

CHAPTER 73
HEALTH INSURANCE PURCHASING COOPERATIVES

191—73.1(75GA,ch158) Purpose. The purpose of this chapter is to implement 1993 Iowa Acts, chapter 158, section 2, authorizing the creation of privately established and operated health insurance purchasing cooperatives, subject to regulation by the division of insurance. The purpose of the health insurance purchasing cooperatives is to improve the quality, access, and affordability of health care by more effectively representing the interests of buyers and consumers and creating a value conscious market. Health insurance purchasing cooperatives as described in the Insurance Division's oral and written briefings, the Pooled Purchasing Group Subcommittee Report, and Jackson Hole papers relied upon by the legislature effectively organize buyers of insurance, risk management, and health care services to negotiate price and quality with sellers of insurance, risk management, and health care services, whether the sellers are organized as insurance companies, health maintenance organizations, or other legally permissible structures.

191—73.2(75GA,ch158) Applicability and scope.

73.2(1) This chapter shall apply to all health insurance purchasing cooperatives operating in this state. However, this chapter shall not apply to any other health insurance or health care marketing, distribution or purchasing mechanism otherwise permitted by law.

73.2(2) A health insurance purchasing cooperative under this chapter is exempt from any law in this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that discriminates against a purchasing group or its members. An insurer is exempt from any law of the state that prohibits providing or offering to provide, to a purchasing group or its members, advantages based upon their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverage, or other matters. A purchasing group is subject to all other applicable laws of this state including Iowa Code chapter 522.

73.2(3) An entity not approved by the division as a HIPC and engaged in the purchase, sale, marketing or distribution of health insurance or health care plans shall not hold itself out as a HIPC, health insurance purchasing cooperative, purchasing cooperative, or otherwise use a confusingly similar name or marketing materials; and a nonapproved entity that does so shall be in violation of this chapter and subject to penalties under Iowa Code chapter 507B. This subrule is not intended to restrict the activities of a purchasing coalition of ERISA-qualified, self-funded employers engaged in the purchase of health care from providers on a nonrisk-bearing basis.

191—73.3(75GA,ch158) Definitions. As used in this chapter:

“Adjusted community rating” means a method used to develop a carrier's premiums which spreads financial risk across a large population and allows adjustments only for certain demographic factors and family composition as provided by state law for insurance carriers providing services to the same consumer or as otherwise approved by the commissioner to accommodate the unique characteristics of a health insurance purchasing cooperative.

“Business plan” means the plan of operation of the health insurance purchasing cooperative.

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

“Commissioner” means the commissioner of insurance for the state of Iowa.

“Division” means the insurance division of the state of Iowa.

“Health insurance purchasing cooperative” means a group of individuals, a group of employers and employees, or a combination of individuals and employers and employees who join together to purchase health insurance or health care benefits.

“HIPC” means health insurance purchasing cooperative. This acronym shall be used interchangeably with the words “health insurance purchasing cooperative” throughout this chapter.

“*HIPC administrator*” means a person or organization charged with overseeing the day-to-day operations of a HIPC.

“*HIPC sponsor*” means an employer, group of employers, or private agent authorized under this chapter to facilitate the purchase of insurance and health care services for participating employers and employees.

“*Service territory*” means any of the following:

1. A regional HIPC as identified by the commissioner. A regional HIPC serves a defined regional market which shall at minimum include the surrounding rural market of any city included in the regional HIPC.

2. A statewide HIPC as identified by the commissioner shall offer service throughout the state. A statewide HIPC may establish regional service areas, governance and negotiations, provided those structures conform to the provisions of paragraph “1.”

“*Small employer*” means an employer as defined in Iowa Code section 513B.2.

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191—73.4(75GA,ch158) Division duties—application—filing requirements—license—audits and examinations.

73.4(1) The division shall have the authority to regulate the establishment and conduct of a HIPC as set forth in this chapter.

73.4(2) A HIPC shall not operate in Iowa without an approved license from the division. An application form shall be completed and signed by an authorized representative of the HIPC sponsor and proposed HIPC administrator (if applicable). The completed application form shall be verified and filed at the division. An application will not be deemed to be filed until all information necessary to properly process the application has been received by the commissioner. Upon filing, the division will make its determination concerning the application and will provide notice of the determination to the HIPC. If approved, a copy of the approved license shall be provided to the HIPC sponsor. The license shall serve as the HIPC’s authorization until the yearly renewal date. Any amendment to the license shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

73.4(3) Each HIPC doing business in the state shall file with the division the following information or documents:

a. A business plan for approval by the commissioner as provided in rule 191—73.7(75GA,ch158). The business plan is a detailed, written plan of operations explaining how the proposed HIPC intends to meet the public policy objectives of reduced cost, increased access and improved quality. The business plan is a written commitment by the HIPC if approved. Failure to comply with the business plan is a basis for license suspension or revocation. Material changes in policy or operations are subject to the prior approval of the commissioner on the same basis as the original business plan.

b. Quarterly financial statements and annual reports on forms approved by the commissioner. Financial statements and annual reports are to ensure the operation of the HIPC in a fiscally sound fashion; to ensure the HIPC is not a risk-bearing entity; to ensure sound financial controls and money management; and to prevent mismanagement or misappropriation of funds either through neglect or malfeasance.

c. Reports of any material changes in the business plan or operation. The changes are subject to approval by the commissioner prior to implementation. The original business plan is the basis of licensure. Material changes in the business plan therefore require similar prior approval by the commissioner.

d. Any other information required by the commissioner deemed pertinent to the operation of a HIPC in the state. The specifics of a business plan, market conditions, enforcement cases, or other issues may make it necessary for the commissioner to gather additional information to make an informed decision in the public interest. Failure to provide requested information is a basis for denial, suspension or revocation of a license.

e. A HIPC shall not enter the market place until the commissioner has approved the business plan.

73.4(4) Financial and performance audits or examinations of the HIPC shall be conducted on a regular basis by the division. Failure to meet minimum standards in a financial or performance audit or examination is the basis for license denial, suspension or revocation, or other action to protect consumers. The commissioner may impose conditions on licensure such as, but not limited to, the removal and replacement of managerial or marketing staff or contractors to remedy compliance or performance problems.

191—73.5(75GA,ch158) Fidelity bond—letter of credit. A HIPC shall maintain in force a fidelity bond on administrators, employees and officers in an amount not less than \$1,000,000 or such greater sum as may be prescribed by the commissioner. The fidelity bond shall be in the form prescribed by the commissioner. In the event a HIPC employs a contract administrator, the administrator shall maintain a \$250,000 letter of credit for the life of the contract payable to the HIPC sponsor. This letter of credit shall be in addition to the fidelity bond.

191—73.6(75GA,ch158) Annual report. The commissioner shall submit an annual report to the general assembly no later than February 1 of each year. The report shall include a description of the operations of all health insurance purchasing cooperatives, a review of the success of health insurance purchasing cooperatives as it pertains to improving the quality, access or affordability of health insurance. The commissioner may require HIPCs to provide information in uniform format for use in compliance with this report and for other public purposes.

191—73.7(75GA,ch158) Business plan. A HIPC shall submit its business plan for the prior review and approval by the commissioner. The business plan shall include but shall not be limited to the following information:

73.7(1) The specific steps by the HIPC sponsor to advance cost control, quality improvement, and improve access to health insurance or health care services. The business plan should affirmatively demonstrate that the HIPC has the technical expertise and physical capacity to serve as a significant group of buyers not currently being served by a HIPC. Significant means at least 10 percent of the population within the proposed service territory. The business plan should affirmatively demonstrate that the HIPC will reduce cost, improve quality and improve access to health insurance or health care services.

73.7(2) The scope of HIPC services to be offered in the service territory and the resources and expertise to be used to implement and administer the plan. The HIPC as a condition of licensure must demonstrate the technical and physical capacity to serve a significant group of buyers over a wide territory, encompassing at minimum a regional health care center and its associated rural market. The HIPC as a condition of licensure must demonstrate the technical and physical capacity to provide equal service quality throughout the entire HIPC service territory.

73.7(3) The corporate charter, bylaws and other business operation documents of the HIPC. As a condition of licensure the HIPC must demonstrate to the satisfaction of the commissioner that its corporate governance makes it an appropriate and effective representative of buyers' interests within the service territory. A HIPC must be more than a marketing or distribution channel for a single product or the products of a single carrier. A HIPC as a condition of licensure must organize and facilitate competition between multiple insurers or health care providers.

73.7(4) A list of officers and directors of the HIPC and the contract administrator if one is employed and personal biographical information or firm descriptions for each. The officers, directors, or contract administrator shall not have a prior record of administrative, civil or criminal violations within any financial service industry. The personal biographical information and firm descriptions shall demonstrate by clear and convincing evidence that those involved in the HIPC have the expertise, experience and character to effectively and professionally represent buyers in a fiduciary capacity.

73.7(5) Evidence of adequate security and prudence in the accounting, deposit, collection, handling and transfer of moneys. Because the HIPC may handle payments or accounting, the HIPC must affirmatively demonstrate adequate financial controls to the satisfaction of the division as a condition of

licensure. Failure to have adequate controls or failure to follow approved procedures shall be a basis to deny, suspend, or revoke licensure.

73.7(6) The market segments and participants to which the HIPC will be marketing. The HIPC must demonstrate to the satisfaction of the commissioner that it will extend HIPC services to a significant group of buyers not currently served by a HIPC. Failure to achieve this result can be the basis of later denial to renew a license.

73.7(7) Disclosure of any preexisting oral or written agreements. Preexisting agreements may raise questions of conflict or demonstrate the intention to create a marketing channel for a single product or single carrier. Conversely, preexisting agreements may assist in affirmatively demonstrating technical or physical capacity to serve a service territory or to extend HIPC services to a significant group of buyers not currently served by a HIPC. Regardless, any preexisting oral or written agreements must be disclosed. Failure to disclose an agreement is the basis for license denial or revocation.

73.7(8) Any other information required by the commissioner to verify the HIPC is qualified.

191—73.8(75GA,ch158) Participants. A HIPC may offer services to any of the following participants:

1. Individuals.
2. A small business as defined in 191—Chapter 71.
3. A business with more than 50 employees.
4. An association and its members.
5. The state or a local government unit.
6. Any other purchaser on a voluntary basis.

Underwriting standards shall be no more restrictive than required of small group health insurance under 191—Chapter 71.

A HIPC's business plan may impose conditions or limitations on members leaving the HIPC to protect against adverse selection. A HIPC shall accept all entities within its chosen market segment in accordance with the regulations governing marketing of insurance to that market segment, e.g., individual, small group, or large group.

A HIPC may provide services to participants out-of-state or out-of-region who elect to join for the benefit of representation and participation in health insurance or health care benefits only when an employer out-of-state or out-of-region has employees within the state or region or an individual is required to have coverage in the state or region due to specific circumstance.

191—73.9(75GA,ch158) Health insurance purchasing cooperative—product offerings—exemptions.

73.9(1) A HIPC shall offer at least one indemnity plan which provides an unrestricted choice of a physician. However, the indemnity plan may require an appropriate utilization review, preauthorization of treatments, or other reasonable cost and utilization oversight.

73.9(2) All small employer group carriers participating in a HIPC shall offer a basic and a standard benefit plan.

73.9(3) A HIPC is not required but may offer an employer-choice managed health care plan. The HIPC may also offer other indemnity plans.

73.9(4) A HIPC cannot offer insurance from a risk retention group not chartered in the state nor a carrier not admitted in the state.

73.9(5) A HIPC shall retain agents who are licensed pursuant to Iowa law if the HIPC markets the products of the HIPC through agents or sales representatives. Alternatively, if the HIPC does not use sales agents or representatives, the HIPC must demonstrate to the satisfaction of the commissioner that the alternative will provide consumer service meeting the same standards as that required of agents.

73.9(6) A participating health plan is not required to be offered outside of the HIPC but may be offered through other distribution or marketing channels. An entity may not be licensed as a HIPC if it offers only one health plan or the products of only one carrier, or related carriers.

191—73.10(75GA,ch158) Insurance risk. A HIPC shall bear no insurance risk. The HIPC shall facilitate the purchase of insurance and health care services. Provisions for participants to retain risk through deductibles, retention levels, or partial or complete self-funding shall be disclosed and shall be subject to approval by the commissioner prior to implementation to ensure that risk is not borne by the HIPC.

191—73.11(75GA,ch158) Rates.

73.11(1) A carrier shall use rate restrictions and regulations applicable to each market segment.

73.11(2) The HIPC may collect a different premium within the HIPC. This difference is predicated on marketing and administrative expenses which the HIPC would assume. Therefore, the carrier could offer the HIPC a lower final rate than the carrier would charge outside of the HIPC.

191—73.12(75GA,ch158) Election—disclosure and confidentiality.

73.12(1) A HIPC may elect to preclude for a period of time a participant who leaves the HIPC from returning to the HIPC to purchase health insurance or health care benefits. However, a HIPC shall not use this subrule to discriminate against high-risk participants.

73.12(2) Subject to review and approval by the commissioner, a HIPC may provide restricted access to information in its possession which is essential to the operation of the HIPC.

Confidentiality must:

- a. Be an inducement for voluntary participation in the program;
- b. Protect the privacy of participants;
- c. Protect negotiating strategy from disclosure to contractors or competitors; or
- d. Protect proprietary information in like circumstances as for insurance.

191—73.13(75GA,ch158) Structure—merger and consolidation.

73.13(1) A HIPC shall be a legal entity which operates on behalf of its sponsor or participants.

73.13(2) A HIPC shall disclose its total administrative cost in its annual report to the commissioner in the same manner and on the same basis as insurance carriers.

73.13(3) The change in control, merger or acquisition of a HIPC is subject to the prior review and approval of the commissioner on the same terms as a change in control, merger or acquisition of an Iowa domestic insurance company.

191—73.14(75GA,ch158) Conflict of interest.

73.14(1) Health care providers or insurers offering competing products within the same service territory shall not participate in a HIPC as a sponsor. A HIPC sponsor employing a HIPC administrator that offers competing products within the same service territory shall demonstrate to the satisfaction of the commissioner precautions to protect the HIPC from unfair competition or disclosure of proprietary information.

73.14(2) A HIPC sponsor shall not be an employee or be affiliated with or a subsidiary of a health care provider or insurer offering competing products within the same service territory.

73.14(3) The employees of a health care provider or insurer may receive services through a HIPC. The employer may vote in corporate governance elections of officers and directors. However, a health care provider or insurer or an employee of a health care provider or insurer may not serve as an officer of a HIPC. A health care provider or insurer or the employee of a health care provider or insurer may be a director of a HIPC or HIPC sponsor, but such persons shall not constitute a majority of the governing board or body of a HIPC or HIPC sponsor.

73.14(4) Compensation to the HIPC's sponsor, administrator, or agents shall not vary based upon the plan selected by participating members.

191—73.15(75GA,ch158) Nondiscrimination and retaliatory protections. An insurer shall not discriminate against or take retaliatory action against a participant employer, employee, agent, sponsor, or administrator of a HIPC. A HIPC shall not discriminate against or take retaliatory actions against an insurer or agent for activities relating to the HIPC.

191—73.16(75GA,ch158) Annual health insurance or health care benefits plan selection. A HIPC shall offer participants an opportunity at least once annually to change health insurance or health care benefits. The HIPC shall determine whether the change in health insurance or health care benefits may be made by the individual employees of an employer participant or by the employer participant on behalf of the employer's employees. The HIPC shall provide pertinent available information including cost and quality of risk management services on health insurance and health care benefits offered to assist the participants in making an informed decision in the selection of health insurance or health care benefits.

191—73.17(75GA,ch158) License subject to conditions—waivers. A new participating buyer shall join when the plan is offered to them or at the annual open enrollment.

73.17(1) The commissioner may limit the number of HIPCs licensed within a geographic service territory. A HIPC must demonstrate probable success in representing a substantial share of the purchasers within the proposed service territory and that it is likely to largely represent purchasers not already served by existing HIPCs within the same service territory. The commissioner may refuse to renew or condition the license of a HIPC that fails in actual operations to achieve these requirements.

73.17(2) Existing HIPCs may present evidence of the anticipated impact of a new HIPC within their geographic service territory to resist an additional licensee. This shall include but is not limited to evidence that the new HIPC will use risk selection against an existing HIPC and the new HIPC will adversely dilute the market leverage of an existing HIPC. The division shall provide notice to existing HIPCs of an applicant's filing. Existing HIPCs must file notice of intent to submit evidence within ten days of the notice. Existing HIPCs may request a hearing or submit evidence in writing.

73.17(3) The commissioner may impose risk adjustments between HIPCs within a geographic service area or between all HIPCs within the state to ensure competition based upon service and effective cost and quality control and not based upon risk selection.

73.17(4) The commissioner may impose additional conditions to protect the interests of participating buyers and consumers, ensure fair and efficient conduct of HIPC duties, and to protect HIPCs from adverse selection or bearing insurance risk.

73.17(5) The commissioner may impose additional conditions or waive restrictions for a specified period of time to facilitate orderly market transition to reform upon a showing of necessity by the applicant HIPC or upon the commissioner's own initiative.

191—73.18(75GA,ch158) Procedures. Actions by a HIPC before the division or the commissioner shall conform to the pertinent procedures set forth in the administrative rules of the insurance division.

191—73.19(75GA,ch158) Data collection—quality evaluation.

73.19(1) The HIPC shall conform to any pertinent reporting provisions of the community health management information system.

73.19(2) A HIPC shall conduct a qualitative review of plans offered through the HIPC in order to provide participating employers and employees an accurate comparative analysis of cost, quality, access, relative value, service, and customer satisfaction. The division may require HIPCs to cooperate in establishing a common basis and methodology for plan evaluation and customer education to facilitate informed choice between plans. A HIPC shall detail in its proposed business plan the methodologies and resources it intends to employ to satisfy this requirement. The HIPC must produce an annual report card on the performance of participating plans.

73.19(3) The division may establish data reporting standards to permit the objective evaluation of HIPCs and their impact on health care costs, quality and access.

191—73.20(75GA,ch158) Examination—costs. The commissioner shall examine a HIPC and may require the most recent audited financial statements from the administrator and such other interim evidence as the commissioner deems appropriate. Reasonable costs of the examination or audit are to be paid by the HIPC. Examination shall include, but not be limited to, premium collection, marketing practices, and financial condition.

191—73.21(75GA,ch158) Trade practices. A HIPC shall be subject to Iowa Code chapter 507B, Insurance Trade Practices.

191—73.22(75GA,ch158) Grounds for denial, nonrenewal, suspension or revocation of certificate. The following constitute grounds for denial, nonrenewal, suspension or revocation of the HIPC's certificate following notice and an opportunity for hearing:

1. Failure to comply with any provisions of the rules of this chapter;
2. Failure to comply with any lawful order of the commissioner;
3. Committing an unfair or deceptive act or practice as defined in Iowa Code chapter 507B;
4. Filing any necessary form with the division which contains fraudulent information or omission;
5. Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a person or health care carrier otherwise not entitled to the HIPC and that have been entrusted to the HIPC in its fiduciary capacity;
6. Failure to demonstrate through clear and convincing evidence that it will extend HIPC services to a significant group of buyers not currently being served by a HIPC; or
7. Failure to demonstrate through clear and convincing evidence that it will reduce the cost, improve the quality, and improve access to or choice of affordable health insurance or health care services.

In addition, the application for certification to be a HIPC may be denied upon a finding by the commissioner that a sufficient number of HIPCs are licensed within a geographic service area and an additional HIPC would adversely affect existing HIPCs.

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191—73.23(75GA,ch158) Hearing and appeal. Prior to denying an application or a renewal application or suspending or revoking a certificate issued under this chapter, a certificate holder shall be provided with written notice of the commissioner's decision and provided an opportunity for a hearing and a right to appeal as provided in rule 191—3.1(17A,502,505) and Iowa Code chapter 17A.

191—73.24(75GA,ch158) Solvency. In the event a HIPC becomes insolvent, the division shall maintain jurisdiction of the HIPC for purposes of protection of the interests of the HIPC participants and the health insurance carriers and health benefit plans pursuant to the pertinent sections of Iowa Code chapter 507C.

These rules are intended to implement 1993 Iowa Acts, chapter 158, section 2.

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