. A small employer carrier shall not be required to offer coverage or accept applications pursuant to this section where any of the following apply:

(1) To a small employer, where the small employer is not physically located in the carrier's established geographic service area.

(2) To an employee, when the employee does not work or reside within the carrier's established geographic service area.

(3) Within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within the carrier's established geographic service area to deliver service adequately to the members of such groups because of the carrier's obligations to existing group policyholders and enrollees.

b. A small employer carrier not required to offer coverage or accept applications pursuant to paragraph "a", subparagraph (3), shall not offer coverage in the applicable area to new employer groups with more than twenty-five eligible employees or to any small employer groups until the later of one hundred eighty days following such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

5. A small employer carrier shall not be required to offer coverage to small employers pursuant to subsection 1 for any period of time where the commissioner determines that the acceptance of the offers by small employers in accordance with subsection 1 would place the small employer carrier in a financially impaired condition.

Sec. 12. NEW SECTION. 513B.7B NOTICE OF INTENT TO OPERATE AS A RISK-ASSUMING CARRIER OR REINSURING CARRIER.

1. a. A small employer carrier authorized to transact the business of insurance in this state shall notify the commissioner at the time of authorization of the carrier's intention to operate

as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to section 513B.7C.

b. The notification of the commissioner concerning the carrier's intention pursuant to paragraph "a" is binding for a five-year period from the date notification is given, except that the initial notification given by carriers after the effective date of this Act is binding for a two-year period. The commissioner may permit a carrier to modify the carrier's decision at any time for good cause.

c. The commissioner shall establish an application process for small employer carriers seeking to change their status pursuant to this subsection.

2. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. The carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

Sec. 13. NEW SECTION. 513B.7C APPLICATION TO BECOME A RISK-ASSUMING CARRIER.

1. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

2. In evaluating an application made pursuant to this section, the commissioner shall consider the following factors:

a. The carrier's financial condition.

b. The carrier's history of rating and underwriting small employer groups.

c. The carrier's commitment to market fairly to all small employers in the state or the carrier's established geographic service area, as applicable.

d. The carrier's experience with managing the risk of small employer groups.

3. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety days of the receipt of the application by the commissioner, the carrier may request a hearing.

4. The commissioner may rescind the approval granted to a risk-assuming carrier under this section if the commissioner finds any of the following:

a. The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with section 513B.7A without the protection provided by the program.

b. The carrier has failed to market fairly to all small employers in the state or the carrier's established geographic service area, as applicable.

c. The carrier has failed to provide coverage to eligible small employers as required under section 513B.7A.

5. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of section 513B.7D.

Sec. 14. NEW SECTION. 513B.7D SMALL EMPLOYER CARRIER REINSURANCE PROGRAM.

1. A nonprofit corporation is established to be known as the Iowa small employer health reinsurance program.

2. A reinsuring carrier is subject to this program.

3. a. The program shall operate subject to the supervision and control of a board. Subject to the provisions of paragraph "b", the board shall consist of nine members appointed by the commissioner, and the commissioner or the commissioner's designee, who shall serve as an ex officio member and as chairperson of the board.

b. In appointing the members of the board, the commissioner shall include representatives of small employers and small employer carriers and such other individuals as determined to

be qualified by the commissioner. At least five of the members of the board shall be representatives of reinsuring carriers and shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines provided by rule of the commissioner.

c. The initial board members shall be appointed as follows:

(1) Three members shall be appointed for a term of two years.

(2) Three members shall be appointed for a term of four years.

(3) Three members shall be appointed for a term of six years.

d. Subsequent members shall be appointed for terms of three years. A board member's term shall continue until the member's successor is appointed.

e. A vacancy in the board shall be filled by the commissioner for the remainder of the term. A member of the board may be removed by the commissioner for cause.

4. The board, within one hundred eighty days after the initial appointments, shall submit a plan of operation to the commissioner. The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines that the plan is suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains and losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval of the commissioner. After the initial plan of operation is submitted and approved by the commissioner, the board may submit to the commissioner any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program.

5. If the board fails to submit a plan of operation within one hundred eighty days after the board's appointment, the commissioner, after notice and hearing, shall establish and adopt a temporary plan of operation. The commissioner shall amend or rescind a plan adopted pursuant to this subsection at the time a plan is submitted by the board and approved by the commissioner.

6. The plan of operation shall do all of the following:

a. Establish procedures for the handling and accounting of program assets and moneys, and for an annual fiscal reporting to the commissioner.

b. Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier.

c. Establish procedures for reinsuring risks in accordance with the provisions of this section.

d. Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program.

e. Provide for any additional matters necessary to implement and administer the program.

7. The same general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business in this state may be exercised by the board under the program, except the power to issue health benefit plans directly to either groups or individuals. Additionally, the board is granted the specific authority to do all or any of the following:

a. Enter into contracts as necessary or proper to administer the provisions and purposes of this chapter, including the authority, with the approval of the commissioner, to enter into contracts with similar programs in other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

b. Sue or be sued, including taking any legal action necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers.

c. Take any legal action necessary to avoid the payment of improper claims made against the program.

d. Define the health benefit plans for which reinsurance will be provided, and issue reinsurance policies, pursuant to this chapter.

e. Establish rules, conditions, and procedures for reinsuring risks under the program.

f. Establish and implement actuarial functions as appropriate for the operation of the program.

g. Assess reinsuring carriers in accordance with the provisions of subsection 11, and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

h. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program.

i. Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

8. A reinsuring carrier may reinsure with the program as provided in this section.

a. With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

b. A small employer carrier may reinsure an entire employer group within sixty days of the commencement of the group's coverage under a health benefit plan.

c. A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty days following the commencement of the coverage with the small employer. A newly eligible employee or dependent of a reinsured small employer may be reinsured within sixty days of the commencement of such person's coverage.

d. (1) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the small employer carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for ten percent of the next fifty thousand dollars of incurred claims during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subparagraph shall not exceed a maximum limit of ten thousand dollars in any one calendar year with respect to any reinsured individual.

(2) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the small employer carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "consumer price index for all urban consumers" of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

e. A small employer carrier may terminate reinsurance for one or more of the reinsured employees or dependents of small employer on any plan anniversary date.

f. Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. § 300c(c)(2)(A), and is thereby subject to requirements that limit the amount of risk that may be ceded to the program that are more restrictive than those specified in paragraph "d", shall be reduced to reflect that portion of the risk above the amount set forth in paragraph "d" that may not be ceded to the program, if any.

9. a. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in paragraph "b" to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan.

b. Premiums for the program shall be as follows:

(1) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection.

(2) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection.

c. The board periodically shall review the methodology established under paragraph "a", including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

10. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 513B.4.

11. a. Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

b. Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(1) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on both of the following:

(a) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(b) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during such calendar year to small employers in this state by reinsuring carriers.

(2) The formula established pursuant to subparagraph (1) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(3) The board, with approval of the commissioner, may change the assessment formula established pursuant to subparagraph (1) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period.

(4) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. § 300 et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(5) Premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

c. (1) Prior to March 1 of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(2) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph (3), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include: an estimate of future assessments, the administrative costs of the program, the

appropriateness of the premiums charged, and the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file the report with the commissioner within ninety days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(3) For any calendar year, the amount specified in this subparagraph is five percent of total premiums earned in the previous year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(4) If assessments in each of two consecutive calendar years exceed by ten percent the amount specified in subparagraph (3), the commissioner may relieve carriers from any or all of the regulations of this chapter or take such other actions as the commissioner deems equitable and necessary to spread the risk of loss and assure portability of coverages and continuity of benefits so as to reduce assessments to ten percent or less of that amount specified in subparagraph (3).

d. If assessments exceed net losses of the program, the excess shall be held in an interest-bearing account and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

e. Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

f. The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

g. A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving such deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the program until such time as it pays such assessments.

12. The participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, or any other joint or collective action required by this chapter shall not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

13. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration all of the following:

a. The need to assure the broad availability of coverages.

b. The objectives of the program.

c. The time and effort expended in placing the coverage.

d. The need to provide ongoing service to the small employer.

e. The levels of compensation currently used in the industry.

f. The overall costs of coverage to small employers selecting these plans.

14. The program is exempt from any and all state or local taxes.

Sec. 15. NEW SECTION. 513B.7E HEALTH BENEFIT PLAN STANDARDS.

1. The commissioner shall adopt by rule the form and level of coverage of the basic health benefit plan and the standard health benefit plan to be made available by a small employer carrier pursuant to section 513B.7A. The commissioner's rules shall include the benefit levels, cost sharing levels, exclusions, and limitations for the basic health benefit plan and the

standard health benefit plan, and shall define for purposes of this chapter, a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

2. The commissioner's rules may include cost containment features such as the following:

a. Utilization review of health care services, including review of medical necessity of hospital and physician services.

b. Case management.

c. Selective contracting with hospitals, physicians, and other health care providers.

d. Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions.

e. Other managed care provisions.

Sec. 16. NEW SECTION. 513B.7F PERIODIC MARKET EVALUATION.

The board shall study and report at least every three years to the commissioner on the effectiveness of this chapter. The report shall analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this chapter. The report may contain recommendations for market conduct or other regulatory standards or action.

Sec. 17. NEW SECTION. 513B.7G APPLICABILITY OF CERTAIN STATE LAWS.

The provisions of chapter 514H shall not apply to basic health benefit plans and standard health benefit plans as provided for in this chapter, except for section 514H.8.

Sec. 18. Section 513B.8, Code Supplement 1991, is amended to read as follows:

513B.8 DISCRETION OF THE COMMISSIONER.

1. The commissioner may suspend all or any part of section 513B.4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

2. The commissioner may suspend or modify the normal work week requirement of thirty or more hours under the definition of eligible employee upon a finding by the commissioner that the suspension would enhance the availability of health insurance to employees of small employers.

3. The commissioner may adopt, by rule or order, transition provisions to facilitate the orderly and coordinated implementation of this Act.

Approved April 28, 1992