

House File 2181

Appropriations: Swartz, Chair; Halvorson of Clayton and Jochem.

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HOUSE FILE 2181

Place On Calendar

BY COMMITTEE ON SMALL BUSINESS
AND COMMERCE

(Formerly House Study Bill 531)

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Vote: Ayes 96 Nays 2 Vote: Ayes 48 Nays 1

Approved April 28, 1986 (p. 1855)

A BILL FOR

1 An Act establishing the Iowa comprehensive health association,
2 providing for a plan of operation, establishing financial
3 procedures, providing eligible expenses, excluding certain
4 requirements, and relating to other provisions of health
5 insurance coverage.

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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HF 2181

1 Section 1. NEW SECTION. 514E.1 DEFINITIONS.

2 As used in this chapter, unless the context otherwise re-
3 quires:

4 1. "Association" means the Iowa comprehensive health as-
5 sociation established by section 514E.2.

6 2. "Association policy" means an individual policy issued
7 by the association that provides the coverage specified in
8 section 514E.4.

9 3. "Carrier" means an insurer providing accident and sick-
10 ness insurance under chapter 509, 514 or 514A and includes a
11 health maintenance organization established under chapter 514B
12 if payments received by the health maintenance organization
13 are considered premiums pursuant to section 514B.31 and are
14 taxed under chapter 432. "Carrier" also includes a
15 corporation which becomes a mutual insurer pursuant to section
16 514.23 and any other person as defined in section 4.1,
17 subsection 13, who is or may become liable for the tax imposed
18 by chapter 432.

19 4. "Commissioner" means the commissioner of insurance.

20 5. "Eligible expenses" means the usual, customary and rea-
21 sonable charges for the health care services specified in
22 section 514E.4.

23 6. "Health care facility" means a health care facility as
24 defined in section 135C.1, subsection 4, a hospital as defined
25 in section 135B.1, subsection 1, or a community mental health
26 center established under chapter 230A.

27 7. "Health care services" means hospital services, medical
28 or surgical services, professional services provided by a
29 physician as defined in section 135.1, dental services, or
30 pharmaceutical or optometric services, the coverage of which
31 is authorized under chapter 509, 514, 514A, or 514B as limited
32 by sections 514E.4 and 514E.5, and includes services for the
33 purposes of preventing, alleviating, curing, or healing human
34 illness, injury, or physical disability.

35 8. "Health insurance" means accident and sickness

1 insurance authorized by chapter 509, 514 or 514A.

2 9. "Health insurance trust fund" means the fund created in
3 section 514E.3.

4 10. "Insured" means an individual who is provided
5 qualified comprehensive health insurance under an association
6 policy, which policy may include dependents and other covered
7 persons.

8 11. "Medicaid" means the federal-state assistance program
9 established under Title XIX of the federal Social Security
10 Act.

11 12. "Medicare" means the federal government health
12 insurance program established under Title XVIII of the Social
13 Security Act.

14 13. "Policy" means a contract, policy, or plan of health
15 insurance.

16 14. "Policy year" means a consecutive twelve-month period
17 during which a policy provides or obligates the carrier to
18 provide health insurance.

19 Sec. 2. NEW SECTION. 514E.2 IOWA COMPREHENSIVE HEALTH
20 ASSOCIATION.

21 1. There is established a nonprofit corporation known as
22 the Iowa comprehensive health insurance association which
23 shall assure that health insurance, as limited by sections
24 514E.4 and 514E.5, is made available to each eligible Iowa
25 resident applying to the association for coverage. All
26 carriers as defined in section 514E.1, subsection 3, providing
27 health insurance or health care services in Iowa shall be mem-
28 bers of the association. The association shall operate under
29 a plan of operation established and approved under subsection
30 3 and shall exercise its powers through a board of directors
31 established under this section.

32 2. The board of directors of the association shall consist
33 of not less than four nor more than eight members selected by
34 the members of the association, subject to approval by the
35 commissioner and a public member selected by the commissioner.

1 In order to select the initial board of directors and
2 organize the association, the commissioner shall give notice
3 to all carriers of the time and place of the organizational
4 meeting. In determining voting rights at the organizational
5 meeting, each carrier member is entitled to one vote in person
6 or by proxy. If the board of directors is not selected within
7 sixty days after the organizational meeting, the commissioner
8 shall appoint the initial board. In approving or selecting
9 members of the board, the commissioner shall consider whether
10 all carriers are fairly represented. Members of the board may
11 be reimbursed from the moneys of the association for expenses
12 incurred by them as members, but shall not be otherwise
13 compensated by the association for their services.

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

- 1 a. The handling and accounting of assets and moneys of the
2 association.
- 3 b. The amount and method of reimbursing members of the
4 board.
- 5 c. Regular times and places for meeting of the board of
6 directors.
- 7 d. Records to be kept of all financial transactions, and
8 the annual fiscal reporting to the commissioner.
- 9 e. Procedures for selecting the board of directors and
10 submitting the selections to the commissioner for approval.
- 11 f. Establishing, in cooperation with the commissioner of
12 insurance and the state comptroller, procedures for the
13 determination and payment to the association from the health
14 insurance trust fund of amounts which represent the net loss
15 for the preceding calendar year to the association. The
16 amount of the payment shall be based upon the amount of funds
17 deposited in the health insurance trust fund and the amount of
18 net loss of the association. If funds deposited in the health
19 insurance trust fund are insufficient to pay all of the
20 losses, the state comptroller shall notify the commissioner of
21 insurance and the association of the amount of the deficiency.
- 22 g. The periodic advertising of the general availability of
23 health insurance coverage from the association.
- 24 h. Additional provisions necessary or proper for the
25 execution of the powers and duties of the association.
- 26 4. The plan of operation may provide that the powers and
27 duties of the association may be delegated to a person who
28 will perform functions similar to those of the association. A
29 delegation under this section takes effect only upon the
30 approval of both the board of directors and the commissioner.
31 The commissioner shall not approve a delegation unless the
32 protections afforded to the insured are substantially
33 equivalent to or greater than those provided under this
34 chapter.
- 35 5. The association has the general powers and authority

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

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

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

12 c. Take legal action necessary to avoid the payment of im-
13 proper claims against the association or the coverage provided
14 by or through the association.

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

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

22 f. Pool risks among members.

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

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

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

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

1 within the authority of the association.

2 k. Hire independent consultants as necessary.

3 l. Develop a method of advising applicants of the availa-
4 bility of other coverages outside the association, and shall
5 promulgate a list of health conditions the existence of which
6 would make an applicant eligible without demonstrating a re-
7 jection of coverage by one carrier.

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

19 6. Rates for coverages issued by the association shall not
20 be unreasonable in relation to the benefits provided, the risk
21 experience, and the reasonable expenses of providing coverage.
22 Separate scales of rates based on age may apply for individual
23 risks. Rates must take into consideration the extra morbidity
24 and administration expenses, if any, for risks insured in the
25 association. The rates for a given classification shall not
26 be more than one hundred fifty percent of the average premium
27 or payment rate for that classification charged by the five
28 carriers with the largest health insurance premium or payment
29 volume in the state during the preceding calendar year. In
30 determining the average rate of the five largest carriers, the
31 rates or payments charged by the carriers shall be actuarially
32 adjusted to determine the rate or payment that would have been
33 charged for benefits similar to those issued by the
34 association.

35 7. Following the close of each calendar year, the

1 association shall determine the net premiums and payments, the
2 expenses of administration, and the incurred losses of the
3 association for the year. The association shall certify the
4 amount of any net loss for the preceding calendar year to the
5 commissioner of insurance and state comptroller who shall make
6 payment to the association according to procedures established
7 under subsection 3, paragraph "f". Any remaining loss, after
8 payment to the association from the health insurance trust
9 fund, shall be assessed by the association to all members in
10 proportion to their respective shares of total health
11 insurance premiums or payments for subscriber contracts
12 received in Iowa during the second preceding calendar year, or
13 with paid losses in the year, coinciding with or ending during
14 the calendar year or on any other equitable basis as provided
15 in the plan of operation. In sharing losses, the association
16 may abate or defer in any part the assessment of a member, if,
17 in the opinion of the board, payment of the assessment would
18 endanger the ability of the member to fulfill its contractual
19 obligations. The association may also provide for an initial
20 or interim assessment against members of the association if
21 necessary to assure the financial capability of the
22 association to meet the incurred or estimated claims expenses
23 or operating expenses of the association until the next
24 calendar year is completed. Net gains, if any, must be held
25 at interest to offset future losses or allocated to reduce
26 future premiums.

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

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

1 approved by the commissioner.

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

4 11. The association shall not issue an association policy
5 to an individual who, on the effective date of the coverage
6 applied for, has not been rejected for, already has, or will
7 have coverage similar to an association policy, as an insured
8 or covered dependent.

9 12. The association shall pay an agent's referral fee of
10 twenty-five dollars to each insurance agent who refers an
11 applicant to the association if that applicant is accepted.

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

15 14. A member who, after July 1, 1986, has paid one or more
16 assessments levied under this chapter may take a credit
17 against the premium taxes, or similar taxes, upon revenues or
18 income of the member that are imposed by the state on health
19 insurance premiums pursuant to chapter 432 or payments subject
20 to taxation under section 514B.31, up to the amount of twenty
21 percent of those taxes due, for each of the five calendar
22 years following the year for which an assessment was paid, or
23 until the aggregate of those assessments has been offset by
24 credits against those taxes if this occurs first. If a member
25 ceases doing business, all uncredited assessments may be
26 credited against its premium tax liability for the year it
27 ceases doing business.

28 Sec. 3. NEW SECTION. 514E.3 HEALTH INSURANCE TRUST FUND
29 -- DEPOSIT OF MONEYS.

30 A health insurance trust fund is created within the state
31 treasury. Commencing in the calendar year beginning January
32 1, 1987, and annually thereafter, there shall be deposited in
33 the health insurance trust fund twenty-five percent of the
34 moneys set aside pursuant to 1985 Iowa Acts, chapter 239,
35 section 8. The moneys in the health insurance trust fund and

1 any income to the fund shall be used to make the payments
2 provided for in section 514E.2, subsection 3, paragraph "f".
3 If after making a payment, there is a balance remaining in the
4 health insurance trust fund, the balance shall be retained in
5 the fund together with any interest or earnings that is earned
6 on the balance and may be used to cover future expenses of the
7 association. However, if the balance of the health insurance
8 trust fund after the payments provided for in section 514E.2,
9 subsection 3, paragraph "f" exceeds ten million dollars, then
10 the amount of the funds in excess of the ten million dollars
11 shall be transferred to the separate account established in
12 1985 Iowa Acts, chapter 239, section 8.

13 Moneys deposited in the health insurance trust fund may be
14 invested by the treasurer of state in the same manner as
15 moneys in the general fund.

16 Sec. 4. NEW SECTION. 514E.4 ASSOCIATION POLICY --
17 COVERAGE AND BENEFIT REQUIREMENTS -- ELIGIBLE EXPENSES.

18 The association policy shall pay only the usual, customary
19 and reasonable charges for medically necessary eligible health
20 care services which exceed the deductible and coinsurance
21 amounts applicable under section 514E.6. Eligible expenses
22 are the charges for the following health care services
23 furnished by a health care provider in an emergency situation
24 or furnished or prescribed by a health care provider:

25 1. Hospital services, including charges for the most
26 common semiprivate room, for the most common private room if
27 semiprivate rooms do not exist in the health care facility, or
28 for the private room if medically necessary, but limited to a
29 total of one hundred eighty days in a calendar year.

30 2. Professional services for the diagnosis or treatment of
31 injuries, illnesses, or conditions, other than mental or
32 dental, which are rendered by a health care provider, or at
33 the direction of a health care provider, by a staff of
34 registered nurses, licensed practical nurses, or other health
35 care providers.

- 1 3. The first twenty professional visits for the diagnosis
2 or treatment of one or more mental conditions, rendered during
3 a calendar year by one or more health care providers, or at
4 their direction, by their staff of registered nurses, licensed
5 practical nurses, or other health care providers.
- 6 4. Drugs and contraceptive devices requiring a prescrip-
7 tion.
- 8 5. Services of a skilled nursing facility as defined in
9 section 135C.1, subsection 3, or services in an intermediate
10 care facility as defined in section 135C.1, subsection 2, to
11 the same extent as the services would be paid in a skilled
12 nursing facility, for not more than one hundred eighty days in
13 a calendar year.
- 14 6. Homemaker-home health services up to one hundred eighty
15 days of service in a calendar year.
- 16 7. Use of radium or other radioactive material.
- 17 8. Oxygen.
- 18 9. Anesthetics.
- 19 10. Prostheses, other than dental.
- 20 11. Rental of durable medical equipment, other than eye
21 glasses and hearing aids, which have no personal use in the
22 absence of the condition for which prescribed.
- 23 12. Diagnostic X rays and laboratory tests.
- 24 13. Oral surgery for any of the following:
- 25 a. Excision of partially or completely erupted impacted
26 teeth.
- 27 b. Excision of a tooth root without the extraction of the
28 entire tooth.
- 29 c. The gums and tissues of the mouth when not performed in
30 connection with the extraction or repair of teeth.
- 31 14. Services of a physical therapist and services of a
32 speech therapist.
- 33 15. Professional ambulance services to the nearest health
34 care facility qualified to treat the illness, injury, or
35 condition.

1 16. Processing of blood, including but not limited to,
2 collecting, testing, fractionating, and distributing blood.

3 Sec. 5. NEW SECTION. 514E.5 EXPENSES EXCLUDED.

4 Eligible expenses shall not include an expense for any of
5 the following:

6 1. Services for which a charge is not made in the absence
7 of insurance or for which there is no legal obligation on the
8 part of a patient to pay.

9 2. Services and charges made for benefits provided under
10 the laws of the United States, including Medicare and
11 Medicaid, military service-connected disabilities, medical
12 services provided for members of the armed forces and their
13 dependents or for employees of the armed forces of the United
14 States, and medical services financed on behalf of all
15 citizens by the United States.

16 3. Benefits which would duplicate the provision of
17 services or payment of charges for any care for an injury,
18 disease, or condition for which either of the following
19 applies:

20 a. It arises out of and in the course of an employment
21 subject to a workers' compensation or similar law.

22 b. Benefits for it are payable without regard to fault
23 under a coverage required to be contained in any motor vehicle
24 or other liability insurance policy or equivalent self-
25 insurance. However, this does not authorize exclusion of
26 charges that exceed the benefits payable under the applicable
27 workers' compensation or no-fault coverage.

28 4. Care which is primarily for a custodial or domiciliary
29 purpose.

30 5. Cosmetic surgery unless provided as the result of an
31 injury or medically necessary surgical procedure.

32 6. Services the provision of which is not within the scope
33 of the license or certificate of the institution or individual
34 rendering the services.

35 7. That part of any charge for services or articles

1 rendered or prescribed by a health care provider which exceeds
2 the prevailing charge in the locality where the service is
3 provided, or a charge for services or articles not medically
4 necessary.

5 8. Services rendered prior to the effective date of
6 coverage under this plan for the person on whose behalf the
7 expense is incurred.

8 9. Routine physical examinations including examinations to
9 determine the need for eye glasses and hearing aids.

10 10. Illness or injury due to an act of war.

11 11. Service of a blood donor and any fee for failure to
12 replace the first three pints of blood provided to an eligible
13 person each calendar year.

14 12. Personal supplies or services provided by a health
15 care facility or any other nonmedical or nonprescribed supply
16 or service.

17 13. Experimental services or supplies. Experimental means
18 a service or supply not recognized by the appropriate medical
19 board as normal mode of treatment for the illness or injury
20 involved.

21 14. Eye surgery if corrective lenses would alleviate the
22 problem.

23 The coverage and benefit requirements of this section for
24 association policies shall not be altered by any other state
25 law without specific reference to this chapter indicating a
26 legislative intent to add or delete from the coverage
27 requirements of this chapter.

28 This chapter does not prohibit the association from issuing
29 additional types of health insurance policies with different
30 types of benefits which, in the opinion of the board of
31 directors, may be of benefit to the citizens of the state.

32 Sec. 6. NEW SECTION. 514E.6 POLICIES, DEDUCTIBLE AND
33 COINSURANCE REQUIREMENTS -- LIMITATIONS -- LIFETIME BENEFIT
34 LIMIT.

35 1. Except as provided in subsection 3, an association

1 policy offered in accordance with this chapter shall include a
2 deductible. Deductibles of five hundred dollars and one
3 thousand dollars on a per person per calendar year basis shall
4 be offered. The board may authorize deductibles in other
5 amounts. The deductibles must be applied to the first five
6 hundred dollars, one thousand dollars, or other authorized
7 amount of eligible expenses incurred by the covered person.

8 2. Except as provided in subsection 3, a mandatory
9 coinsurance requirement shall be imposed at the rate of twenty
10 percent of eligible expenses in excess of the mandatory
11 deductible.

12 3. The maximum aggregate out-of-pocket payments for
13 eligible expenses by the insured in the form of deductibles
14 and coinsurance shall not exceed in a policy year:

15 a. One thousand five hundred dollars for an individual
16 five-hundred-dollar deductible policy.

17 b. Two thousand dollars for an individual one-thousand-
18 dollar deductible policy.

19 c. Three thousand dollars for a family five-hundred-dollar
20 deductible policy.

21 d. Four thousand dollars for a family one-thousand-dollar
22 deductible policy.

23 e. An amount authorized by the board for any other de-
24 ductible policy.

25 4. For a family policy, the maximum annual deductible
26 under the policy shall be the deductible chosen for a maximum
27 of two individuals under the policy.

28 5. Eligible expenses incurred by a covered person in the
29 last three months of a calendar year, and applied toward a
30 deductible, shall also be applied toward the deductible amount
31 in the next calendar year.

32 6. The lifetime benefit per covered person is two hundred
33 fifty thousand dollars.

34 7. The association shall, in addition to other policies,
35 offer Medicare supplement policies designed to supplement

1 Medicare and provide coverage of at least fifty percent of the
2 deductible and eighty percent of the covered expenses in
3 section 514E.4. Medicare supplement plans are subject to the
4 same limitations on premiums, deductibility, and annual out-
5 of-pocket expenses as other association policies.

6 Sec. 7. NEW SECTION. 514E.7 POLICIES -- ELIGIBLE PERSONS
7 -- DEPENDENT COVERAGE -- PREEXISTING CONDITIONS.

8 1. A person is not eligible for an association policy if
9 the person, at the effective date of coverage, has or will
10 have coverage under any insurance plan that has coverage
11 equivalent to an association policy. Only residents of this
12 state are eligible for an association policy. Coverage under
13 an association policy is in excess of, and shall not
14 duplicate, coverage under any other form of health insurance.

15 2. A person is eligible to apply for an association policy
16 only if that person has been rejected for similar health
17 insurance coverage or is only offered health insurance
18 coverage at a rate exceeding the association rate.

19 3. An association policy shall provide that coverage of a
20 dependent unmarried person terminates when the person becomes
21 nineteen years of age or, if the person is enrolled full time
22 in an accredited educational institution, terminates at
23 twenty-five years of age. The policy shall also provide in
24 substance that attainment of the limiting age does not operate
25 to terminate coverage when the person is and continues to be
26 both of the following:

27 a. Incapable of self-sustaining employment by reason of
28 mental retardation or physical handicap.

29 b. Primarily dependent for support and maintenance upon
30 the person in whose name the contract is issued.

31 Proof of incapacity and dependency must be furnished to the
32 carrier within one hundred twenty days of the person's attain-
33 ment of the limiting age, and subsequently as may be required
34 by the carrier, but not more frequently than annually after
35 the two-year period following the person's attainment of the

1 limiting age.

2 4. An association policy that provides coverage for a
3 family member of the person in whose name the contract is
4 issued shall also provide, as to the family member's coverage,
5 that the health insurance benefits applicable for children
6 include the coverage required under section 514C.1.

7 5. An association policy may contain provisions under
8 which coverage is excluded during a period of six months
9 following the effective date of coverage as to a given covered
10 individual for preexisting conditions, as long as either of
11 the following exist:

12 a. The condition has manifested itself within a period of
13 six months before the effective date of coverage in such a
14 manner as would cause an ordinarily prudent person to seek
15 diagnosis or treatment.

16 b. Medical advice or treatment was recommended or received
17 within a period of six months before the effective date of
18 coverage.

19 These preexisting condition exclusions shall be waived to
20 the extent to which similar exclusions have been satisfied
21 under any prior health insurance coverage which was
22 involuntarily terminated, if the application for pool coverage
23 is made not later than thirty days following the involuntary
24 termination. In that case, coverage in the pool shall be
25 effective from the date on which the prior coverage was
26 terminated.

27 This subsection does not prohibit preexisting conditions
28 coverage in an association policy that is more favorable to
29 the insured than that specified in this subsection.

30 6. An individual is not eligible for coverage by the
31 association if any of the following apply:

32 a. The individual is at the time of application eligible
33 for health care benefits under chapter 249A.

34 b. The individual has terminated coverage by the
35 association within the past twelve months.

1 c. The individual is an inmate of a public institution or
2 is eligible for public programs for which medical care is
3 provided.

4 Sec. 8. NEW SECTION. 514E.8 POLICIES -- RENEWAL
5 PROVISIONS -- ELECTION TO CONTINUE COVERAGE UPON DEATH OF
6 POLICYHOLDER.

7 1. An association policy shall contain provisions under
8 which the association is obligated to renew the contract until
9 the day on which the individual in whose name the contract is
10 issued first becomes eligible for Medicare coverage, except
11 that in a family policy covering both husband and wife, the
12 age of the younger spouse shall be used as the basis for
13 meeting the durational requirements of this subsection.
14 However, when the individual in whose name the contract is
15 issued becomes eligible for Medicare coverage, the person
16 shall be eligible for the Medicare supplement plan offered by
17 the association.

18 2. The association shall not change the rates for
19 association policies except on a class basis with a clear
20 disclosure in the policy of the association's right to do so.

21 3. An association policy shall provide that upon the death
22 of the individual in whose name the policy is issued, every
23 other individual then covered under the contract may elect,
24 within a period specified in the policy, to continue coverage
25 under the same or a different policy until such time as the
26 person would have ceased to be entitled to coverage had the
27 individual in whose name the policy was issued lived.

28 Sec. 9. NEW SECTION. 514E.9 RULES.

29 Pursuant to chapter 17A, the commissioner shall adopt rules
30 to provide for disclosure by carriers of the availability of
31 insurance coverage from the association, and to otherwise
32 implement this chapter.

33 Sec. 10. NEW SECTION. 514E.10 COLLECTIVE ACTION.

34 Neither the participation by carriers or members in the
35 association, the establishment of rates, forms, or procedures

1 for coverage issued by the association, nor any joint or
2 collective action required by this chapter shall be the basis
3 of any legal civil action, or criminal liability against the
4 association or members of it either jointly or separately.

5 Sec. 11. NEW SECTION. 514E.11 NOTICE OF ASSOCIATION
6 POLICY.

7 Commencing July 1, 1986, every carrier, including a health
8 maintenance organization subject to chapter 514B, authorized
9 to provide health care insurance or coverage for health care
10 services in Iowa, shall provide a notice and an application
11 for coverage by the association to any person who receives a
12 rejection of coverage for health insurance or health care
13 services, or a notice to any person who is informed that a
14 rate for health insurance or coverage for health care services
15 will exceed the rate of an association policy, that effective
16 January 1, 1987, that person is eligible to apply for health
17 insurance provided by the association. Application for the
18 health insurance shall be on forms prescribed by the board and
19 made available to the carriers.

20 Sec. 12. Health insurance coverage provided under this Act
21 shall not be effective until January 1 following the effective
22 date of this Act.

23 EXPLANATION

24 This bill establishes the Iowa comprehensive health
25 association, the purpose of which is to provide accident and
26 health insurance for persons who might otherwise not be
27 eligible for the coverage or who cannot obtain it at a
28 reasonable cost. The association shall offer a Medicare
29 supplement plan. Carriers who write accident and health
30 insurance in Iowa and who are subject to the insurance premium
31 tax are required to be members of the association. Self-
32 insurers would not be members of the association. When
33 premiums and payments from the health insurance trust fund
34 created by this Act are insufficient to provide financing for
35 the association, members of the association must be assessed

1 amounts sufficient to finance the association and coverages
2 provided by it. Credit against certain premium taxes is
3 provided to offset the assessment. The coverage limitations
4 are specified as well as the duties of the commissioner of
5 insurance and the association. A portion of the funds
6 collected pursuant to 1985 Iowa Acts, chapter 239, is used in
7 the health insurance trust fund created by this Act. The
8 balance of funds in the health insurance trust fund shall not
9 exceed ten million dollars.

HOUSE FILE 2181
FISCAL NOTE

REQUESTED BY REPRESENTATIVE BRAMMER

In compliance with a written request received February 5, 1986, a fiscal note for HOUSE FILE 2181 is hereby submitted pursuant to Joint Rule 17. Data used in developing this fiscal note are available from the Legislative Fiscal Bureau to members of the Legislature upon request.

House File 2181 establishes the Iowa Comprehensive Health Association to provide accident and health insurance for persons who are not eligible or who cannot obtain coverage at a reasonable cost. Carriers who write accident and health insurance in Iowa and who are subject to the insurance premium tax are required to be members of the Association. The bill requires 25 percent of the moneys deposited in the Insurance Premium Set Aside Fund to be deposited in the Health Insurance Trust Fund commencing January 1, 1987.

Fiscal Effect: Assuming the Insurance Premium Tax will generate approximately \$80 million annually, House File 2181 would transfer approximately \$2.0 million (25%) annually from the Insurance Premium Set Aside Fund to the Health Insurance Trust Fund created in this Act commencing January 1, 1987.

The estimated cost to the Insurance Department is expected to be less than \$500 per year.
(LSB 8068H, TCF)

FILED FEBRUARY 13, 1986

BY DENNIS PROUTY, FISCAL DIRECTOR

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HOUSE FILE 2181

H-5089

1 Amend House File 2181 as follows:

- 2 1. Page 1, by striking lines 27 through 34 and
3 inserting in lieu thereof the following:
4 "7. "Health care services" means services, the
5 coverage of which is authorized under chapter 509,
6 chapter 514, chapter 514A, or chapter 514B as limited
7 by sections 514E.4 and 514E.5, and includes services
8 for the purposes of preventing, alleviating, curing,
9 or healing human illness, injury or physical
10 disability."

H-5089 FILED FEBRUARY 13, 1986 BY BRAMMER of Linn

Adopted 2/17/86 (p. 518)

HOUSE FILE 2181

H-5098

1 Amend House File 2181 as follows:

- 2 1. Page 8, by striking line 31 and inserting the
3 following: "treasury. Commencing July".
4 2. Page 17, by inserting after line 19 the
5 following:
6 "Sec. _____. There is appropriated from the general
7 fund of the state on January 1, 1987 for the period
8 January 1, 1987 to July 1, 1987, to the Iowa
9 comprehensive health association the sum of twenty-
10 five thousand (25,000) dollars or as much thereof as
11 necessary for salaries and expenses."

H-5098 FILED FEBRUARY 13, 1986 BY BRAMMER of Linn

Adopted 2/14 (p. 318)

HOUSE FILE 2181
AMENDMENT H-5098
FISCAL NOTE

REQUESTED BY REPRESENTATIVE BRAMMER

In compliance with a written request received February 13, 1986, a fiscal note for AMENDMENT H5098 TO H.F. 2181 is hereby submitted pursuant to Joint Rule 17. Data used in developing this fiscal note are available from the Legislative Fiscal Bureau to members of the Legislature upon request.

Amendment H5098 to House File 2181 would delay the effective date of transferring 25 percent of the Insurance Premium Set Aside Fund to the Health Insurance Trust Fund from January 1, 1987 to July 1, 1987. The amendment also provides for an appropriation to the Health Insurance Trust Fund.

Fiscal Effect: Amendment H5098 provides a \$25,000 start up appropriation to the Health Insurance Trust Fund for the period January 1, 1987 through June 30, 1987. The amendment transfer \$2.0 million (25%) from the insurance Premium Set Aside Fund to the Health Insurance Trust Fund effective July 1, 1987 instead of January 1, 1987.

The estimated cost to the Insurance Department is expected to be less than \$500 per year.
(LSB 8068H.2. TCF)

FILED FEBRUARY 13, 1986

BY DENNIS PROUTY, FISCAL DIRECTOR

HOUSE FILE 2181

H-5220

- 1 Amend House File 2181 as follows:
- 2 1. Title page, line 5, by inserting after the word
- 3 "coverage" the following: and providing an appropriation".

H-5220 FILED MARCH 3, 1986 BY BRAMMER of Linn

ADOPTED BY UNANIMOUS CONSENT

(p. 523)

Gen. Commerce 3/6 No Pass 3/26 (p. 904)

House File 2181

COMMERCE: Palmer, Chair; Tieden and Jensen

Appropriation 4/2

HOUSE FILE 2181
BY COMMITTEE ON SMALL BUSINESS
AND COMMERCE

(As Amended and Passed by the House March 3, 1986)

Passed House, Date 3-3-86 (p. 523) Passed Senate, Date 4-16-86 (p. 1164)

Vote: Ayes 96 Nays 2 Vote: Ayes 48 Nays 1

Approved April 28, 1986 (p. 1855)

A BILL FOR

- 1 An Act establishing the Iowa comprehensive health association,
- 2 providing for a plan of operation, establishing financial
- 3 procedures, providing eligible expenses, excluding certain
- 4 requirements, and relating to other provisions of health
- 5 insurance coverage and providing an appropriation.
- 6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

HOUSE FILE 2181

S-5533

- 1 Amend House File 2181 as amended, passed, and
- 2 reprinted by the House as follows:
- 3 1. Page 14, line 14, by inserting after the word
- 4 "rejected" the following: "for medical reasons".
- 5 2. Page 14, line 16, by inserting after the word
- 6 "coverage" the following: "that is similar to the
- 7 association's coverage".

S-5533 Filed April 2, 1986

BY HOLDEN

28/10 4/10 (p. 1164)

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HF 2181

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1 Section 1. NEW SECTION. 514E.1 DEFINITIONS.

2 As used in this chapter, unless the context otherwise re-
3 quires:

4 1. "Association" means the Iowa comprehensive health as-
5 sociation established by section 514E.2.

6 2. "Association policy" means an individual policy issued
7 by the association that provides the coverage specified in
8 section 514E.4.

9 3. "Carrier" means an insurer providing accident and sick-
10 ness insurance under chapter 509, 514 or 514A and includes a
11 health maintenance organization established under chapter 514B
12 if payments received by the health maintenance organization
13 are considered premiums pursuant to section 514B.31 and are
14 taxed under chapter 432. "Carrier" also includes a
15 corporation which becomes a mutual insurer pursuant to section
16 514.23 and any other person as defined in section 4.1,
17 subsection 13, who is or may become liable for the tax imposed
18 by chapter 432.

19 4. "Commissioner" means the commissioner of insurance.

20 5. "Eligible expenses" means the usual, customary and rea-
21 sonable charges for the health care services specified in
22 section 514E.4.

23 6. "Health care facility" means a health care facility as
24 defined in section 135C.1, subsection 4, a hospital as defined
25 in section 135B.1, subsection 1, or a community mental health
26 center established under chapter 230A.

27 7. "Health care services" means services, the coverage of
28 which is authorized under chapter 509, chapter 514, chapter
29 514A, or chapter 514B as limited by sections 514E.4 and
30 514E.5, and includes services for the purposes of preventing,
31 alleviating, curing, or healing human illness, injury or
32 physical disability.

33 8. "Health insurance" means accident and sickness
34 insurance authorized by chapter 509, 514 or 514A.

35 9. "Health insurance trust fund" means the fund created in

1 section 514E.3.

2 10. "Insured" means an individual who is provided
3 qualified comprehensive health insurance under an association
4 policy, which policy may include dependents and other covered
5 persons.

6 11. "Medicaid" means the federal-state assistance program
7 established under Title XIX of the federal Social Security
8 Act.

9 12. "Medicare" means the federal government health
10 insurance program established under Title XVIII of the Social
11 Security Act.

12 13. "Policy" means a contract, policy, or plan of health
13 insurance.

14 14. "Policy year" means a consecutive twelve-month period
15 during which a policy provides or obligates the carrier to
16 provide health insurance.

17 Sec. 2. NEW SECTION. 514E.2 IOWA COMPREHENSIVE HEALTH
18 ASSOCIATION.

19 1. There is established a nonprofit corporation known as
20 the Iowa comprehensive health insurance association which
21 shall assure that health insurance, as limited by sections
22 514E.4 and 514E.5, is made available to each eligible Iowa
23 resident applying to the association for coverage. All
24 carriers as defined in section 514E.1, subsection 3, providing
25 health insurance or health care services in Iowa shall be mem-
26 bers of the association. The association shall operate under
27 a plan of operation established and approved under subsection
28 3 and shall exercise its powers through a board of directors
29 established under this section.

30 2. The board of directors of the association shall consist
31 of not less than four nor more than eight members selected by
32 the members of the association, subject to approval by the
33 commissioner and a public member selected by the commissioner.

34 In order to select the initial board of directors and
35 organize the association, the commissioner shall give notice

1 to all carriers of the time and place of the organizational
2 meeting. In determining voting rights at the organizational
3 meeting, each carrier member is entitled to one vote in person
4 or by proxy. If the board of directors is not selected within
5 sixty days after the organizational meeting, the commissioner
6 shall appoint the initial board. In approving or selecting
7 members of the board, the commissioner shall consider whether
8 all carriers are fairly represented. Members of the board may
9 be reimbursed from the moneys of the association for expenses
10 incurred by them as members, but shall not be otherwise
11 compensated by the association for their services.

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

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

- 1 b. The amount and method of reimbursing members of the
2 board.
- 3 c. Regular times and places for meeting of the board of
4 directors.
- 5 d. Records to be kept of all financial transactions, and
6 the annual fiscal reporting to the commissioner.
- 7 e. Procedures for selecting the board of directors and
8 submitting the selections to the commissioner for approval.
- 9 f. Establishing, in cooperation with the commissioner of
10 insurance and the state comptroller, procedures for the
11 determination and payment to the association from the health
12 insurance trust fund of amounts which represent the net loss
13 for the preceding calendar year to the association. The
14 amount of the payment shall be based upon the amount of funds
15 deposited in the health insurance trust fund and the amount of
16 net loss of the association. If funds deposited in the health
17 insurance trust fund are insufficient to pay all of the
18 losses, the state comptroller shall notify the commissioner of
19 insurance and the association of the amount of the deficiency.
- 20 g. The periodic advertising of the general availability of
21 health insurance coverage from the association.
- 22 h. Additional provisions necessary or proper for the
23 execution of the powers and duties of the association.
- 24 4. The plan of operation may provide that the powers and
25 duties of the association may be delegated to a person who
26 will perform functions similar to those of the association. A
27 delegation under this section takes effect only upon the
28 approval of both the board of directors and the commissioner.
29 The commissioner shall not approve a delegation unless the
30 protections afforded to the insured are substantially
31 equivalent to or greater than those provided under this
32 chapter.
- 33 5. The association has the general powers and authority
34 enumerated by this subsection and executed in accordance with
35 the plan of operation approved by the commissioner under

- 1 subsection 3. The association has the general powers and
2 authority granted under the laws of this state to carriers
3 licensed to issue health insurance. In addition, the
4 association may do any of the following:
- 5 a. Enter into contracts as necessary or proper to carry
6 out this chapter.
 - 7 b. Sue or be sued, including taking any legal action
8 necessary or proper for recovery of any assessments for, on
9 behalf of, or against participating carriers.
 - 10 c. Take legal action necessary to avoid the payment of im-
11 proper claims against the association or the coverage provided
12 by or through the association.
 - 13 d. Establish or utilize a medical review committee to
14 determine the reasonably appropriate level and extent of
15 health care services in each instance.
 - 16 e. Establish appropriate rates, scales of rates, rate
17 classifications, and rating adjustments, which rates shall not
18 be unreasonable in relation to the coverage provided and the
19 reasonable operations expenses of the association.
 - 20 f. Pool risks among members.
 - 21 g. Issue association policies on an indemnity or provision
22 of service basis providing the coverage required by this
23 chapter.
 - 24 h. Administer separate pools, separate accounts, or other
25 plans or arrangements considered appropriate for separate
26 members or groups of members.
 - 27 i. Operate and administer any combination of plans, pools,
28 or other mechanisms considered appropriate to best accomplish
29 the fair and equitable operation of the association.
 - 30 j. Appoint from among members appropriate legal,
31 actuarial, and other committees as necessary to provide
32 technical assistance in the operation of the association,
33 policy and other contract design, and any other functions
34 within the authority of the association.
 - 35 k. Hire independent consultants as necessary.

1 1. Develop a method of advising applicants of the availa-
2 bility of other coverages outside the association, and shall
3 promulgate a list of health conditions the existence of which
4 would make an applicant eligible without demonstrating a re-
5 jection of coverage by one carrier.

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

17 6. Rates for coverages issued by the association shall not
18 be unreasonable in relation to the benefits provided, the risk
19 experience, and the reasonable expenses of providing coverage.
20 Separate scales of rates based on age may apply for individual
21 risks. Rates must take into consideration the extra morbidity
22 and administration expenses, if any, for risks insured in the
23 association. The rates for a given classification shall not
24 be more than one hundred fifty percent of the average premium
25 or payment rate for that classification charged by the five
26 carriers with the largest health insurance premium or payment
27 volume in the state during the preceding calendar year. In
28 determining the average rate of the five largest carriers, the
29 rates or payments charged by the carriers shall be actuarially
30 adjusted to determine the rate or payment that would have been
31 charged for benefits similar to those issued by the
32 association.

33 7. Following the close of each calendar year, the
34 association shall determine the net premiums and payments, the
35 expenses of administration, and the incurred losses of the

1 association for the year. The association shall certify the
2 amount of any net loss for the preceding calendar year to the
3 commissioner of insurance and state comptroller who shall make
4 payment to the association according to procedures established
5 under subsection 3, paragraph "f". Any remaining loss, after
6 payment to the association from the health insurance trust
7 fund, shall be assessed by the association to all members in
8 proportion to their respective shares of total health
9 insurance premiums or payments for subscriber contracts
10 received in Iowa during the second preceding calendar year, or
11 with paid losses in the year, coinciding with or ending during
12 the calendar year or on any other equitable basis as provided
13 in the plan of operation. In sharing losses, the association
14 may abate or defer in any part the assessment of a member, if,
15 in the opinion of the board, payment of the assessment would
16 endanger the ability of the member to fulfill its contractual
17 obligations. The association may also provide for an initial
18 or interim assessment against members of the association if
19 necessary to assure the financial capability of the
20 association to meet the incurred or estimated claims expenses
21 or operating expenses of the association until the next
22 calendar year is completed. Net gains, if any, must be held
23 at interest to offset future losses or allocated to reduce
24 future premiums.

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

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

35 10. All policy forms issued by the association must be

1 filed with and approved by the commissioner before their use.

2 11. The association shall not issue an association policy
3 to an individual who, on the effective date of the coverage
4 applied for, has not been rejected for, already has, or will
5 have coverage similar to an association policy, as an insured
6 or covered dependent.

7 12. The association shall pay an agent's referral fee of
8 twenty-five dollars to each insurance agent who refers an
9 applicant to the association if that applicant is accepted.

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

13 14. A member who, after July 1, 1986, has paid one or more
14 assessments levied under this chapter may take a credit
15 against the premium taxes, or similar taxes, upon revenues or
16 income of the member that are imposed by the state on health
17 insurance premiums pursuant to chapter 432 or payments subject
18 to taxation under section 514B.31, up to the amount of twenty
19 percent of those taxes due, for each of the five calendar
20 years following the year for which an assessment was paid, or
21 until the aggregate of those assessments has been offset by
22 credits against those taxes if this occurs first. If a member
23 ceases doing business, all uncredited assessments may be
24 credited against its premium tax liability for the year it
25 ceases doing business.

26 Sec. 3. NEW SECTION. 514E.3 HEALTH INSURANCE TRUST FUND
27 -- DEPOSIT OF MONEYS.

28 A health insurance trust fund is created within the state
29 treasury. Commencing July 1, 1987, and annually thereafter,
30 there shall be deposited in the health insurance trust fund
31 twenty-five percent of the moneys set aside pursuant to 1985
32 Iowa Acts, chapter 239, section 8. The moneys in the health
33 insurance trust fund and any income to the fund shall be used
34 to make the payments provided for in section 514E.2,
35 subsection 3, paragraph "f". If after making a payment, there

1 is a balance remaining in the health insurance trust fund, the
2 balance shall be retained in the fund together with any
3 interest or earnings that is earned on the balance and may be
4 used to cover future expenses of the association. However, if
5 the balance of the health insurance trust fund after the
6 payments provided for in section 514E.2, subsection 3,
7 paragraph "f" exceeds ten million dollars, then the amount of
8 the funds in excess of the ten million dollars shall be
9 transferred to the separate account established in 1985 Iowa
10 Acts, chapter 239, section 8.

11 Moneys deposited in the health insurance trust fund may be
12 invested by the treasurer of state in the same manner as
13 moneys in the general fund.

14 Sec. 4. NEW SECTION. 514E.4 ASSOCIATION POLICY --
15 COVERAGE AND BENEFIT REQUIREMENTS -- ELIGIBLE EXPENSES.

16 The association policy shall pay only the usual, customary
17 and reasonable charges for medically necessary eligible health
18 care services which exceed the deductible and coinsurance
19 amounts applicable under section 514E.6. Eligible expenses
20 are the charges for the following health care services
21 furnished by a health care provider in an emergency situation
22 or furnished or prescribed by a health care provider:

23 1. Hospital services, including charges for the most
24 common semiprivate room, for the most common private room if
25 semiprivate rooms do not exist in the health care facility, or
26 for the private room if medically necessary, but limited to a
27 total of one hundred eighty days in a calendar year.

28 2. Professional services for the diagnosis or treatment of
29 injuries, illnesses, or conditions, other than mental or
30 dental, which are rendered by a health care provider, or at
31 the direction of a health care provider, by a staff of
32 registered nurses, licensed practical nurses, or other health
33 care providers.

34 3. The first twenty professional visits for the diagnosis
35 or treatment of one or more mental conditions, rendered during

- 1 a calendar year by one or more health care providers, or at
2 their direction, by their staff of registered nurses, licensed
3 practical nurses, or other health care providers.
- 4 4. Drugs and contraceptive devices requiring a prescrip-
5 tion.
- 6 5. Services of a skilled nursing facility as defined in
7 section 135C.1, subsection 3, or services in an intermediate
8 care facility as defined in section 135C.1, subsection 2, to
9 the same extent as the services would be paid in a skilled
10 nursing facility, for not more than one hundred eighty days in
11 a calendar year.
- 12 6. Homemaker-home health services up to one hundred eighty
13 days of service in a calendar year.
- 14 7. Use of radium or other radioactive material.
- 15 8. Oxygen.
- 16 9. Anesthetics.
- 17 10. Prostheses, other than dental.
- 18 11. Rental of durable medical equipment, other than eye
19 glasses and hearing aids, which have no personal use in the
20 absence of the condition for which prescribed.
- 21 12. Diagnostic X rays and laboratory tests.
- 22 13. Oral surgery for any of the following:
- 23 a. Excision of partially or completely erupted impacted
24 teeth.
- 25 b. Excision of a tooth root without the extraction of the
26 entire tooth.
- 27 c. The gums and tissues of the mouth when not performed in
28 connection with the extraction or repair of teeth.
- 29 14. Services of a physical therapist and services of a
30 speech therapist.
- 31 15. Professional ambulance services to the nearest health
32 care facility qualified to treat the illness, injury, or
33 condition.
- 34 16. Processing of blood, including but not limited to,
35 collecting, testing, fractionating, and distributing blood.

1 Sec. 5. NEW SECTION. 514E.5 EXPENSES EXCLUDED.

2 Eligible expenses shall not include an expense for any of
3 the following:

4 1. Services for which a charge is not made in the absence
5 of insurance or for which there is no legal obligation on the
6 part of a patient to pay.

7 2. Services and charges made for benefits provided under
8 the laws of the United States, including Medicare and
9 Medicaid, military service-connected disabilities, medical
10 services provided for members of the armed forces and their
11 dependents or for employees of the armed forces of the United
12 States, and medical services financed on behalf of all
13 citizens by the United States.

14 3. Benefits which would duplicate the provision of
15 services or payment of charges for any care for an injury,
16 disease, or condition for which either of the following
17 applies:

18 a. It arises out of and in the course of an employment
19 subject to a workers' compensation or similar law.

20 b. Benefits for it are payable without regard to fault
21 under a coverage required to be contained in any motor vehicle
22 or other liability insurance policy or equivalent self-
23 insurance. However, this does not authorize exclusion of
24 charges that exceed the benefits payable under the applicable
25 workers' compensation or no-fault coverage.

26 4. Care which is primarily for a custodial or domiciliary
27 purpose.

28 5. Cosmetic surgery unless provided as the result of an
29 injury or medically necessary surgical procedure.

30 6. Services the provision of which is not within the scope
31 of the license or certificate of the institution or individual
32 rendering the services.

33 7. That part of any charge for services or articles
34 rendered or prescribed by a health care provider which exceeds
35 the prevailing charge in the locality where the service is

1 provided, or a charge for services or articles not medically
2 necessary.

3 8. Services rendered prior to the effective date of
4 coverage under this plan for the person on whose behalf the
5 expense is incurred.

6 9. Routine physical examinations including examinations to
7 determine the need for eye glasses and hearing aids.

8 10. Illness or injury due to an act of war.

9 11. Service of a blood donor and any fee for failure to
10 replace the first three pints of blood provided to an eligible
11 person each calendar year.

12 12. Personal supplies or services provided by a health
13 care facility or any other nonmedical or nonprescribed supply
14 or service.

15 13. Experimental services or supplies. Experimental means
16 a service or supply not recognized by the appropriate medical
17 board as normal mode of treatment for the illness or injury
18 involved.

19 14. Eye surgery if corrective lenses would alleviate the
20 problem.

21 The coverage and benefit requirements of this section for
22 association policies shall not be altered by any other state
23 law without specific reference to this chapter indicating a
24 legislative intent to add or delete from the coverage
25 requirements of this chapter.

26 This chapter does not prohibit the association from issuing
27 additional types of health insurance policies with different
28 types of benefits which, in the opinion of the board of
29 directors, may be of benefit to the citizens of the state.

30 Sec. 6. NEW SECTION. 514E.6 POLICIES, DEDUCTIBLE AND
31 COINSURANCE REQUIREMENTS -- LIMITATIONS -- LIFETIME BENEFIT
32 LIMIT.

33 1. Except as provided in subsection 3, an association
34 policy offered in accordance with this chapter shall include a
35 deductible. Deductibles of five hundred dollars and one

1 thousand dollars on a per person per calendar year basis shall
2 be offered. The board may authorize deductibles in other
3 amounts. The deductibles must be applied to the first five
4 hundred dollars, one thousand dollars, or other authorized
5 amount of eligible expenses incurred by the covered person.

6 2. Except as provided in subsection 3, a mandatory
7 coinsurance requirement shall be imposed at the rate of twenty
8 percent of eligible expenses in excess of the mandatory
9 deductible.

10 3. The maximum aggregate out-of-pocket payments for
11 eligible expenses by the insured in the form of deductibles
12 and coinsurance shall not exceed in a policy year:

13 a. One thousand five hundred dollars for an individual
14 five-hundred-dollar deductible policy.

15 b. Two thousand dollars for an individual one-thousand-
16 dollar deductible policy.

17 c. Three thousand dollars for a family five-hundred-dollar
18 deductible policy.

19 d. Four thousand dollars for a family one-thousand-dollar
20 deductible policy.

21 e. An amount authorized by the board for any other de-
22 ductible policy.

23 4. For a family policy, the maximum annual deductible
24 under the policy shall be the deductible chosen for a maximum
25 of two individuals under the policy.

26 5. Eligible expenses incurred by a covered person in the
27 last three months of a calendar year, and applied toward a
28 deductible, shall also be applied toward the deductible amount
29 in the next calendar year.

30 6. The lifetime benefit per covered person is two hundred
31 fifty thousand dollars.

32 7. The association shall, in addition to other policies,
33 offer Medicare supplement policies designed to supplement
34 Medicare and provide coverage of at least fifty percent of the
35 deductible and eighty percent of the covered expenses in

1 section 514E.4. Medicare supplement plans are subject to the
2 same limitations on premiums, deductibility, and annual out-
3 of-pocket expenses as other association policies.

4 Sec. 7. NEW SECTION. 514E.7 POLICIES -- ELIGIBLE PERSONS
5 - -DEPENDENT COVERAGE -- PREEXISTING CONDITIONS.

6 1. A person is not eligible for an association policy if
7 the person, at the effective date of coverage, has or will
8 have coverage under any insurance plan that has coverage
9 equivalent to an association policy. Only residents of this
10 state are eligible for an association policy. Coverage under
11 an association policy is in excess of, and shall not
12 duplicate, coverage under any other form of health insurance.

13 2. A person is eligible to apply for an association policy
14 only if that person has been rejected for similar health
15 insurance coverage or is only offered health insurance
16 coverage at a rate exceeding the association rate.

17 3. An association policy shall provide that coverage of a
18 dependent unmarried person terminates when the person becomes
19 nineteen years of age or, if the person is enrolled full time
20 in an accredited educational institution, terminates at
21 twenty-five years of age. The policy shall also provide in
22 substance that attainment of the limiting age does not operate
23 to terminate coverage when the person is and continues to be
24 both of the following:

25 a. Incapable of self-sustaining employment by reason of
26 mental retardation or physical handicap.

27 b. Primarily dependent for support and maintenance upon
28 the person in whose name the contract is issued.

29 Proof of incapacity and dependency must be furnished to the
30 carrier within one hundred twenty days of the person's attain-
31 ment of the limiting age, and subsequently as may be required
32 by the carrier, but not more frequently than annually after
33 the two-year period following the person's attainment of the
34 limiting age.

35 4. An association policy that provides coverage for a

1 family member of the person in whose name the contract is
2 issued shall also provide, as to the family member's coverage,
3 that the health insurance benefits applicable for children
4 include the coverage required under section 514C.1.

5 5. An association policy may contain provisions under
6 which coverage is excluded during a period of six months
7 following the effective date of coverage as to a given covered
8 individual for preexisting conditions, as long as either of
9 the following exist:

10 a. The condition has manifested itself within a period of
11 six months before the effective date of coverage in such a
12 manner as would cause an ordinarily prudent person to seek
13 diagnosis or treatment.

14 b. Medical advice or treatment was recommended or received
15 within a period of six months before the effective date of
16 coverage.

17 These preexisting condition exclusions shall be waived to
18 the extent to which similar exclusions have been satisfied
19 under any prior health insurance coverage which was
20 involuntarily terminated, if the application for pool coverage
21 is made not later than thirty days following the involuntary
22 termination. In that case, coverage in the pool shall be
23 effective from the date on which the prior coverage was
24 terminated.

25 This subsection does not prohibit preexisting conditions
26 coverage in an association policy that is more favorable to
27 the insured than that specified in this subsection.

28 6. An individual is not eligible for coverage by the
29 association if any of the following apply:

30 a. The individual is at the time of application eligible
31 for health care benefits under chapter 249A.

32 b. The individual has terminated coverage by the
33 association within the past twelve months.

34 c. The individual is an inmate of a public institution or
35 is eligible for public programs for which medical care is

1 provided.

2 Sec. 8. NEW SECTION. 514E.8 POLICIES -- RENEWAL
3 PROVISIONS -- ELECTION TO CONTINUE COVERAGE UPON DEATH OF
4 POLICYHOLDER.

5 1. An association policy shall contain provisions under
6 which the association is obligated to renew the contract until
7 the day on which the individual in whose name the contract is
8 issued first becomes eligible for Medicare coverage, except
9 that in a family policy covering both husband and wife, the
10 age of the younger spouse shall be used as the basis for
11 meeting the durational requirements of this subsection.
12 However, when the individual in whose name the contract is
13 issued becomes eligible for Medicare coverage, the person
14 shall be eligible for the Medicare supplement plan offered by
15 the association.

16 2. The association shall not change the rates for
17 association policies except on a class basis with a clear
18 disclosure in the policy of the association's right to do so.

19 3. An association policy shall provide that upon the death
20 of the individual in whose name the policy is issued, every
21 other individual then covered under the contract may elect,
22 within a period specified in the policy, to continue coverage
23 under the same or a different policy until such time as the
24 person would have ceased to be entitled to coverage had the
25 individual in whose name the policy was issued lived.

26 Sec. 9. NEW SECTION. 514E.9 RULES.

27 Pursuant to chapter 17A, the commissioner shall adopt rules
28 to provide for disclosure by carriers of the availability of
29 insurance coverage from the association, and to otherwise
30 implement this chapter.

31 Sec. 10. NEW SECTION. 514E.10 COLLECTIVE ACTION.

32 Neither the participation by carriers or members in the
33 association, the establishment of rates, forms, or procedures
34 for coverage issued by the association, nor any joint or
35 collective action required by this chapter shall be the basis

1 of any legal civil action, or criminal liability against the
2 association or members of it either jointly or separately.

3 Sec. 11. NEW SECTION. 514E.11 NOTICE OF ASSOCIATION
4 POLICY.

5 Commencing July 1, 1986, every carrier, including a health
6 maintenance organization subject to chapter 514B, authorized
7 to provide health care insurance or coverage for health care
8 services in Iowa, shall provide a notice and an application
9 for coverage by the association to any person who receives a
10 rejection of coverage for health insurance or health care
11 services, or a notice to any person who is informed that a
12 rate for health insurance or coverage for health care services
13 will exceed the rate of an association policy, that effective
14 January 1, 1987, that person is eligible to apply for health
15 insurance provided by the association. Application for the
16 health insurance shall be on forms prescribed by the board and
17 made available to the carriers.

18 Sec. 12. There is appropriated from the general fund of
19 the state on January 1, 1987 for the period January 1, 1987 to
20 July 1, 1987, to the Iowa comprehensive health association the
21 sum of twenty-five thousand (25,000) dollars or as much
22 thereof as necessary for salaries and expenses.

23 Sec. 13. Health insurance coverage provided under this Act
24 shall not be effective until January 1 following the effective
25 date of this Act.

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Brammer, Chair
Swartz
Hatch
Hummel HF2191
Kremer

HSB 531

SMALL BUSINESS AND COMMERCE

SENATE/HOUSE FILE 2181
BY (PROPOSED COMMITTEE ON SMALL
BUSINESS AND COMMERCE BILL
BY THE INSURANCE GUARANTY
FUND AND RISK SHARING POOL
STUDY COMMITTEE)

Study Bill 531

Small Business and Commerce: Brammer, Chair; Hatch, Hummel, Kremer and Swartz.

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

1 An Act establishing the Iowa comprehensive health association,
2 providing for a plan of operation, establishing financial
3 procedures, providing eligible expenses, excluding certain
4 requirements, and relating to other provisions of health
5 insurance coverage.

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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1 Section 1. NEW SECTION. 514E.1 DEFINITIONS.

2 As used in this chapter, unless the context otherwise re-
3 quires:

4 1. "Association" means the Iowa comprehensive health as-
5 sociation established by section 514E.2.

6 2. "Association policy" means an individual policy issued
7 by the association that provides the coverage specified in
8 section 514E.4.

9 3. "Carrier" means an insurer providing accident and sick-
10 ness insurance under chapter 509, 514 or 514A and includes a
11 health maintenance organization established under chapter 514B
12 if payments received by the health maintenance organization
13 are considered premiums pursuant to section 514B.31 and are
14 taxed under chapter 432. "Carrier" also includes a
15 corporation which becomes a mutual insurer pursuant to section
16 514.23 and any other person as defined in section 4.1,
17 subsection 13, who is or may become liable for the tax imposed
18 by chapter 432.

19 4. "Commissioner" means the commissioner of insurance.

20 5. "Eligible expenses" means the usual, customary and rea-
21 sonable charges for the health care services specified in
22 section 514E.4.

23 6. "Health care facility" means a health care facility as
24 defined in section 135C.1, subsection 4, a hospital as defined
25 in section 135B.1, subsection 1, or a community mental health
26 center established under chapter 230A.

27 7. "Health care services" means hospital services, medical
28 or surgical services, dental services, or pharmaceutical or
29 optometric services, the coverage of which is authorized under
30 chapter 509, 514, 514A, or 514B as limited by sections 514E.4
31 and 514E.5, and includes services for the purposes of prevent-
32 ing, alleviating, curing, or healing human illness, injury, or
33 physical disability.

34 8. "Health insurance" means accident and sickness
35 insurance authorized by chapter 509, 514 or 514A.

1 9. "Health insurance trust fund" means the fund created in
2 section 514E.3.

3 10. "Insured" means an individual who is provided
4 qualified comprehensive health insurance under an association
5 policy, which policy may include dependents and other covered
6 persons.

7 11. "Medicaid" means the federal-state assistance program
8 established under Title XIX of the federal Social Security
9 Act.

10 12. "Medicare" means the federal government health
11 insurance program established under Title XVIII of the Social
12 Security Act.

13 13. "Policy" means a contract, policy, or plan of health
14 insurance.

15 14. "Policy year" means a consecutive twelve-month period
16 during which a policy provides or obligates the carrier to
17 provide health insurance.

18 Sec. 2. NEW SECTION. 514E.2 IOWA COMPREHENSIVE HEALTH
19 ASSOCIATION.

20 1. There is established a nonprofit corporation known as
21 the Iowa comprehensive health insurance association which
22 shall assure that health insurance, as limited by sections
23 514E.4 and 514E.5, is made available to each eligible Iowa
24 resident applying to the association for coverage. All
25 carriers as defined in section 514E.1, subsection 3, providing
26 health insurance or health care services in Iowa shall be mem-
27 bers of the association. The association shall operate under
28 a plan of operation established and approved under subsection
29 3 and shall exercise its powers through a board of directors
30 established under this section.

31 2. The board of directors of the association shall consist
32 of not less than five nor more than nine members selected by
33 the members of the association, subject to approval by the
34 commissioner.

35 In order to select the initial board of directors and

1 organize the association, the commissioner shall give notice
2 to all carriers of the time and place of the organizational
3 meeting. In determining voting rights at the organizational
4 meeting, each carrier member is entitled to one vote in person
5 or by proxy. If the board of directors is not selected within
6 sixty days after the organizational meeting, the commissioner
7 shall appoint the initial board. In approving or selecting
8 members of the board, the commissioner shall consider whether
9 all carriers are fairly represented. Members of the board may
10 be reimbursed from the moneys of the association for expenses
11 incurred by them as members, but shall not be otherwise
12 compensated by the association for their services.

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

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

1 association.

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

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

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

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

10 f. Establishing, in cooperation with the commissioner of
11 insurance and the state comptroller, procedures for the
12 determination and payment to the association from the health
13 insurance trust fund of amounts which represent the net loss
14 for the preceding calendar year to the association. The
15 amount of the payment shall be based upon the amount of funds
16 deposited in the health insurance trust fund and the amount of
17 net loss of the association. If funds deposited in the health
18 insurance trust fund are insufficient to pay all of the
19 losses, the state comptroller shall notify the commissioner of
20 insurance and the association of the amount of the deficiency.

21 g. The periodic advertising of the general availability of
22 health insurance coverage from the association.

23 h. Additional provisions necessary or proper for the
24 execution of the powers and duties of the association.

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

34 5. The association has the general powers and authority
35 enumerated by this subsection and executed in accordance with

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

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

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

11 c. Take legal action necessary to avoid the payment of im-
12 proper claims against the association or the coverage provided
13 by or through the association.

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

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

21 f. Pool risks among members.

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

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

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

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

1 k. Hire independent consultants as necessary.

2 1. Develop a method of advising applicants of the availa-
3 bility of other coverages outside the association, and shall
4 promulgate a list of health conditions the existence of which
5 would make an applicant eligible without demonstrating a re-
6 jection of coverage by one carrier.

7 m. Include in its policies a provision providing for
8 subrogation rights by the association in a case in which the
9 association pays expenses on behalf of an individual who is
10 injured or suffers a disease under circumstances creating a
11 liability upon another person to pay damages to the extent of
12 the expenses paid by the association.

13 6. Rates for coverages issued by the association shall not
14 be unreasonable in relation to the benefits provided, the risk
15 experience, and the reasonable expenses of providing coverage.
16 Separate scales of rates based on age may apply for individual
17 risks. Rates must take into consideration the extra morbidity
18 and administration expenses, if any, for risks insured in the
19 association. The rates for a given classification shall not
20 be more than one hundred fifty percent of the average premium
21 or payment rate for that classification charged by the five
22 carriers with the largest health insurance premium or payment
23 volume in the state during the preceding calendar year. In
24 determining the average rate of the five largest carriers, the
25 rates or payments charged by the carriers shall be actuarially
26 adjusted to determine the rate or payment that would have been
27 charged for benefits similar to those issued by the
28 association.

29 7. Following the close of each calendar year, the
30 association shall determine the net premiums and payments, the
31 expenses of administration, and the incurred losses of the
32 association for the year. The association shall certify the
33 amount of any net loss for the preceding calendar year to the
34 commissioner of insurance and state comptroller who shall make
35 payment to the association according to procedures established

1 under subsection 3, paragraph "f". Any remaining loss, after
2 payment to the association from the health insurance trust
3 fund, shall be assessed by the association to all members in
4 proportion to their respective shares of total health
5 insurance premiums or payments for subscriber contracts
6 received in Iowa during the second preceding calendar year, or
7 with paid losses in the year, coinciding with or ending during
8 the calendar year or on any other equitable basis as provided
9 in the plan of operation. In sharing losses, the association
10 may abate or defer in any part the assessment of a member, if,
11 in the opinion of the board, payment of the assessment would
12 endanger the ability of the member to fulfill its contractual
13 obligations. The association may also provide for an initial
14 or interim assessment against members of the association if
15 necessary to assure the financial capability of the
16 association to meet the incurred or estimated claims expenses
17 or operating expenses of the association until the next
18 calendar year is completed. Net gains, if any, must be held
19 at interest to offset future losses or allocated to reduce
20 future premiums.

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

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

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

33 11. The association shall not issue an association policy
34 to an individual who, on the effective date of the coverage
35 applied for, has not been rejected for, already has, or will

1 have coverage similar to an association policy, as an insured
2 or covered dependent.

3 12. The association shall pay an agent's referral fee of
4 twenty-five dollars to each insurance agent who refers an
5 applicant to the association if that applicant is accepted.

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

9 14. A member who, after July 1, 1986, has paid one or more
10 assessments levied under this chapter may take a credit
11 against the premium taxes, or similar taxes, upon revenues or
12 income of the member that are imposed by the state on health
13 insurance premiums pursuant to chapter 432 or payments subject
14 to taxation under section 514B.31, up to the amount of twenty
15 percent of those taxes due, for each of the five calendar
16 years following the year for which an assessment was paid, or
17 until the aggregate of those assessments has been offset by
18 credits against those taxes if this occurs first. If a member
19 ceases doing business, all uncredited assessments may be
20 credited against its premium tax liability for the year it
21 ceases doing business.

22 Sec. 3. NEW SECTION. 514E.3 HEALTH INSURANCE TRUST FUND
23 -- DEPOSIT OF MONEYS.

24 A health insurance trust fund is created within the state
25 treasury. Commencing in the calendar year beginning January
26 1, 1987, and annually thereafter, there shall be deposited in
27 the health insurance trust fund twenty-five percent of the
28 moneys set aside pursuant to 1985 Iowa Acts, chapter 239,
29 section 8. The moneys in the health insurance trust fund and
30 any income to the fund shall be used to make the payments
31 provided for in section 514E.2, subsection 3, paragraph "f".
32 If after making a payment, there is a balance remaining in the
33 health insurance trust fund, the balance shall be retained in
34 the fund together with any interest or earnings that is earned
35 on the balance and may be used to cover future expenses of the

1 association. However, if the balance of the health insurance
2 trust fund after the payments provided for in section 514E.2,
3 subsection 3, paragraph "f" exceeds ten million dollars, then
4 the amount of the funds in excess of the ten million dollars
5 shall be transferred to the separate account established in
6 1985 Iowa Acts, chapter 239, section 8.

7 Moneys deposited in the health insurance trust fund may be
8 invested by the treasurer of state in the same manner as
9 moneys in the general fund.

10 Sec. 4. NEW SECTION. 514E.4 ASSOCIATION POLICY --
11 COVERAGE AND BENEFIT REQUIREMENTS -- ELIGIBLE EXPENSES.

12 The association policy shall pay only the usual, customary
13 and reasonable charges for medically necessary eligible health
14 care services which exceed the deductible and coinsurance
15 amounts applicable under section 514E.6. Eligible expenses
16 are the charges for the following health care services
17 furnished by a health care provider in an emergency situation
18 or furnished or prescribed by a health care provider:

19 1. Hospital services, including charges for the most
20 common semiprivate room, for the most common private room if
21 semiprivate rooms do not exist in the health care facility, or
22 for the private room if medically necessary, but limited to a
23 total of one hundred eighty days in a calendar year.

24 2. Professional services for the diagnosis or treatment of
25 injuries, illnesses, or conditions, other than mental or
26 dental, which are rendered by a health care provider, or at
27 the direction of a health care provider, by a staff of
28 registered nurses, licensed practical nurses, or other health
29 care providers.

30 3. The first twenty professional visits for the diagnosis
31 or treatment of one or more mental conditions, rendered during
32 a calendar year by one or more health care providers, or at
33 their direction, by their staff of registered nurses, licensed
34 practical nurses, or other health care providers.

35 4. Drugs and contraceptive devices requiring a prescrip-

1 tion.

2 5. Services of a skilled nursing facility as defined in
3 section 135C.1, subsection 3, or services in an intermediate
4 care facility as defined in section 135C.1, subsection 2, to
5 the same extent as the services would be paid in a skilled
6 nursing facility, for not more than one hundred eighty days in
7 a calendar year.

8 6. Homemaker-home health services up to one hundred eighty
9 days of service in a calendar year.

10 7. Use of radium or other radioactive material.

11 8. Oxygen.

12 9. Anesthetics.

13 10. Prostheses, other than dental.

14 11. Rental of durable medical equipment, other than eye
15 glasses and hearing aids, which have no personal use in the
16 absence of the condition for which prescribed.

17 12. Diagnostic X rays and laboratory tests.

18 13. Oral surgery for any of the following:

19 a. Excision of partially or completely erupted impacted
20 teeth.

21 b. Excision of a tooth root without the extraction of the
22 entire tooth.

23 c. The gums and tissues of the mouth when not performed in
24 connection with the extraction or repair of teeth.

25 14. Services of a physical therapist and services of a
26 speech therapist.

27 15. Professional ambulance services to the nearest health
28 care facility qualified to treat the illness, injury, or
29 condition.

30 16. Processing of blood, including but not limited to,
31 collecting, testing, fractionating, and distributing blood.

32 Sec. 5. NEW SECTION. 514E.5 EXPENSES EXCLUDED.

33 Eligible expenses shall not include an expense for any of
34 the following:

35 1. Services for which a charge is not made in the absence

1 of insurance or for which there is no legal obligation on the
2 part of a patient to pay.

3 2. Services and charges made for benefits provided under
4 the laws of the United States, including Medicare and
5 Medicaid, military service-connected disabilities, medical
6 services provided for members of the armed forces and their
7 dependents or for employees of the armed forces of the United
8 States, and medical services financed on behalf of all
9 citizens by the United States.

10 3. Benefits which would duplicate the provision of
11 services or payment of charges for any care for an injury,
12 disease, or condition for which either of the following
13 applies:

14 a. It arises out of and in the course of an employment
15 subject to a workers' compensation or similar law.

16 b. Benefits for it are payable without regard to fault
17 under a coverage required to be contained in any motor vehicle
18 or other liability insurance policy or equivalent self-
19 insurance. However, this does not authorize exclusion of
20 charges that exceed the benefits payable under the applicable
21 workers' compensation or no-fault coverage.

22 4. Care which is primarily for a custodial or domiciliary
23 purpose.

24 5. Cosmetic surgery unless provided as the result of an
25 injury or medically necessary surgical procedure.

26 6. Services the provision of which is not within the scope
27 of the license or certificate of the institution or individual
28 rendering the services.

29 7. That part of any charge for services or articles
30 rendered or prescribed by a health care provider which exceeds
31 the prevailing charge in the locality where the service is
32 provided, or a charge for services or articles not medically
33 necessary.

34 8. Services rendered prior to the effective date of
35 coverage under this plan for the person on whose behalf the

1 expense is incurred.

2 9. Routine physical examinations including examinations to
3 determine the need for eye glasses and hearing aids.

4 10. Illness or injury due to an act of war.

5 11. Service of a blood donor and any fee for failure to
6 replace the first three pints of blood provided to an eligible
7 person each calendar year.

8 12. Personal supplies or services provided by a health
9 care facility or any other nonmedical or nonprescribed supply
10 or service.

11 13. Experimental services or supplies. Experimental means
12 a service or supply not recognized by the appropriate medical
13 board as normal mode of treatment for the illness or injury
14 involved.

15 14. Eye surgery if corrective lenses would alleviate the
16 problem.

17 The coverage and benefit requirements of this section for
18 association policies shall not be altered by any other state
19 law without specific reference to this chapter indicating a
20 legislative intent to add or delete from the coverage
21 requirements of this chapter.

22 This chapter does not prohibit the association from issuing
23 additional types of health insurance policies with different
24 types of benefits which, in the opinion of the board of
25 directors, may be of benefit to the citizens of the state.

26 Sec. 6. NEW SECTION. 514E.6 POLICIES, DEDUCTIBLE AND
27 COINSURANCE REQUIREMENTS -- LIMITATIONS -- LIFETIME BENEFIT
28 LIMIT.

29 1. Except as provided in subsection 3, an association
30 policy offered in accordance with this chapter shall include a
31 deductible. Deductibles of five hundred dollars and one
32 thousand dollars on a per person per calendar year basis shall
33 be offered. The board may authorize deductibles in other
34 amounts. The deductibles must be applied to the first five
35 hundred dollars, one thousand dollars, or other authorized

1 amount of eligible expenses incurred by the covered person.

2 2. Except as provided in subsection 3, a mandatory
3 coinsurance requirement shall be imposed at the rate of twenty
4 percent of eligible expenses in excess of the mandatory
5 deductible.

6 3. The maximum aggregate out-of-pocket payments for
7 eligible expenses by the insured in the form of deductibles
8 and coinsurance shall not exceed in a policy year:

9 a. One thousand five hundred dollars for an individual
10 five-hundred-dollar deductible policy.

11 b. Two thousand dollars for an individual one-thousand-
12 dollar deductible policy.

13 c. Three thousand dollars for a family five-hundred-dollar
14 deductible policy.

15 d. Four thousand dollars for a family one-thousand-dollar
16 deductible policy.

17 e. An amount authorized by the board for any other de-
18 ductible policy.

19 4. For a family policy, the maximum annual deductible
20 under the policy shall be the deductible chosen for a maximum
21 of two individuals under the policy.

22 5. Eligible expenses incurred by a covered person in the
23 last three months of a calendar year, and applied toward a
24 deductible, shall also be applied toward the deductible amount
25 in the next calendar year.

26 6. The lifetime benefit per covered person is two hundred
27 fifty thousand dollars.

28 7. The association shall, in addition to other policies,
29 offer Medicare supplement policies designed to supplement
30 Medicare and provide coverage of at least fifty percent of the
31 deductible and eighty percent of the covered expenses in
32 section 514E.4. Medicare supplement plans are subject to the
33 same limitations on premiums, deductibility, and annual out-
34 of-pocket expenses as other association policies.

35 Sec. 7. NEW SECTION. 514E.7 POLICIES -- ELIGIBLE PERSONS

1 -- DEPENDENT COVERAGE -- PREEXISTING CONDITIONS.

2 1. A person is not eligible for an association policy if
3 the person, at the effective date of coverage, has or will
4 have coverage under any insurance plan that has coverage
5 equivalent to an association policy. Only residents of this
6 state are eligible for an association policy. Coverage under
7 an association policy is in excess of, and shall not
8 duplicate, coverage under any other form of health insurance.

9 2. A person is eligible to apply for an association policy
10 only if that person has been rejected for similar health
11 insurance coverage or is only offered health insurance
12 coverage at a rate exceeding the association rate.

13 3. An association policy shall provide that coverage of a
14 dependent unmarried person terminates when the person becomes
15 nineteen years of age or, if the person is enrolled full time
16 in an accredited educational institution, terminates at
17 twenty-five years of age. The policy shall also provide in
18 substance that attainment of the limiting age does not operate
19 to terminate coverage when the person is and continues to be
20 both of the following:

21 a. Incapable of self-sustaining employment by reason of
22 mental retardation or physical handicap.

23 b. Primarily dependent for support and maintenance upon
24 the person in whose name the contract is issued.

25 Proof of incapacity and dependency must be furnished to the
26 carrier within one hundred twenty days of the person's attain-
27 ment of the limiting age, and subsequently as may be required
28 by the carrier, but not more frequently than annually after
29 the two-year period following the person's attainment of the
30 limiting age.

31 4. An association policy that provides coverage for a
32 family member of the person in whose name the contract is
33 issued shall also provide, as to the family member's coverage,
34 that the health insurance benefits applicable for children
35 include the coverage required under section 514C.1.

1 5. An association policy may contain provisions under
2 which coverage is excluded during a period of six months
3 following the effective date of coverage as to a given covered
4 individual for preexisting conditions, as long as either of
5 the following exist:

6 a. The condition has manifested itself within a period of
7 six months before the effective date of coverage in such a
8 manner as would cause an ordinarily prudent person to seek
9 diagnosis or treatment.

10 b. Medical advice or treatment was recommended or received
11 within a period of six months before the effective date of
12 coverage.

13 These preexisting condition exclusions shall be waived to
14 the extent to which similar exclusions have been satisfied
15 under any prior health insurance coverage which was
16 involuntarily terminated, if the application for pool coverage
17 is made not later than thirty days following the involuntary
18 termination. In that case, coverage in the pool shall be
19 effective from the date on which the prior coverage was
20 terminated.

21 This subsection does not prohibit preexisting conditions
22 coverage in an association policy that is more favorable to
23 the insured than that specified in this subsection.

24 6. An individual is not eligible for coverage by the
25 association if any of the following apply:

26 a. The individual is at the time of application eligible
27 for health care benefits under chapter 249A.

28 b. The individual has terminated coverage by the
29 association within the past twelve months.

30 c. The individual is an inmate of a public institution or
31 is eligible for public programs for which medical care is
32 provided.

33 Sec. 8. NEW SECTION. 514E.8 POLICIES -- RENEWAL
34 PROVISIONS -- ELECTION TO CONTINUE COVERAGE UPON DEATH OF
35 POLICYHOLDER.

1 1. An association policy shall contain provisions under
2 which the association is obligated to renew the contract until
3 the day on which the individual in whose name the contract is
4 issued first becomes eligible for Medicare coverage, except
5 that in a family policy covering both husband and wife, the
6 age of the younger spouse shall be used as the basis for
7 meeting the durational requirements of this subsection.
8 However, when the individual in whose name the contract is
9 issued becomes eligible for Medicare coverage, the person
10 shall be eligible for the Medicare supplement plan offered by
11 the association.

12 2. The association shall not change the rates for
13 association policies except on a class basis with a clear
14 disclosure in the policy of the association's right to do so.

15 3. An association policy shall provide that upon the death
16 of the individual in whose name the policy is issued, every
17 other individual then covered under the contract may elect,
18 within a period specified in the policy, to continue coverage
19 under the same or a different policy until such time as the
20 person would have ceased to be entitled to coverage had the
21 individual in whose name the policy was issued lived.

22 Sec. 9. NEW SECTION. 514E.9 RULES.

23 Pursuant to chapter 17A, the commissioner shall adopt rules
24 to provide for disclosure by carriers of the availability of
25 insurance coverage from the association, and to otherwise
26 implement this chapter.

27 Sec. 10. NEW SECTION. 514E.10 COLLECTIVE ACTION.

28 Neither the participation by carriers or members in the
29 association, the establishment of rates, forms, or procedures
30 for coverage issued by the association, nor any joint or
31 collective action required by this chapter shall be the basis
32 of any legal civil action, or criminal liability against the
33 association or members of it either jointly or separately.

34 Sec. 11. NEW SECTION. 514E.11 NOTICE OF ASSOCIATION
35 POLICY.

1 Commencing July 1, 1986, every carrier, including a health
2 maintenance organization subject to chapter 514B, authorized
3 to provide health care insurance or coverage for health care
4 services in Iowa, shall provide a notice and an application
5 for coverage by the association to any person who receives a
6 rejection of coverage for health insurance or health care
7 services, or a notice to any person who is informed that a
8 rate for health insurance or coverage for health care services
9 will exceed the rate of an association policy, that effective
10 January 1, 1987, that person is eligible to apply for health
11 insurance provided by the association. Application for the
12 health insurance shall be on forms prescribed by the board and
13 made available to the carriers.

14 Sec. 12. 1985 Iowa Acts, chapter 239, section 8, is
15 amended to read as follows:

16 SEC. 8. For each fiscal year beginning July 1, 1985,
17 except for the amount appropriated in section 7 of this Act,
18 the entire increase, as determined by the commissioner of
19 insurance and certified to the comptroller of state, or taxes
20 paid under chapter 432 on premiums and payments on individual
21 and group accident and health insurance policies and
22 certificates and individual and group subscriber contracts
23 under chapter 514 shall be set aside in a separate account
24 within the general fund and reserved solely for the purposes
25 of implementing the programs to be studied as provided in
26 section 9 of this Act. The balance of the account shall be
27 considered part of the balance of the general fund of the
28 state except for purposes of determining the annual inflation
29 factor under section 422.4, subsection 17. The funds within
30 the account shall not be expended except as otherwise provided
31 by the general assembly. Interest accruing on the funds
32 within the account shall remain in the account unless other-
33 wise provided by the general assembly.

34 Sec. 13. Health insurance coverage provided under this Act
35 shall not be effective until January 1 following the effective

1 date of this Act.

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EXPLANATION

This bill establishes the Iowa comprehensive health association, the purpose of which is to provide accident and health insurance for persons who might otherwise not be eligible for the coverage or who cannot obtain it at a reasonable cost. The association shall offer a Medicare supplement plan. Carriers who write accident and health insurance in Iowa and who are subject to the insurance premium tax are required to be members of the association. Self-insurers would not be members of the association. When premiums and payments from the health insurance trust fund created by this Act are insufficient to provide financing for the association, members of the association must be assessed amounts sufficient to finance the association and coverages provided by it. Credit against certain premium taxes is provided to offset the assessment. The coverage limitations are specified as well as the duties of the commissioner of insurance and the association. The bill also provides that interest accruing on the moneys collected pursuant to 1985 Iowa Acts, chapter 239, section 8, shall remain a part of the fund created in that Act. A portion of those funds are used in the health insurance trust fund created by this Act. The balance of funds in the health insurance trust fund shall not exceed ten million dollars.

HOUSE FILE 2181

AN ACT

ESTABLISHING THE IOWA COMPREHENSIVE HEALTH ASSOCIATION, PROVIDING FOR A PLAN OF OPERATION, ESTABLISHING FINANCIAL PROCEDURES, PROVIDING ELIGIBLE EXPENSES, EXCLUDING CERTAIN REQUIREMENTS, AND RELATING TO OTHER PROVISIONS OF HEALTH INSURANCE COVERAGE AND PROVIDING AN APPROPRIATION.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. 514E.1 DEFINITIONS.

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

1. "Association" means the Iowa comprehensive health association established by section 514E.2.
2. "Association policy" means an individual policy issued by the association that provides the coverage specified in section 514E.4.
3. "Carrier" means an insurer providing accident and sickness insurance under chapter 509, 514 or 514A and includes a health maintenance organization established under chapter 514B if payments received by the health maintenance organization are considered premiums pursuant to section 514B.31 and are taxed under chapter 432. "Carrier" also includes a corporation which becomes a mutual insurer pursuant to section 514.23 and any other person as defined in section 4.1, subsection 13, who is or may become liable for the tax imposed by chapter 432.
4. "Commissioner" means the commissioner of insurance.
5. "Eligible expenses" means the usual, customary and reasonable charges for the health care services specified in section 514E.4.
6. "Health care facility" means a health care facility as defined in section 135C.1, subsection 4, a hospital as defined in section 135B.1, subsection 1, or a community mental health center established under chapter 230A.

7. "Health care services" means services, the coverage of which is authorized under chapter 509, chapter 514, chapter 514A, or chapter 514B as limited by sections 514E.4 and 514E.5, and includes services for the purposes of preventing, alleviating, curing, or healing human illness, injury or physical disability.

8. "Health insurance" means accident and sickness insurance authorized by chapter 509, 514 or 514A.

9. "Health insurance trust fund" means the fund created in section 514E.3.

10. "Insured" means an individual who is provided qualified comprehensive health insurance under an association policy, which policy may include dependents and other covered persons.

11. "Medicaid" means the federal-state assistance program established under Title XIX of the federal Social Security Act.

12. "Medicare" means the federal government health insurance program established under Title XVIII of the Social Security Act.

13. "Policy" means a contract, policy, or plan of health insurance.

14. "Policy year" means a consecutive twelve-month period during which a policy provides or obligates the carrier to provide health insurance.

Sec. 2. NEW SECTION. 514E.2 IOWA COMPREHENSIVE HEALTH ASSOCIATION.

1. There is established a nonprofit corporation known as the Iowa comprehensive health insurance association which shall assure that health insurance, as limited by sections 514E.4 and 514E.5, is made available to each eligible Iowa resident applying to the association for coverage. All carriers as defined in section 514E.1, subsection 3, providing health insurance or health care services in Iowa shall be members of the association. The association shall operate under a plan of operation established and approved under subsection 1 and shall exercise its powers through a board of directors established under this section.

2. The board of directors of the association shall consist of not less than four nor more than eight members selected by the members of the association, subject to approval by the commissioner and a public member selected by the commissioner.

In order to select the initial board of directors and organize the association, the commissioner shall give notice to all carriers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each carrier member is entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after the organizational meeting, the commissioner shall appoint the initial board. In approving or selecting members of the board, the commissioner shall consider whether all carriers are fairly represented. 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. Establishing, in cooperation with the commissioner of insurance and the state comptroller, procedures for the determination and payment to the association from the health insurance trust fund of amounts which represent the net loss for the preceding calendar year to the association. The amount of the payment shall be based upon the amount of funds deposited in the health insurance trust fund and the amount of net loss of the association. If funds deposited in the health insurance trust fund are insufficient to pay all of the losses, the state comptroller shall notify the commissioner of insurance and the association of the amount of the deficiency.

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

h. 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, and shall promulgate a list of health conditions the existence of which would make an applicant eligible without demonstrating a rejection of coverage by one carrier.

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 not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing coverage. Separate scales of rates based on age may apply for individual risks. Rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification shall not be more than one hundred fifty percent of the average premium or payment rate for that 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. 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 state comptroller who shall make payment to the association according to procedures established under subsection 3, paragraph "f". Any remaining loss, after payment to the association from the health insurance trust fund, 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.

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

11. The association shall not issue an association policy to an individual who, on the effective date of the coverage applied for, has not been rejected for, already has, or will

have coverage similar to an association policy, as an insured or covered dependent.

12. The association shall pay an agent's referral fee of twenty-five dollars to each insurance agent who refers an applicant to the association if that applicant is accepted.

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

14. A member who, after July 1, 1985, has paid one or more assessments levied under this chapter may take a credit against the premium taxes, or similar taxes, upon revenues or income of the member that are imposed by the state on health insurance premiums pursuant to chapter 432 or payments subject to taxation under section 514B.31, up to the amount of twenty percent of those taxes due, for each of the five calendar years following the year for which an assessment was paid, or until the aggregate of those assessments has been offset by credits against those taxes if this occurs first. If a member ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

Sec. 3. NEW SECTION. 514E.7 HEALTH INSURANCE TRUST FUND - DEPOSIT OF MONEYS.

A health insurance trust fund is created within the state treasury. Commencing July 1, 1987, and annually thereafter, there shall be deposited in the health insurance trust fund twenty-five percent of the moneys set aside pursuant to 1985 Iowa Acts, chapter 239, section 8. The moneys in the health insurance trust fund and any income to the fund shall be used to make the payments provided for in section 514E.2, subsection 3, paragraph "f". If after making a payment, there is a balance remaining in the health insurance trust fund, the balance shall be retained in the fund together with any interest or earnings that is earned on the balance and may be used to cover future expenses of the association. However, if the balance of the health insurance trust fund after the payments provided for in section 514E.2, subsection 3,

paragraph "f" exceeds ten million dollars, then the amount of the funds in excess of the ten million dollars shall be transferred to the separate account established in 1985 Iowa Acts, chapter 239, section 8.

Moneys deposited in the health insurance trust fund may be invested by the treasurer of state in the same manner as moneys in the general fund.

Sec. 4. NEW SECTION. 514E.4 ASSOCIATION POLICY -- COVERAGE AND BENEFIT REQUIREMENTS -- ELIGIBLE EXPENSES.

The association policy shall pay only the usual, customary and reasonable charges for medically necessary eligible health care services which exceed the deductible and coinsurance amounts applicable under section 514E.6. Eligible expenses are the charges for the following health care services furnished by a health care provider in an emergency situation or furnished or prescribed by a health care provider:

1. Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty days in a calendar year.
2. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered nurses, licensed practical nurses, or other health care providers.
3. The first twenty professional visits for the diagnosis or treatment of one or more mental conditions, rendered during a calendar year by one or more health care providers, or at their direction, by their staff of registered nurses, licensed practical nurses, or other health care providers.
4. Drugs and contraceptive devices requiring a prescription.
5. Services of a skilled nursing facility as defined in section 135C.1, subsection 3, or services in an intermediate care facility as defined in section 135C.1, subsection 2, to

the same extent as the services would be paid in a skilled nursing facility, for not more than one hundred eighty days in a calendar year.

6. Homemaker-home health services up to one hundred eighty days of service in a calendar year.
7. Use of radium or other radioactive material.
8. Oxygen.
9. Anesthetics.
10. Prostheses, other than dental.
11. Rental of durable medical equipment, other than eye glasses and hearing aids, which have no personal use in the absence of the condition for which prescribed.
12. Diagnostic X rays and laboratory tests.
13. Oral surgery for any of the following:
 - a. Excision of partially or completely erupted impacted teeth.
 - b. Excision of a tooth root without the extraction of the entire tooth.
 - c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
14. Services of a physical therapist and services of a speech therapist.
15. Professional ambulance services to the nearest health care facility qualified to treat the illness, injury, or condition.
16. Processing of blood, including but not limited to, collecting, testing, fractionating, and distributing blood.

Sec. 5. NEW SECTION. 514E.5 EXPENSES EXCLUDED.

Eligible expenses shall not include an expense for any of the following:

1. Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of a patient to pay.
2. Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service-connected disabilities, medical services provided for members of the armed forces and their

dependents or for employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States.

3. Benefits which would duplicate the provision of services or payment of charges for any care for an injury, disease, or condition for which either of the following applies:

a. It arises out of and in the course of an employment subject to a workers' compensation or similar law.

b. Benefits for it are payable without regard to fault under a coverage required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance. However, this does not authorize exclusion of charges that exceed the benefits payable under the applicable workers' compensation or no-fault coverage.

4. Care which is primarily for a custodial or domiciliary purpose.

5. Cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure.

6. Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

7. That part of any charge for services or articles rendered or prescribed by a health care provider which exceeds the prevailing charge in the locality where the service is provided, or a charge for services or articles not medically necessary.

8. Services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred.

9. Routine physical examinations including examinations to determine the need for eye glasses and hearing aids.

10. Illness or injury due to an act of war.

11. Service of a blood donor and any fee for failure to replace the first three pints of blood provided to an eligible person each calendar year.

12. Personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

13. Experimental services or supplies. Experimental means a service or supply not recognized by the appropriate medical board as normal mode of treatment for the illness or injury involved.

14. Eye surgery if corrective lenses would alleviate the problem.

The coverage and benefit requirements of this section for association policies shall not be altered by any other state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits which, in the opinion of the board of directors, may be of benefit to the citizens of the state.

Sec. 6. NEW SECTION. 5148.6 POLICIES, DEDUCTIBLE AND COINSURANCE REQUIREMENTS -- LIMITATIONS -- LIFETIME BENEFIT LIMIT.

1. Except as provided in subsection 3, an association policy offered in accordance with this chapter shall include a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall be offered. The board may authorize deductibles in other amounts. The deductibles must be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

2. Except as provided in subsection 3, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.

3. The maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance shall not exceed in a policy year:

- a. One thousand five hundred dollars for an individual five-hundred-dollar deductible policy.
 - b. Two thousand dollars for an individual one-thousand-dollar deductible policy.
 - c. Three thousand dollars for a family five-hundred-dollar deductible policy.
 - d. Four thousand dollars for a family one-thousand-dollar deductible policy.
 - e. An amount authorized by the board for any other deductible policy.
4. For a family policy, the maximum annual deductible under the policy shall be the deductible chosen for a maximum of two individuals under the policy.
5. Eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.
6. The lifetime benefit per covered person is two hundred fifty thousand dollars.

7. The association shall, in addition to other policies, offer Medicare supplement policies designed to supplement Medicare and provide coverage of at least fifty percent of the deductible and eighty percent of the covered expenses in section 514E.4. Medicare supplement plans are subject to the same limitations on premiums, deductibility, and annual out-of-pocket expenses as other association policies.

Sec. 7. NEW SECTION. 514E.7 POLICIES -- ELIGIBLE PERSONS -- DEPENDENT COVERAGE -- PREEXISTING CONDITIONS.

1. A person is not eligible for an association policy if the person, at the effective date of coverage, has or will have coverage under any insurance plan that has coverage equivalent to an association policy. Only residents of this state are eligible for an association policy. Coverage under an association policy is in excess of, and shall not duplicate, coverage under any other form of health insurance.
2. A person is eligible to apply for an association policy only if that person has been rejected for similar health

insurance coverage or is only offered health insurance coverage at a rate exceeding the association rate.

3. An association policy shall provide that coverage of a dependent unmarried person terminates when the person becomes nineteen years of age or, if the person is enrolled full time in an accredited educational institution, terminates at twenty-five years of age. The policy shall also provide in substance that attainment of the limiting age does not operate to terminate coverage when the person is and continues to be both of the following:

- a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
- b. Primarily dependent for support and maintenance upon the person in whose name the contract is issued.

Proof of incapacity and dependency must be furnished to the carrier within one hundred twenty days of the person's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two-year period following the person's attainment of the limiting age.

4. An association policy that provides coverage for a family member of the person in whose name the contract is issued shall also provide, as to the family member's coverage, that the health insurance benefits applicable for children include the coverage required under section 514C.1.

5. An association policy may contain provisions under which coverage is excluded during a period of six months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as either of the following exist:

- a. The condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis or treatment.
- b. Medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

These preexisting condition exclusions shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage which was involuntarily terminated, if the application for pool coverage is made not later than thirty days following the involuntary termination. In that case, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

This subsection does not prohibit preexisting conditions coverage in an association policy that is more favorable to the insured than that specified in this subsection.

6. An individual is not eligible for coverage by the association if any of the following apply:

- a. The individual is at the time of application eligible for health care benefits under chapter 249A.
- b. The individual has terminated coverage by the association within the past twelve months.
- c. The individual is an inmate of a public institution or is eligible for public programs for which medical care is provided.

Sec. 8. NEW SECTION. 514E.8 POLICIES -- RENEWAL PROVISIONS -- ELECTION TO CONTINUE COVERAGE UPON DEATH OF POLICYHOLDER.

1. An association policy shall contain provisions under which the association is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the durational requirements of this subsection. However, when the individual in whose name the contract is issued becomes eligible for Medicare coverage, the person shall be eligible for the Medicare supplement plan offered by the association.

2. The association shall not change the rates for association policies except on a class basis with a clear disclosure in the policy of the association's right to do so.

3. An association policy shall provide that upon the death of the individual in whose name the policy is issued, every other individual then covered under the contract may elect, within a period specified in the policy, to continue coverage under the same or a different policy until such time as the person would have ceased to be entitled to coverage had the individual in whose name the policy was issued lived.

Sec. 9. NEW SECTION. 514E.9 RULES.

Pursuant to chapter 17A, the commissioner shall adopt rules to provide for disclosure by carriers of the availability of insurance coverage from the association, and to otherwise implement this chapter.

Sec. 10. NEW SECTION. 514E.10 COLLECTIVE ACTION.

Neither the participation by carriers or members in the association, the establishment of rates, forms, or procedures for coverage issued by the association, nor any joint or collective action required by this chapter shall be the basis of any legal civil action, or criminal liability against the association or members of it either jointly or separately.

Sec. 11. NEW SECTION. 514E.11 NOTICE OF ASSOCIATION POLICY.

Commencing July 1, 1986, every carrier, including a health maintenance organization subject to chapter 515B, authorized to provide health care insurance or coverage for health care services in Iowa, shall provide a notice and an application for coverage by the association to any person who receives a rejection of coverage for health insurance or health care services, or a notice to any person who is informed that a rate for health insurance or coverage for health care services will exceed the rate of an association policy, that effective January 1, 1987, that person is eligible to apply for health insurance provided by the association. Application for the health insurance shall be on forms prescribed by the board and made available to the carriers.

Sec. 12. There is appropriated from the general fund of the state on January 1, 1987 for the period January 1, 1987 to July 1, 1987, to the Iowa comprehensive health association the

sum of twenty-five thousand (25,000) dollars or as much thereof as necessary for salaries and expenses.

Sec. 13. Health insurance coverage provided under this Act shall not be effective until January 1 following the effective date of this Act.

DONALD D. AVENSON
Speaker of the House

ROBERT T. ANDERSON
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 2181, Seventy-first General Assembly.

JOSEPH O'HERN
Chief Clerk of the House

Approved _____, 1986

TERRY E. BRANSTAD
Governor

H.F. 2181