Senate Amendment to
House Amendment to
Senate File 2293

H-8512

Amend the amendment, S-5183, to Senate File 2293, as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, after line 2 by inserting:

<___. Page 2, after line 6 by inserting:

<Sec. ___. Section 505.8, Code Supplement 2011, is amended by adding the following new subsection:

NEW SUBSECTION. 6A. The commissioner shall establish a bureau, to be known as the "*health insurance and cost containment bureau*", as provided in section 505.20.>

___. Page 2, after line 15 by inserting:

<Sec. ___. NEW SECTION. **505.20 Health insurance and cost containment bureau — advisory board.**

1. *a.* The commissioner shall establish a bureau, to be known as the "*health insurance and cost containment bureau*", for the purpose of creating methodologies to hold health carriers accountable for the fair treatment of health care providers and developing affordability standards for health carriers that direct carriers to promote improved accessibility, quality, and affordability of health care.

b. The commissioner shall employ professional and clerical staff to carry out the purposes and functions of the bureau.

c. The commissioner shall adopt rules under chapter 17A, in collaboration with the health insurance and cost containment advisory board, to administer and implement the purposes and functions of the bureau.

2. *a.* A health insurance and cost containment advisory board is created to assist the commissioner in carrying out the purposes of the bureau. The advisory board shall consist of seven voting members and seven nonvoting members. The voting members shall be appointed by the governor, subject to confirmation by the senate. The governor shall designate one voting member as chairperson and one as vice chairperson.

b. The voting members of the advisory board shall be appointed by the governor as follows:

(1) Two persons who represent the interests of small business from nominations made to the governor by nationally recognized groups that represent the interests of small business.

(2) Two persons who represent the interests of consumers from nominations made to the governor by nationally recognized groups that represent the interests of consumers.

(3) One person who is an insurance producer licensed under chapter 522B.

(4) One person who is a health care actuary or

economist with expertise in health insurance.

(5) One person who is a health care provider.

c. The nonvoting members are as follows:

(1) The commissioner of insurance or the commissioner's designee.

(2) The director of human services or the director's designee.

(3) The director of public health or the director's designee.

(4) Four members of the general assembly, one appointed by the speaker of the house of representatives, one appointed by the minority leader of the house of representatives, one appointed by the majority leader of the senate, and one appointed by the minority leader of the senate.

d. Meetings of the advisory board shall be held at the call of the chairperson or upon the request of at least two voting members. Four voting members shall constitute a quorum and the affirmative vote of four voting members shall be necessary for any action taken by the advisory board.

e. The voting members of the advisory board shall be appointed for staggered terms of three years within sixty days after the effective date of this Act and by December 15 of each year thereafter. The initial terms of the voting members of the advisory board shall be staggered at the discretion of the governor. A voting member of the board is eligible for reappointment. The governor shall fill a vacancy on the board in the same manner as the original appointment for the remainder of the term.

f. Voting members of the advisory board may be reimbursed from the moneys collected from assessment fees for the administration of the bureau and the advisory board pursuant to subsection 7, for actual and necessary expenses incurred in the performance of their duties, but shall not be otherwise compensated for their services.

g. It shall be the duty of the advisory board to assist the bureau in carrying out the purposes and functions of the bureau by making recommendations for the creation of methodologies that hold health carriers in the state accountable for the fair treatment of health care providers and developing affordability standards for health carriers that direct such carriers to promote improved accessibility, quality, and affordability of health care. The advisory board shall also offer input to the commissioner regarding proposed rules, the operation of the bureau, and any other topics relevant to administering and implementing the

purposes and functions of the bureau.

3. *a.* Health care affordability efforts shall initially focus on the primary care level of care in an effort to create a stronger primary care system and greater supply of more highly compensated primary care providers by targeting more funding to primary care.

b. Beginning on December 31, 2013, and each year thereafter, each health carrier shall report to the bureau, in a format and including information as required by the commissioner by rule, the carrier's proportion of medical expense paid for primary care for the previous twelve months and the proportion of medical expense to be allocated to primary care for the succeeding twelve months beginning on January 1, 2014, and each year thereafter. The proportion of medical expense paid for primary care shall increase by at least one percentage point per year for five years beginning on January 1, 2014.

c. Each health carrier shall submit a plan to the bureau each year in a format and including information as required by the commissioner by rule, that demonstrates how the increase in spending for primary care will be accomplished. The increase in spending for primary care shall be accomplished without contributing to an increase in premiums.

4. Each health carrier shall support the implementation of the medical home system as developed and implemented by the department of public health and the medical home system advisory council pursuant to sections 135.157, 135.158, and 135.159, by implementing the phase of the medical home system pursuant to section 135.159, subsection 11, that involves insurers and self-insured companies in making the medical home system available to individuals with private health care coverage. The health insurance and cost containment advisory board shall work collaboratively with the medical home system advisory council to implement this phase. In addition to the reimbursement methodologies and incentives for participation in the medical home system described in section 135.159, subsection 8, the advisory board and the medical home system advisory council shall review additional payment and system reforms to support the expanded implementation of the medical home system including but not limited to all of the following:

a. Rewarding high-quality, low-cost providers.

b. Creating participant incentives to receive care from high-quality, low-cost providers.

c. Fostering collaboration among providers to reduce cost shifting from one part of the health care

continuum to another.

d. Creating incentives for providing health care in the least restrictive, most appropriate setting.

e. Creating incentives to promote diversity in the size, geographic location, and accessibility of practices designated as medical homes throughout the state.

5. Each health carrier shall demonstrate by December 31, 2013, implementation of incentives consistent with the efforts of the department of public health and the electronic health information advisory council and executive committee pursuant to section 135.156 to promote adoption of electronic health records by health care providers at all levels of the health care continuum. Health carriers shall submit a report to the bureau by December 31, 2014, concerning the incentive programs that have been implemented in a format and including information as required by the commissioner by rule.

6. Each health carrier shall participate in efforts regarding comprehensive delivery system reform, including payment reform, in coordination with other payers and health care providers.

a. As an initial step to inform such efforts, the bureau and advisory board shall develop a plan to implement an all-payer claims database by December 31, 2013, to provide for the collection and analysis of claims data from multiple payers of health care delivered at all levels including but not limited to primary care, specialist care, outpatient surgery, inpatient stays, laboratory testing, and pharmacy data. The plan shall provide for development and implementation of a database that complies with any applicable requirements of the federal Act and that most effectively and efficiently provides data to determine health care utilization patterns and rates; identify gaps in prevention and health promotion services; evaluate access to care; assist with benefit design and planning; analyze statewide and local health care expenditures by provider, employer, and geography; inform the development of payment systems for providers; and establish clinical guidelines related to quality, safety, and continuity of care. The bureau shall submit the plan to the general assembly by December 31, 2012, including statutory changes necessary to collect and use such data, a standard means of collecting the data, an implementation and maintenance schedule, and a proposed budget and financing options for the database.

b. The bureau and advisory board shall also

recommend a provider payment system plan to reform the health care provider payment system beyond primary care providers, including but not limited to specialty care, hospital, and long-term care providers, as an effective way to promote coordination of care, lower costs, and improve quality.

7. *a.* Funding to operate the bureau and the advisory board shall come from federal and private grants and from assessment fees charged to health carriers. The commissioner shall charge an assessment fee to all health carriers in this state, as necessary to support the activities and operations of the bureau and the advisory board as provided under this section. No state funding shall be appropriated or allocated for the operation or administration of the bureau or the advisory board. The assessment shall provide for the sharing of bureau and advisory board expenses on an equitable and proportionate basis among health carriers in the state as provided in this subsection.

b. Following the close of each calendar year, the commissioner shall determine the expenses for operation and administration of the bureau and the advisory board. The expenses incurred shall be assessed by the commissioner to all health carriers 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 by rule. In sharing expenses, the commissioner may abate or defer in any part the assessment of a health carrier, if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the health carrier to fulfill its contractual obligations. The commissioner may also provide for an initial or interim assessment against health carriers if necessary to assure the financial capability of the commissioner to meet the incurred or estimated operating expenses of the bureau and the advisory board until the next calendar year is completed.

c. 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 health carrier 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 health carrier 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 commissioner shall have the express authority to require health carriers to report on an annual basis each health carrier's total health insurance premiums and payments for subscriber contracts and paid losses. A health carrier is liable for its share of the assessment calculated in accordance with this subsection regardless of whether it participates in the individual insurance market.

8. The commissioner shall keep an accurate accounting of all activities, receipts, and expenditures of the bureau and advisory board and annually submit to the governor, the general assembly, and the public, a report concerning such accounting.

9. The bureau and the advisory board shall coordinate their activities with the Iowa Medicaid enterprise of the department of human services, the department of revenue, the department of public health, and the insurance division of the department of commerce to ensure that the state fulfills the requirements of the federal Act and to ensure that in the event that a health insurance exchange is established in the state, the functions and activities of the bureau and the advisory board can be seamlessly integrated into the exchange.

10. As used in this section, unless the context otherwise requires:

a. "*Advisory board*" means the health insurance and cost containment advisory board.

b. "*Bureau*" means the health insurance and cost containment bureau.

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

d. "*Federal Act*" means the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those Acts.

e. "*Health care provider*" means a physician who is licensed under chapter 148, or a person who is licensed as a physician assistant under chapter 148C or as an advanced registered nurse practitioner.

f. "*Health carrier*" means an entity subject to the insurance laws and rules 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 hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

g. (1) *"Health insurance"* 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.

(2) *"Health insurance"* does not include any of the following:

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

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

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

(d) Workers' compensation or similar insurance.

(e) Automobile medical-payment insurance.

(f) Credit-only insurance.

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

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

(3) *"Health insurance"* does not include benefits provided under a separate policy as follows:

(a) Limited scope dental or vision benefits.

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

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

(4) *"Health insurance"* does not include benefits offered as independent noncoordinated benefits as follows:

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

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

(5) *"Health insurance"* 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, or similar supplemental coverage provided to coverage under group health insurance coverage.

(6) *"Group health insurance coverage"* means health insurance offered in connection with a group health plan.>>

2. Page 1, after line 4 by inserting:

<___. Page 9, after line 5 by inserting:

<Sec. ___. NEW SECTION. **513B.16 Premium rate increases — public hearing and comment.**

1. All health insurance carriers licensed to do business in the state under this chapter shall immediately notify the commissioner and policyholders of any proposed rate increase exceeding the average annual health spending growth rate stated in the most recent national health expenditure projection published by the centers for Medicare and Medicaid services of the United States department of health and human services, at least ninety days prior to the effective date of the increase. Such notice shall specify the rate increase proposed that is applicable to each policyholder and shall include ranking and quantification of those factors that are responsible for the amount of the rate increase proposed. The notice shall include information about how the policyholder can contact the consumer advocate for assistance.

2. The commissioner shall hold a public hearing at least thirty days before the proposed rate increase is to take effect.

3. The consumer advocate shall solicit public comments on each proposed health insurance rate increase if the increase exceeds the average annual health spending growth rate as provided in subsection 1, and shall post without delay during the normal business hours of the division, all comments received on the insurance division's internet site prior to the effective date of the increase.

4. The consumer advocate shall present the public testimony, if any, and public comments received, for consideration by the commissioner prior to the effective date of the increase.>>

3. Page 1, by striking lines 5 and 6 and inserting:

<___. Page 15, after line 14 by inserting:>

4. Page 8, by striking lines 25 and 26.

5. By renumbering as necessary.