CHAPTER 513C

INDIVIDUAL HEALTH INSURANCE MARKET REFORM

Referred to in §87.4, 296.7, 331.301, 364.4, 505.28, 505.29, 514E.2, 514E.7, 514I.3, 514K.2, 669.14, 670.7

513C.1 Short title.
513C.2 Purpose.
513C.3 Definitions.
513C.4 Applicability and scope.
513C.5 Restrictions relating to premium rates.
513C.6 Provisions on renewability of coverage.
513C.7 Availability of coverage.
513C.8 Health benefit plan standards.
513C.9 Standards to assure fair marketing.
513C.10 Iowa individual health benefit reinsurance association.
513C.11 Self-funded employer-sponsored health benefit plan participation in reinsurance association.
513C.12 Commissioner's duties.

513C.1 Short title.

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

95 Acts, ch 5, §3

513C.2 Purpose.

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

95 Acts, ch 5, §4

513C.3 Definitions.

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

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

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

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

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

5. *"Carrier"* means any entity that provides individual health benefit plans in this state. For purposes of this chapter, carrier includes an insurance company, a group hospital or medical service corporation, a fraternal benefit society, a health maintenance organization, and any other entity providing an individual plan of health insurance or health benefits subject to state insurance regulation.

6. *"Commissioner"* means the commissioner of insurance.

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

8. *"Established service area"* means a geographic area, as approved by the commissioner and based upon the carrier's certificate of authority to transact business in this state, within which the carrier is authorized to provide coverage.

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

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

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

12. *"Qualifying event"* means any of the following:

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

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

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

d. Loss of eligibility for the Hawki program authorized in chapter 514I.

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

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

(2) An individual health insurance benefit plan, including coverage provided under a health maintenance organization contract, a hospital or medical service plan contract, or a fraternal benefit society contract, that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, provided that such policy has been in effect for a period of at least one year.

b. For purposes of this subsection, an association policy under chapter 514E is not considered *"qualifying existing coverage"* or *"qualifying previous coverage"*.

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

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

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

95 Acts, ch 5, §5; 2002 Acts, ch 1111, §14; 2003 Acts, ch 108, §131; 2004 Acts, ch 1110, §35; 2004 Acts, ch 1158, §1; 2012 Acts, ch 1023, §79, 157; 2017 Acts, ch 148, §46 - 51; 2023 Acts, ch 19, §1190

Referred to in §514A.3B

Subsection 12, paragraph d amended

513C.4 Applicability and scope.

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

2. An affiliated carrier that is a health maintenance organization having a certificate of

authority under section 514B.5 shall be considered to be a separate carrier for the purposes of this chapter.

95 Acts, ch 5, §6; 96 Acts, ch 1034, §48

513C.5 Restrictions relating to premium rates.

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

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

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

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

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

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

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

2. Notwithstanding subsection 1, the commissioner, with the concurrence of the board established under chapter 514E, may by order reduce or eliminate the allowed rating bands provided under subsection 1, paragraphs "*a*", "*b*", "*c*", and "*e*", or otherwise limit or eliminate the use of experience rating.

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

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

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

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

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

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

d. Any provisions relating to any preexisting condition.

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

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

7. A carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner and shall contain information as specified by the commissioner. A copy of the certification

shall be retained by the carrier at its principal place of business. Rate adjustments made in order to comply with this section are exempt from loss ratio requirements.

8. A carrier shall make the information and documentation maintained pursuant to subsection 6 available to the commissioner upon request. The information and documentation shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

95 Acts, ch 5, §7; 2001 Acts, ch 125, §2; 2002 Acts, ch 1119, §65; 2017 Acts, ch 148, §52
Referred to in §513C.3

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 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 in that market with the approval of the commissioner and only if the carrier does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner. Notice to the commissioner, 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 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 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 making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such plan to the commissioner. Notice to the commissioner, 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 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 finds that the continuation of the coverage is not in the best interests of the individuals, or would impair the carrier's ability to meet its contractual obligations.

2. At the time of coverage renewal, a carrier 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 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.

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

5. A carrier 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 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 offering coverage through a bona fide association is not required to renew or 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.

7. An individual who has coverage as a dependent under a basic or standard health benefit plan may, when that individual is no longer a dependent under such coverage, elect to continue coverage under the basic or standard health benefit plan if the individual so elects immediately upon termination of the coverage under which the individual was covered as a dependent.

95 Acts, ch 5, §8; 97 Acts, ch 103, §36; 2005 Acts, ch 70, §11, 51; 2017 Acts, ch 148, §53

513C.7 Availability of coverage.

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

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

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

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

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

c. A pregnancy existing on the effective date of coverage.

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

95 Acts, ch 5, §9; 97 Acts, ch 103, §37 – 39; 99 Acts, ch 165, §9, 10; 2003 Acts, ch 91, §24; 2004 Acts, ch 1158, §2, 21; 2008 Acts, ch 1188, §40, 41, 43; 2012 Acts, ch 1023, §157; 2017 Acts, ch 148, §54, 55

513C.8 Health benefit plan standards.

The board of directors of the Iowa comprehensive health insurance association, with the approval of the commissioner, shall adopt the form and level of coverage of the basic health benefit plan and the standard health benefit plan for the individual market which shall provide benefits substantially similar to the current state of the individual market.

95 Acts, ch 5, §10; 2001 Acts, ch 125, §3; 2004 Acts, ch 1110, §36; 2004 Acts, ch 1158, §3

Referred to in §513C.3

513C.9 Standards to assure fair marketing.

1. A carrier or an agent shall not do either of the following:

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

b. Encourage or direct individuals to seek coverage from another carrier because of

the health status, claims experience, industry, occupation, or geographic location of the individuals.

2. Subsection 1, paragraph *"a"*, shall not apply with respect to information provided by a carrier or an agent to an individual regarding the established geographic service area of the carrier or the restricted network provision of the carrier.

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

4. Notwithstanding subsection 3, 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 5.

5. Subsection 3 does not apply with respect to the compensation paid to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status or other permitted rating characteristics of the individual or the individual's dependents.

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

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

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

95 Acts, ch 5, §11; 97 Acts, ch 103, §40; 2006 Acts, ch 1117, §56; 2017 Acts, ch 148, §56

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.

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

513C.11 Self-funded employer-sponsored health benefit plan participation in reinsurance association.

1. A self-funded employer-sponsored health benefit plan qualified under the federal Employee Retirement Income Security Act of 1974 may voluntarily elect to participate in the Iowa individual health benefit reinsurance association established in section 513C.10 in accordance with the plan of operation and subject to such terms and conditions adopted by the board of the association established in section 514E.2 to provide portability and continuity to its covered employees and their covered spouses and dependents subject to the same terms and conditions as a participating insurer.

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

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

95 Acts, ch 5, §13; 2002 Acts, ch 1119, §67

513C.12 Commissioner's duties.

The commissioner shall adopt rules administering this chapter.

97 Acts, ch 103, §41