376.2 may, by resolution adopted by the council and filed in the office of city clerk on or before August 20, 1997, choose to change the term of mayor as follows:

1. An office of mayor scheduled to be filled at the regular city election in November 1997, shall be for a two-year term, beginning in January 1998, and the office shall next be filled at the regular city election in November 1999, and every four years thereafter.

2. An office of mayor on the ballot in the regular city election in November 1995 and scheduled to be filled at the regular city election in November 1999, shall be for a two-year term, beginning in January 2000, and the office shall next be filled at the regular city election in November 2001, and every four years thereafter.

Sec. 2. EFFECTIVE DATE. This Act, being deemed of immediate importance, takes effect upon enactment.

Approved May 1, 1997

CHAPTER 103

HEALTH CARE COVERAGE — PORTABILITY AND CONTINUITY

H.F. 701

AN ACT relating to the requirements for portability and continuity of health care coverage for individuals among certain types of health care coverage, and related matters.

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

Section 1. Section 509.3, Code 1997, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. In addition to the provisions required in subsections 1 through 8, the commissioner shall require provisions through the adoption of rules implementing the federal Health Insurance Portability and Accountability Act, Pub. L. No. 104-191.

Sec. 2. Section 513B.2, subsection 1, Code 1997, is amended to read as follows:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 513B.4, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier in establishing premium rates for applicable health ~~benefit plans~~ insurance coverages.

Sec. 3. Section 513B.2, subsection 4, Code 1997, is amended by striking the subsection and inserting in lieu thereof the following:

4. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

Sec. 4. Section 513B.2, subsection 6, paragraph a, Code 1997, is amended to read as follows:

a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health ~~benefit plans~~ insurance coverages meet one or more of the following requirements:

(1) The ~~plans~~ coverages are marketed and sold through individuals and organizations which are not participating in the marketing or sales of other distinct groupings of small employers for the small employer carrier.

(2) The ~~plans~~ coverages have been acquired from another small employer carrier as a distinct grouping of plans.

(3) The ~~plans~~ coverages are provided through an association with membership of not less than fifty small employers which has been formed for purposes other than obtaining insurance.

Sec. 5. Section 513B.2, subsection 9, Code 1997, is amended to read as follows:

9. "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~~ health insurance coverage of a small employer, but does not include an employee who works on a part-time, temporary, or substitute basis.

Sec. 6. Section 513B.2, subsection 10, Code 1997, is amended by striking the subsection and inserting in lieu thereof the following:

10. a. "Health insurance coverage" means benefits consisting of health care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

b. "Health insurance coverage" does not include any of the following:

(1) Coverage for accident-only, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical-payment insurance.

(6) Credit-only insurance.

(7) Coverage for on-site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

(1) Limited scope dental or vision benefits.

(2) Benefits for long-term care, nursing home care, home health care, or community-based care.

(3) Any other similar limited benefits as provided by rule of the commissioner.

d. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

e. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under § 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided to coverage under group health insurance coverage.

f. "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan.

Sec. 7. Section 513B.2, subsection 12, paragraphs a, b, and c, Code 1997, are amended to read as follows:

a. The individual meets all of the following:

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

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

b. The individual is employed by an employer that offers multiple health ~~benefit plans~~ insurance coverages and the individual elects a different ~~plan~~ coverage 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~~ insurance coverage and the request for enrollment is made within thirty days after issuance of the court order.

Sec. 8. Section 513B.2, subsection 12, Code 1997, is amended by adding the following new paragraphs:

NEW PARAGRAPH. d. The individual changes status and becomes an eligible employee and requests enrollment within sixty-three days after the date of the change in status.

NEW PARAGRAPH. e. The individual was covered under a mandated continuation of group health plan or group health insurance coverage plan until the coverage under that plan was exhausted.

Sec. 9. Section 513B.2, subsection 13, Code 1997, is amended to read as follows:

13. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health ~~benefit plans~~ insurance coverages with the same or similar coverage.

Sec. 10. Section 513B.2, Code 1997, is amended by adding the following new subsections:

NEW SUBSECTION. 7A. "Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.

d. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.

e. 10 U.S.C. ch. 55.

f. A health or medical care program provided through the Indian health service or a tribal organization.

g. A state health benefits risk pool.

h. A health plan offered under 5 U.S.C. ch. 89.

i. A public health plan as defined under federal regulations.

j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. § 2504(e).

k. An organized delivery system licensed by the director of public health.

NEW SUBSECTION. 9A. a. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

b. For purposes of this subsection, "medical care" means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in subparagraph (1).

(3) Insurance covering medical care referred to in subparagraph (1) or (2).

c. For purposes of this subsection, a partnership which establishes and maintains a plan, fund, or program to provide medical care to present or former partners in the partnership or to their dependents directly or through insurance, reimbursement, or other method, which would not be an employee benefit welfare plan but for this paragraph, shall be treated as an employee benefit welfare plan which is a group health plan.

(1) For purposes of a group health plan, an employer includes the partnership in relation to any partner.

(2) For purposes of a group health plan, the term "participant" also includes both of the following:

(a) An individual who is a partner in relation to a partnership which maintains a group health plan.

(b) An individual who is a self-employed individual in connection with a group health plan maintained by the self-employed individual where one or more employees are participants, if the individual is or may become eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive a benefit.

NEW SUBSECTION. 13A. "Preexisting conditions exclusion" means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Sec. 11. Section 513B.2, subsection 14, Code 1997, is amended by striking the subsection.

Sec. 12. Section 513B.3, subsection 3, Code 1997, is amended to read as follows:

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

Sec. 13. Section 513B.3, subsection 4, paragraphs a and c, Code 1997, are amended to read as follows:

a. Except as provided in paragraph "b", for purposes of this subchapter, 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 subchapter shall apply as if all health ~~benefit plans~~ insurance coverages delivered or issued for delivery to small employers in this state by such carriers were issued by one carrier.

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~~ insurance coverages 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~~ insurance coverages being retained by the ceding carrier.

Sec. 14. Section 513B.4, subsection 1, paragraph c, subparagraph (1), Code 1997, 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~~ insurance coverage into which the small employer carrier is actively enrolling new insureds who are small employers.

Sec. 15. Section 513B.4, subsection 1, paragraph d, Code 1997, is amended to read as follows:

d. In the case of health ~~benefit plans~~ insurance coverages 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", for a period of three years following July 1, 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~~ insurance coverage 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. 16. Section 513B.4, subsection 3, unnumbered paragraph 3, Code 1997, is amended to read as follows:

Rating factors shall produce premiums for identical groups which differ only by amounts attributable to ~~plan~~ coverage 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~~ insurance coverages issued or renewed in the same calendar month as having the same rating period.

Sec. 17. Section 513B.4, subsection 4, Code 1997, is amended to read as follows:

4. For purposes of this section, a health ~~benefit plan~~ insurance coverage that contains a restricted network provision shall not be considered similar coverage to a health ~~benefit plan~~ insurance coverage that does not contain such a provision, if the restriction of benefits to network providers results in substantial differences in claims costs.

Sec. 18. Section 513B.4A, Code 1997, is amended to read as follows:

513B.4A EXEMPTION FROM PREMIUM RATE RESTRICTIONS.

A Taft-Hartley trust or a carrier with the written authorization of such a trust may make a written request to the commissioner for an exemption from the application of any provisions of section 513B.4 with respect to ~~a health benefit plan~~ health insurance coverage provided to such a trust. The commissioner may grant an exemption if the commissioner finds that application of section 513B.4 with respect to the trust would have a substantial adverse effect on the participants and beneficiaries of such trust, and would require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained. An exemption granted under this section shall not apply to an individual if the individual participates in a trust as an associate member of an employee organization.

Sec. 19. Section 513B.5, Code 1997, is amended by striking the section and inserting in lieu thereof the following:

513B.5 PROVISIONS ON RENEWABILITY OF COVERAGE.

1. Health insurance coverage subject to this chapter is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except for one or more of the following reasons:

a. The health insurance coverage sponsor fails to pay, or to make timely payment of, premiums or contributions pursuant to the terms of the health insurance coverage.

b. The health insurance coverage sponsor performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's or organized delivery system's minimum participation requirements.

d. Noncompliance with the carrier's or organized delivery system's employer contribution requirements.

e. A decision by the carrier or organized delivery system to discontinue offering a particular type of health insurance coverage in the state's small employer market. Health insurance coverage may be discontinued by the carrier or organized delivery system in that market only if the carrier or organized delivery system does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner or director of public health. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provides notice of its decision not to renew such plan to all affected small employers, participants, and beneficiaries no less than ninety days prior to the nonrenewal of the plan.

(3) Offers to each plan sponsor of the discontinued coverage, the option to purchase any other coverage currently offered by the carrier or organized delivery system to other employers in this state.

(4) Acts uniformly, in opting to discontinue the coverage and in offering the option under subparagraph (3), without regard to the claims experience of the sponsors under the discontinued coverage or to a health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

f. A decision by the carrier or organized delivery system to discontinue offering and to cease to renew all of its health insurance coverage delivered or issued for delivery to small employers in this state. A carrier or organized delivery system making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such coverage to the commissioner or director of public health. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provide notice of its decision not to renew such coverage to all affected small employers, participants, and beneficiaries no less than one hundred eighty days prior to the nonrenewal of the coverage.

(3) Discontinue all health insurance coverage issued or delivered for issuance to small employers in this state and cease renewal of such coverage.

g. The membership of an employer in an association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage under this paragraph occurs uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner or director of public health 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 or organized delivery system's ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier or organized delivery system may modify the health insurance coverage for a product offered under group health insurance coverage in the small group market, for coverage that is available in such market other than only through one or more bona fide associations, if such modification is consistent with the laws of this state, and is effective on a uniform basis among group health insurance coverage with that product.

2. A carrier or organized delivery system that elects not to renew health insurance coverage under subsection 1, paragraph "f", shall not write any new business in the small employer market in this state for a period of five years after the date of notice to the commissioner or director of public health.

3. This section, with respect to a carrier or organized delivery system doing business in one established geographic service area of the state, applies only to such carrier's or organized delivery system's operations in that service area.

Sec. 20. Section 513B.6, unnumbered paragraph 1, Code 1997, is amended to read as follows:

A small employer carrier or organized delivery system shall make reasonable disclosure in solicitation and sales materials provided to small employers of all of the following:

Sec. 21. Section 513B.6, subsection 2, Code 1997, is amended to read as follows:

2. The provisions concerning the small employer carrier's or organized delivery system's right to change premium rates and factors, including case characteristics, which affect changes in premium rates.

Sec. 22. Section 513B.7, Code 1997, is amended to read as follows:

513B.7 MAINTENANCE OF RECORDS.

1. A small employer carrier or organized delivery system shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

2. A small employer carrier or organized delivery system shall file each March 1 with the commissioner or director an actuarial certification that the small employer carrier or organized delivery system is in compliance with this section and that the rating methods of the small employer carrier or organized delivery system are actuarially sound. A copy of the certification shall be retained by the small employer carrier or organized delivery system at its principal place of business.

3. A small employer carrier or organized delivery system shall make the information and documentation described in subsection 1 available to the commissioner or organized delivery system upon request. The information is not a public record or otherwise subject to disclosure under chapter 22, and is considered proprietary and trade secret information and is not subject to disclosure by the commissioner or director to persons outside of the division or department except as agreed to by the small employer carrier or organized delivery system or as ordered by a court of competent jurisdiction.

Sec. 23. NEW SECTION. 513B.9A ELIGIBILITY TO ENROLL.

A carrier or organized delivery system offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.
b. Medical condition, including both physical and mental conditions.
c. Claims experience.
d. Receipt of health care.
e. Medical history.
f. Genetic information.
g. Evidence of insurability, including conditions arising out of acts of domestic violence.
h. Disability.

2. Subsection 1 does not require group health insurance coverage to provide particular benefits other than those provided under the terms of the coverage, and does not prevent a coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

3. Rules for eligibility to enroll under group health insurance coverage include rules defining any applicable waiting periods for such enrollment.

4. a. A carrier or organized delivery system offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage.

b. Paragraph "a" shall not be construed to do either of the following:

(1) Restrict the amount that an employer may be charged for health insurance coverage.

(2) Prevent a carrier or organized delivery system offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Sec. 24. Section 513B.10, Code 1997, is amended by striking the section and inserting in lieu thereof the following:

513B.10 AVAILABILITY OF COVERAGE.

1. a. A carrier or an organized delivery system that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter. A carrier or organized delivery system shall offer health insurance coverage which constitutes a basic health benefit plan and which constitutes a standard health benefit plan.

b. A carrier or organized delivery system that offers health insurance coverage in the small group market through a network plan may do either of the following:

(1) Limit employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan.

(2) Deny such coverage to such employers within the service area of such plan if the carrier or organized delivery system has demonstrated to the applicable state authority, both of the following:

(a) The carrier or organized delivery system will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees.

(b) The carrier or organized delivery system is applying this subparagraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents, or any health status-related factor relating to such employees or dependents.

c. A carrier or organized delivery system, upon denying health insurance coverage in any service area pursuant to paragraph "b", subparagraph (2), shall not offer coverage in the small group market within such service area for a period of one hundred eighty days after the date such coverage is denied.

d. A carrier or organized delivery system may deny health insurance coverage in the small group market if the issuer has demonstrated to the commissioner or director of public health both of the following:

(1) The carrier or organized delivery system does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier or organized delivery system is applying the provisions of this subparagraph uniformly to all employers in the small group market in this state consistent with state law and without regard to the claims experience of those employers and the employees and dependents of such employers, or any health status-related factor relating to such employees and their dependents.

e. A carrier or organized delivery system, upon denying health insurance coverage pursuant to paragraph "d", shall not offer coverage in connection with health insurance coverages in the small group market in this state for a period of one hundred eighty days after the date such coverage is denied or until the carrier or organized delivery system has demonstrated to the commissioner or director of public health that the carrier or organized delivery system has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner or director may provide for the application of this paragraph on a service area-specific basis.

f. Paragraph "a" shall not be construed to preclude a carrier or organized delivery system from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in the small group market.

2. A carrier or organized delivery system, subject to subsection 1, shall issue health insurance coverage to an eligible small employer that applies for the coverage and agrees to make the required premium payments and satisfy the other reasonable provisions of the health insurance coverage not inconsistent with this chapter. A carrier or organized delivery system is not required to issue health insurance coverage to a self-employed individual who is covered by, or is eligible for coverage under, health insurance coverage offered by an employer.

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

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

4. Health insurance coverage for small employers shall satisfy all of the following:

a. A carrier or organized delivery system offering group health insurance coverage, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.

(2) The exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

b. A carrier or organized delivery system offering group health insurance coverage shall not impose any preexisting condition as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. A carrier or organized delivery system shall waive any waiting period applicable to a

preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this section, "affiliation period" means a period of time not to exceed sixty days for new entrants and not to exceed ninety days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors. This paragraph does not preclude application of a waiting period applicable to all new enrollees under the health insurance coverage, provided that any carrier or organized delivery system-imposed waiting period is no longer than sixty days and is used in lieu of a preexisting condition exclusion.

d. Health insurance coverage may exclude coverage for late enrollees for preexisting conditions for a period not to exceed eighteen months.

e. (1) Requirements used by a carrier or organized delivery system in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier or organized delivery system.

(2) In applying minimum participation requirements with respect to a small employer, a carrier or organized delivery system shall not consider employees or dependents who have other creditable coverage in determining whether the applicable percentage of participation is met.

(3) A carrier or organized delivery system shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

f. (1) If a carrier or organized delivery system offers coverage to a small employer, the carrier or organized delivery system shall offer coverage to all eligible employees of the small employer and the employees' dependents. A carrier or organized delivery system shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(2) Except as provided under paragraphs "a" and "d", a carrier or organized delivery system shall not modify health insurance coverage with respect to a small employer or any eligible employee or dependent through riders, endorsements, or other means, to restrict or exclude coverage or benefits for certain diseases, medical conditions, or services otherwise covered by the health insurance coverage.

g. A carrier or organized delivery system offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection 1 with respect to a small employer where any of the following apply:

(1) The small employer does not have eligible individuals who live, work, or reside in the service area for the network plan.

(2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier or organized delivery system, if required, has demonstrated to the commissioner or the director of public health that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying the requirements of this lettered paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and the employees' dependents, or any health status-related factor relating to such employees and dependents.

(3) A carrier or organized delivery system, upon denying health insurance coverage in a service area pursuant to subparagraph (2), shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the coverage is denied.

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

6. A carrier or organized delivery system shall not be required to provide coverage to small employers pursuant to subsection 1 if the carrier or organized delivery system elects not to offer new coverage to small employers in this state. However, a carrier or organized delivery system that elects not to offer new coverage to small employers under this subsection shall be allowed to maintain its existing policies in the state, subject to the requirements of section 513B.5.

7. A carrier or organized delivery system that elects not to offer new coverage to small employers pursuant to subsection 6 shall provide notice to the commissioner or director of public health and is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner or director.

Sec. 25. Section 513B.11, subsection 2, Code 1997, is amended to read as follows:

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~~ insurance coverage 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. 26. Section 513B.13, subsection 7, unnumbered paragraph 1, Code 1997, is amended to read as follows:

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~~ insurance coverages directly to either groups or individuals. Additionally, the board is granted the specific authority to do all or any of the following:

Sec. 27. Section 513B.13, subsection 7, paragraph d, Code 1997, is amended to read as follows:

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

Sec. 28. Section 513B.13, subsection 8, paragraph b, Code 1997, is amended to read as follows:

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~~ health insurance coverage.

Sec. 29. Section 513B.13, subsection 9, paragraph a, Code 1997, is amended to read as follows:

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 commis-

sioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health ~~benefit plans~~ insurance coverages with benefits similar to the standard health benefit plan.

Sec. 30. Section 513B.13, subsection 10, Code 1997, is amended to read as follows:

10. If ~~a health benefit plan~~ health insurance coverage 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.

Sec. 31. Section 513B.13, subsection 11, paragraph b, subparagraphs (1), (2), and (3), Code 1997, are amended to read as follows:

(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~~ insurance coverages 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~~ insurance coverages 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~~ insurance coverages 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~~ insurance coverages 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~~ insurance coverages and to premiums from newly issued health ~~benefit plans~~ insurance coverages to vary during a transition period.

Sec. 32. Section 513B.13, subsection 11, paragraph c, subparagraph (3), Code 1997, is amended to read as follows:

(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~~ insurance coverages delivered or issued for delivery to small employers in this state by reinsuring carriers.

Sec. 33. Section 513B.15, Code 1997, is amended to read as follows:

513B.15 PERIODIC MARKET EVALUATION.

The board shall study and report at least every three years to the commissioner on the effectiveness of this subchapter. The report shall analyze the effectiveness of the subchapter 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~~ insurance coverages to small employers in fulfillment of the purposes of this subchapter. The report may contain recommendations for market conduct or other regulatory standards or action.

Sec. 34. Section 513B.17, subsection 3, Code 1997, is amended to read as follows:

3. The commissioner may adopt, by rule or order, transition provisions to facilitate ~~the~~

~~orderly and coordinated implementation of 1992 Iowa Acts, chapter 1167~~ the implementation and administration of this chapter.

Sec. 35. Section 513B.17A, Code 1997, is amended to read as follows:

513B.17A RESTORATION OF TERMINATED COVERAGE.

The commissioner may adopt rules to require small employer carriers, as a condition of transacting business with small employers in this state after July 1, 1993, to reissue ~~a health benefit plan~~ health insurance coverage to any small employer whose health ~~benefit plan~~ insurance coverage is terminated or not renewed by a carrier after January 1, 1993, unless the carrier's termination is pursuant to section 513B.5. The commissioner may prescribe such terms for the reissuance of coverage as the commissioner finds are reasonable and necessary to provide continuity of coverage to such employers.

Sec. 36. Section 513C.6, Code 1997, is amended by striking the section and inserting in lieu thereof the following:

513C.6 PROVISIONS ON RENEWABILITY OF COVERAGE.

1. An individual health benefit plan subject to this chapter is renewable with respect to an eligible individual or dependents, at the option of the individual, except for one or more of the following reasons:

a. The individual fails to pay, or to make timely payment of, premiums or contributions pursuant to the terms of the individual health benefit plan.

b. The individual performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the individual health benefit plan.

c. A decision by the individual carrier or organized delivery system to discontinue offering a particular type of individual health benefit plan in the state's individual insurance market. An individual health benefit plan may be discontinued by the carrier or organized delivery system in that market with the approval of the commissioner or the director and only if the carrier or organized delivery system does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner or director. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected individuals.

(2) Provides notice of its decision not to renew such plan to all affected individuals no less than ninety days prior to the nonrenewal date of any discontinued individual health benefit plans.

(3) Offers to each individual of the discontinued plan the option to purchase any other health plan currently offered by the carrier or organized delivery system to individuals in this state.

(4) Acts uniformly in opting to discontinue the plan and in offering the option under subparagraph (3), without regard to the claims experience of any affected eligible individual or beneficiary under the discontinued plan or to a health status-related factor relating to any covered individuals or beneficiaries who may become eligible for the coverage.

d. A decision by the carrier or organized delivery system to discontinue offering and to cease to renew all of its individual health benefit plans delivered or issued for delivery to individuals in this state. A carrier or organized delivery system making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such plan to the commissioner or director. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected individuals.

(2) Provide notice of its decision not to renew such plan to all individuals and to the commissioner or director in each state in which an individual under the discontinued plan is known to reside no less than one hundred eighty days prior to the nonrenewal of the plan.

e. The commissioner or director finds that the continuation of the coverage is not in the best interests of the individuals, or would impair the carrier's or organized delivery system's

ability to meet its contractual obligations.

2. At the time of coverage renewal, a carrier or organized delivery system may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

3. An individual carrier or organized delivery system that elects not to renew an individual health benefit plan under subsection 1, paragraph "d", shall not write any new business in the individual market in this state for a period of five years after the date of notice to the commissioner or director.

4. This section, with respect to a carrier or organized delivery system doing business in one established geographic service area of the state, applies only to such carrier's or organized delivery system's operations in that service area.

5. A carrier or organized delivery system offering coverage through a network plan is not required to renew or continue in force coverage or to accept applications from an individual who no longer resides or lives in, or is no longer employed in, the service area of such carrier or organized delivery system, or no longer resides or lives in, or is no longer employed in, a service area for which the carrier is authorized to do business, but only if coverage is not offered or terminated uniformly without regard to health status-related factors of a covered individual.

6. A carrier or organized delivery system offering coverage through a bona fide association is not required to renew a* continue in force coverage or to accept applications from an individual through an association if the membership of the individual in the association on which the basis of coverage is provided ceases, but only if the coverage is not offered or terminated under this paragraph uniformly without regard to health status-related factors of a covered individual.

Sec. 37. Section 513C.7, subsection 1, paragraph b, Code 1997, is amended to read as follows:

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

Sec. 38. Section 513C.7, subsection 2, Code 1997, is amended to read as follows:

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~~ sixty-three days of notification of a premium rate increase applicable to the underwritten benefit plan.

Sec. 39. Section 513C.7, subsection 4, paragraph b, Code 1997, is amended to read as follows:

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~~ sixty-three days prior to the effective date of the new coverage.

Sec. 40. Section 513C.9, Code 1997, is amended by adding the following new subsection:

NEW SUBSECTION. 4A. Notwithstanding subsection 4, a commission shall be paid to an agent related to the sale of a basic or standard health benefit plan under this chapter. A commission paid pursuant to this subsection shall not be considered by the board for purposes of section 513C.10, subsection 9.

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* The word "or" probably intended

Sec. 41. NEW SECTION. 513C.12 COMMISSIONER'S DUTIES.
The commissioner shall adopt rules administering this chapter.

Sec. 42. Section 514E.1, Code 1997, is amended by adding the following new subsections:

NEW SUBSECTION. 3A. "Church plan" means the same as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 3(33).

NEW SUBSECTION. 4A. "Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.

d. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.

e. 10 U.S.C. ch. 55.

f. A health or medical care program provided through the Indian health service or a tribal organization.

g. A state health benefits risk pool.

h. A health plan offered under 5 U.S.C. ch. 89.

i. A public health plan as defined under federal regulations.

j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. § 2504(e).

k. An organized delivery system licensed by the director of public health.

NEW SUBSECTION. 4B. "Director" means the director of public health.

NEW SUBSECTION. 5A. "Federally eligible individual" means an individual who satisfies the following:

a. For whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage is eighteen or more months with no more than a sixty-three day lapse of coverage, and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan.

b. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the federal Social Security Act, or a state plan under Title XIX of that Act, or any successor program, and does not have other health insurance coverage.

c. With respect to whom the most recent coverage within the coverage period described in paragraph "a" was not terminated based on a nonpayment of premiums or fraud.

d. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, and elected such coverage.

e. Who, if the individual elected continuation coverage as provided in paragraph "d", has exhausted the continuation coverage under the provision or program.

NEW SUBSECTION. 5B. "Governmental plan" means as defined under section 3(32) of the federal Employee Retirement Income Security Act of 1974 and any federal governmental plan.

NEW SUBSECTION. 5C. a. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

b. For purposes of this subsection, "medical care" means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in subparagraph (1).

(3) Insurance covering medical care referred to in subparagraph (1) or (2).

c. For purposes of this chapter, the following apply:

(1) A plan, fund, or program established or maintained by a partnership which, but for this subsection, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care for present or former partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.

(2) With respect to a group health plan, the term "employer" includes a partnership with respect to a partner.

(3) With respect to a group health plan, the term participant includes the following:

(a) With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.

(b) With respect to a group health plan maintained by a self-employed individual under which one or more of the self-employed individual's employees are participants, the self-employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual's dependents may be eligible to receive benefits under the plan.

NEW SUBSECTION. 8A. a. "Health insurance coverage" means health insurance coverage offered to individuals, but does not include short-term limited duration insurance.

b. "Health insurance coverage" does not include any of the following:

(1) Coverage for accident-only, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical-payment insurance.

(6) Credit-only insurance.

(7) Coverage for on-site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

(1) Limited-scope dental or vision benefits.

(2) Benefits for long-term care, nursing home care, home health care, or community-based care.

(3) Any other similar limited benefits as provided by rule of the commissioner.

d. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

e. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55 and similar supplemental coverage provided to coverage under group health insurance coverage.

NEW SUBSECTION. 10A. "Involuntary termination" includes, but is not limited to, termination of coverage when a conversion policy is not available or where benefits under a state or federal law providing for continuation of coverage upon termination of employment will cease or have ceased.

NEW SUBSECTION. 12A. "Organized delivery system" means an organized delivery system as licensed by the director of the department of public health.

NEW SUBSECTION. 15. "Preexisting condition exclusion", with respect to coverage, means a limitation or exclusion of benefits relating to a condition based on the fact that the

condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Sec. 43. Section 514E.1, subsection 9, Code 1997, is amended by striking the subsection.

Sec. 44. Section 514E.2, subsection 1, Code 1997, is amended to read as follows:

1. There is established a nonprofit corporation known as the Iowa comprehensive health insurance association which shall assure that health insurance, as limited by sections 514E.4 and 514E.5, is made available to each eligible Iowa resident and each federally eligible individual applying to the association for coverage. All carriers as defined in section 514E.1, subsection 3, and all organized delivery systems licensed by the director of public health providing health insurance or health care services in Iowa shall be members of the association. The association shall operate under a plan of operation established and approved under subsection 3 and shall exercise its powers through a board of directors established under this section.

Sec. 45. Section 514E.2, subsection 2, unnumbered paragraph 1, Code 1997, is amended to read as follows:

The board of directors of the association shall consist of four members selected by the members of the association, two of whom shall be representatives from corporations operating pursuant to chapter 514 on July 1, 1989, or any successors in interest, and two of whom shall be representatives of organized delivery systems or insurers providing coverage pursuant to chapter 509 or 514A; four public members selected by the governor; the commissioner or the commissioner's designee from the division of insurance; and two members of the general assembly, one of whom shall be appointed by the speaker of the house and one of whom shall be appointed by the president of the senate, after consultation with the majority leader and the minority leader of the senate, who shall be ex officio and nonvoting members. The composition of the board of directors shall be in compliance with sections 69.16 and 69.16A. The governor's appointees shall be chosen from a broad cross-section of the residents of this state.

Sec. 46. Section 514E.2, subsection 3, paragraph f, Code 1997, is amended by striking the paragraph.

Sec. 47. Section 514E.2, subsection 7, Code 1997, is amended to read as follows:

7. Following the close of each calendar year, the association shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the association for the year. The association shall certify the amount of any net loss for the preceding calendar year to the commissioner of insurance and director of revenue and finance ~~who shall make payment to the association according to procedures established under subsection 3, paragraph "f"~~. Any ~~remaining~~ loss~~, after payment to the association from the health insurance trust fund,~~ 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 in any part 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 members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the next calendar year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums.

Sec. 48. Section 514E.2, subsection 12, Code 1997, is amended by striking the subsection.

Sec. 49. Section 514E.5, subsection 2, Code 1997, is amended to read as follows:

2. Services and charges made for benefits provided under the laws of the United States, ~~including~~ excluding Medicare and Medicaid, military service-connected disabilities, but including medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States.

However, the association policy shall pay benefits as a primary payer in any case where benefit coverage provided under the laws of the United States~~, including Medicare and Medicaid,~~ or under the laws of this state is, by rule or statute, secondary to all other coverages.

Sec. 50. Section 514E.6, subsection 3, paragraph e, Code 1997, is amended by striking the paragraph and inserting in lieu thereof the following:

e. An amount as determined by the association for any other association policy offered.

Sec. 51. Section 514E.6, subsection 6, Code 1997, is amended by striking the subsection and inserting in lieu thereof the following:

6. The association, in addition to other policies, shall offer one which is comparable to the standard health benefit plan as defined in section 513B.2.

Sec. 52. Section 514E.7, subsections 1, 2, and 5, Code 1997, are amended by striking the subsections and inserting in lieu thereof the following:

1. An individual who is and continues to be a resident is eligible for plan coverage if evidence is provided of any of the following:

a. A notice of rejection or refusal to issue substantially similar insurance for health reasons by one carrier or organized delivery system.

b. A refusal by a carrier or organized delivery system to issue insurance except at a rate exceeding the plan rate.

c. That the individual is a federally defined eligible individual.

A rejection or refusal by a carrier or organized delivery system offering only stoploss, excess of loss, or reinsurance coverage with respect to an applicant under paragraphs "a" and "b" is not sufficient evidence for purposes of this subsection.

5. a. A preexisting condition exclusion shall not apply to a federally defined eligible individual.

b. Plan coverage shall not impose any preexisting condition as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. Plan coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage for preexisting conditions. Such preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, provided both of the following apply:

(1) Application for association coverage is made no later than sixty-three days following such involuntary termination and, in such case, coverage under the plan is effective from the date on which such prior coverage was terminated.

(2) The applicant is not eligible for continuation or conversion rights that would provide

coverage substantially similar to plan coverage.

d. This subsection does not prohibit preexisting conditions coverage in an association policy that is more favorable to the insured than that specified in this subsection.

If the association policy contains a waiting period for preexisting conditions, an insured may retain any existing coverage the insured has under an insurance plan that has coverage equivalent to the association policy for the duration of the waiting period only.

Sec. 53. Section 514E.7, subsection 6, Code 1997, is amended to read as follows:

6. An individual is not eligible for coverage by the association if any of the following apply:

a. The individual is at the time of application eligible for health care benefits under chapter 249A.

b. The individual has terminated coverage by the association within the past twelve months, except that this paragraph does not apply to an applicant who is a federally eligible individual.

c. The individual is an inmate of a public institution ~~or is eligible for public programs for which medical care is provided~~, except that this paragraph does not apply to an applicant who is a federally defined eligible individual.

d. The individual premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of the employee, of a government agency or health care provider.

e. The individual, on the effective date of the coverage applied for, has not been rejected for, already has, or will have coverage similar to an association policy as an insured or covered dependent. This paragraph does not apply to an applicant who is a federally eligible individual.

Sec. 54. Section 514E.9, Code 1997, is amended to read as follows:

514E.9 RULES.

Pursuant to chapter 17A, the commissioner and the director of public health shall adopt rules to provide for disclosure by carriers and organized delivery systems of the availability of insurance coverage from the association, and to otherwise implement this chapter.

Sec. 55. Section 514E.11, Code 1997, is amended to read as follows:

514E.11 NOTICE OF ASSOCIATION POLICY.

~~Commencing July 1, 1986, every~~ Every carrier, including a health maintenance organization subject to chapter 514B and an organized delivery system, authorized to provide health care insurance or coverage for health care services in Iowa, shall provide a notice ~~and an application for~~ of the availability of coverage by the association to any person who receives a rejection of coverage for health insurance or health care services, or a notice to any person who is informed that a rate for health insurance or coverage for health care services will exceed the rate of an association policy, ~~that effective January 1, 1987,~~ that person is eligible to apply for health insurance provided by the association. Application for the health insurance shall be on forms prescribed by the board and made available to the carriers and organized delivery systems.

Sec. 56. Section 514E.3, Code 1997, is repealed.

Approved May 1, 1997