Reprinted

APR [illegible]

WAYS & MEANS CALENDAR

HOUSE FILE 688

BY COMMITTEE ON WAYS AND MEANS

(SUCCESSOR TO HF 638)

Passed House, Date 4/22/91 (p.1412) Passed Senate, Date 5/2/91 (P.1610)

Vote: Ayes 93 Nays 0 Vote: Ayes 48 Nays 0

Approved June 5, 1991

A BILL FOR

An Act relating to health insurance reforms by limiting small group premium rating practices, increasing access to affordable basic benefits health insurance, and authorizing certain premium credits and tax exemptions for qualifying health insurance plans and insureds.

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

HOUSE FILE 688

H-3630

Amend House File 688 as follows:

1. Page 6, by striking line 19, and inserting the following: "under a class of business, or in a defined geographic region if the carrier is a health maintenance organization. The small employer carrier shall".

By HAVERLAND of Polk

H-3630 FILED APRIL 15, 1991

W/D 4/22/91

HOUSE FILE 688

H-3667

Amend House File 688 as follows:

1. Page 6, by striking line 19, and inserting the following: "under a class of business, or all classes of business in a defined geographic region if the carrier is a health maintenance organization. The small employer carrier shall".

By HAVERLAND of Polk

H-3667 FILED APRIL 17, 1991

Adopted 4/22 (p 1411)

889 FH

TLSB 1679HZ 74

mj/mc/6

S.F. _____ H.F. 688

Section 1. NEW SECTION. 513B.1 TITLE -- PURPOSE.

1. This chapter shall be known and may be cited as the Model Small Group Rating Law.

2. The intent of this chapter is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

Sec. 2. NEW SECTION. 513B.2 DEFINITIONS.

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 513B.4, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier in establishing premium rates for applicable health benefit plans.

2. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health insurance plans with the same or similar coverage.

3. "Carrier" means any person who provides health insurance in this state. For the purposes of this chapter, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation.

4. "Case characteristics" means demographic or other relevant characteristics of a small employer, as determined by

a small employer carrier, which are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of this chapter.

5. "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans meet one or more of the following requirements:

(1) The plans are marketed and sold through individuals and organizations which are not participating in the marketing or sales of other distinct groupings of small employers for the small employer carrier.

(2) The plans have been acquired from another small employer carrier as a distinct grouping of plans.

(3) The plans are provided through an association with membership of not less than fifty small employers which has been formed for purposes other than obtaining insurance.

b. A small employer carrier may establish no more than two additional groupings under each of the subparagraphs in paragraph "a" on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

c. The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

6. "Commissioner" means the commissioner of insurance.

7. "Division" means the division of insurance.

8. "Health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance

organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical-payment insurance.

9. "Index rate" means for each class of business for small employers with similar case characteristics the average of the applicable base premium rate and the corresponding highest premium rate.

10. "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

11. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

12. "Small employer" means a person actively engaged in business who, on at least fifty percent of the employer's working days during the preceding year, employed no more than twenty-five full-time equivalent eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation are considered one employer.

13. "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer.

Sec. 3. NEW SECTION. 513B.3 SMALL GROUP HEALTH BENEFIT PLANS SUBJECT TO RATING RESTRICTIONS.

1. Except as provided in subsection 2, this chapter applies to any health benefit plan which provides coverage to two or more employees of a small employer.

2. This chapter does not apply to individual health

insurance policies which are subject to policy form and premium rate approval by the commissioner.

3. A small employer group shall, at a minimum, have at least two participating employees at the date of issue of the health benefit plan.

Sec. 4. NEW SECTION. 513B.4 RESTRICTIONS RELATING TO THE PREMIUM RATES.

1. Premium rates for health benefit plans subject to this chapter are subject to the following requirements:

a. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent.

b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent of the index rate.

c. The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate.

(2) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined

from the small employer carrier's rate manual for the class of business.

d. In the case of health benefit plans issued prior to the effective date of this chapter, a premium rate for a rating period may exceed the ranges described in subsection 1, paragraph "a" or "b" of this section, for a period of five years following the effective date of this chapter. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

2. This section does not affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

3. A small employer shall not be involuntarily transferred by a small employer carrier into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

Sec. 5. NEW SECTION. 513B.5 PROVISIONS ON RENEWABILITY

OF COVERAGE.

1. Except as provided in subsection 2, a health benefit plan subject to this chapter is renewable to all eligible employees and dependents at the option of the small employer, except for one or more of the following reasons:

a. Nonpayment of required premiums.

b. Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative.

c. Noncompliance with plan provisions.

d. The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan.

e. The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

2. A small employer carrier may cease to renew all plans under a class of business. The small employer carrier shall provide notice at least ninety days prior to termination of coverage to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside. A small employer carrier which exercises its right to cease to renew all plans in a class of business shall not do either or both of the following:

a. Establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the commissioner.

b. Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the small employer carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status, or duration of coverage.

Sec. 6. NEW SECTION. 513B.6 DISCLOSURE OF RATING

PRACTICES AND RENEWABILITY PROVISIONS.

A small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of all of the following:

1. The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

2. The provisions concerning the small employer carrier's right to change premium rates and factors, including case characteristics, which affect changes in premium rates.

3. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans.

4. The provisions relating to renewability of coverage.

Sec. 7. NEW SECTION. 513B.7 MAINTENANCE OF RECORDS.

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

2. A small employer carrier shall file each March 1 with the commissioner an actuarial certification that the small employer carrier is in compliance with this section and that the rating methods of the small employer carrier are actuarially sound. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

3. A small employer carrier shall make the information and documentation described in subsection 1 available to the commissioner upon request. The information is not a public record or otherwise subject to disclosure under chapter 22, and is considered proprietary and trade secret information and

is not subject to disclosure by the commissioner to persons outside of the division except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Sec. 8. NEW SECTION. 513B.8 DISCRETION OF THE COMMISSIONER.

The commissioner may suspend all or any part of section 513B.4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Sec. 9. NEW SECTION. 513B.9 EFFECTIVE DATE -- APPLICABILITY.

This chapter shall apply to a health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after the effective date of this chapter. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this chapter.

Sec. 10. LEGISLATIVE INTENT. The legislature finds that the rising cost of comprehensive group health coverage is exceeding the affordability of many small businesses and their employees. The legislature further finds that preexisting standards for uniformity have had an adverse impact on the cost of health coverage. Statutorily imposed uniformity in benefit structures has discouraged innovation to develop affordable health insurance to assure access to cost-effective preventive care and to secure against catastrophic sickness and injury, by requiring coverage of less cost-effective discretionary or elective care on equally favorable terms. Those Iowans who now have health insurance, have comprehensive benefits, but the cost has created a growing, disenfranchised

class of uninsured Iowans dependent upon charitable care or public assistance. It is therefore the intent of the general assembly to reduce costs of health insurance and increase access to basic health care by enacting new chapter 514H authorizing the development of basic hospital and medical coverage for uninsured small groups.

Sec. 11. NEW SECTION. 514H.1 DEFINITIONS.

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

1. "Basic benefit coverage" means basic health care services rendered by health professionals licensed pursuant to state law together with hospital expenses.

2. "Basic health care services" means services which an enrollee might reasonably require in order to be maintained in good health, including at a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services rendered within or outside of a hospital.

3. "Commissioner" means the commissioner of insurance.

4. "Eligible dependent" means an enrolled dependent of a subscriber entitled to coverage under a basic benefit coverage policy or subscription contract.

5. "Group" means a group composed of eligible employees of a single employer and their dependents. A group shall not have more than twenty-five full-time equivalent employees in number. Employees may not be segregated by division, job responsibilities, employment status, employment location, or any other rationale. For purposes of this chapter, group size will be determined at the time of application for the basic benefit coverage policy, and on each anniversary of the date of issue of the basic benefit coverage policy. Carriers shall confirm the size of groups by certification of the employer which certification shall be maintained in the carrier's file.

6. "Insurer" means any insurer issuing a group accident and sickness insurance policy on an expense incurred basis and any group hospital or medical service contract issued pursuant

to chapter 509, 514, or 514A, or any group health maintenance organization contract under chapter 514B.

7. "Policy" means the entire contract between the insurer and the insured, including the policy riders, endorsements, and the application, if attached, and includes individual subscriber contracts issued under chapter 514B.

8. "Subscriber" means an enrolled eligible employee with coverage under a basic benefit coverage policy.

Sec. 12. NEW SECTION. 514H.2 ISSUANCE OF BASIC BENEFIT COVERAGE POLICIES AND SUBSCRIPTION CONTRACTS PERMITTED.

An insurer may issue a basic benefit coverage policy or subscription contract meeting the criteria set forth in this chapter.

For purposes of this chapter, a basic benefit coverage policy or subscription contract means a policy or subscription contract which the insurer may choose to offer to individuals, spouses, families, or groups of twenty-five or less formed for purposes other than obtaining insurance coverage, and which meets the following criteria:

1. The individual, spouse, family, or group obtaining coverage under the policy or subscription contract has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage for all of the twelve-month period immediately preceding the effective date of the basic hospital and medical coverage policy or subscription contract, provided that for groups in existence for less than twelve months, the group has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage since inception of the group.

2. The insurer may include any or all of the following managed care provisions, subject to the approval of the commissioner, to control costs:

a. A procedure for preauthorization by the insurer, or its designees.

b. An exclusion for services that are not medically necessary or are not covered preventive health services.

c. First-dollar coverage for preventive and emergency care.

d. Except as otherwise provided, copayments for all other physician visits.

e. Exclusions or limitations upon benefits or direct pay requirements otherwise mandated.

f. Deductibles or copayments which vary based upon the service provided.

3. The insurer may include any or all of the following managed care provisions to control costs:

a. A preferred panel of providers who have entered into written agreements with the insurer to provide services at specified levels of reimbursement. Any such written agreement between a provider and an insurer shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary.

b. Provisions requiring a second surgical opinion.

c. A procedure for utilization review by the insurer or its designees.

This section does not prohibit an insurer from including in its policy or subscription contract additional managed care and cost control provisions which, subject to the approval of the commissioner, have the potential to control costs in a manner which does not result in inequitable treatment of insureds or subscribers.

4. The policy or subscription contract shall provide basic levels of primary, preventive, and hospital care for covered individuals, including, but not limited to, all of the following:

a. A minimum of thirty days of inpatient hospitalization coverage per policy year.

b. Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member.

c. Obstetrical care, including physician's services, delivery room, and other medically necessary hospital services.

d. For covered individuals, a basic level of primary and preventive care, including but not limited to, two physician office visits per calendar year.

e. Such other coverages as the commissioner may determine are cost-effective pursuant to section 514H.7.

5. The commissioner may also authorize the issuance of a basic benefit coverage family plan for spouses or dependents of employees, even if the employer currently provides individual health benefits exclusively for employees. The commissioner may also authorize the issuance of a basic benefit coverage plan for part-time employees or full-time, part-year employees, even if the employer currently offers health benefits for full-time employees.

Sec. 13. NEW SECTION. 514H.3 DISCLOSURE REQUIREMENTS FOR BASIC BENEFIT COVERAGE POLICIES AND SUBSCRIPTION CONTRACTS.

Upon offering coverage under a basic benefit coverage policy or subscription contract for an individual, spouse, family, or group member, the insurer shall provide such individual, spouse, family, or group member with a written disclosure statement containing at least the following:

1. An explanation of those mandated benefits and providers not covered by the policy or subscription contract.

2. An explanation of the managed care and cost control features of the policy or subscription contract, along with all appropriate mailing addresses and telephone numbers to be utilized by insureds in seeking information or authorization.

3. The written statement shall be provided to the prospective policynolder no later than at the time of policy delivery, and the original of the written statement shall be retained in the files of the insurer for the longer of the following:

a. The period of time that the policy or subscription contract remains in effect.

b. Five years.

4. Any material statement made by an applicant for coverage under a basic benefit coverage policy or subscription contract which falsely certifies as to the applicant's eligibility for coverage pursuant to section 514H.2 is a basis for termination of coverage under the policy or subscription contract.

5. All marketing communications intended to be utilized in the marketing of a basic benefit coverage policy or subscription contract in this state shall be submitted for review and their use is conditioned upon the prior approval of the commissioner. Marketing communications shall contain the disclosures required by this section.

Sec. 14. NEW SECTION. 514H.4 FORMS AND RATES TO BE FILED WITH AND APPROVED BY THE COMMISSIONER.

1. All basic hospital and medical coverage policy forms including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms shall be submitted to the commissioner.

2. A basic benefit coverage policy or subscription contract shall not be issued or issued for delivery in this state unless the rates have been filed with and approved by the commissioner.

3. Each form filing submitted to the commissioner for approval shall contain a transmittal page as prescribed by the commissioner and the following materials arranged in this order:

a. The printed form or forms, completed by using information concerning a fictitious applicant.

b. Rates, manuals of classification, and manuals of rules and premiums, and modifications of the rates, manuals of classification, and manuals of rules and premiums.

c. Actuarial memorandum.

d. Any additional enclosure required by the commissioner.

Sec. 15. NEW SECTION. 514H.5 STANDARDS FOR LOSS RATIOS.

Basic benefit coverage policies shall return a cumulative loss ratio of at least seventy percent. Such loss ratio is on the basis of incurred claims and earned premiums for all calculating or rating periods such that the cumulative loss ratio from inception equals or exceeds the seventy percent minimum loss ratio. Where coverage is provided on a direct service rather than indemnity basis, such loss ratio is on the basis of incurred health care expenses and earned premiums for such period. For purposes of achieving and maintaining the minimum cumulative loss ratio, the experience of all basic benefit coverage policies of a insurer is combined.

All claim experience for basic benefit coverage policies is pooled for the purposes of establishing premiums and rates, and the claim experience of a given individual group shall not be a factor in determining the rates of a policy.

Sec. 16. NEW SECTION. 514H.6 RECORDKEEPING AND REPORTING REQUIREMENT.

Each basic benefit coverage policy or subscription contract in this state shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and other information as required by the commissioner. Each insurer providing such policies or contracts shall furnish an annual report to the commissioner. The report shall be in a

form prescribed by the commissioner and shall contain the information required by the commissioner to analyze the success of insurance coverage issued pursuant to this chapter.

Sec. 17. NEW SECTION. 514H.7 COST-BENEFIT ANALYSIS.

1. The commissioner may, based upon reasonable actuarial evidence as to cost effectiveness, determine any of the following:

a. What benefits or direct pay requirements must be minimally included in a basic benefit coverage policy or subscription contract.

b. What otherwise mandated benefits or direct pay requirements may be exempted from coverage by a basic benefit coverage policy or subscription contract.

c. What cost containment procedures must be minimally included in a basic benefit coverage policy or subscription contract.

d. What cost containment procedures otherwise restricted may be utilized by a basic benefit coverage policy or subscription contract.

2. The commissioner may retain a consultant to assist in the analysis of any benefit or requirement, and may convene an advisory panel to assist the commissioner in the review of evidence and practices by the health care and insurance industries.

3. The commissioner may assess a fee against health insurers, hospital service plans, and health maintenance organizations licensed in the state to defray consulting fees and expenses incurred by the commissioner under this section.

4. The commissioner may also require medical professional societies or providers associations to contribute on a proportionate and reasonable basis to the payment of the commissioner's consultants and expenses under this section as a condition of reviewing a benefit or requirement impacting upon such medical professionals or providers.

Sec. 18. NEW SECTION. 514H.8 PRESUMED EXCLUSION OF

MANDATED BENEFITS.

A mandated benefit or direct pay requirement otherwise imposed by state law, but excluded under section 514H.2, shall not be included in a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the inclusion of the benefit or direct pay requirement is cost-effective. The commissioner's finding shall be based upon review of actuarial evidence, including a cost-benefit analysis, and the determination that inclusion of the mandated benefit or direct pay requirement is in the best interests of affordable health care coverage.

Sec. 19. NEW SECTION. 514H.9 PRESUMED ALLOWANCE OF COST-CONTAINMENT PROCEDURES.

A cost-containment restriction otherwise imposed by state law does not apply to a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the restricted cost-containment measure is not cost-effective, and its exclusion is in the best interests of affordable health care coverage.

Sec. 20. NEW SECTION. 514H.10 SHARED COST OPTION FOR PRIVATE EMPLOYERS BASIC BENEFIT PLAN.

The commissioner, in cooperation with insurance carriers interested in participating, shall develop a group health insurance plan providing basic coverage, to be marketed to employers by insurance carriers approved by the commissioner, which employers have not offered health care benefits to their employees within the preceding twelve months and which are likely to have eligible employees under the employer-sponsored health care plan premium credit provided by section 514H.12. This shared cost option for private employers basic benefit coverage plan is subject to such additional requirements as the commissioner may impose to assure that an affordable policy is effectively marketed to benefit eligible low-income employees and their families. The premium credit under section 514H.12 is limited to the shared cost option for

private employers plan approved by the commissioner under this section, and is not available to other basic benefit coverage plans generally authorized by this chapter, in order to facilitate administration of the participation limits imposed by section 514H.12.

Sec. 21. NEW SECTION. 514H.11 HEALTH INSURANCE ACCESS.

1. The commissioner shall with all due diligence adopt by rule the recommendations of the national association of insurance commissioners concerning health insurance access by small employer groups, provided that the final recommendations are generally consistent with the following principles:

a. Guaranteed transferability of benefits or eligibility, with no new preexisting condition waiting periods or individual underwriting, for employees transferring to new employers or employers switching insurance carriers, for persons who are receiving assistance pursuant to chapter 249A, or persons who are provided health insurance coverage pursuant to the person's service as a member of a branch of the armed forces of the United States of America.

b. A risk transfer or sharing device to equitably distribute the risk of adverse selection posed to insurers by guaranteed access.

2. Within six months of adopting any rule pursuant to subsection 1, the commissioner shall prepare and deliver a report to the general assembly regarding the success, if any, of the rules, and make such recommendations as necessary, including offering proposed legislation, to effectuate the general assembly's goals of guaranteeing access to health insurance by employees and employers and retention of currently insured persons within the private health insurance market, regardless of change in employer, employment status, or change in insurance carrier.

Sec. 22. NEW SECTION. 514H.12 EMPLOYER-SPONSORED HEALTH PLAN PREMIUM CREDIT.

1. The division shall adopt rules to implement and

administer the premium credit authorized by this section, which rules shall include the minimum standard application form for premium credit eligibility. Forms shall be printed by participating insurance companies and provided to employers and employers' employees wishing to apply for premium credit eligibility.

2. The amount of the premium credit is equal to twenty-five dollars per month, per participating eligible employee for which the employer provides an employer-sponsored group basic benefit plan approved by the commissioner of insurance pursuant to section 514H.10, provided that the employer satisfies all of the following conditions:

a. The employer has not provided health insurance coverage, in whole or in part, to employees within the immediately preceding twelve months before contracting with an insurance carrier for basic benefit insurance approved pursuant to section 514H.10.

b. The employer employs twenty-five or fewer full-time equivalent employees.

c. The employer paid either of the following:

(1) Seventy-five percent or more of the premium for individual coverage of the participating eligible employee.

(2) Fifty percent or more of the premium for family coverage of the participating eligible employee and the employee's spouse and dependents.

3. An employee is eligible for participation in the subsidized insurance premium credit group health insurance plan if the family income of the employee is less than or equal to one hundred fifty percent of the federal poverty level as reported annually in the federal register. An employee application for eligibility is current for up to one year.

4. Earned premium credit is limited to the first five thousand full-year equivalent participating eligible employee applications under this section preapproved by the division in

any single fiscal year.

5. The carrier shall credit to the participating employer's premium liability, an amount equal to the premium credit earned pursuant to subsection 2, against the premium due in the year after the credit is earned.

6. The premium credit provided by this section is only available in connection with a basic benefit plan approved by the commissioner which satisfies any conditions imposed by rules adopted pursuant to subsection 1 which the commissioner determines are necessary or convenient to implement and administer the premium credit.

7. a. A person submitting an intentionally fraudulent premium credit application forfeits the credit and shall pay to the division a liquidated damages penalty of one hundred percent of the credit forfeited.

b. A person submitting a premium credit application which that person should have known was false forfeits the credit and shall pay to the division a liquidated damages penalty of ten percent of the credit forfeited.

8. The insurance carrier shall receive a premium tax credit equal to, at a minimum, the premium credit earned by the carrier's insureds pursuant to subsection 2.

Sec. 23. NEW SECTION. 432.11 PREMIUM TAX EXEMPTION FOR BASIC BENEFIT HEALTH PLANS.

Premiums collected on sales of basic benefit health policies, approved by the commissioner pursuant to chapter 514H, are exempt from premium tax.

Sec. 24. NEW SECTION. 432.11A PREMIUM TAX CREDIT FOR EMPLOYER-SPONSORED HEALTH PLAN PREMIUM CREDIT.

An insurance carrier approved by the commissioner pursuant to section 514H.10 to offer a policy eligible for the premium credit provided by section 514H.12, shall receive a premium tax credit equal to the premium credit earned by participating employers pursuant to section 514H.12, subsection 2, and any additional amount allowed by the commissioner pursuant to a

contract for administrative expenses.

Sec. 25. Section 509.1, subsection 1, paragraph c, Code 1991, is amended by striking the paragraph.

Sec. 26. RULES. The commissioner shall adopt rules to implement the basic benefit coverage policy program and the shared cost option plan established in section 514H.10.

Sec. 27. Section 509.17A, Code 1991, is repealed.

EXPLANATION

This bill adopts the national association of insurance commissioners premium rates and renewability of coverage for health insurance sold to small groups model Act (small group rating law), authorizes the insurance commissioner to approve basic benefit health insurance, and provides for premium credits and tax exemptions intended to encourage certain employers to provide health insurance. The bill restricts the percentage increase in premium which may be charged to a small employer for a new rating period, and provisions are included which discourage a small employer carrier from excluding coverage to high risk employees by establishing certain requirements which must be met to transfer a small employer from one class of business to another, or prohibiting the cancellation or nonrenewal of small employer policies except under certain circumstances.

The bill authorizes the commissioner to approve basic benefit health plans. Under these provisions, a basic benefit health plan may be approved which does not provide coverage for certain mandated benefits. Rates for these plans must be approved prior to the plans being offered.

The bill provides premium credit incentives for small employers relating to the provision of health insurance for the employees of the small employer. A $25 per month per employee premium credit is provided for employers who pay for 75 percent of individual coverage or 50 percent of family coverage for employees with a total family income of less than or equal to 150 percent of the federal poverty line.

The bill provides that the carrier is to receive a premium tax credit equal to at least the premium credit earned by the carrier's insureds.

Section 509.17A is repealed which authorized the commissioner to adopt by rule the national association of insurance commissioners small group rating law upon its completion.

Sen Ways. Means Amend (3641) : D. Pass 4/29/91 (J. 1535)

HOUSE FILE 685
BY COMMITTEE ON WAYS AND MEANS

(SUCCESSOR TO HF 638)

(Amended and Passed by the House April 22, 1991)

As amended by House
As Passed House, Date 5/3/91 (p. 2081) Passed Senate, Date 5/2/91 (p. 1610)
Vote: Ayes 99 Nays 0 Vote: Ayes 48 Nays 0
Approved June 5, 1991

A BILL FOR

An Act relating to health insurance reforms by limiting small group premium rating practices, increasing access to affordable basic benefits health insurance, and authorizing certain premium credits and tax exemptions for qualifying health insurance plans and insureds.

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

House Amendments _____

TLSB 1679HZ 74
mj/mc/6

S.F. _____ H.F. ___688___

Section 1. NEW SECTION. 513B.1 TITLE -- PURPOSE.

1. This chapter shall be known and may be cited as the Model Small Group Rating Law.

2. The intent of this chapter is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

Sec. 2. NEW SECTION. 513B.2 DEFINITIONS.

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 513B.4, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier in establishing premium rates for applicable health benefit plans.

2. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health insurance plans with the same or similar coverage.

3. "Carrier" means any person who provides health insurance in this state. For the purposes of this chapter, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation.

4. "Case characteristics" means demographic or other relevant characteristics of a small employer, as determined by

a small employer carrier, which are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of this chapter.

5. "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans meet one or more of the following requirements:

(1) The plans are marketed and sold through individuals and organizations which are not participating in the marketing or sales of other distinct groupings of small employers for the small employer carrier.

(2) The plans have been acquired from another small employer carrier as a distinct grouping of plans.

(3) The plans are provided through an association with membership of not less than fifty small employers which has been formed for purposes other than obtaining insurance.

b. A small employer carrier may establish no more than two additional groupings under each of the subparagraphs in paragraph "a" on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

c. The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

6. "Commissioner" means the commissioner of insurance.

7. "Division" means the division of insurance.

8. "Health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance

organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical-payment insurance.

9. "Index rate" means for each class of business for small employers with similar case characteristics the average of the applicable base premium rate and the corresponding highest premium rate.

10. "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

11. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

12. "Small employer" means a person actively engaged in business who, on at least fifty percent of the employer's working days during the preceding year, employed no more than twenty-five full-time equivalent eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation are considered one employer.

13. "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer.

Sec. 3. NEW SECTION. 513B.3 SMALL GROUP HEALTH BENEFIT PLANS SUBJECT TO RATING RESTRICTIONS.

1. Except as provided in subsection 2, this chapter applies to any health benefit plan which provides coverage to two or more employees of a small employer.

2. This chapter does not apply to individual health

insurance policies which are subject to policy form and premium rate approval by the commissioner.

3. A small employer group shall, at a minimum, have at least two participating employees at the date of issue of the health benefit plan.

Sec. 4. NEW SECTION. 513B.4 RESTRICTIONS RELATING TO THE PREMIUM RATES.

1. Premium rates for health benefit plans subject to this chapter are subject to the following requirements:

a. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent.

b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent of the index rate.

c. The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate.

(2) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined

from the small employer carrier's rate manual for the class of business.

d. In the case of health benefit plans issued prior to the effective date of this chapter, a premium rate for a rating period may exceed the ranges described in subsection 1, paragraph "a" or "b" of this section, for a period of five years following the effective date of this chapter. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

2. This section does not affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

3. A small employer shall not be involuntarily transferred by a small employer carrier into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

Sec. 5. NEW SECTION. 513B.5 PROVISIONS ON RENEWABILITY

OF COVERAGE.

1. Except as provided in subsection 2, a health benefit plan subject to this chapter is renewable to all eligible employees and dependents at the option of the small employer, except for one or more of the following reasons:

a. Nonpayment of required premiums.

b. Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative.

c. Noncompliance with plan provisions.

d. The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan.

e. The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

2. A small employer carrier may cease to renew all plans under a class of business, or all classes of business in a defined geographic region if the carrier is a health maintenance organization. The small employer carrier shall provide notice at least ninety days prior to termination of coverage to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside. A small employer carrier which exercises its right to cease to renew all plans in a class of business shall not do either or both of the following:

a. Establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the commissioner.

b. Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the small employer carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim

experience, health status, or duration of coverage.

Sec. 6. NEW SECTION. 513B.6 DISCLOSURE OF RATING PRACTICES AND RENEWABILITY PROVISIONS.

A small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of all of the following:

1. The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

2. The provisions concerning the small employer carrier's right to change premium rates and factors, including case characteristics, which affect changes in premium rates.

3. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans.

4. The provisions relating to renewability of coverage.

Sec. 7. NEW SECTION. 513B.7 MAINTENANCE OF RECORDS.

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

2. A small employer carrier shall file each March 1 with the commissioner an actuarial certification that the small employer carrier is in compliance with this section and that the rating methods of the small employer carrier are actuarially sound. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

3. A small employer carrier shall make the information and documentation described in subsection 1 available to the commissioner upon request. The information is not a public

record or otherwise subject to disclosure under chapter 22, and is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the division except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Sec. 8. NEW SECTION. 513B.8 DISCRETION OF THE COMMISSIONER.

The commissioner may suspend all or any part of section 513B.4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Sec. 9. NEW SECTION. 513B.9 EFFECTIVE DATE -- APPLICABILITY.

This chapter shall apply to a health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after the effective date of this chapter. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this chapter.

Sec. 10. LEGISLATIVE INTENT. The legislature finds that the rising cost of comprehensive group health coverage is exceeding the affordability of many small businesses and their employees. The legislature further finds that preexisting standards for uniformity have had an adverse impact on the cost of health coverage. Statutorily imposed uniformity in benefit structures has discouraged innovation to develop affordable health insurance to assure access to cost-effective preventive care and to secure against catastrophic sickness and injury, by requiring coverage of less cost-effective discretionary or elective care on equally favorable terms.

Those Iowans who now have health insurance, have comprehensive benefits, but the cost has created a growing, disenfranchised class of uninsured Iowans dependent upon charitable care or public assistance. It is therefore the intent of the general assembly to reduce costs of health insurance and increase access to basic health care by enacting new chapter 514H authorizing the development of basic hospital and medical coverage for uninsured small groups.

Sec. 11. NEW SECTION. 514H.1 DEFINITIONS.

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

1. "Basic benefit coverage" means basic health care services rendered by health professionals licensed pursuant to state law together with hospital expenses.

2. "Basic health care services" means services which an enrollee might reasonably require in order to be maintained in good health, including at a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services rendered within or outside of a hospital.

3. "Commissioner" means the commissioner of insurance.

4. "Eligible dependent" means an enrolled dependent of a subscriber entitled to coverage under a basic benefit coverage policy or subscription contract.

5. "Group" means a group composed of eligible employees of a single employer and their dependents. A group shall not have more than twenty-five full-time equivalent employees in number. Employees may not be segregated by division, job responsibilities, employment status, employment location, or any other rationale. For purposes of this chapter, group size will be determined at the time of application for the basic benefit coverage policy, and on each anniversary of the date of issue of the basic benefit coverage policy. Carriers shall confirm the size of groups by certification of the employer which certification shall be maintained in the carrier's file.

6. "Insurer" means any insurer issuing a group accident

and sickness insurance policy on an expense incurred basis and any group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A, or any group health maintenance organization contract under chapter 514B.

7. "Policy" means the entire contract between the insurer and the insured, including the policy riders, endorsements, and the application, if attached, and includes individual subscriber contracts issued under chapter 514B.

8. "Subscriber" means an enrolled eligible employee with coverage under a basic benefit coverage policy.

Sec. 12. NEW SECTION. 514H.2 ISSUANCE OF BASIC BENEFIT COVERAGE POLICIES AND SUBSCRIPTION CONTRACTS PERMITTED.

An insurer may issue a basic benefit coverage policy or subscription contract meeting the criteria set forth in this chapter.

For purposes of this chapter, a basic benefit coverage policy or subscription contract means a policy or subscription contract which the insurer may choose to offer to individuals, spouses, families, or groups of twenty-five or less formed for purposes other than obtaining insurance coverage, and which meets the following criteria:

1. The individual, spouse, family, or group obtaining coverage under the policy or subscription contract has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage for all of the twelve-month period immediately preceding the effective date of the basic hospital and medical coverage policy or subscription contract, provided that for groups in existence for less than twelve months, the group has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage since inception of the group.

2. The insurer may include any or all of the following managed care provisions, subject to the approval of the commissioner, to control costs:

a. A prccedure for preauthorization by the insurer, or its designees.

b. An exclusion for services that are not medically necessary or are not covered preventive health services.

c. First-dollar coverage for preventive and emergency care.

d. Except as otherwise provided, copayments for all other physician visits.

e. Exclusions or limitations upon benefits or direct pay requirements otherwise mandated.

f. Deductibles or copayments which vary based upon the service provided.

3. The insurer may include any or all of the following managed care provisions to control costs:

a. A preferred panel of providers who have entered into written agreements with the insurer to provide services at specified levels of reimbursement. Any such written agreement between a provider and an insurer shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary.

b. Provisions requiring a second surgical opinion.

c. A procedure for utilization review by the insurer or its designees.

This section does not prohibit an insurer from including in its policy or subscription contract additional managed care and cost control provisions which, subject to the approval of the commissioner, have the potential to control costs in a manner which does not result in inequitable treatment of insureds or subscribers.

4. The policy or subscription contract shall provide basic levels of primary, preventive, and hospital care for covered individuals, including, but not limited to, all of the following:

a. A minimum of thirty days of inpatient hospitalization coverage per policy year.

b. Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member.

c. Obstetrical care, including physician's services, delivery room, and other medically necessary hospital services.

d. For covered individuals, a basic level of primary and preventive care, including but not limited to, two physician office visits per calendar year.

e. Such other coverages as the commissioner may determine are cost-effective pursuant to section 514H.7.

5. The commissioner may also authorize the issuance of a basic benefit coverage family plan for spouses or dependents of employees, even if the employer currently provides individual health benefits exclusively for employees. The commissioner may also authorize the issuance of a basic benefit coverage plan for part-time employees or full-time, part-year employees, even if the employer currently offers health benefits for full-time employees.

Sec. 13. NEW SECTION. 514H.3 DISCLOSURE REQUIREMENTS FOR BASIC BENEFIT COVERAGE POLICIES AND SUBSCRIPTION CONTRACTS.

Upon offering coverage under a basic benefit coverage policy or subscription contract for an individual, spouse, family, or group member, the insurer shall provide such individual, spouse, family, or group member with a written disclosure statement containing at least the following:

1. An explanation of those mandated benefits and providers not covered by the policy or subscription contract.

2. An explanation of the managed care and cost control features of the policy or subscription contract, along with all appropriate mailing addresses and telephone numbers to be utilized by insureds in seeking information or authorization.

3. The written statement shall be provided to the prospective policyholder no later than at the time of policy delivery, and the original of the written statement shall be retained in the files of the insurer for the longer of the following:

a. The period of time that the policy or subscription contract remains in effect.

b. Five years.

4. Any material statement made by an applicant for coverage under a basic benefit coverage policy or subscription contract which falsely certifies as to the applicant's eligibility for coverage pursuant to section 514H.2 is a basis for termination of coverage under the policy or subscription contract.

5. All marketing communications intended to be utilized in the marketing of a basic benefit coverage policy or subscription contract in this state shall be submitted for review and their use is conditioned upon the prior approval of the commissioner. Marketing communications shall contain the disclosures required by this section.

Sec. 14. NEW SECTION. 514H.4 FORMS AND RATES TO BE FILED WITH AND APPROVED BY THE COMMISSIONER.

1. All basic hospital and medical coverage policy forms including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms shall be submitted to the commissioner.

2. A basic benefit coverage policy or subscription contract shall not be issued or issued for delivery in this

state unless the rates have been filed with and approved by the commissioner.

3. Each form filing submitted to the commissioner for approval shall contain a transmittal page as prescribed by the commissioner and the following materials arranged in this order:

a. The printed form or forms, completed by using information concerning a fictitious applicant.

b. Rates, manuals of classification, and manuals of rules and premiums, and modifications of the rates, manuals of classification, and manuals of rules and premiums.

c. Actuarial memorandum.

d. Any additional enclosure required by the commissioner.

Sec. 15. NEW SECTION. 514H.5 STANDARDS FOR LOSS RATIOS.

Basic benefit coverage policies shall return a cumulative loss ratio of at least seventy percent. Such loss ratio is on the basis of incurred claims and earned premiums for all calculating or rating periods such that the cumulative loss ratio from inception equals or exceeds the seventy percent minimum loss ratio. Where coverage is provided on a direct service rather than indemnity basis, such loss ratio is on the basis of incurred health care expenses and earned premiums for such period. For purposes of achieving and maintaining the minimum cumulative loss ratio, the experience of all basic benefit coverage policies of a insurer is combined.

All claim experience for basic benefit coverage policies is pooled for the purposes of establishing premiums and rates, and the claim experience of a given individual group shall not be a factor in determining the rates of a policy.

Sec. 16. NEW SECTION. 514H.6 RECORDKEEPING AND REPORTING REQUIREMENT.

Each basic benefit coverage policy or subscription contract in this state shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and other information as required by the commissioner. Each

insurer providing such policies or contracts shall furnish an annual report to the commissioner. The report shall be in a form prescribed by the commissioner and shall contain the information required by the commissioner to analyze the success of insurance coverage issued pursuant to this chapter.

Sec. 17. NEW SECTION. 514H.7 COST-BENEFIT ANALYSIS.

1. The commissioner may, based upon reasonable actuarial evidence as to cost effectiveness, determine any of the following:

a. What benefits or direct pay requirements must be minimally included in a basic benefit coverage policy or subscription contract.

b. What otherwise mandated benefits or direct pay requirements may be exempted from coverage by a basic benefit coverage policy or subscription contract.

c. What cost containment procedures must be minimally included in a basic benefit coverage policy or subscription contract.

d. What cost containment procedures otherwise restricted may be utilized by a basic benefit coverage policy or subscription contract.

2. The commissioner may retain a consultant to assist in the analysis of any benefit or requirement, and may convene an advisory panel to assist the commissioner in the review of evidence and practices by the health care and insurance industries.

3. The commissioner may assess a fee against health insurers, hospital service plans, and health maintenance organizations licensed in the state to defray consulting fees and expenses incurred by the commissioner under this section.

4. The commissioner may also require medical professional societies or providers associations to contribute on a proportionate and reasonable basis to the payment of the commissioner's consultants and expenses under this section as a condition of reviewing a benefit or requirement impacting

upon such medical professionals or providers.

Sec. 18. NEW SECTION. 514H.8 PRESUMED EXCLUSION OF MANDATED BENEFITS.

A mandated benefit or direct pay requirement otherwise imposed by state law, but excluded under section 514H.2, shall not be included in a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the inclusion of the benefit or direct pay requirement is cost-effective. The commissioner's finding shall be based upon review of actuarial evidence, including a cost-benefit analysis, and the determination that inclusion of the mandated benefit or direct pay requirement is in the best interests of affordable health care coverage.

Sec. 19. NEW SECTION. 514H.9 PRESUMED ALLOWANCE OF COST-CONTAINMENT PROCEDURES.

A cost-containment restriction otherwise imposed by state law does not apply to a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the restricted cost-containment measure is not cost-effective, and its exclusion is in the best interests of affordable health care coverage.

Sec. 20. NEW SECTION. 514H.10 SHARED COST OPTION FOR PRIVATE EMPLOYERS BASIC BENEFIT PLAN.

The commissioner, in cooperation with insurance carriers interested in participating, shall develop a group health insurance plan providing basic coverage, to be marketed to employers by insurance carriers approved by the commissioner, which employers have not offered health care benefits to their employees within the preceding twelve months and which are likely to have eligible employees under the employer-sponsored health care plan premium credit provided by section 514H.12. This shared cost option for private employers basic benefit coverage plan is subject to such additional requirements as the commissioner may impose to assure that an affordable policy is effectively marketed to benefit eligible low-income

employees and their families. The premium credit under section 514H.12 is limited to the shared cost option for private employers plan approved by the commissioner under this section, and is not available to other basic benefit coverage plans generally authorized by this chapter, in order to facilitate administration of the participation limits imposed by section 514H.12.

Sec. 21. NEW SECTION. 514H.11 HEALTH INSURANCE ACCESS.

1. The commissioner shall with all due diligence adopt by rule the recommendations of the national association of insurance commissioners concerning health insurance access by small employer groups, provided that the final recommendations are generally consistent with the following principles:

a. Guaranteed transferability of benefits or eligibility, with no new preexisting condition waiting periods or individual underwriting, for employees transferring to new employers or employers switching insurance carriers, for persons who are receiving assistance pursuant to chapter 249A, or persons who are provided health insurance coverage pursuant to the person's service as a member of a branch of the armed forces of the United States of America.

b. A risk transfer or sharing device to equitably distribute the risk of adverse selection posed to insurers by guaranteed access.

2. Within six months of adopting any rule pursuant to subsection 1, the commissioner shall prepare and deliver a report to the general assembly regarding the success, if any, of the rules, and make such recommendations as necessary, including offering proposed legislation, to effectuate the general assembly's goals of guaranteeing access to health insurance by employees and employers and retention of currently insured persons within the private health insurance market, regardless of change in employer, employment status, or change in insurance carrier.

Sec. 22. NEW SECTION. 514H.12 EMPLOYER-SPONSORED HEALTH

PLAN PREMIUM CREDIT.

1. The division shall adopt rules to implement and administer the premium credit authorized by this section, which rules shall include the minimum standard application form for premium credit eligibility. Forms shall be printed by participating insurance companies and provided to employers and employers' employees wishing to apply for premium credit eligibility.

2. The amount of the premium credit is equal to twenty-five dollars per month, per participating eligible employee for which the employer provides an employer-sponsored group basic benefit plan approved by the commissioner of insurance pursuant to section 514H.10, provided that the employer satisfies all of the following conditions:

a. The employer has not provided health insurance coverage, in whole or in part, to employees within the immediately preceding twelve months before contracting with an insurance carrier for basic benefit insurance approved pursuant to section 514H.10.

b. The employer employs twenty-five or fewer full-time equivalent employees.

c. The employer paid either of the following:

(1) Seventy-five percent or more of the premium for individual coverage of the participating eligible employee.

(2) Fifty percent or more of the premium for family coverage of the participating eligible employee and the employee's spouse and dependents.

3. An employee is eligible for participation in the subsidized insurance premium credit group health insurance plan if the family income of the employee is less than or equal to one hundred fifty percent of the federal poverty level as reported annually in the federal register. An employee application for eligibility is current for up to one year.

4. Earned premium credit is limited to the first five

thousand full-year equivalent participating eligible employee applications under this section preapproved by the division in any single fiscal year.

5. The carrier shall credit to the participating employer's premium liability, an amount equal to the premium credit earned pursuant to subsection 2, against the premium due in the year after the credit is earned.

6. The premium credit provided by this section is only available in connection with a basic benefit plan approved by the commissioner which satisfies any conditions imposed by rules adopted pursuant to subsection 1 which the commissioner determines are necessary or convenient to implement and administer the premium credit.

7. a. A person submitting an intentionally fraudulent premium credit application forfeits the credit and shall pay to the division a liquidated damages penalty of one hundred percent of the credit forfeited.

b. A person submitting a premium credit application which that person should have known was false forfeits the credit and shall pay to the division a liquidated damages penalty of ten percent of the credit forfeited.

8. The insurance carrier shall receive a premium tax credit equal to, at a minimum, the premium credit earned by the carrier's insureds pursuant to subsection 2.

Sec. 23. NEW SECTION. 432.11 PREMIUM TAX EXEMPTION FOR BASIC BENEFIT HEALTH PLANS.

Premiums collected on sales of basic benefit health policies, approved by the commissioner pursuant to chapter 514H, are exempt from premium tax.

Sec. 24. NEW SECTION. 432.11A PREMIUM TAX CREDIT FOR EMPLOYER-SPONSORED HEALTH PLAN PREMIUM CREDIT.

An insurance carrier approved by the commissioner pursuant to section 514H.10 to offer a policy eligible for the premium credit provided by section 514H.12, shall receive a premium tax credit equal to the premium credit earned by participating

employers pursuant to section 514H.12, subsection 2, and any additional amount allowed by the commissioner pursuant to a contract for administrative expenses.

Sec. 25. Section 509.1, subsection 1, paragraph c, Code 1991, is amended by striking the paragraph.

Sec. 26. RULES. The commissioner shall adopt rules to implement the basic benefit coverage policy program and the shared cost option plan established in section 514H.10.

Sec. 27. Section 509.17A, Code 1991, is repealed.

HOUSE FILE 688

S-3678

Amend the amendment, S-3641, to House File 688, as amended, passed, and reprinted by the House, as follows:

1. Page 1, by inserting after line 27 the following:

"___. Page 15, line 29, by striking the words "licensed in the state" and inserting the following: "issuing or issuing for delivery in this state basic benefit coverage policies or subscription contracts"."

2. Page 1, line 31, by inserting after the word "policy" the following: "or subscription contract".

By ELAINE SZYMONIAK

S-3678 FILED MAY 2, 1991

ADOPTED (p. 1616)

HOUSE FILE 688

S-3641

Amend House File 688, as amended, passed, and reprinted by the House, as follows:

1. Page 3, line 11, by inserting after the word "the" the following: "lowest".

2. Page 5, by inserting after line 20, the following:

"e. Rates for individual employees or dependents may be adjusted for claims experience or health status at the date of issue as long as the total rates for the small employer are in compliance with this section. An individual employee or dependent adjustment in rates for claims experience or health status shall not be increased subsequent to the date of issue. The commissioner may prohibit individual rating upon adoption of health insurance access rules pursuant to section 514H.11."

3. Page 13, by striking line 35, and inserting the following: "contract shall be filed with, and is subject to the approval of, the commissioner before the basic benefit coverage policy or subscription contract is issued or issued for delivery in this state."

4. Page 14, by striking lines 1 and 2.

5. Page 14, by striking lines 9 through 11.

6. Page 14, line 28, by inserting after the word "experience" the following: ", and health status and duration from the date of issue".

7. Page 15, line 32, by inserting after the word "associations" the following: "requesting the inclusion of a benefit or requirement in a basic benefit coverage policy".

8. By renumbering as necessary.

By COMMITTEE ON WAYS AND MEANS
WILLIAM W. DIELEMAN, Chairperson

S-3641 FILED APRIL 29, 1991
Adopted as amended by 36 78 5/2/91 (p. 1610)

HOUSE FILE 688

S-3651

Amend House File 688, as amended, passed, and reprinted by the House, as follows:

1. Page 15, line 29, by striking the words "licensed in the state" and inserting the following: "issuing or issuing for delivery in this state basic benefit coverage policies or subscription contracts".

2. Page 15, line 32, by inserting after the word "associations" the following: "requesting the inclusion of a benefit or requirement in a basic benefit coverage policy or subscription contract".

By ELAINE SZYMONIAK

S-3651 FILED APRIL 30, 1991
Placed o/c 5/2

SENATE AMENDMENT TO HOUSE FILE 688

H-4024

Amend House File 688, as amended, passed, and reprinted by the House, as follows:

1. Page 3, line 11, by inserting after the word "the" the following: "lowest".

2. Page 5, by inserting after line 20, the following:

"e. Rates for individual employees or dependents may be adjusted for claims experience or health status at the date of issue as long as the total rates for the small employer are in compliance with this section. An individual employee or dependent adjustment in rates for claims experience or health status shall not be increased subsequent to the date of issue. The commissioner may prohibit individual rating upon adoption of health insurance access rules pursuant to section 514H.11."

3. Page 13, by striking line 35, and inserting the following: "contract shall be filed with, and is subject to the approval of, the commissioner before the basic benefit coverage policy or subscription contract is issued or issued for delivery in this state."

4. Page 14, by striking lines 1 and 2.

5. Page 14, by striking lines 9 through 11.

6. Page 14, line 28, by inserting after the word "experience" the following: ", and health status and duration from the date of issue".

7. Page 15, line 29, by striking the words "licensed in the state" and inserting the following: "issuing or issuing for delivery in this state basic benefit coverage policies or subscription contracts".

8. Page 15, line 32, by inserting after the word "associations" the following: "requesting the inclusion of a benefit or requirement in a basic benefit coverage policy or subscription contract".

9. By renumbering as necessary.

RECEIVED FROM THE SENATE

H-4024 FILED MAY 2, 1991

Adopted 5/3/91 (SJ 2081)

JUL 09 91

HOUSE FILE 688

AN ACT

RELATING TO HEALTH INSURANCE REFORMS BY LIMITING SMALL GROUP PREMIUM RATING PRACTICES, INCREASING ACCESS TO AFFORDABLE BASIC BENEFITS HEALTH INSURANCE, AND AUTHORIZING CERTAIN PREMIUM CREDITS AND TAX EXEMPTIONS FOR QUALIFYING HEALTH INSURANCE PLANS AND INSUREDS.

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

Section 1. NEW SECTION. 513B.1 TITLE -- PURPOSE.

1. This chapter shall be known and may be cited as the Model Small Group Rating Law.

2. The intent of this chapter is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

Sec. 2. NEW SECTION. 513B.2 DEFINITIONS.

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 513B.4, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier

in establishing premium rates for applicable health benefit plans.

2. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health insurance plans with the same or similar coverage.

3. "Carrier" means any person who provides health insurance in this state. For the purposes of this chapter, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation.

4. "Case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of this chapter.

5. "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans meet one or more of the following requirements:

(1) The plans are marketed and sold through individuals and organizations which are not participating in the marketing or sales of other distinct groupings of small employers for the small employer carrier.

(2) The plans have been acquired from another small employer carrier as a distinct grouping of plans.

(3) The plans are provided through an association with membership of not less than fifty small employers which has been formed for purposes other than obtaining insurance.

b. A small employer carrier may establish no more than two additional groupings under each of the subparagraphs in paragraph "a" on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

c. The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

6. "Commissioner" means the commissioner of insurance.

7. "Division" means the division of insurance.

8. "Health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical-payment insurance.

9. "Index rate" means for each class of business for small employers with similar case characteristics the average of the applicable base premium rate and the corresponding highest premium rate.

10. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

11. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

12. "Small employer" means a person actively engaged in business who, on at least fifty percent of the employer's working days during the preceding year, employed no more than twenty-five full-time equivalent eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation are considered one employer.

13. "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer.

Sec. 3. NEW SECTION. 513B.3 SMALL GROUP HEALTH BENEFIT PLANS SUBJECT TO RATING RESTRICTIONS.

1. Except as provided in subsection 2, this chapter applies to any health benefit plan which provides coverage to two or more employees of a small employer.

2. This chapter does not apply to individual health insurance policies which are subject to policy form and premium rate approval by the commissioner.

3. A small employer group shall, at a minimum, have at least two participating employees at the date of issue of the health benefit plan.

Sec. 4. NEW SECTION. 513B.4 RESTRICTIONS RELATING TO THE PREMIUM RATES.

1. Premium rates for health benefit plans subject to this chapter are subject to the following requirements:

a. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent.

b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent of the index rate.

c. The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate.

(2) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business.

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

d. In the case of health benefit plans issued prior to the effective date of this chapter, a premium rate for a rating period may exceed the ranges described in subsection 1, paragraph "a" or "b" of this section, for a period of five years following the effective date of this chapter. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined

from the small employer carrier's rate manual for the class of business.

e. Rates for individual employees or dependents may be adjusted for claims experience or health status at the date of issue as long as the total rates for the small employer are in compliance with this section. An individual employee or dependent adjustment in rates for claims experience or health status shall not be increased subsequent to the date of issue. The commissioner may prohibit individual rating upon adoption of health insurance access rules pursuant to section 514H.11.

2. This section does not affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

3. A small employer shall not be involuntarily transferred by a small employer carrier into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

Sec. 5. NEW SECTION. 513B.5 PROVISIONS ON RENEWABILITY OF COVERAGE.

1. Except as provided in subsection 2, a health benefit plan subject to this chapter is renewable to all eligible employees and dependents at the option of the small employer, except for one or more of the following reasons:

a. Nonpayment of required premiums.

b. Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative.

c. Noncompliance with plan provisions.

d. The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan.

e. The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

2. A small employer carrier may cease to renew all plans under a class of business, or all classes of business in a defined geographic region if the carrier is a health maintenance organization. The small employer carrier shall provide notice at least ninety days prior to termination of coverage to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside. A small employer carrier which exercises its right to cease to renew all plans in a class of business shall not do either or both of the following:

a. Establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the commissioner.

b. Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the small employer carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status, or duration of coverage.

Sec. 6. NEW SECTION. 513B.6 DISCLOSURE OF RATING PRACTICES AND RENEWABILITY PROVISIONS.

A small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of all of the following:

1. The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer.

2. The provisions concerning the small employer carrier's right to change premium rates and factors, including case characteristics, which affect changes in premium rates.

3. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans.

4. The provisions relating to renewability of coverage.

Sec. 7. NEW SECTION. 513B.7 MAINTENANCE OF RECORDS.

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

2. A small employer carrier shall file each March 1 with the commissioner an actuarial certification that the small employer carrier is in compliance with this section and that the rating methods of the small employer carrier are actuarially sound. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

3. A small employer carrier shall make the information and documentation described in subsection 1 available to the commissioner upon request. The information is not a public record or otherwise subject to disclosure under chapter 22, and is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the division except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Sec. 8. NEW SECTION. 513B.8 DISCRETION OF THE COMMISSIONER.

The commissioner may suspend all or any part of section 513B.4 as to the premium rates applicable to one or more small

employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Sec. 9. NEW SECTION. 513B.9 EFFECTIVE DATE -- APPLICABILITY.

This chapter shall apply to a health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after the effective date of this chapter. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this chapter.

Sec. 10. LEGISLATIVE INTENT. The legislature finds that the rising cost of comprehensive group health coverage is exceeding the affordability of many small businesses and their employees. The legislature further finds that preexisting standards for uniformity have had an adverse impact on the cost of health coverage. Statutorily imposed uniformity in benefit structures has discouraged innovation to develop affordable health insurance to assure access to cost-effective preventive care and to secure against catastrophic sickness and injury, by requiring coverage of less cost-effective discretionary or elective care on equally favorable terms. Those Iowans who now have health insurance, have comprehensive benefits, but the cost has created a growing, disenfranchised class of uninsured Iowans dependent upon charitable care or public assistance. It is therefore the intent of the general assembly to reduce costs of health insurance and increase access to basic health care by enacting new chapter 514H authorizing the development of basic hospital and medical coverage for uninsured small groups.

Sec. 11. NEW SECTION. 514H.1 DEFINITIONS.

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

1. "Basic benefit coverage" means basic health care services rendered by health professionals licensed pursuant to state law together with hospital expenses.

2. "Basic health care services" means services which an enrollee might reasonably require in order to be maintained in good health, including at a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services rendered within or outside of a hospital.

3. "Commissioner" means the commissioner of insurance.

4. "Eligible dependent" means an enrolled dependent of a subscriber entitled to coverage under a basic benefit coverage policy or subscription contract.

5. "Group" means a group composed of eligible employees of a single employer and their dependents. A group shall not have more than twenty-five full-time equivalent employees in number. Employees may not be segregated by division, job responsibilities, employment status, employment location, or any other rationale. For purposes of this chapter, group size will be determined at the time of application for the basic benefit coverage policy, and on each anniversary of the date of issue of the basic benefit coverage policy. Carriers shall confirm the size of groups by certification of the employer which certification shall be maintained in the carrier's file.

6. "Insurer" means any insurer issuing a group accident and sickness insurance policy on an expense incurred basis and any group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A, or any group health maintenance organization contract under chapter 514B.

7. "Policy" means the entire contract between the insurer and the insured, including the policy riders, endorsements, and the application, if attached, and includes individual subscriber contracts issued under chapter 514B.

8. "Subscriber" means an enrolled eligible employee with coverage under a basic benefit coverage policy.

Sec. 12. NEW SECTION. 514H.2 ISSUANCE OF BASIC BENEFIT COVERAGE POLICIES AND SUBSCRIPTION CONTRACTS PERMITTED.

An insurer may issue a basic benefit coverage policy or subscription contract meeting the criteria set forth in this chapter.

For purposes of this chapter, a basic benefit coverage policy or subscription contract means a policy or subscription contract which the insurer may choose to offer to individuals, spouses, families, or groups of twenty-five or less formed for purposes other than obtaining insurance coverage, and which meets the following criteria:

1. The individual, spouse, family, or group obtaining coverage under the policy or subscription contract has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage for all of the twelve-month period immediately preceding the effective date of the basic hospital and medical coverage policy or subscription contract, provided that for groups in existence for less than twelve months, the group has been without hospital and medical insurance coverage, a health services plan, or employer-sponsored health care coverage since inception of the group.

2. The insurer may include any or all of the following managed care provisions, subject to the approval of the commissioner, to control costs:

a. A procedure for preauthorization by the insurer, or its designees.

b. An exclusion for services that are not medically necessary or are not covered preventive health services.

c. First-dollar coverage for preventive and emergency care.

d. Except as otherwise provided, copayments for all other physician visits.

e. Exclusions or limitations upon benefits or direct pay requirements otherwise mandated.

f. Deductibles or copayments which vary based upon the service provided.

3. The insurer may include any or all of the following managed care provisions to control costs:

a. A preferred panel of providers who have entered into written agreements with the insurer to provide services at specified levels of reimbursement. Any such written agreement between a provider and an insurer shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary.

b. Provisions requiring a second surgical opinion.

c. A procedure for utilization review by the insurer or its designees.

This section does not prohibit an insurer from including in its policy or subscription contract additional managed care and cost control provisions which, subject to the approval of the commissioner, have the potential to control costs in a manner which does not result in inequitable treatment of insureds or subscribers.

4. The policy or subscription contract shall provide basic levels of primary, preventive, and hospital care for covered individuals, including, but not limited to, all of the following:

a. A minimum of thirty days of inpatient hospitalization coverage per policy year.

b. Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary and appropriate screening,

including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member.

c. Obstetrical care, including physician's services, delivery room, and other medically necessary hospital services.

d. For covered individuals, a basic level of primary and preventive care, including but not limited to, two physician office visits per calendar year.

e. Such other coverages as the commissioner may determine are cost-effective pursuant to section 514H.7.

5. The commissioner may also authorize the issuance of a basic benefit coverage family plan for spouses or dependents of employees, even if the employer currently provides individual health benefits exclusively for employees. The commissioner may also authorize the issuance of a basic benefit coverage plan for part-time employees or full-time, part-year employees, even if the employer currently offers health benefits for full-time employees.

Sec. 13. NEW SECTION. 514H.3 DISCLOSURE REQUIREMENTS FOR BASIC BENEFIT COVERAGE POLICIES AND SUBSCRIPTION CONTRACTS.

Upon offering coverage under a basic benefit coverage policy or subscription contract for an individual, spouse, family, or group member, the insurer shall provide such individual, spouse, family, or group member with a written disclosure statement containing at least the following:

1. An explanation of those mandated benefits and providers not covered by the policy or subscription contract.

2. An explanation of the managed care and cost control features of the policy or subscription contract, along with all appropriate mailing addresses and telephone numbers to be utilized by insureds in seeking information or authorization.

3. The written statement shall be provided to the prospective policyholder no later than at the time of policy

delivery, and the original of the written statement shall be retained in the files of the insurer for the longer of the following:

a. The period of time that the policy or subscription contract remains in effect.

b. Five years.

4. Any material statement made by an applicant for coverage under a basic benefit coverage policy or subscription contract which falsely certifies as to the applicant's eligibility for coverage pursuant to section 514H.2 is a basis for termination of coverage under the policy or subscription contract.

5. All marketing communications intended to be utilized in the marketing of a basic benefit coverage policy or subscription contract in this state shall be submitted for review and their use is conditioned upon the prior approval of the commissioner. Marketing communications shall contain the disclosures required by this section.

Sec. 14. NEW SECTION. 514H.4 FORMS AND RATES TO BE FILED WITH AND APPROVED BY THE COMMISSIONER.

1. All basic hospital and medical coverage policy forms including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms shall be submitted to the commissioner.

2. A basic benefit coverage policy or subscription contract shall be filed with, and is subject to the approval of, the commissioner before the basic benefit coverage policy or subscription contract is issued or issued for delivery in this state.

3. Each form filing submitted to the commissioner for approval shall contain a transmittal page as prescribed by the commissioner and the following materials arranged in this order:

a. The printed form or forms, completed by using information concerning a fictitious applicant.

b. Actuarial memorandum.

c. Any additional enclosure required by the commissioner.

Sec. 15. NEW SECTION. 514H.5 STANDARDS FOR LOSS RATIOS.

Basic benefit coverage policies shall return a cumulative loss ratio of at least seventy percent. Such loss ratio is on the basis of incurred claims and earned premiums for all calculating or rating periods such that the cumulative loss ratio from inception equals or exceeds the seventy percent minimum loss ratio. Where coverage is provided on a direct service rather than indemnity basis, such loss ratio is on the basis of incurred health care expenses and earned premiums for such period. For purposes of achieving and maintaining the minimum cumulative loss ratio, the experience of all basic benefit coverage policies of a insurer is combined.

All claim experience for basic benefit coverage policies is pooled for the purposes of establishing premiums and rates, and the claim experience, and health status and duration from the date of issue of a given individual group shall not be a factor in determining the rates of a policy.

Sec. 16. NEW SECTION. 514H.6 RECORDKEEPING AND REPORTING REQUIREMENT.

Each basic benefit coverage policy or subscription contract in this state shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and other information as required by the commissioner. Each insurer providing such policies or contracts shall furnish an annual report to the commissioner. The report shall be in a form prescribed by the commissioner and shall contain the information required by the commissioner to analyze the success of insurance coverage issued pursuant to this chapter.

Sec. 17. NEW SECTION. 514H.7 COST-BENEFIT ANALYSIS.

1. The commissioner may, based upon reasonable actuarial evidence as to cost-effectiveness, determine any of the following:

a. What benefits or direct pay requirements must be minimally included in a basic benefit coverage policy or subscription contract.

b. What otherwise mandated benefits or direct pay requirements may be exempted from coverage by a basic benefit coverage policy or subscription contract.

c. What cost containment procedures must be minimally included in a basic benefit coverage policy or subscription contract.

d. What cost containment procedures otherwise restricted may be utilized by a basic benefit coverage policy or subscription contract.

2. The commissioner may retain a consultant to assist in the analysis of any benefit or requirement, and may convene an advisory panel to assist the commissioner in the review of evidence and practices by the health care and insurance industries.

3. The commissioner may assess a fee against health insurers, hospital service plans, and health maintenance organizations issuing or issuing for delivery in this state basic benefit coverage policies or subscription contracts to defray consulting fees and expenses incurred by the commissioner under this section.

4. The commissioner may also require medical professional societies or providers associations requesting the inclusion of a benefit or requirement in a basic benefit coverage policy or subscription contract to contribute on a proportionate and reasonable basis to the payment of the commissioner's consultants and expenses under this section as a condition of reviewing a benefit or requirement impacting upon such medical professionals or providers.

Sec. 18. NEW SECTION. 514H.8 PRESUMED EXCLUSION OF MANDATED BENEFITS.

A mandated benefit or direct pay requirement otherwise imposed by state law, but excluded under section 514H.2, shall

not be included in a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the inclusion of the benefit or direct pay requirement is cost-effective. The commissioner's finding shall be based upon review of actuarial evidence, including a cost-benefit analysis, and the determination that inclusion of the mandated benefit or direct pay requirement is in the best interests of affordable health care coverage.

Sec. 19. NEW SECTION. 514H.9 PRESUMED ALLOWANCE OF COST-CONTAINMENT PROCEDURES.

A cost-containment restriction otherwise imposed by state law does not apply to a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the restricted cost-containment measure is not cost-effective, and its exclusion is in the best interests of affordable health care coverage.

Sec. 20. NEW SECTION. 514H.10 SHARED COST OPTION FOR PRIVATE EMPLOYERS BASIC BENEFIT PLAN.

The commissioner, in cooperation with insurance carriers interested in participating, shall develop a group health insurance plan providing basic coverage, to be marketed to employers by insurance carriers approved by the commissioner, which employers have not offered health care benefits to their employees within the preceding twelve months and which are likely to have eligible employees under the employer-sponsored health care plan premium credit provided by section 514H.12. This shared cost option for private employers basic benefit coverage plan is subject to such additional requirements as the commissioner may impose to assure that an affordable policy is effectively marketed to benefit eligible low-income employees and their families. The premium credit under section 514H.12 is limited to the shared cost option for private employers plan approved by the commissioner under this section, and is not available to other basic benefit coverage plans generally authorized by this chapter, in order to

facilitate administration of the participation limits imposed by section 514H.12.

Sec. 21. NEW SECTION. 514H.11 HEALTH INSURANCE ACCESS.

1. The commissioner shall with all due diligence adopt by rule the recommendations of the national association of insurance commissioners concerning health insurance access by small employer groups, provided that the final recommendations are generally consistent with the following principles:

a. Guaranteed transferability of benefits or eligibility, with no new preexisting condition waiting periods or individual underwriting, for employees transferring to new employers or employers switching insurance carriers, for persons who are receiving assistance pursuant to chapter 249A, or persons who are provided health insurance coverage pursuant to the person's service as a member of a branch of the armed forces of the United States of America.

b. A risk transfer or sharing device to equitably distribute the risk of adverse selection posed to insurers by guaranteed access.

2. Within six months of adopting any rule pursuant to subsection 1, the commissioner shall prepare and deliver a report to the general assembly regarding the success, if any, of the rules, and make such recommendations as necessary, including offering proposed legislation, to effectuate the general assembly's goals of guaranteeing access to health insurance by employees and employers and retention of currently insured persons within the private health insurance market, regardless of change in employer, employment status, or change in insurance carrier.

Sec. 22. NEW SECTION. 514H.12 EMPLOYER-SPONSORED HEALTH PLAN PREMIUM CREDIT.

1. The division shall adopt rules to implement and administer the premium credit authorized by this section, which rules shall include the minimum standard application form for premium credit eligibility. Forms shall be printed

by participating insurance companies and provided to employers and employers' employees wishing to apply for premium credit eligibility.

2. The amount of the premium credit is equal to twenty-five dollars per month, per participating eligible employee for which the employer provides an employer-sponsored group basic benefit plan approved by the commissioner of insurance pursuant to section 514H.10, provided that the employer satisfies all of the following conditions:

a. The employer has not provided health insurance coverage, in whole or in part, to employees within the immediately preceding twelve months before contracting with an insurance carrier for basic benefit insurance approved pursuant to section 514H.10.

b. The employer employs twenty-five or fewer full-time equivalent employees.

c. The employer paid either of the following:

(1) Seventy-five percent or more of the premium for individual coverage of the participating eligible employee.

(2) Fifty percent or more of the premium for family coverage of the participating eligible employee and the employee's spouse and dependents.

3. An employee is eligible for participation in the subsidized insurance premium credit group health insurance plan if the family income of the employee is less than or equal to one hundred fifty percent of the federal poverty level as reported annually in the federal register. An employee application for eligibility is current for up to one year.

4. Earned premium credit is limited to the first five thousand full-year equivalent participating eligible employee applications under this section preapproved by the division in any single fiscal year.

5. The carrier shall credit to the participating employer's premium liability, an amount equal to the premium

credit earned pursuant to subsection 2, against the premium due in the year after the credit is earned.

6. The premium credit provided by this section is only available in connection with a basic benefit plan approved by the commissioner which satisfies any conditions imposed by rules adopted pursuant to subsection 1 which the commissioner determines are necessary or convenient to implement and administer the premium credit.

7. a. A person submitting an intentionally fraudulent premium credit application forfeits the credit and shall pay to the division a liquidated damages penalty of one hundred percent of the credit forfeited.

b. A person submitting a premium credit application which that person should have known was false forfeits the credit and shall pay to the division a liquidated damages penalty of ten percent of the credit forfeited.

8. The insurance carrier shall receive a premium tax credit equal to, at a minimum, the premium credit earned by the carrier's insureds pursuant to subsection 2.

Sec. 23. NEW SECTION. 432.11 PREMIUM TAX EXEMPTION FOR BASIC BENEFIT HEALTH PLANS.

Premiums collected on sales of basic benefit health policies, approved by the commissioner pursuant to chapter 514H, are exempt from premium tax.

Sec. 24. NEW SECTION. 432.11A PREMIUM TAX CREDIT FOR EMPLOYER-SPONSORED HEALTH PLAN PREMIUM CREDIT.

An insurance carrier approved by the commissioner pursuant to section 514H.10 to offer a policy eligible for the premium credit provided by section 514H.12, shall receive a premium tax credit equal to the premium credit earned by participating employers pursuant to section 514H.12, subsection 2, and any additional amount allowed by the commissioner pursuant to a contract for administrative expenses.

Sec. 25. Section 509.1, subsection 1, paragraph c, Code 199 , is amended by striking the paragraph.

Sec. 26. RULES. The commissioner shall adopt rules to implement the basic benefit coverage policy program and the shared cost option plan established in section 514H.10.

Sec. 27. Section 509.17A, Code 1991, is repealed.

ROBERT C. ARNOULD
Speaker of the House

JOE J. WELSH
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 688, Seventy-fourth General Assembly.

JOSEPH O'HERN
Chief Clerk of the House

Approved April 5, 1991

HF 688

TERRY E. BRANSTAD
Governor