514E.2 Iowa comprehensive health insurance association.

1. The Iowa comprehensive health insurance association is established as a nonprofit corporation. The association shall assure that benefit plans as authorized in section 514E.1, subsection 2, for an association policy, are made available to each eligible Iowa resident and each federally eligible individual applying to the association for coverage. The association shall also be responsible for administering the Iowa individual health benefit reinsurance association pursuant to all of the terms and conditions contained in chapter 513C.

a. All carriers and all organized delivery systems licensed by the director of public health providing health insurance or health care services in Iowa, whether on an individual or group basis, and all other insurers designated by the association's board of directors and approved by the commissioner shall be members of the association.

b. 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.

2. *a.* The board of directors of the association shall consist of all of the following:

(1) Two members who shall be representatives of the two largest domestic carriers of individual health insurance in the state as of the calendar year ending December 31, 2000, based on earned premium standards.

(2) Three members who shall be representatives of the three largest carriers of health insurance in the state, based on earned premium standards, excluding Medicare supplement coverage premiums, that are not otherwise represented.

(3) Two members selected by the members of the association, one of whom shall be a representative from a corporation operating pursuant to chapter 514 on July 1, 1989, or any successor in interest, and one of whom shall be a representative of an organized delivery system or an insurer providing coverage pursuant to chapter 509 or 514A.

(4) Four public members selected by the governor.

(5) The commissioner or the commissioner's designee from the division of insurance.

(6) Four members of the general assembly, one of whom shall be appointed by the speaker of the house of representatives, one of whom shall be appointed by the minority leader of the house of representatives, one of whom shall be appointed by the president of the senate after consultation with the majority leader, and one of whom shall be appointed by the minority leader of the senate, who shall be ex officio, nonvoting members.

b. 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.

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

3. The association shall submit to the commissioner a plan of operation for the association and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner prior to the date on which the coverage under this chapter must be made available. After notice and hearing, the commissioner shall approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association, and provides for the sharing of association losses, if any, on an equitable and proportionate basis among the member carriers. If the association fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or if at any later time the association fails to submit suitable amendments to the plan, the commissioner shall adopt, pursuant to chapter 17A, rules necessary to implement this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

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

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

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

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

e. Procedures for selecting the board of directors and submitting the selections to the commissioner for approval.

f. The periodic advertising of the general availability of health insurance coverage from the association.

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

4. The plan of operation may provide that the powers and duties of the association may be delegated to a person who will perform functions similar to those of the association. A delegation under this section takes effect only upon the approval of both the board of directors and the commissioner. The commissioner shall not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

5. The association has the general powers and authority enumerated by this subsection and executed in accordance with the plan of operation approved by the commissioner under subsection 3. The association has the general powers and authority granted under the laws of this state to carriers licensed to issue health insurance. In addition, the association may do any of the following:

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

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

c. Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

d. Establish or utilize a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

e. Establish appropriate rates, scales of rates, rate classifications, and rating adjustments, which rates shall not be unreasonable in relation to the coverage provided and the reasonable operations expenses of the association.

f. Pool risks among members.

g. Issue association policies on an indemnity or provision of service basis providing the coverage required by this chapter.

h. Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

i. Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

j. Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other functions within the authority of the association.

k. Hire independent consultants as necessary.

l. Develop a method of advising applicants of the availability of other coverages outside the association.

m. Include in its policies a provision providing for subrogation rights by the association in a case in which the association pays expenses on behalf of an individual who is injured or suffers a disease under circumstances creating a liability upon another person to pay damages to the extent of the expenses paid by the association but only to the extent the damages exceed the policy deductible and coinsurance amounts paid by the insured. The association may waive its subrogation rights if it determines that the exercise of the rights would be impractical, uneconomical, or would work a hardship on the insured.

6. Rates for coverages issued by the association shall reflect rating characteristics used in the individual insurance market. The rates for a given classification shall not be more than one hundred fifty percent of the average premium or payment rate for the classification charged by the five carriers with the largest health insurance premium or payment volume in the state during the preceding calendar year. In determining the average rate of the five largest carriers, the rates or payments charged by the carriers shall be actuarially adjusted

to determine the rate or payment that would have been charged for benefits similar to those issued by the association.

7. *a.* 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. Any loss 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.

b. For purposes of this subsection, *"total health insurance premiums"* and *"payments for subscriber contracts"* include, without limitation, premiums or other amounts paid to or received by a member for individual and group health plan care coverage provided under any chapter of the Code or Acts, and *"paid losses"* includes, without limitation, claims paid by a member operating on a self-funded basis for individual and group health plan care coverage provided under any chapter of the Code or Acts. For purposes of calculating and conducting the assessment, the association shall have the express authority to require members to report on an annual basis each member's total health insurance premiums and payments for subscriber contracts and paid losses. A member is liable for its share of the assessment calculated in accordance with this section regardless of whether it participates in the individual insurance market.

8. The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations, made by an independent certified public accountant.

9. The association is subject to examination by the commissioner of insurance. Not later than April 30 of each year, the board of directors shall submit to the commissioner a financial report for the preceding calendar year in a form approved by the commissioner.

10. The association is subject to oversight by the legislative fiscal committee of the legislative council. Not later than April 30 of each year, the board of directors shall submit to the legislative fiscal committee a financial report for the preceding year in a form approved by the committee.

11. All policy forms issued by the association must be filed with and approved by the commissioner before their use.

12. The association is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

13. An insurer may offset an assessment made pursuant to this chapter against its premium tax liability pursuant to chapter 432 to the extent of twenty percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If an insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

86 Acts, ch 1156, §2; 89 Acts, ch 304, §1004 – 1006; 90 Acts, ch 1223, §28; 97 Acts, ch 103, §44 – 48; 2001 Acts, ch 125, §7; 2003 Acts, ch 145, §286; 2004 Acts, ch 1110, §44 – 46; 2004 Acts, ch 1158, §10 – 13, 21; 2005 Acts, ch 70, §14 – 16, 51; 2008 Acts, ch 1156, §50, 58; 2008 Acts, ch 1188, §18; 2009 Acts, ch 118, §3, 5

2005 amendments take effect April 28, 2005, and apply retroactively on and after July 1, 1986; 2005 Acts, ch 70, §51