513C.10 Iowa individual health benefit reinsurance association.

1. The Iowa individual health benefit reinsurance association is established as a nonprofit corporation.

a. All persons that provide health benefit plans in this state including insurers providing accident and sickness insurance under chapter 509, 514, or 514A, whether on an individual or group basis; fraternal benefit societies providing hospital, medical, or nursing benefits under chapter 512B; and health maintenance organizations, other entities providing health insurance or health benefits subject to state insurance regulation, and all other insurers as designated by the board of directors of the Iowa comprehensive health insurance association with the approval of the commissioner shall be members of the association. However, the state, including a department, an independent agency, the state board of regents, and an institution under the control of the state board of regents, shall not be a member of the association.

b. The association shall be incorporated under chapter 504, shall operate under a plan of operation established and approved pursuant to chapter 504, and shall exercise its powers through the board of directors established under chapter 514E.

2. *a.* Rates for basic and standard coverages as provided in this chapter shall be determined by each carrier as the product of a basic and standard factor and the lowest rate available for issuance by that carrier adjusted for rating characteristics and benefits. Basic and standard factors shall be established annually by the Iowa comprehensive health insurance association board with the approval of the commissioner. Multiple basic and standard factors for a distinct grouping of basic and standard policies may be established. A basic and standard factor is limited to a minimum value defined as the ratio of the average of the lowest rate available for issuance and the maximum rate allowable by law divided by the lowest rate available for issuance. A basic and standard factor is limited to a maximum value defined as the ratio of the maximum rate allowable by law divided by the lowest rate available for issuance. The maximum rate allowable by law and the lowest rate available for issuance is determined based on the rate restrictions under this chapter. For policies written after January 1, 2002, rates for the basic and standard coverages as provided in this chapter shall be calculated using the basic and standard factors and shall be no lower than the maximum rate allowable by law. However, to maintain assessable loss assessments at or below one percent of total health insurance premiums or payments as determined in accordance with subsection 6, the Iowa comprehensive health insurance association board with the approval of the commissioner may increase the value for any basic and standard factor greater than the maximum value.

b. The Iowa individual health benefit reinsurance association may, with the approval of the commissioner, increase cost-sharing provisions including, but not limited to, basic and standard plan deductibles, coinsurance, or copayments.

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

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

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

6. The assessable loss plus necessary operating expenses for the association, plus any additional expenses as provided by law, shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year, or on any other equitable basis as provided in the plan of operation. In sharing losses, the association

may abate or defer any part of the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against the members of the association to meet the operating expenses of the association until the next calendar year is completed. 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.

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

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

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

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

95 Acts, ch 5, §12; 2000 Acts, ch 1023, §21; 2001 Acts, ch 125, §4 – 6; 2002 Acts, ch 1119, §66; 2003 Acts, ch 91, §25, 26, 53; 2004 Acts, ch 1049, §191; 2004 Acts, ch 1110, §37, 38; 2004 Acts, ch 1158, §4, 5; 2004 Acts, ch 1175, §394; 2012 Acts, ch 1023, §157; 2017 Acts, ch 148, §57 – 59; 2025 Acts, ch 159, §24 – 26

Referred to in §507A.4, 513C.9, 513C.11, 513D.1

2025 amendment to subsection 1, paragraph a applies retroactively to January 1, 2020; 2025 Acts, ch 159, §26

Subsection 1, paragraph a amended