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SENATE FILE **84**

BY COMMITTEE ON HUMAN RESOURCES  
(P. 291) H. 2/7/95 Commerce - Regulation  
(P. 453) H. 2/16/95 Do Pass  
(SUCCESSOR TO SSB 53)

Passed Senate, Date <sup>(P. 240)</sup> 2/2/95 Passed House, Date <sup>P. 470</sup> 2/21/95  
Vote: Ayes 46 Nays 3 Vote: Ayes 96 Nays 0  
Approved 3/2/95

**A BILL FOR**

1 An Act relating to health care reform and health care costs by  
2 providing for the regulation of insurance and health care plan  
3 providers.

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

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S.F. 84

1 Section 1. NEW SECTION. 513C.1 SHORT TITLE.

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

4 Sec. 2. NEW SECTION. 513C.2 PURPOSE.

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

14 Sec. 3. NEW SECTION. 513C.3 DEFINITIONS.

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

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

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

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

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

34 5. "Carrier" means any entity that provides individual  
35 health benefit plans in this state. For purposes of this

1 chapter, carrier includes an insurance company, a group  
2 hospital or medical service corporation, a fraternal benefit  
3 society, a health maintenance organization, and any other  
4 entity providing an individual plan of health insurance or  
5 health benefits subject to state insurance regulation.

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

7 7. "Director" means the director of public health  
8 appointed pursuant to section 135.2.

9 8. "Eligible individual" means an individual who is a  
10 resident of this state and who either has qualifying existing  
11 coverage or has had qualifying existing coverage within the  
12 immediately preceding thirty days, or an individual who has  
13 had a qualifying event occur within the immediately preceding  
14 thirty days.

15 9. "Established service area" means a geographic area, as  
16 approved by the commissioner and based upon the carrier's  
17 certificate of authority to transact business in this state,  
18 within which the carrier is authorized to provide coverage or  
19 a geographic area, as approved by the director and based upon  
20 the organized delivery system's license to transact business  
21 in this state, within which the organized delivery system is  
22 authorized to provide coverage.

23 10. "Filed rate" means, for a rating period related to  
24 each block of business, the rate charged to all individuals  
25 with similar rating characteristics for individual health  
26 benefit plans.

27 11. "Individual health benefit plan" means any hospital or  
28 medical expense incurred policy or certificate, hospital or  
29 medical service plan, or health maintenance organization  
30 subscriber contract sold to an individual, or any  
31 discretionary group trust or association policy, whether  
32 issued within or outside of the state, providing hospital or  
33 medical expense incurred coverage to individuals residing  
34 within this state. Individual health benefit plan does not  
35 include a self-insured group health plan, a self-insured

1 multiple employer group health plan, a group conversion plan,  
2 an insured group health plan, accident-only, specified  
3 disease, short-term hospital or medical, hospital confinement  
4 indemnity, credit, dental, vision, medicare supplement, long-  
5 term care, or disability income insurance coverage, coverage  
6 issued as a supplement to liability insurance, workers'  
7 compensation or similar insurance, or automobile medical  
8 payment insurance.

9 12. "Organized delivery system" means an organized  
10 delivery system licensed by the director.

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

16 14. "Qualifying event" means any of the following:

17 a. Loss of eligibility for medical assistance provided  
18 pursuant to chapter 249A or medicare coverage provided  
19 pursuant to Title XVIII of the federal Social Security Act.

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

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

23 15. "Qualifying existing coverage" or "qualifying previous  
24 coverage" means benefits or coverage provided under any of the  
25 following:

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

30 b. An individual health insurance benefit plan, including  
31 coverage provided under a health maintenance organization  
32 contract, a hospital or medical service plan contract, or a  
33 fraternal benefit society contract, that provides benefits  
34 similar to or exceeding the benefits provided under the  
35 standard health benefit plan, provided that such policy has

1 been in effect for a period of at least one year.

2 c. An organized delivery system that provides benefits  
3 similar to or exceeding the benefits provided under the  
4 standard health benefit plan, provided that the benefits  
5 provided by the organized delivery system have been in effect  
6 for a period of at least one year.

7 16. "Rating characteristics" means demographic or other  
8 objective characteristics of individuals which are considered  
9 by the carrier in the determination of premium rates for the  
10 individuals and which are approved by the commissioner.

11 17. "Rating period" means the period for which premium  
12 rates established by a carrier are in effect.

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

19 Sec. 4. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

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

28 2. An affiliated carrier that is a health maintenance  
29 organization having a certificate of authority under section  
30 513C.5 shall be considered to be a separate carrier for the  
31 purposes of this chapter.

32 Sec. 5. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO  
33 PREMIUM RATES.

34 1. Premium rates for any block of individual health  
35 benefit plan business issued on or after January 1, 1996, or

1 the date rules are adopted by the commissioner of insurance  
2 and the director of public health and become effective,  
3 whichever date is later, by a carrier subject to this chapter  
4 shall be limited to the composite effect of allocating costs  
5 among the following:

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

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

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

18 d. Rating characteristics other than age, geographic area,  
19 and family composition shall not be used by a carrier without  
20 the prior approval of the commissioner.

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

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

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

35 2. Notwithstanding subsection 1, the commissioner, with

1 the concurrence of the board of the Iowa individual health  
2 benefit reinsurance association established in section  
3 513C.10, may by order reduce or eliminate the allowed rating  
4 bands provided under subsection 1, paragraphs "a", "b", "c",  
5 and "f", or otherwise limit or eliminate the use of experience  
6 rating. The commissioner shall also develop a recommendation  
7 for the elimination of age as a rating characteristic, and  
8 shall submit such recommendation by January 8, 1996.

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

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

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

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

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

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

29 d. Any provisions relating to any preexisting condition.

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

32 6. A carrier shall maintain at its principal place of  
33 business a complete and detailed description of its rating  
34 practices, including information and documentation that  
35 demonstrate that its rating methods and practices are based

1 upon commonly accepted actuarial assumptions and are in  
2 accordance with sound actuarial principles.

3 7. A carrier shall file with the commissioner annually on  
4 or before March 15, an actuarial certification certifying that  
5 the carrier is in compliance with this chapter and that the  
6 rating methods of the carrier are actuarially sound. The  
7 certification shall be in a form and manner and shall contain  
8 information as specified by the commissioner. A copy of the  
9 certification shall be retained by the carrier at its  
10 principal place of business. Rate adjustments made in order  
11 to comply with this section are exempt from loss ratio  
12 requirements.

13 8. A carrier shall make the information and documentation  
14 maintained pursuant to subsection 5 available to the  
15 commissioner upon request. The information and documentation  
16 shall be considered proprietary and trade secret information  
17 and shall not be subject to disclosure by the commissioner to  
18 persons outside of the division except as agreed to by the  
19 carrier or as ordered by a court of competent jurisdiction.

20 Sec. 6. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

21 1. An individual health benefit plan is renewable at the  
22 option of the individual, except in any of the following  
23 cases:

- 24 a. Nonpayment of the required premiums.
- 25 b. Fraud or misrepresentation.
- 26 c. The insured individual becomes eligible for medicare  
27 coverage under Title XVIII of the federal Social Security Act.
- 28 d. The carrier elects not to renew all of its individual  
29 health benefit plans in the state. In such case, the carrier  
30 shall provide notice of the decision not to renew coverage to  
31 all affected individuals and to the commissioner in each state  
32 in which an affected insured individual is known to reside at  
33 least ninety days prior to the nonrenewal of the health  
34 benefit plan by the carrier. Notice to the commissioner under  
35 this paragraph shall be provided at least three working days.



1 prior to the notice to the affected individuals.

2 e. The commissioner finds that the continuation of the  
3 coverage would not be in the best interests of the  
4 policyholders or certificate holders, or would impair the  
5 carrier's ability to meet its contractual obligations.

6 2. A carrier that elects not to renew all of its  
7 individual health benefit plans in this state shall be  
8 prohibited from writing new individual health benefit plans in  
9 this state for a period of five years from the date of the  
10 notice to the commissioner.

11 3. With respect to a carrier doing business in an  
12 established geographic service area of the state, this section  
13 applies only to the carrier's operations in the service area.

14 Sec. 7. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

15 1. A carrier or an organized delivery system, as a  
16 condition of issuing individual health benefit plans in this  
17 state, shall make available a basic or standard health benefit  
18 plan to an eligible individual who applies for a plan and  
19 agrees to make the required premium payments and to satisfy  
20 other reasonable provisions of the basic or standard health  
21 benefit plan. A carrier or an organized delivery system is  
22 not required to issue a basic or standard health benefit plan  
23 to an individual who meets any of the following criteria:

24 a. The individual is covered or is eligible for coverage  
25 under a health benefit plan provided by the individual's  
26 employer.

27 b. An eligible individual who does not apply for a basic  
28 or standard health benefit plan within thirty days of a  
29 qualifying event or within thirty days upon becoming  
30 ineligible for qualifying existing coverage.

31 c. The individual is covered or is eligible for any  
32 continued group coverage under section 4980b of the Internal  
33 Revenue Code, sections 601 through 608 of the federal Employee  
34 Retirement Income Security Act of 1974, sections 2201 through  
35 2208 of the federal Public Health Service Act, or any state-

1 required continued group coverage. For purposes of this  
2 subsection, an individual who would have been eligible for  
3 such continuation of coverage, but is not eligible solely  
4 because the individual or other responsible party failed to  
5 make the required coverage election during the applicable time  
6 period, is deemed to be eligible for such group coverage until  
7 the date on which the individual's continuing group coverage  
8 would have expired had an election been made.

9 2. A carrier or an organized delivery system shall issue  
10 the basic or standard health benefit plan to an individual  
11 currently covered by an underwritten benefit plan issued by  
12 that carrier or an organized delivery system at the option of  
13 the individual. This option must be exercised within thirty  
14 days of notification of a premium rate increase applicable to  
15 the underwritten benefit plan.

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

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

27 b. An organized delivery system shall file with the  
28 director, in a form and manner prescribed by the director, the  
29 basic or standard health benefit plan to be used by the  
30 organized delivery system. A basic or standard health benefit  
31 plan filed pursuant to this paragraph may be used by the  
32 organized delivery system beginning thirty days after it is  
33 filed unless the director disapproves of its use.

34 The director may at any time, after providing notice and an  
35 opportunity for a hearing to the organized delivery system,

1 disapprove the continued use by an organized delivery system  
2 of a basic or standard health benefit plan on the grounds that  
3 the plan does not meet the requirements of this chapter.

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

10 (1) A condition that would cause an ordinarily prudent  
11 person to seek medical advice, diagnosis, care, or treatment  
12 during the twelve months immediately preceding the effective  
13 date of coverage.

14 (2) A condition for which medical advice, diagnosis, care,  
15 or treatment was recommended or received during the twelve  
16 months immediately preceding the effective date of coverage.

17 (3) A pregnancy existing on the effective date of  
18 coverage.

19 b. A carrier or an organized delivery system shall waive  
20 any time period applicable to a preexisting condition  
21 exclusion or limitation period with respect to particular  
22 services in an individual health benefit plan for the period  
23 of time an individual was previously covered by qualifying  
24 previous coverage that provided benefits with respect to such  
25 services, provided that the qualifying previous coverage was  
26 continuous to a date not more than thirty days prior to the  
27 effective date of the new coverage.

28 5. A carrier or an organized delivery system is not  
29 required to offer coverage or accept applications pursuant to  
30 subsection 1 from any individual not residing in the carrier's  
31 or the organized delivery system's established geographic  
32 access area.

33 6. A carrier or an organized delivery system shall not  
34 modify a basic or standard health benefit plan with respect to  
35 an individual or dependent through riders, endorsements, or

1 other means to restrict or exclude coverage for certain  
2 diseases or medical conditions otherwise covered by the health  
3 benefit plan.

4 Sec. 8. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN  
5 STANDARDS.

6 The commissioner shall adopt by rule the form and level of  
7 coverage of the basic health benefit plan and the standard  
8 health benefit plan for the individual market which shall  
9 provide benefits substantially similar to those as provided  
10 for under chapter 513B with respect to small group coverage,  
11 but which shall be appropriately adjusted to reflect the  
12 individual market.

13 Sec. 9. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR  
14 MARKETING.

15 1. A carrier or an organized delivery system issuing  
16 individual health benefit plans in this state shall make  
17 available the basic or standard health benefit plan to  
18 residents of this state. If a carrier or an organized  
19 delivery system denies other individual health benefit plan  
20 coverage to an eligible individual on the basis of the health  
21 status or claims experience of the eligible individual, or the  
22 individual's dependents, the carrier or the organized delivery  
23 system shall offer the individual the opportunity to purchase  
24 a basic or standard health benefit plan.

25 2. A carrier, or an organized delivery system, or an agent  
26 shall not do either of the following:

27 a. Encourage or direct individuals to refrain from filing  
28 an application for coverage with the carrier or the organized  
29 delivery system because of the health status, claims  
30 experience, industry, occupation, or geographic location of  
31 the individuals.

32 b. Encourage or direct individuals to seek coverage from  
33 another carrier or another organized delivery system because  
34 of the health status, claims experience, industry, occupation,  
35 or geographic location of the individuals.

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

7 4. A carrier or an organized delivery system shall not,  
8 directly or indirectly, enter into any contract, agreement, or  
9 arrangement with an agent that provides for, or results in,  
10 the compensation paid to an agent for a sale of a basic or  
11 standard health benefit plan to vary because of the health  
12 status or permitted rating characteristics of the individual  
13 or the individual's dependents.

14 5. Subsection 4 does not apply with respect to the  
15 compensation paid to an agent on the basis of percentage of  
16 premium, provided that the percentage shall not vary because  
17 of the health status or other permitted rating characteristics  
18 of the individual or the individual's dependents.

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

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

24 8. If a carrier or an organized delivery system enters  
25 into a contract, agreement, or other arrangement with a third-  
26 party administrator to provide administrative, marketing, or  
27 other services related to the offering of individual health  
28 benefit plans in this state, the third-party administrator is  
29 subject to this section as if it were a carrier or an  
30 organized delivery system.

31 Sec. 10. NEW SECTION. 513C.10 IOWA INDIVIDUAL HEALTH  
32 BENEFIT REINSURANCE ASSOCIATION.

33 1. A nonprofit corporation is established to be known as  
34 the Iowa individual health benefit reinsurance association.  
35 All persons that provide health benefit plans in this state

1 including insurers providing accident and sickness insurance  
2 under chapter 509, 514, or 514A; fraternal benefit societies  
3 providing hospital, medical, or nursing benefits under chapter  
4 512B; health maintenance organizations, organized delivery  
5 systems, and all other entities providing health insurance or  
6 health benefits subject to state insurance regulation shall be  
7 members of this association. The association shall be  
8 incorporated under chapter 504A, shall operate under a plan of  
9 operation established and approved pursuant to chapter 504A,  
10 and shall exercise its powers through a board of directors  
11 established under this section.

12 2. The initial board of directors of the association shall  
13 consist of seven members appointed by the commissioner as  
14 follows:

15 a. Four members shall be representatives of the four  
16 largest carriers of individual health insurance in the state,  
17 excluding medicare supplement coverage premiums, as of the  
18 calendar year ending December 31, 1994.

19 b. Three members shall be representatives of the three  
20 largest writers of health insurance in the state which are not  
21 otherwise represented.

22 After an initial term, board members shall be nominated and  
23 elected by the members of the association.

24 Members of the board may be reimbursed from the funds of  
25 the association for expenses incurred by them as members, but  
26 shall not otherwise be compensated by the association for  
27 their services.

28 3. The association shall submit to the commissioner a plan  
29 of operation for the association and any amendments to the  
30 association's articles of incorporation necessary and  
31 appropriate to assure the fair, reasonable, and equitable  
32 administration of the association. The plan shall provide for  
33 the sharing of losses related to basic and standard plans, if  
34 any, on an equitable and proportional basis among the members  
35 of the association. If the association fails to submit a

1 suitable plan of operation within one hundred eighty days  
2 after the appointment of the board of directors, the  
3 commissioner shall adopt rules necessary to implement this  
4 section. The rules shall continue in force until modified by  
5 the commissioner or superseded by a plan submitted by the  
6 association and approved by the commissioner. In addition to  
7 other requirements, the plan of operation shall provide for  
8 all of the following:

9 a. The handling and accounting of assets and funds of the  
10 association.

11 b. The amount of and method for reimbursing the expenses  
12 of board members.

13 c. Regular times and places for meetings of the board of  
14 directors.

15 d. Records to be kept relating to all financial  
16 transactions, and annual fiscal reporting to the commissioner.

17 e. Procedures for selecting the board of directors.

18 f. Additional provisions necessary or proper for the  
19 execution of the powers and duties of the association.

20 4. The plan of operation may provide that the powers and  
21 duties of the association may be delegated to a person who  
22 will perform functions similar to those of the association. A  
23 delegation under this section takes effect only upon the  
24 approval of the board of directors.

25 5. The association has the general powers and authority  
26 enumerated by this section and executed in accordance with the  
27 plan of operation approved by the commissioner under  
28 subsection 3. In addition, the association may do any of the  
29 following:

30 a. Enter into contracts as necessary or proper to  
31 administer this chapter.

32 b. Sue or be sued, including taking any legal action  
33 necessary or proper for recovery of any assessments for, on  
34 behalf of, or against members of the association or other  
35 participating persons.

1 c. Appoint from among members appropriate legal,  
2 actuarial, and other committees as necessary to provide  
3 technical assistance in the operation of the association,  
4 including the hiring of independent consultants as necessary.

5 d. Perform any other functions within the authority of the  
6 association.

7 6. Rates for basic and standard coverages as provided in  
8 this chapter shall be determined by each carrier or organized  
9 delivery system as the average of the lowest rate available  
10 for issuance by that carrier or organized delivery system  
11 adjusted for rate characteristics and benefits and the maximum  
12 rate allowable by law after adjustments for rate  
13 characteristics and benefits.

14 7. Following the close of each calendar year, the  
15 association, in conjunction with the commissioner, shall  
16 require each carrier or organized delivery system to report  
17 the amount of earned premiums and the associated paid losses  
18 for all basic and standard plans issued by the carrier or  
19 organized delivery system. The reporting of these amounts  
20 must be certified by an officer of the carrier or the  
21 organized delivery system.

22 8. The board shall determine the amount of loss, if any,  
23 from all basic and standard plans issued in the state by all  
24 carriers and organized delivery systems by aggregating the  
25 data reported in subsection 7. A loss shall be equal to  
26 ninety percent of earned premiums minus total paid claims.

27 9. The loss plus necessary operating expenses for the  
28 association, plus any additional expenses as provided by law,  
29 shall be assessed by the association to all members in  
30 proportion to their respective shares of total health  
31 insurance premiums or payments for subscriber contracts  
32 received in Iowa during the second preceding calendar year, or  
33 with paid losses in the year, coinciding with or ending during  
34 the calendar year, or on any other equitable basis as provided  
35 in the plan of operation. In sharing losses, the association



1 may abate or defer any part of the assessment of a member, if,  
2 in the opinion of the board, payment of the assessment would  
3 endanger the ability of the member to fulfill its contractual  
4 obligations. The association may also provide for an initial  
5 or interim assessment against members of the association if  
6 necessary to assure the financial viability of the association  
7 to meet the operating expenses of the association until the  
8 next calendar year is completed.

9 10. The collected assessments shall be disbursed to a  
10 carrier or an organized delivery system in proportion to the  
11 loss that carrier or organized delivery system represented of  
12 the aggregate loss as determined in subsection 8.

13 11. A carrier or an organized delivery system may petition  
14 the association board to seek remedy from writing a  
15 significantly disproportionate share of basic and standard  
16 policies in relation to total premiums written in the state  
17 for health benefit plans. Upon a finding that a carrier or an  
18 organized delivery system has written a disproportionate  
19 share, the board may agree to compensate the carrier or the  
20 organized delivery system either by paying to the carrier or  
21 the organized delivery system an additional fee not to exceed  
22 two percent of earned premiums from basic and standard  
23 policies for that carrier or organized delivery system or by  
24 petitioning the commissioner or director, as appropriate, for  
25 remedy.

26 12. a. The commissioner, upon a finding that the  
27 acceptance of the offer of basic and standard coverage by  
28 individuals pursuant to this chapter would place the  
29 individual health insurance carrier in a financially impaired  
30 condition, shall not require the carrier to offer coverage or  
31 accept applications for any period of time the financial  
32 impairment is deemed to exist.

33 b. The director, upon a finding that the acceptance of the  
34 offer of basic and standard coverage by individuals pursuant  
35 to this chapter would place the organized delivery system in a

1 financially impaired condition, shall not require the  
2 organized delivery system to offer coverage or accept  
3 applications for any period of time the financial impairment  
4 is deemed to exist.

5 Sec. 11. NEW SECTION. 513C.11 SELF-FUNDED EMPLOYER-  
6 SPONSORED HEALTH BENEFIT PLAN PARTICIPATION IN IOWA INDIVIDUAL  
7 HEALTH BENEFIT REINSURANCE ASSOCIATION.

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

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

23 3. When and if the federal government imposes conditions  
24 of portability and continuity on self-funded employers  
25 qualified under the federal Employee Retirement Income  
26 Security Act of 1974 that the commissioner deems are  
27 substantially similar to those required of Iowa insurers,  
28 coverage under such qualified plan shall be deemed qualified  
29 prior coverage for purposes of chapters 513B and 513C.

30 EXPLANATION

31 This bill relates to health care reform and health care  
32 costs by amending or creating provisions relating to insurance  
33 regulation.

34 New chapter 513C is created relating to individual health  
35 coverage. New section 513C.1 provides the title, the

1 Individual Health Insurance Market Reform Act.

2 New section 513C.2 states the purpose of the chapter.

3 New section 513C.3 establishes the definitions of key terms  
4 used in the chapter.

5 New section 513C.4 provides that the chapter applies to an  
6 individual health benefit plan delivered or issued for  
7 delivery to residents in this state on or after July 1, 1995.

8 New section 513C.5 establishes restrictions relating to  
9 premium rates for individual health benefit plans. Among  
10 those factors, the carrier is not to apply gender or industry  
11 classification rating characteristics, and experience rating  
12 characteristics only apply when an individual who is obtaining  
13 health coverage does not currently have qualifying coverage,  
14 as defined in the chapter. Certain other restrictions apply  
15 relating to the transfer of an individual into and out of a  
16 block of business, and required disclosures relating to the  
17 coverage are enumerated.

18 New section 513C.6 relates to the renewal of an individual  
19 health benefit plan. Such plan is renewable at the option of  
20 the individual, except under certain enumerated circumstances.  
21 The section also provides that a carrier that elects not to  
22 renew all of its individual health benefit plans in this state  
23 shall be prohibited from writing new individual health benefit  
24 plans in this state for a period of five years from the date  
25 of the notice required to be provided to the commissioner of  
26 such election.

27 New section 513C.7 provides that a carrier issuing  
28 individual health benefit plans must issue such plan to an  
29 individual applying for the plan except under certain defined  
30 circumstances.

31 New section 513C.8 provides that the commissioner is to  
32 adopt rules relating to the form and level of coverage of the  
33 basic and standard health benefit plan for the individual  
34 market.

35 New section 513C.9 establishes standards to assure fair

1 marketing of individual basic and standard health benefit  
2 plans. Restrictions are also established relating to carrier  
3 and the agent concerning the marketing of such plans.

4 New section 513C.10 establishes an Iowa individual health  
5 benefit reinsurance association to provide for the sharing of  
6 losses related to basic and standard plans, if any, on an  
7 equitable and proportional basis among the members of the  
8 association.

9 New section 513C.11 is created which provides that a self-  
10 funded employer-sponsored health benefit plan qualified under  
11 the federal Employee Retirement Incomes Security Act of 1974  
12 may voluntarily elect to participate in the individual  
13 reinsurance pool to provide portability and continuity to the  
14 employer's covered employees and their spouses and dependents  
15 subject to the same terms and conditions as a participating  
16 insurer.

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**SENATE FILE 84  
FISCAL NOTE**

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A fiscal note for Senate File 84 is hereby submitted pursuant to Joint Rule 17. Data used in developing this fiscal note is available from the Legislative Fiscal Bureau to members of the Legislature upon request.

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Senate File 84 makes changes in regulatory matters related to individual health insurance. Among other provisions, the Bill would set restrictions relating to premium rates, guarantee portability of insurance should an individual change jobs or careers, and establish an Iowa Individual Health Benefit Reinsurance Association. The Bill also allows for the deduction of 100.0% of insurance premiums from State individual taxable income.

Assumptions:

1. Calculations assume the federal government will reinstate the 25.0% deduction of insurance premiums from taxable income. Therefore, the estimate computes the fiscal effect of increasing the deduction for self-employed individuals from 25.0% to 100.0%.
2. The deduction would apply to two populations: A) self-employed individuals and B) other individuals who pay for insurance out of pocket and do not receive pre-tax treatment of premiums. The estimate assumes these two populations are mutually exclusive.
3. There are an estimated 2.6 million insured Iowans. Of these, approximately 91.5% receive pre-tax treatment from an employer and would not receive the deduction. The remaining 8.5% of insured non-self-employed individuals would be eligible to receive the deduction.
4. The total amount of the employee share of health insurance premiums in Iowa is estimated to be \$1.1 billion.
5. This estimate does not consider the costs or benefits associated with uninsured individuals becoming insured as a result of the deductibility of insurance premiums.
6. Estimates in FY 1998 and FY 1999 assume an increase in the price of premiums of 3.0% in excess of the Consumer Price Index.

Fiscal Impact:

The estimated fiscal impact of allowing a 100.0% deduction of insurance premiums from State individual taxable income would be a decrease in revenues to the General Fund of \$15.0 million in FY 1997, \$15.5 million in FY 1998, and \$15.9 million in FY 1999.

The fiscal impact is generated by two populations:

## 1. Self-Employed Taxpayers

The Legislature's micro-simulation tax model estimates the FY 1997 fiscal impact of increasing the deduction on this population to be an \$8.5 million decrease in General Fund revenues.

## 2. Non-Self-Employed Taxpayers

Approximately 8.5% of the total employee share of health insurance premiums (\$1.1 billion) would be deducted by families currently receiving no pre-tax treatment. Assuming a marginal tax rate of 7.0%, the impact would be a decrease to the General Fund of approximately \$6.5 million in FY 1997.

Sources:

1990 U.S. Census Data

"Improving Access to Uninsured and Underinsured Iowans," Health Systems Research, Inc., November 15, 1990 (LSB 1854sv, VMT)

FILED FEBRUARY 14, 1995

BY DENNIS PROUTY, FISCAL DIRECTOR

## SENATE FILE 84

S-3027

1 Amend Senate File 84 as follows:

- 2 1. Page 2, line 5, by inserting after the word  
3 "regulation." the following: "'Carrier" does not  
4 include an organized delivery system."  
5 2. Page 4, lines 7 and 8, by striking the words  
6 "or other objective".  
7 3. Page 5, by striking lines 18 through 20.  
8 4. Page 5, line 25, by striking the letter "f."  
9 and inserting the following: "e."  
10 5. Page 5, line 29, by striking the letter "g."  
11 and inserting the following: "f."  
12 6. Page 6, line 5, by striking the letter "'f"  
13 and inserting the following: "'e".  
14 7. By striking page 13, line 15, through page 17,  
15 line 4, and inserting the following:  
16 "a. Four members shall be representatives of the  
17 four largest domestic carriers of individual health  
18 insurance in the state as of the calendar year ending  
19 December 31, 1994.  
20 b. Three members shall be representatives of the  
21 three largest carriers of health insurance in the  
22 state, excluding medicare supplement coverage  
23 premiums, which are not otherwise represented. In the  
24 event a carrier to be represented pursuant to this  
25 paragraph does not appoint a representative, the board  
26 member shall be a representative of the next largest  
27 carrier which satisfies the criteria.  
28 After an initial term, board members shall be  
29 nominated and elected by the members of the  
30 association.  
31 Members of the board may be reimbursed from the  
32 funds of the association for expenses incurred by them  
33 as members, but shall not otherwise be compensated by  
34 the association for their services.  
35 3. The association shall submit to the  
36 commissioner a plan of operation for the association  
37 and any amendments to the association's articles of  
38 incorporation necessary and appropriate to assure the  
39 fair, reasonable, and equitable administration of the  
40 association. The plan shall provide for the sharing  
41 of losses related to basic and standard plans, if any,  
42 on an equitable and proportional basis among the  
43 members of the association. If the association fails  
44 to submit a suitable plan of operation within one  
45 hundred eighty days after the appointment of the board  
46 of directors, the commissioner shall adopt rules  
47 necessary to implement this section. The rules shall  
48 continue in force until modified by the commissioner  
49 or superseded by a plan submitted by the association  
50 and approved by the commissioner. In addition to

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Page 2

1 other requirements, the plan of operation shall  
2 provide for all of the following:  
3 a. The handling and accounting of assets and funds  
4 of the association.  
5 b. The amount of and method for reimbursing the  
6 expenses of board members.  
7 c. Regular times and places for meetings of the  
8 board of directors.  
9 d. Records to be kept relating to all financial  
10 transactions, and annual fiscal reporting to the  
11 commissioner.  
12 e. Procedures for selecting the board of  
13 directors.  
14 f. Additional provisions necessary or proper for  
15 the execution of the powers and duties of the  
16 association.

17 4. The plan of operation may provide that the  
18 powers and duties of the association may be delegated  
19 to a person who will perform functions similar to  
20 those of the association. A delegation under this  
21 section takes effect only upon the approval of the  
22 board of directors.

23 5. The association has the general powers and  
24 authority enumerated by this section and executed in  
25 accordance with the plan of operation approved by the  
26 commissioner under subsection 3. In addition, the  
27 association may do any of the following:  
28 a. Enter into contracts as necessary or proper to  
29 administer this chapter.  
30 b. Sue or be sued, including taking any legal  
31 action necessary or proper for recovery of any  
32 assessments for, on behalf of, or against members of  
33 the association or other participating persons.  
34 c. Appoint from among members appropriate legal,  
35 actuarial, and other committees as necessary to  
36 provide technical assistance in the operation of the  
37 association, including the hiring of independent  
38 consultants as necessary.  
39 d. Perform any other functions within the  
40 authority of the association.

41 6. Rates for basic and standard coverages as  
42 provided in this chapter shall be determined by each  
43 carrier or organized delivery system as the average of  
44 the lowest rate available for issuance by that carrier  
45 or organized delivery system adjusted for rating  
46 characteristics and benefits and the maximum rate  
47 allowable by law after adjustments for rate  
48 characteristics and benefits.

49 7. Following the close of each calendar year, the  
50 association, in conjunction with the commissioner,

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1 shall require each carrier or organized delivery  
2 system to report the amount of earned premiums and the  
3 associated paid losses for all basic and standard  
4 plans issued by the carrier or organized delivery  
5 system. The reporting of these amounts must be  
6 certified by an officer of the carrier or organized  
7 delivery system.

8 8. The board shall develop procedures and make  
9 assessments and distributions as required to equalize  
10 the individual carrier and organized delivery system  
11 gains or losses so that each carrier or organized  
12 delivery system receives the same ratio of paid claims  
13 to ninety percent of earned premiums as the aggregate  
14 of all basic and standard plans insured by all  
15 carriers and organized delivery systems in the state.

16 9. If the statewide aggregate ratio of paid claims  
17 to ninety percent of earned premiums is greater than  
18 one, the dollar difference between ninety percent of  
19 earned premiums and the paid claims shall represent an  
20 assessable loss.

21 10. The assessable loss plus necessary operating  
22 expenses for the association, plus any additional  
23 expenses as provided by law, shall be assessed by the  
24 association to all members in proportion to their  
25 respective shares of total health insurance premiums  
26 or payments for subscriber contracts received in Iowa  
27 during the second preceding calendar year, or with  
28 paid losses in the year, coinciding with or ending  
29 during the calendar year, or on any other equitable  
30 basis as provided in the plan of operation. In  
31 sharing losses, the association may abate or defer any  
32 part of the assessment of a member, if, in the opinion  
33 of the board, payment of the assessment would endanger  
34 the ability of the member to fulfill its contractual  
35 obligations. The association may also provide for an  
36 initial or interim assessment against the members of  
37 the association to meet the operating expenses of the  
38 association until the next calendar year is completed.

39 11. The board shall develop procedures for  
40 distributing the assessable loss assessments to each  
41 carrier and organized delivery system in proportion to  
42 the carrier's and organized delivery system's  
43 respective share of premium for basic and standard  
44 plans to the statewide total premium for all basic and  
45 standard plans.

46 12. The board shall ensure that procedures for  
47 collecting and distributing assessments are as  
48 efficient as possible for carriers and organized  
49 delivery systems. The board may establish procedures  
50 which combine, or offset, the assessment from, and the

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Page 4

1 distribution due to, a carrier or organized delivery  
2 system.

3 13. A carrier or an organized delivery system may  
4 petition the association board to seek remedy from  
5 writing a significantly disproportionate share of  
6 basic and standard policies in relation to total  
7 premiums written in this state for health benefit  
8 plans. Upon a finding that a carrier or organized  
9 delivery system has written a disproportionate share,  
10 the board may agree to compensate the carrier or  
11 organized delivery system either by paying to the  
12 carrier or organized delivery system an additional fee  
13 not to exceed two percent of earned premiums from  
14 basic and standard policies for that carrier or  
15 organized delivery system or by petitioning the  
16 commissioner or director, as appropriate for remedy.

17 14. a. The commissioner, upon a finding that the  
18 acceptance of the offer of basic and standard coverage  
19 by individuals pursuant to this chapter would place  
20 the carrier in a financially impaired condition, shall  
21 not require the carrier to offer coverage or accept  
22 applications for any period of time the financial  
23 impairment is deemed to exist.

24 b. The director, upon a finding that the  
25 acceptance of the offer of basic and standard coverage  
26 by individuals pursuant to this chapter would place  
27 the organized delivery system in a financially  
28 impaired condition, shall not required the organized  
29 delivery system to offer coverage or accept  
30 applications for any period of time the financial  
31 impairment is deemed to exist."

32 8. Title page, by striking lines 1 through 3 and  
33 inserting the following: "An Act relating to  
34 individual health insurance and individual health  
35 benefit plan reforms."

36 9. By renumbering and relettering as necessary.

By TOM VILSACK

S-3027 FILED FEBRUARY 2, 1995  
ADOPTED

## SENATE FILE 84

## S-3028

1 Amend Senate File 84 as follows:

2 1. Page 1, by inserting before line 1 the  
3 following:

4 "Section 1. Section 422.7, Code 1995, is amended  
5 by adding the following new subsection:  
6 NEW SUBSECTION. 32. Subtract, to the extent not  
7 otherwise deducted in computing adjusted gross income,  
8 the amounts paid by the taxpayer for the purchase of  
9 health benefits coverage or insurance for the taxpayer  
10 or taxpayer's spouse or dependent.

11 Sec. 2. Section 422.9, subsection 2, Code 1995, is  
12 amended by adding the following new paragraph:

13 NEW PARAGRAPH. i. If the taxpayer has a deduction  
14 for medical care expenses under section 213 of the  
15 Internal Revenue Code, the taxpayer shall recompute  
16 for the purposes of this subsection the amount of the  
17 deduction under section 213 by excluding from medical  
18 care, as defined in section 213, the amount subtracted  
19 under section 422.7, subsection 32."

20 2. Page 17, by inserting after line 29 the  
21 following:

22 "Sec. \_\_\_\_ . EFFECTIVE DATE. Sections 1 and 2 of  
23 this Act, which amend section 422.7 by adding a new  
24 subsection 32, and section 422.9, subsection 2, by  
25 adding a new paragraph "i", are effective January 1,  
26 1996, for tax years beginning on or after that date."

27 3. Title page, line 3, by inserting after the  
28 word "providers" the following: ", and establishing  
29 an income tax credit for certain individuals".

30 4. By renumbering as necessary.

By BERL E. PRIEBE

SHELDON RITTNER

EMIL J. HUSAK

JOHN P. KIBBIE

H. KAY HEDGE

TONY BISIGNANO

S-3028 FILED FEBRUARY 2, 1995  
ADOPTED

## SENATE FILE 84

## S-3029

1 Amend Senate File 84 as follows:

2 1. Page 17, by inserting after line 29 the  
3 following:

4 "Sec. \_\_\_\_ . Section 505.21, Code 1995, is  
5 repealed."

6 2. Renumber as necessary.

By SHELDON RITTNER

BERL E. PRIEBE

H. KAY HEDGE

JOHN P. KIBBIE

S-3029 FILED FEBRUARY 2, 1995  
WITHDRAWN

2-15/95  
NO  
RECOMMENDATION 2-7-95 Commerce  
2-15-95 w/pd mean  
H. B. 95 Confirmed Business  
Columbia

SENATE FILE **84**  
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SSB 53)

(AS AMENDED AND PASSED BY THE SENATE FEBRUARY 2, 1995)

- New Language by the Senate
- \* - Language Stricken by the Senate

Passed Senate, Date <sup>(p.242)</sup> 2/2/95      Passed House, Date <sup>(p.470)</sup> 2/21/95  
 Vote: Ayes 46 Nays 3      Vote: Ayes 96 Nays 0  
 Approved Shank 2ND, 1995

**A BILL FOR**

1 An Act relating to individual health insurance and individual  
 2 health benefit plan reforms, and establishing an income tax  
 3 credit for certain individuals.

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

S.F. 84

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1 Section 1. Section 422.7, Code 1995, is amended by adding  
2 the following new subsection:

3 NEW SUBSECTION. 32. Subtract, to the extent not otherwise  
4 deducted in computing adjusted gross income, the amounts paid  
5 by the taxpayer for the purchase of health benefits coverage  
6 or insurance for the taxpayer or taxpayer's spouse or  
7 dependent.

8 Sec. 2. Section 422.9, subsection 2, Code 1995, is amended  
9 by adding the following new paragraph:

10 NEW PARAGRAPH. i. If the taxpayer has a deduction for  
11 medical care expenses under section 213 of the Internal  
12 Revenue Code, the taxpayer shall recompute for the purposes of  
13 this subsection the amount of the deduction under section 213  
14 by excluding from medical care, as defined in section 213, the  
15 amount subtracted under section 422.7, subsection 32.

16 Sec. 3. NEW SECTION. 513C.1 SHORT TITLE.

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

19 Sec. 4. NEW SECTION. 513C.2 PURPOSE.

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

29 Sec. 5. NEW SECTION. 513C.3 DEFINITIONS.

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

32 1. "Actuarial certification" means a written statement by  
33 a member of the American academy of actuaries or other  
34 individual acceptable to the commissioner that an individual  
35 carrier is in compliance with the provision of section 513C.5

1 which is based upon the actuary's or individual's examination,  
2 including a review of the appropriate records and the  
3 actuarial assumptions and methods used by the carrier in  
4 establishing premium rates for applicable individual health  
5 benefit plans.

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

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

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

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

21 "Carrier" does not include an organized delivery system.

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

23 7. "Director" means the director of public health  
24 appointed pursuant to section 135.2.

25 8. "Eligible individual" means an individual who is a  
26 resident of this state and who either has qualifying existing  
27 coverage or has had qualifying existing coverage within the  
28 immediately preceding thirty days, or an individual who has  
29 had a qualifying event occur within the immediately preceding  
30 thirty days.

31 9. "Established service area" means a geographic area, as  
32 approved by the commissioner and based upon the carrier's  
33 certificate of authority to transact business in this state,  
34 within which the carrier is authorized to provide coverage or  
35 a geographic area, as approved by the director and based upon

1 the organized delivery system's license to transact business  
2 in this state, within which the organized delivery system is  
3 authorized to provide coverage.

4 10. "Filed rate" means, for a rating period related to  
5 each block of business, the rate charged to all individuals  
6 with similar rating characteristics for individual health  
7 benefit plans.

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

25 12. "Organized delivery system" means an organized  
26 delivery system licensed by the director.

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

32 14. "Qualifying event" means any of the following:

33 a. Loss of eligibility for medical assistance provided  
34 pursuant to chapter 249A or medicare coverage provided  
35 pursuant to Title XVIII of the federal Social Security Act.

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

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

4 15. "Qualifying existing coverage" or "qualifying previous  
5 coverage" means benefits or coverage provided under any of the  
6 following:

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

11 b. An individual health insurance benefit plan, including  
12 coverage provided under a health maintenance organization  
13 contract, a hospital or medical service plan contract, or a  
14 fraternal benefit society contract, that provides benefits  
15 similar to or exceeding the benefits provided under the  
16 standard health benefit plan, provided that such policy has  
17 been in effect for a period of at least one year.

18 c. An organized delivery system that provides benefits  
19 similar to or exceeding the benefits provided under the  
20 standard health benefit plan, provided that the benefits  
21 provided by the organized delivery system have been in effect  
22 for a period of at least one year.

\* 23 16. "Rating characteristics" means demographic  
24 characteristics of individuals which are considered by the  
25 carrier in the determination of premium rates for the  
26 individuals and which are approved by the commissioner.

27 17. "Rating period" means the period for which premium  
28 rates established by a carrier are in effect.

29 18. "Restricted network provision" means a provision of an  
30 individual health benefit plan that conditions the payment of  
31 benefits, in whole or in part, on the use of health care  
32 providers that have entered into a contractual arrangement  
33 with the carrier or the organized delivery system to provide  
34 health care services to covered individuals.

35 Sec. 6. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.



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

9 2. An affiliated carrier that is a health maintenance  
10 organization having a certificate of authority under section  
11 513C.5 shall be considered to be a separate carrier for the  
12 purposes of this chapter.

13 Sec. 7. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO  
14 PREMIUM RATES.

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

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

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

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

\* 34 d. Premium rates for individual health benefit plans shall  
35 comply with the requirements of this section notwithstanding

1 any assessments paid or payable by the carrier pursuant to any  
2 reinsurance program or risk adjustment mechanism.

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

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

13 2. Notwithstanding subsection 1, the commissioner, with  
14 the concurrence of the board of the Iowa individual health  
15 benefit reinsurance association established in section  
16 513C.10, may by order reduce or eliminate the allowed rating  
17 bands provided under subsection 1, paragraphs "a", "b", "c",  
18 and "e", or otherwise limit or eliminate the use of experience  
19 rating. The commissioner shall also develop a recommendation  
20 for the elimination of age as a rating characteristic, and  
21 shall submit such recommendation by January 8, 1996.

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

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

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

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

1 characteristics.

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

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

7 d. Any provisions relating to any preexisting condition.

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

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

16 7. A carrier shall file with the commissioner annually on  
17 or before March 15, an actuarial certification certifying that  
18 the carrier is in compliance with this chapter and that the  
19 rating methods of the carrier are actuarially sound. The  
20 certification shall be in a form and manner and shall contain  
21 information as specified by the commissioner. A copy of the  
22 certification shall be retained by the carrier at its  
23 principal place of business. Rate adjustments made in order  
24 to comply with this section are exempt from loss ratio  
25 requirements.

26 8. A carrier shall make the information and documentation  
27 maintained pursuant to subsection 5 available to the  
28 commissioner upon request. The information and documentation  
29 shall be considered proprietary and trade secret information  
30 and shall not be subject to disclosure by the commissioner to  
31 persons outside of the division except as agreed to by the  
32 carrier or as ordered by a court of competent jurisdiction.

33 Sec. 8. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

34 1. An individual health benefit plan is renewable at the  
35 option of the individual, except in any of the following

1 cases:

2 a. Nonpayment of the required premiums.

3 b. Fraud or misrepresentation.

4 c. The insured individual becomes eligible for medicare  
5 coverage under Title XVIII of the federal Social Security Act.

6 d. The carrier elects not to renew all of its individual  
7 health benefit plans in the state. In such case, the carrier  
8 shall provide notice of the decision not to renew coverage to  
9 all affected individuals and to the commissioner in each state  
10 in which an affected insured individual is known to reside at  
11 least ninety days prior to the nonrenewal of the health  
12 benefit plan by the carrier. Notice to the commissioner under  
13 this paragraph shall be provided at least three working days  
14 prior to the notice to the affected individuals.

15 e. The commissioner finds that the continuation of the  
16 coverage would not be in the best interests of the  
17 policyholders or certificate holders, or would impair the  
18 carrier's ability to meet its contractual obligations.

19 2. A carrier that elects not to renew all of its  
20 individual health benefit plans in this state shall be  
21 prohibited from writing new individual health benefit plans in  
22 this state for a period of five years from the date of the  
23 notice to the commissioner.

24 3. With respect to a carrier doing business in an  
25 established geographic service area of the state, this section  
26 applies only to the carrier's operations in the service area.

27 Sec. 9. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

28 1. A carrier or an organized delivery system, as a  
29 condition of issuing individual health benefit plans in this  
30 state, shall make available a basic or standard health benefit  
31 plan to an eligible individual who applies for a plan and  
32 agrees to make the required premium payments and to satisfy  
33 other reasonable provisions of the basic or standard health  
34 benefit plan. A carrier or an organized delivery system is  
35 not required to issue a basic or standard health benefit plan

1 to an individual who meets any of the following criteria:

2 a. The individual is covered or is eligible for coverage  
3 under a health benefit plan provided by the individual's  
4 employer.

5 b. An eligible individual who does not apply for a basic  
6 or standard health benefit plan within thirty days of a  
7 qualifying event or within thirty days upon becoming  
8 ineligible for qualifying existing coverage.

9 c. The individual is covered or is eligible for any  
10 continued group coverage under section 4980b of the Internal  
11 Revenue Code, sections 601 through 608 of the federal Employee  
12 Retirement Income Security Act of 1974, sections 2201 through  
13 2208 of the federal Public Health Service Act, or any state-  
14 required continued group coverage. For purposes of this  
15 subsection, an individual who would have been eligible for  
16 such continuation of coverage, but is not eligible solely  
17 because the individual or other responsible party failed to  
18 make the required coverage election during the applicable time  
19 period, is deemed to be eligible for such group coverage until  
20 the date on which the individual's continuing group coverage  
21 would have expired had an election been made.

22 2. A carrier or an organized delivery system shall issue  
23 the basic or standard health benefit plan to an individual  
24 currently covered by an underwritten benefit plan issued by  
25 that carrier or an organized delivery system at the option of  
26 the individual. This option must be exercised within thirty  
27 days of notification of a premium rate increase applicable to  
28 the underwritten benefit plan.

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

35 The commissioner may at any time, after providing notice

1 and an opportunity for a hearing to the carrier, disapprove  
2 the continued use by a carrier of a basic or standard health  
3 benefit plan on the grounds that the plan does not meet the  
4 requirements of this chapter.

5 b. An organized delivery system shall file with the  
6 director, in a form and manner prescribed by the director, the  
7 basic or standard health benefit plan to be used by the  
8 organized delivery system. A basic or standard health benefit  
9 plan filed pursuant to this paragraph may be used by the  
10 organized delivery system beginning thirty days after it is  
11 filed unless the director disapproves of its use.

12 The director may at any time, after providing notice and an  
13 opportunity for a hearing to the organized delivery system,  
14 disapprove the continued use by an organized delivery system  
15 of a basic or standard health benefit plan on the grounds that  
16 the plan does not meet the requirements of this chapter.

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

23 (1) A condition that would cause an ordinarily prudent  
24 person to seek medical advice, diagnosis, care, or treatment  
25 during the twelve months immediately preceding the effective  
26 date of coverage.

27 (2) A condition for which medical advice, diagnosis, care,  
28 or treatment was recommended or received during the twelve  
29 months immediately preceding the effective date of coverage.

30 (3) A pregnancy existing on the effective date of  
31 coverage.

32 b. A carrier or an organized delivery system shall waive  
33 any time period applicable to a preexisting condition  
34 exclusion or limitation period with respect to particular  
35 services in an individual health benefit plan for the period

1 of time an individual was previously covered by qualifying  
2 previous coverage that provided benefits with respect to such  
3 services, provided that the qualifying previous coverage was  
4 continuous to a date not more than thirty days prior to the  
5 effective date of the new coverage.

6 5. A carrier or an organized delivery system is not  
7 required to offer coverage or accept applications pursuant to  
8 subsection 1 from any individual not residing in the carrier's  
9 or the organized delivery system's established geographic  
10 access area.

11 6. A carrier or an organized delivery system shall not  
12 modify a basic or standard health benefit plan with respect to  
13 an individual or dependent through riders, endorsements, or  
14 other means to restrict or exclude coverage for certain  
15 diseases or medical conditions otherwise covered by the health  
16 benefit plan.

17 Sec. 10. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN  
18 STANDARDS.

19 The commissioner shall adopt by rule the form and level of  
20 coverage of the basic health benefit plan and the standard  
21 health benefit plan for the individual market which shall  
22 provide benefits substantially similar to those as provided  
23 for under chapter 513B with respect to small group coverage,  
24 but which shall be appropriately adjusted to reflect the  
25 individual market.

26 Sec. 11. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR  
27 MARKETING.

28 1. A carrier or an organized delivery system issuing  
29 individual health benefit plans in this state shall make  
30 available the basic or standard health benefit plan to  
31 residents of this state. If a carrier or an organized  
32 delivery system denies other individual health benefit plan  
33 coverage to an eligible individual on the basis of the health  
34 status or claims experience of the eligible individual, or the  
35 individual's dependents, the carrier or the organized delivery

1 system shall offer the individual the opportunity to purchase  
2 a basic or standard health benefit plan.

3 2. A carrier, or an organized delivery system, or an agent  
4 shall not do either of the following:

5 a. Encourage or direct individuals to refrain from filing  
6 an application for coverage with the carrier or the organized  
7 delivery system because of the health status, claims  
8 experience, industry, occupation, or geographic location of  
9 the individuals.

10 b. Encourage or direct individuals to seek coverage from  
11 another carrier or another organized delivery system because  
12 of the health status, claims experience, industry, occupation,  
13 or geographic location of the individuals.

14 3. Subsection 2, paragraph "a", shall not apply with  
15 respect to information provided by a carrier or an organized  
16 delivery system or an agent to an individual regarding the  
17 established geographic service area of the carrier or the  
18 organized delivery system, or the restricted network provision  
19 of the carrier or the organized delivery system.

20 4. A carrier or an organized delivery system shall not,  
21 directly or indirectly, enter into any contract, agreement, or  
22 arrangement with an agent that provides for, or results in,  
23 the compensation paid to an agent for a sale of a basic or  
24 standard health benefit plan to vary because of the health  
25 status or permitted rating characteristics of the individual  
26 or the individual's dependents.

27 5. Subsection 4 does not apply with respect to the  
28 compensation paid to an agent on the basis of percentage of  
29 premium, provided that the percentage shall not vary because  
30 of the health status or other permitted rating characteristics  
31 of the individual or the individual's dependents.

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

35 7. A violation of this section by a carrier or an agent is



1 an unfair trade practice under chapter 507B.

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

9 Sec. 12. NEW SECTION. 513C.10 IOWA INDIVIDUAL HEALTH  
10 BENEFIT REINSURANCE ASSOCIATION.

11 1. A nonprofit corporation is established to be known as  
12 the Iowa individual health benefit reinsurance association.  
13 All persons that provide health benefit plans in this state  
14 including insurers providing accident and sickness insurance  
15 under chapter 509, 514, or 514A; fraternal benefit societies  
16 providing hospital, medical, or nursing benefits under chapter  
17 512B; health maintenance organizations, organized delivery  
18 systems, and all other entities providing health insurance or  
19 health benefits subject to state insurance regulation shall be  
20 members of this association. The association shall be  
21 incorporated under chapter 504A, shall operate under a plan of  
22 operation established and approved pursuant to chapter 504A,  
23 and shall exercise its powers through a board of directors  
24 established under this section.

25 2. The initial board of directors of the association shall  
26 consist of seven members appointed by the commissioner as  
27 follows:

28 a. Four members shall be representatives of the four  
29 largest domestic carriers of individual health insurance in  
30 the state as of the calendar year ending December 31, 1994.

31 b. Three members shall be representatives of the three  
32 largest carriers of health insurance in the state, excluding  
33 medicare supplement coverage premiums, which are not otherwise  
34 represented. In the event a carrier to be represented  
35 pursuant to this paragraph does not appoint a representative,

1 the board member shall be a representative of the next largest  
2 carrier which satisfies the criteria.

3 After an initial term, board members shall be nominated and  
4 elected by the members of the association.

5 Members of the board may be reimbursed from the funds of  
6 the association for expenses incurred by them as members, but  
7 shall not otherwise be compensated by the association for  
8 their services.

9 3. The association shall submit to the commissioner a plan  
10 of operation for the association and any amendments to the  
11 association's articles of incorporation necessary and  
12 appropriate to assure the fair, reasonable, and equitable  
13 administration of the association. The plan shall provide for  
14 the sharing of losses related to basic and standard plans, if  
15 any, on an equitable and proportional basis among the members  
16 of the association. If the association fails to submit a  
17 suitable plan of operation within one hundred eighty days  
18 after the appointment of the board of directors, the  
19 commissioner shall adopt rules necessary to implement this  
20 section. The rules shall continue in force until modified by  
21 the commissioner or superseded by a plan submitted by the  
22 association and approved by the commissioner. In addition to  
23 other requirements, the plan of operation shall provide for  
24 all of the following:

25 a. The handling and accounting of assets and funds of the  
26 association.

27 b. The amount of and method for reimbursing the expenses  
28 of board members.

29 c. Regular times and places for meetings of the board of  
30 directors.

31 d. Records to be kept relating to all financial  
32 transactions, and annual fiscal reporting to the commissioner.

33 e. Procedures for selecting the board of directors.

34 f. Additional provisions necessary or proper for the  
35 execution of the powers and duties of the association.

1 4. The plan of operation may provide that the powers and  
2 duties of the association may be delegated to a person who  
3 will perform functions similar to those of the association. A  
4 delegation under this section takes effect only upon the  
5 approval of the board of directors.

6 5. The association has the general powers and authority  
7 enumerated by this section and executed in accordance with the  
8 plan of operation approved by the commissioner under  
9 subsection 3. In addition, the association may do any of the  
10 following:

11 a. Enter into contracts as necessary or proper to  
12 administer this chapter.

13 b. Sue or be sued, including taking any legal action  
14 necessary or proper for recovery of any assessments for, on  
15 behalf of, or against members of the association or other  
16 participating persons.

17 c. Appoint from among members appropriate legal,  
18 actuarial, and other committees as necessary to provide  
19 technical assistance in the operation of the association,  
20 including the hiring of independent consultants as necessary.

21 d. Perform any other functions within the authority of the  
22 association.

23 6. Rates for basic and standard coverages as provided in  
24 this chapter shall be determined by each carrier or organized  
25 delivery system as the average of the lowest rate available  
26 for issuance by that carrier or organized delivery system  
27 adjusted for rating characteristics and benefits and the  
28 maximum rate allowable by law after adjustments for rate  
29 characteristics and benefits.

30 7. Following the close of each calendar year, the  
31 association, in conjunction with the commissioner, shall  
32 require each carrier or organized delivery system to report  
33 the amount of earned premiums and the associated paid losses  
34 for all basic and standard plans issued by the carrier or  
35 organized delivery system. The reporting of these amounts

1 must be certified by an officer of the carrier or organized  
2 delivery system.

3 8. The board shall develop procedures and make assessments  
4 and distributions as required to equalize the individual  
5 carrier and organized delivery system gains or losses so that  
6 each carrier or organized delivery system receives the same  
7 ratio of paid claims to ninety percent of earned premiums as  
8 the aggregate of all basic and standard plans insured by all  
9 carriers and organized delivery systems in the state.

10 9. If the statewide aggregate ratio of paid claims to  
11 ninety percent of earned premiums is greater than one, the  
12 dollar difference between ninety percent of earned premiums  
13 and the paid claims shall represent an assessable loss.

14 10. The assessable loss plus necessary operating expenses  
15 for the association, plus any additional expenses as provided  
16 by law, shall be assessed by the association to all members in  
17 proportion to their respective shares of total health  
18 insurance premiums or payments for subscriber contracts,  
19 received in Iowa during the second preceding calendar year, or  
20 with paid losses in the year, coinciding with or ending during  
21 the calendar year, or on any other equitable basis as provided  
22 in the plan of operation. In sharing losses, the association  
23 may abate or defer any part of the assessment of a member, if,  
24 in the opinion of the board, payment of the assessment would  
25 endanger the ability of the member to fulfill its contractual  
26 obligations. The association may also provide for an initial  
27 or interim assessment against the members of the association  
28 to meet the operating expenses of the association until the  
29 next calendar year is completed.

30 11. The board shall develop procedures for distributing  
31 the assessable loss assessments to each carrier and organized  
32 delivery system in proportion to the carrier's and organized  
33 delivery system's respective share of premium for basic and  
34 standard plans to the statewide total premium for all basic  
35 and standard plans.

1 12. The board shall ensure that procedures for collecting  
2 and distributing assessments are as efficient as possible for  
3 carriers and organized delivery systems. The board may  
4 establish procedures which combine, or offset, the assessment  
5 from, and the distribution due to, a carrier or organized  
6 delivery system.

7 13. A carrier or an organized delivery system may petition  
8 the association board to seek remedy from writing a  
9 significantly disproportionate share of basic and standard  
10 policies in relation to total premiums written in this state  
11 for health benefit plans. Upon a finding that a carrier or  
12 organized delivery system has written a disproportionate  
13 share, the board may agree to compensate the carrier or  
14 organized delivery system either by paying to the carrier or  
15 organized delivery system an additional fee not to exceed two  
16 percent of earned premiums from basic and standard policies  
17 for that carrier or organized delivery system or by  
18 petitioning the commissioner or director, as appropriate for  
19 remedy.

20 14. a. The commissioner, upon a finding that the  
21 acceptance of the offer of basic and standard coverage by  
22 individuals pursuant to this chapter would place the carrier  
23 in a financially impaired condition, shall not require the  
24 carrier to offer coverage or accept applications for any  
25 period of time the financial impairment is deemed to exist.

26 b. The director, upon a finding that the acceptance of the  
27 offer of basic and standard coverage by individuals pursuant  
28 to this chapter would place the organized delivery system in a  
29 financially impaired condition, shall not required the  
30 organized delivery system to offer coverage or accept  
31 applications for any period of time the financial impairment  
32 is deemed to exist.

33 Sec. 13. NEW SECTION. 513C.11 SELF-FUNDED EMPLOYER-  
34 SPONSORED HEALTH BENEFIT PLAN PARTICIPATION IN IOWA INDIVIDUAL  
35 HEALTH BENEFIT REINSURANCE ASSOCIATION.

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

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

16 3. When and if the federal government imposes conditions  
17 of portability and continuity on self-funded employers  
18 qualified under the federal Employee Retirement Income  
19 Security Act of 1974 that the commissioner deems are  
20 substantially similar to those required of Iowa insurers,  
21 coverage under such qualified plan shall be deemed qualified  
22 prior coverage for purposes of chapters 513B and 513C.

23 Sec. 14. EFFECTIVE DATE. Sections 1 and 2 of this Act,  
24 which amend section 422.7 by adding a new subsection 32, and  
25 section 422.9, subsection 2, by adding a new paragraph "i",  
26 are effective January 1, 1996, for tax years beginning on or  
27 after that date.

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SENATE FILE 84

H-3113

1 Amend Senate File 84, as amended, passed, and  
 2 reprinted by the Senate, as follows:  
 3 1. Page 13, line 26, by striking the word "seven"  
 4 and inserting the following: "nine".  
 5 2. Page 14, by inserting after line 2 the  
 6 following:  
 7 "c. Two members shall be members of the public and  
 8 shall be appointed by the governor and subject to  
 9 senate confirmation."  
 10 3. Page 14, by striking lines 3 and 4 and  
 11 inserting the following:  
 12 "Appointments to the board shall be coordinated so  
 13 that the board is bipartisan and gender-balanced in  
 14 accordance with sections 69.16 and 69.16A."

By DODERER of Johnson  
 MYERS of Johnson  
 HOLVECK of Polk

(p. 469) Lost 2/21/95

H-3113 FILED FEBRUARY 20, 1995

SENATE FILE 84

H-3114

1 Amend Senate File 84, as amended, passed, and  
 2 reprinted by the Senate, as follows:  
 3 1. Page 18, by striking line 26 and inserting the  
 4 following: "apply retroactively to January 1, 1995,  
 5 for tax years beginning on or".  
 6 2. Title page, line 3, by inserting after the  
 7 word "individuals" the following: "and providing for  
 8 retroactive applicability".

By DODERER of Johnson  
 WEIGEL of Chickasaw  
 HOLVECK of Polk  
 CONNORS of Polk  
 WARNSTADT of Woodbury  
 DREES of Carroll  
 MCCOY of Polk  
 O'BRIEN of Boone  
 KOENIGS of Mitchell  
 MYERS of Johnson  
 MURPHY of Dubuque

JOCHUM of Dubuque  
 KREIMAN of Davis  
 OLLIE of Clinton  
 WITT of Black Hawk  
 SCHRADER of Marion  
 RUNNING of Linn  
 MUNDIE of Webster  
 COHOON of Des Moines  
 BAKER of Polk  
 MASCHER of Johnson  
 CATALDO of Polk

H-3114 FILED FEBRUARY 20, 1995

(p. 470) Lost 2/21/95

## SENATE FILE 84

H-3115

- 1 Amend Senate File 84, as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 6, by inserting after line 2 the  
4 following:  
5 "\_\_\_\_. Premium rates for any block of business or  
6 for any individual health insurance benefit plans  
7 shall not vary or be changed based upon the gender of  
8 the eligible individual."  
9 2. By renumbering as necessary.

By DODERER of Johnson

H-3115 FILED FEBRUARY 20, 1995

*(p.468) 2/21/95 Lost*

## SENATE FILE 84

H-3116

- 1 Amend the amendment, H-3115, to Senate File 84, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:  
4 1. Page 1, by striking lines 7 and 8 and  
5 inserting the following: "shall be established in  
6 accordance with actuarial principles, but the premium  
7 rates shall not be determined according to an  
8 individual's gender, and shall not be excessive,  
9 inadequate, or unfairly discriminatory."

By DODERER of Johnson

H-3116 FILED FEBRUARY 21, 1995

*(p.468) Adopted  
2-21-95*



Uilsack - ch  
Szymoniak  
Kramer

SSB-53

Human Resources

Sponsored By

SENATE FILE 84

BY (PROPOSED COMMITTEE ON HUMAN  
RESOURCES BILL BY CHAIR-  
PERSON SZYMONIAK)

Passed Senate, Date \_\_\_\_\_ Passed House, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

### A BILL FOR

1 An Act relating to health care reform and health care costs by  
2 providing for the regulation of insurance and health care plan  
3 providers, establishing income tax credits for certain  
4 individuals, establishing certain individual requirements, and  
5 providing for penalties, an effective date provision, and an  
6 applicability provision.

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

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1 Section 1. Section 422.7, Code 1995, is amended by adding  
2 the following new subsection:

3 NEW SUBSECTION. 32. Subtract, to the extent not otherwise  
4 deducted in computing adjusted gross income, the amounts paid  
5 by the taxpayer for the purchase of health insurance for the  
6 taxpayer or taxpayer's spouse or dependent.

7 Sec. 2. NEW SECTION. 505.22 SELF-FUNDED EMPLOYER-  
8 SPONSORED HEALTH BENEFIT PLAN PARTICIPATION IN IOWA INDIVIDUAL  
9 HEALTH BENEFIT REINSURANCE ASSOCIATION.

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

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

25 3. When and if the federal government imposes conditions  
26 of portability and continuity on self-funded employers  
27 qualified under the federal Employee Retirement Income  
28 Security Act of 1974 that the commissioner deems are  
29 substantially similar to those required of Iowa insurers,  
30 coverage under such qualified plan shall be deemed qualified  
31 prior coverage for purposes of chapters 513B and 513C.

32 Sec. 3. Section 507B.4, subsection 1, Code 1995, is  
33 amended by adding the following new paragraph:

34 NEW PARAGRAPH. k. Misrepresents the access to health care  
35 practitioners under a managed care health plan. The

1 commissioner shall adopt rules providing for monitoring of  
2 such plans.

3 Sec. 4. Section 513B.2, subsection 12, paragraph a,  
4 subparagraph (3), Code 1995, is amended to read as follows:

5 (3) The individual requests enrollment within thirty sixty  
6 days after termination of the qualifying previous coverage.

7 Sec. 5. Section 513B.2, subsection 12, paragraph c, Code  
8 1995, is amended to read as follows:

9 c. A court has ordered that coverage be provided for a  
10 spouse or minor or dependent child under a covered employee's  
11 health benefit plan and the request for enrollment is made  
12 within thirty sixty days after issuance of the court order.

13 Sec. 6. Section 513B.37, subsection 1, paragraph a, Code  
14 1995, is amended to read as follows:

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

18 Sec. 7. Section 513B.38, Code 1995, is amended by adding  
19 the following new subsection:

20 NEW SUBSECTION. 4. Upon the determination of the  
21 commissioner pursuant to section 513B.37, subsection 1,  
22 paragraph "a", to include expanded preventative care services  
23 and mental health and substance abuse treatment coverage, the  
24 commissioner shall do all of the following:

25 a. Adopt by rule, with all due diligence, requirements for  
26 the provision of expanded coverage for benefits for expanded  
27 preventative care services.

28 b. Adopt by rule, with all due diligence, requirements for  
29 the provision of coverage for benefits for mental health and  
30 substance abuse services.

31 Sec. 8. NEW SECTION. 513B.44 INDIVIDUAL HEALTH PLAN  
32 PREMIUM CREDIT.

33 1. The division shall adopt rules to implement and  
34 administer the premium credit authorized by this section,  
35 which rules shall include the minimum standard application

1 form for premium credit eligibility. Forms shall be printed  
2 by participating insurance companies, health maintenance  
3 organizations, or health insurance purchasing cooperatives and  
4 provided to individuals wishing to apply for premium credit  
5 eligibility.

6 2. The amount of the premium credit is equal to twenty-  
7 five dollars per month, per participating eligible individual  
8 or fifty dollars per month per eligible family purchasing a  
9 health plan from an insurer, health maintenance organization,  
10 or organized delivery system authorized to do business in this  
11 state, whether purchased directly or through a health  
12 insurance purchasing cooperative.

13 3. An individual or family is eligible for participation  
14 in the subsidized insurance premium credit health insurance  
15 plan if the family income is less than or equal to two hundred  
16 percent of the federal poverty level as published annually in  
17 the federal register by the United States department of health  
18 and human services. An application for eligibility is valid  
19 for up to one year. Notwithstanding the income requirement of  
20 this subsection, the division by rule may increase the income  
21 limitation for the purpose of increasing the number of  
22 eligible individuals and families to assure that the premium  
23 credit is fully utilized to the extent authorized in this  
24 section.

25 4. The earned premium credit is limited to the first full-  
26 year equivalent participating eligible applications submitted  
27 under this section preapproved by the division in any single  
28 fiscal year, which request in the aggregate four million five  
29 hundred thousand dollars in earned premium credit.

30 5. The carrier shall credit to the participating  
31 individual's or family's premium liability, an amount equal to  
32 the premium credit earned pursuant to subsection 2. If  
33 purchased through a health insurance purchasing cooperative,  
34 the cooperative shall reduce the member assessment to the  
35 individual or family by an equal amount.

1 6. The premium credit provided by this section is only  
2 available in connection with either of the following:

3 a. A basic benefit plan approved by the commissioner.

4 b. A major medical policy approved by the commissioner  
5 providing coverage to an eligible individual or family, either  
6 on a group or individual basis. An individual or family may  
7 acquire group coverage for which they are financially  
8 responsible through an employer's participation in a health  
9 insurance purchasing cooperative.

10 7. The policy shall also satisfy any conditions imposed by  
11 rules adopted pursuant to subsection 1 which the commissioner  
12 determines are necessary or convenient to implement and  
13 administer the premium credit.

14 8. a. A person submitting an intentionally fraudulent  
15 premium credit application forfeits the credit and shall pay  
16 to the division a liquidated damages penalty of one hundred  
17 fifty percent of the credit forfeited.

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

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

25 10. The division shall submit an annual report to the  
26 general assembly concerning the number of eligible applicants  
27 for the individual health plan premium credit established in  
28 this section, the number of applications approved and the  
29 aggregate amount of premium credits issued to eligible  
30 applicants, and the number and amount of liquidated damage  
31 penalties assessed and collected.

32 Sec. 9. NEW SECTION. 513C.1 SHORT TITLE.

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

35 Sec. 10. NEW SECTION. 513C.2 PURPOSE.

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

10 Sec. 11. NEW SECTION. 513C.3 DEFINITIONS.

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

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

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

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

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

30 5. "Carrier" means any entity that provides individual  
31 health benefit plans in this state. For purposes of this  
32 chapter, carrier includes an insurance company, a group  
33 hospital or medical service corporation, a fraternal benefit  
34 society, a health maintenance organization, and any other  
35 entity providing an individual plan of health insurance or

1 health benefits subject to state insurance regulation.

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

3 7. "Director" means the director of public health  
4 appointed pursuant to section 135.2.

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

11 9. "Established service area" means a geographic area, as  
12 approved by the commissioner and based upon the carrier's  
13 certificate of authority to transact business in this state,  
14 within which the carrier is authorized to provide coverage or  
15 a geographic area, as approved by the director and based upon  
16 the organized delivery system's license to transact business  
17 in this state, within which the organized delivery system is  
18 authorized to provide coverage.

19 10. "Filed rate" means, for a rating period related to  
20 each block of business, the rate charged to all individuals  
21 with similar rating characteristics for individual health  
22 benefit plans.

23 11. "Individual health benefit plan" means any hospital or  
24 medical expense incurred policy or certificate, hospital or  
25 medical service plan, or health maintenance organization  
26 subscriber contract sold to an individual, or any  
27 discretionary group trust or association policy providing  
28 hospital or medical expense incurred coverage to individuals.  
29 Individual health benefit plan does not include a self-insured  
30 group health plan, a self-insured multiple employer group  
31 health plan, a group conversion plan, an insured group health  
32 plan, accident-only, specified disease, short-term hospital or  
33 medical, hospital confinement indemnity, credit, dental,  
34 vision, medicare supplement, long-term care, or disability  
35 income insurance coverage, coverage issued as a supplement to

1 liability insurance, workers' compensation or similar  
2 insurance, or automobile medical payment insurance.

3 12. "Organized delivery system" means an organized  
4 delivery system licensed by the director.

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

10 14. "Qualifying event" means any of the following:

11 a. Loss of eligibility for medical assistance provided  
12 pursuant to chapter 249A or medicare coverage provided  
13 pursuant to Title XVIII of the federal Social Security Act.

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

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

17 15. "Qualifying existing coverage" or "qualifying previous  
18 coverage" means benefits or coverage provided under any of the  
19 following:

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

24 b. An individual health insurance benefit plan, including  
25 coverage provided under a health maintenance organization  
26 contract, a hospital or medical service plan contract, or a  
27 fraternal benefit society contract, that provides benefits  
28 similar to or exceeding the benefits provided under the  
29 standard health benefit plan, provided that such policy has  
30 been in effect for a period of at least one year.

31 c. An organized delivery system that provides benefits  
32 similar to or exceeding the benefits provided under the  
33 standard health benefit plan, provided that the benefits  
34 provided by the organized delivery system have been in effect  
35 for a period of at least one year.



1 16. "Rating characteristics" means demographic or other  
2 objective characteristics of individuals which are considered  
3 by the carrier in the determination of premium rates for the  
4 individuals and which are approved by the commissioner.

5 17. "Rating period" means the period for which premium  
6 rates established by a carrier are in effect.

7 18. "Restricted network provision" means a provision of an  
8 individual health benefit plan that conditions the payment of  
9 benefits, in whole or in part, on the use of health care  
10 providers that have entered into a contractual arrangement  
11 with the carrier or the organized delivery system to provide  
12 health care services to covered individuals.

13 Sec. 12. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

14 This chapter applies to an individual health benefit plan  
15 delivered or issued for delivery to residents of this state on  
16 or after July 1, 1995.

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

25 2. An affiliated carrier that is a health maintenance  
26 organization having a certificate of authority under section  
27 513C.5 shall be considered to be a separate carrier for the  
28 purposes of this chapter.

29 Sec. 13. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO  
30 PREMIUM RATES.

31 1. Premium rates for any block of individual health  
32 benefit plan business issued on or after July 1, 1995, by a  
33 carrier subject to this chapter are subject to the composite  
34 effect of all of the following:

35 a. After making actuarial adjustments based upon benefit

1 design and rating characteristics, the filed rate for any  
2 block of business shall not exceed the filed rate for any  
3 other block of business by more than twenty percent.

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

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

12 d. Rating characteristics other than age, geographic area,  
13 and family composition shall not be used by a carrier without  
14 the prior approval of the commissioner.

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

19 f. An adjustment, not to exceed fifteen percent annually  
20 due to the claim experience or health status of a block of  
21 business.

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

28 2. Notwithstanding subsection 1, the commissioner, with  
29 the concurrence of the board of the Iowa individual health  
30 benefit reinsurance association established in section  
31 513C.10, may by order reduce or eliminate the allowed rating  
32 bands provided under subsection 1, paragraphs "a", "b", "c",  
33 and "f", or otherwise limit or eliminate the use of experience  
34 rating. The commissioner shall also develop a recommendation  
35 for the elimination of age as a rating characteristic, and

1 shall submit such recommendation by January 8, 1996.

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

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

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

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

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

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

22 d. Any provisions relating to any preexisting condition.

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

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

31 7. A carrier shall file with the commissioner annually on  
32 or before March 15, an actuarial certification certifying that  
33 the carrier is in compliance with this chapter and that the  
34 rating methods of the carrier are actuarially sound. The  
35 certification shall be in a form and manner and shall contain

1 information as specified by the commissioner. A copy of the  
2 certification shall be retained by the carrier at its  
3 principal place of business. Rate adjustments made in order  
4 to comply with this section are exempt from loss ratio  
5 requirements.

6 8. A carrier shall make the information and documentation  
7 maintained pursuant to subsection 5 available to the  
8 commissioner upon request. The information and documentation  
9 shall be considered proprietary and trade secret information  
10 and shall not be subject to disclosure by the commissioner to  
11 persons outside of the division except as agreed to by the  
12 carrier or as ordered by a court of competent jurisdiction.

13 Sec. 14. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

14 1. An individual health benefit plan is renewable at the  
15 option of the individual, except in any of the following  
16 cases:

17 a. Nonpayment of the required premiums.

18 b. Fraud or misrepresentation.

19 c. The insured individual becomes eligible for medicare  
20 coverage under Title XVIII of the federal Social Security Act.

21 d. The carrier elects not to renew all of its individual  
22 health benefit plans in the state. In such case, the carrier  
23 shall provide notice of the decision not to renew coverage to  
24 all affected individuals and to the commissioner in each state  
25 in which an affected insured individual is known to reside at  
26 least ninety days prior to the nonrenewal of the health  
27 benefit plan by the carrier. Notice to the commissioner under  
28 this paragraph shall be provided at least three working days  
29 prior to the notice to the affected individuals.

30 e. The commissioner finds that the continuation of the  
31 coverage would not be in the best interests of the  
32 policyholders or certificate holders, or would impair the  
33 carrier's ability to meet its contractual obligations.

34 2. A carrier that elects not to renew all of its  
35 individual health benefit plans in this state shall be

1 prohibited from writing new individual health benefit plans in  
2 this state for a period of five years from the date of the  
3 notice to the commissioner.

4 3. With respect to a carrier doing business in an  
5 established geographic service area of the state, this section  
6 applies only to the carrier's operations in the service area.

7 Sec. 15. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

8 1. A carrier or an organized delivery system issuing an  
9 individual health benefit plan in this state shall issue a  
10 basic or standard health benefit plan to an eligible  
11 individual who applies for a plan and agrees to make the  
12 required premium payments and to satisfy other reasonable  
13 provisions of the basic or standard health benefit plan. A  
14 carrier or an organized delivery system is not required to  
15 issue a basic or standard health benefit plan to an individual  
16 who meets any of the following criteria:

17 a. The individual is covered or is eligible for coverage  
18 under a health benefit plan provided by the individual's  
19 employer.

20 b. An eligible individual who does not apply for a basic  
21 or standard health benefit plan within thirty days of a  
22 qualifying event or within thirty days upon becoming  
23 ineligible for qualifying existing coverage.

24 c. The individual is covered or is eligible for any  
25 continued group coverage under section 4980b of the Internal  
26 Revenue Code, sections 601 through 608 of the federal Employee  
27 Retirement Income Security Act of 1974, sections 2201 through  
28 2208 of the federal Public Health Service Act, or any state-  
29 required continued group coverage. For purposes of this  
30 subsection, an individual who would have been eligible for  
31 such continuation of coverage, but is not eligible solely  
32 because the individual or other responsible party failed to  
33 make the required coverage election during the applicable time  
34 period, is deemed to be eligible for such group coverage until  
35 the date on which the individual's continuing group coverage

1 would have expired had an election been made.

2 2. A carrier or an organized delivery system shall issue  
3 the basic or standard health benefit plan to an individual  
4 currently covered by an underwritten benefit plan issued by  
5 that carrier or an organized delivery system at the option of  
6 the individual. This option must be exercised within thirty  
7 days of notification of a premium rate increase applicable to  
8 the underwritten benefit plan.

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

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

20 b. An organized delivery system shall file with the  
21 director, in a form and manner prescribed by the director, the  
22 basic or standard health benefit plan to be used by the  
23 organized delivery system. A basic or standard health benefit  
24 plan filed pursuant to this paragraph may be used by the  
25 organized delivery system beginning thirty days after it is  
26 filed unless the director disapproves of its use.

27 The director may at any time, after providing notice and an  
28 opportunity for a hearing to the organized delivery system,  
29 disapprove the continued use by an organized delivery system  
30 of a basic or standard health benefit plan on the grounds that  
31 the plan does not meet the requirements of this chapter.

32 4. a. The individual basic or standard health benefit  
33 plan shall not deny, exclude, or limit benefits for a covered  
34 individual for losses incurred more than twelve months  
35 following the effective date of the individual's coverage due

1 to a preexisting condition. A preexisting condition shall not  
2 be defined more restrictively than any of the following:

3 (1) A condition that would cause an ordinarily prudent  
4 person to seek medical advice, diagnosis, care, or treatment  
5 during the twelve months immediately preceding the effective  
6 date of coverage.

7 (2) A condition for which medical advice, diagnosis, care,  
8 or treatment was recommended or received during the twelve  
9 months immediately preceding the effective date of coverage.

10 (3) A pregnancy existing on the effective date of  
11 coverage.

12 b. A carrier or an organized delivery system shall waive  
13 any time period applicable to a preexisting condition  
14 exclusion or limitation period with respect to particular  
15 services in an individual health benefit plan for the period  
16 of time an individual was previously covered by qualifying  
17 previous coverage that provided benefits with respect to such  
18 services, provided that the qualifying previous coverage was  
19 continuous to a date not more than thirty days prior to the  
20 effective date of the new coverage.

21 5. A carrier or an organized delivery system is not  
22 required to offer coverage or accept applications pursuant to  
23 subsection 1 from any individual not residing in the carrier's  
24 or the organized delivery system's established geographic  
25 access area.

26 6. A carrier or an organized delivery system shall not  
27 modify a basic or standard health benefit plan with respect to  
28 an individual or dependent through riders, endorsements, or  
29 other means to restrict or exclude coverage for certain  
30 diseases or medical conditions otherwise covered by the health  
31 benefit plan.

32 Sec. 16. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN  
33 STANDARDS.

34 The commissioner shall adopt by rule the form and level of  
35 coverage of the basic health benefit plan and the standard

1 health benefit plan for the individual market which shall be  
2 substantially similar to those as provided for under chapter  
3 513B with respect to small group coverage.

4 Sec. 17. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR  
5 MARKETING.

6 1. A carrier or an organized delivery system issuing  
7 individual health benefit plans in this state shall make  
8 available the basic or standard health benefit plan to  
9 residents of this state. If a carrier or an organized  
10 delivery system denies other individual health benefit plan  
11 coverage to an eligible individual on the basis of the health  
12 status or claims experience of the eligible individual, or the  
13 individual's dependents, the carrier or the organized delivery  
14 system shall offer the individual the opportunity to purchase  
15 a basic or standard health benefit plan.

16 2. A carrier, or an organized delivery system, or an agent  
17 shall not do either of the following:

18 a. Encourage or direct individuals to refrain from filing  
19 an application for coverage with the carrier or the organized  
20 delivery system because of the health status, claims  
21 experience, industry, occupation, or geographic location of  
22 the individuals.

23 b. Encourage or direct individuals to seek coverage from  
24 another carrier or another organized delivery system because  
25 of the health status, claims experience, industry, occupation,  
26 or geographic location of the individuals.

27 3. Subsection 2, paragraph "a", shall not apply with  
28 respect to information provided by a carrier or an organized  
29 delivery system or an agent to an individual regarding the  
30 established geographic service area of the carrier or the  
31 organized delivery system, or the restricted network provision  
32 of the carrier or the organized delivery system.

33 4. A carrier or an organized delivery system shall not,  
34 directly or indirectly, enter into any contract, agreement, or  
35 arrangement with an agent that provides for, or results in,



1 the compensation paid to an agent for a sale of a basic or  
2 standard health benefit plan to vary because of the health  
3 status or permitted rating characteristics of the individual  
4 or the individual's dependents.

5 5. Subsection 4 does not apply with respect to the  
6 compensation paid to an agent on the basis of percentage of  
7 premium, provided that the percentage shall not vary because  
8 of the health status or other permitted rating characteristics  
9 of the individual or the individual's dependents.

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

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

15 8. If a carrier or an organized delivery system enters  
16 into a contract, agreement, or other arrangement with a third-  
17 party administrator to provide administrative, marketing, or  
18 other services related to the offering of individual health  
19 benefit plans in this state, the third-party administrator is  
20 subject to this section as if it were a carrier or an  
21 organized delivery system.

22 Sec. 18. NEW SECTION. 513C.10 IOWA INDIVIDUAL HEALTH  
23 BENEFIT REINSURANCE ASSOCIATION.

24 1. A nonprofit corporation is established to be known as  
25 the Iowa individual health benefit reinsurance association.  
26 All persons that provide health benefit plans in this state  
27 including insurers providing accident and sickness insurance  
28 under chapter 509, 514, or 514A; fraternal benefit societies  
29 providing hospital, medical, or nursing benefits under chapter  
30 512B; health maintenance organizations, organized delivery  
31 systems, and all other entities providing health insurance or  
32 health benefits subject to state insurance regulation shall be  
33 members of this association. The association shall be  
34 incorporated under chapter 504A, shall operate under a plan of  
35 operation established and approved pursuant to chapter 504A,

1 and shall exercise its powers through a board of directors  
2 established under this section.

3 2. The initial board of directors of the association shall  
4 consist of seven members appointed by the commissioner as  
5 follows:

6 a. Four members shall be representatives of the four  
7 largest carriers of individual health insurance in the state,  
8 excluding medicare supplement coverage premiums, as of the  
9 calendar year ending December 31, 1994.

10 b. Three members shall be representatives of the three  
11 largest writers of health insurance in the state which are not  
12 otherwise represented.

13 After an initial term, board members shall be nominated and  
14 elected by the members of the association.

15 Members of the board may be reimbursed from the funds of  
16 the association for expenses incurred by them as members, but  
17 shall not otherwise be compensated by the association for  
18 their services.

19 3. The association shall submit to the commissioner a plan  
20 of operation for the association and any amendments to the  
21 association's articles of incorporation necessary and  
22 appropriate to assure the fair, reasonable, and equitable  
23 administration of the association. The plan shall provide for  
24 the sharing of losses related to basic and standard plans, if  
25 any, on an equitable and proportional basis among the members  
26 of the association. If the association fails to submit a  
27 suitable plan of operation within one hundred eighty days  
28 after the appointment of the board of directors, the  
29 commissioner shall adopt rules necessary to implement this  
30 section. The rules shall continue in force until modified by  
31 the commissioner or superseded by a plan submitted by the  
32 association and approved by the commissioner. In addition to  
33 other requirements, the plan of operation shall provide for  
34 all of the following:

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

1 association.

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

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

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

8 e. Procedures for selecting the board of directors.

9 f. Additional provisions necessary or proper for the  
10 execution of the powers and duties of the association.

11 4. The plan of operation may provide that the powers and  
12 duties of the association may be delegated to a person who  
13 will perform functions similar to those of the association. A  
14 delegation under this section takes effect only upon the  
15 approval of the board of directors.

16 5. The association has the general powers and authority  
17 enumerated by this section and executed in accordance with the  
18 plan of operation approved by the commissioner under  
19 subsection 3. In addition, the association may do any of the  
20 following:

21 a. Enter into contracts as necessary or proper to  
22 administer this chapter.

23 b. Sue or be sued, including taking any legal action  
24 necessary or proper for recovery of any assessments for, on  
25 behalf of, or against members of the association or other  
26 participating persons.

27 c. Appoint from among members appropriate legal,  
28 actuarial, and other committees as necessary to provide  
29 technical assistance in the operation of the association,  
30 including the hiring of independent consultants as necessary.

31 d. Perform any other functions within the authority of the  
32 association.

33 6. Rates for basic and standard coverages as provided in  
34 this chapter shall be determined by each carrier or organized  
35 delivery system as the average of the lowest rate available

1 for issuance by that carrier or organized delivery system  
2 adjusted for rate characteristics and benefits and the maximum  
3 rate allowable by law after adjustments for rate  
4 characteristics and benefits.

5 7. Following the close of each calendar year, the  
6 association, in conjunction with the commissioner, shall  
7 require each carrier or organized delivery system to report  
8 the amount of earned premiums and the associated paid losses  
9 for all basic and standard plans issued by the carrier or  
10 organized delivery system. The reporting of these amounts  
11 must be certified by an officer of the carrier or the  
12 organized delivery system.

13 8. The board shall determine the amount of loss, if any,  
14 from all basic and standard plans issued in the state by all  
15 carriers and organized delivery systems by aggregating the  
16 data reported in subsection 7. A loss shall be equal to  
17 ninety percent of earned premiums minus total paid claims.

18 9. The loss plus necessary operating expenses for the  
19 association, plus any additional expenses as provided by law,  
20 shall be assessed by the association to all members in  
21 proportion to their respective shares of total health  
22 insurance premiums or payments for subscriber contracts  
23 received in Iowa during the second preceding calendar year, or  
24 with paid losses in the year, coinciding with or ending during  
25 the calendar year, or on any other equitable basis as provided  
26 in the plan of operation. In sharing losses, the association  
27 may abate or defer any part of the assessment of a member, if,  
28 in the opinion of the board, payment of the assessment would  
29 endanger the ability of the member to fulfill its contractual  
30 obligations. The association may also provide for an initial  
31 or interim assessment against members of the association if  
32 necessary to assure the financial viability of the association  
33 to meet the operating expenses of the association until the  
34 next calendar year is completed.

35 10. The collected assessments shall be disbursed to a

1 carrier or an organized delivery system in proportion to the  
2 loss that carrier or organized delivery system represented of  
3 the aggregate loss as determined in subsection 8.

4 11. A carrier or an organized delivery system may petition  
5 the association board to seek remedy from writing a  
6 significantly disproportionate share of basic and standard  
7 policies in relation to total premiums written in the state  
8 for health benefit plans. Upon a finding that a carrier or an  
9 organized delivery system has written a disproportionate  
10 share, the board may agree to compensate the carrier or the  
11 organized delivery system either by paying to the carrier or  
12 the organized delivery system an additional fee not to exceed  
13 two percent of earned premiums from basic and standard  
14 policies for that carrier or organized delivery system or by  
15 petitioning the commissioner or director, as appropriate, for  
16 remedy.

17 12. a. The commissioner, upon a finding that the  
18 acceptance of the offer of basic and standard coverage by  
19 individuals pursuant to this chapter would place the  
20 individual health insurance carrier in a financially impaired  
21 condition, shall not require the carrier to offer coverage or  
22 accept applications for any period of time the financial  
23 impairment is deemed to exist.

24 b. The director, upon a finding that the acceptance of the  
25 offer of basic and standard coverage by individuals pursuant  
26 to this chapter would place the organized delivery system in a  
27 financially impaired condition, shall not require the  
28 organized delivery system to offer coverage or accept  
29 applications for any period of time the financial impairment  
30 is deemed to exist.

31 Sec. 19. NEW SECTION. 513C.11 INSURANCE DIVISION  
32 REPORTS.

33 1. The insurance division shall annually provide a written  
34 report to the general assembly beginning January 1, 1996,  
35 which evaluates the effect of this chapter on providing

1 universal coverage for all Iowans. This report may be  
2 completed in conjunction with the report required by section  
3 505.21 relating to the establishment of a requirement that an  
4 employer provide access to health care to the employer's  
5 employees.

6 2. The insurance division shall submit an annual report to  
7 the general assembly on or before January 15 of each year  
8 concerning the aggregate number of insureds who have coverage  
9 through an individual health benefit plan issued under this  
10 chapter and the net increase or decrease in the number of  
11 insureds from the previous year.

12 Sec. 20. INSURANCE DIVISION STUDIES. The insurance  
13 division shall review, study, and make recommendations to the  
14 general assembly concerning the Iowa comprehensive health  
15 insurance association established under chapter 514E, with the  
16 intent to merge the Iowa comprehensive health insurance  
17 program with an individual health reinsurance program. The  
18 division shall submit a written report to the general assembly  
19 no later than January 8, 1996, including the division's  
20 findings and recommendations.

21 It is the intent of the general assembly that any merger of  
22 the Iowa comprehensive health insurance program with an  
23 individual health reinsurance program shall only occur if  
24 those whom the Iowa comprehensive health insurance association  
25 presently serves or would serve in the future are able to  
26 obtain health coverage equal to or better than such coverage  
27 in terms of cost, coverage, and plan restrictions than  
28 presently available through the Iowa comprehensive health  
29 insurance association.

30 Sec. 21. INTERIM STUDY REQUEST. The legislative council  
31 is requested to establish an interim study committee to review  
32 the potential for adoption of a variety of plans which may be  
33 formed to enable an individual or family to participate in  
34 financial instruments which provide for accumulation of  
35 deposits for the potential payment of health care

1 expenditures. In particular, the committee should review the  
2 potential offered by family health accounts and their  
3 applicability in the provision of health security for  
4 individuals and families. Issues to be reviewed shall include  
5 limitations on deposits, extent of usage for health care  
6 expenditures, tax consequences, extent to which deposits can  
7 be used, the role of financial institutions, withdrawal  
8 parameters, and penalties. A report with recommendations  
9 shall be presented to the general assembly no later than  
10 January 3, 1996.

11 Sec. 22. STUDY PROPOSAL. The insurance division, on or  
12 before September 1, 1995, shall provide a written proposal to  
13 the legislative council of the general assembly, and the  
14 chairperson, vice chairperson, and ranking member of the  
15 Senate and House committees on human resources detailing a  
16 plan for the study of all available financing mechanisms and  
17 cost containment mechanisms which might assist in the  
18 attainment of universal coverage for all Iowa citizens.

19 Sec. 23. APPLICABILITY. Notwithstanding the provisions of  
20 sections 513C.4 and 513C.5, chapter 513C, as enacted in this  
21 Act, is not applicable to an individual health benefit plan  
22 delivered or issued for delivery in this state or to a block  
23 of individual health benefit plan business until such time as  
24 rules implementing the chapter have been adopted by the  
25 insurance division pursuant to chapter 17A.

26 Sec. 24. EFFECTIVE DATE. Section 1 of this Act, which  
27 amends section 422.7 by adding a new subsection 32, is  
28 effective January 1, 1996, for tax years beginning on or after  
29 that date.

30 EXPLANATION

31 This bill relates to health care reform and health care  
32 costs by amending or creating provisions relating to insurance  
33 regulation, establishing a tax deduction, and requiring  
34 certain state agency studies.

35 Section 422.7 is amended to implement the deduction of 100

1 percent of a taxpayer's cost for the purchase of health  
2 insurance from adjusted gross income in computing state  
3 individual income tax.

4 New section 505.22 is created which provides that a self-  
5 funded employer-sponsored health benefit plan qualified under  
6 the federal Employee Retirement Incomes Security Act of 1974  
7 may voluntarily elect to participate in the individual  
8 reinsurance pool to provide portability and continuity to the  
9 employer's covered employees and their spouses and dependents  
10 subject to the same terms and conditions as a participating  
11 insurer.

12 Section 507B.4, subsection 1, which relates to unfair  
13 methods of competition and unfair or deceptive acts, is  
14 amended to include the misrepresentation by an individual of  
15 access to health care practitioners under a managed care  
16 health plan.

17 Section 513B.2, subsection 12, which defines a late  
18 enrollee for purposes of small group health coverage, is  
19 amended to not include an individual, or a spouse or minor  
20 dependent child under a court order requiring coverage, who,  
21 in addition to existing requirements, requests enrollment  
22 within 60 days after termination of qualifying previous  
23 coverage for an individual, or within 60 days after the  
24 issuance of the court order. Currently, such request for  
25 coverage must be made within 30 days.

26 Section 513B.37 is amended to provide that the commissioner  
27 is to determine what benefits or direct pay requirements must  
28 be minimally included in a standard health benefit plan.

29 Section 513B.38 is amended to provide that the commissioner  
30 may extend standard benefits to include preventative care  
31 services and mental health and substance abuse treatment  
32 coverage.

33 New section 513B.44 is created and directs the insurance  
34 division to implement and administer a premium credit to be  
35 provided to individuals wishing to apply for the premium



1 credit.

2 New chapter 513C is created relating to individual health  
3 coverage. New section 513C.1 provides the title, the  
4 Individual Health Insurance Market Reform Act.

5 New section 513C.2 states the purpose of the chapter.

6 New section 513C.3 establishes the definitions of key terms  
7 used in the chapter.

8 New section 513C.4 provides that the chapter applies to an  
9 individual health benefit plan delivered or issued for  
10 delivery to residents in this state on or after July 1, 1995.

11 New section 513C.5 establishes restrictions relating to  
12 premium rates for individual health benefit plans. Among  
13 those factors, the carrier is not to apply gender or industry  
14 classification rating characteristics, and experience rating  
15 characteristics only apply when an individual who is obtaining  
16 health coverage does not currently have qualifying coverage,  
17 as defined in the chapter. Certain other restrictions apply  
18 relating to the transfer of an individual into and out of a  
19 block of business, and required disclosures relating to the  
20 coverage are enumerated.

21 New section 513C.6 relates to the renewal of an individual  
22 health benefit plan. Such plan is renewable at the option of  
23 the individual, except under certain enumerated circumstances.  
24 The section also provides that a carrier that elects not to  
25 renew all of its individual health benefit plans in this state  
26 shall be prohibited from writing new individual health benefit  
27 plans in this state for a period of five years from the date  
28 of the notice required to be provided to the commissioner of  
29 such election.

30 New section 513C.7 provides that a carrier issuing  
31 individual health benefit plans must issue such plan to an  
32 individual applying for the plan except under certain defined  
33 circumstances.

34 New section 513C.8 provides that the commissioner is to  
35 adopt rules relating to the form and level of coverage of the

1 basic and standard health benefit plan for the individual  
2 market.

3 New section 513C.9 establishes standards to assure fair  
4 marketing of individual basic and standard health benefit  
5 plans. Restrictions are also established relating to carrier  
6 and the agent concerning the marketing of such plans.

7 New section 513C.10 establishes an Iowa individual health  
8 benefit reinsurance association to provide for the sharing of  
9 losses related to basic and standard plans, if any, on an  
10 equitable and proportional basis among the members of the  
11 association.

12 New section 513C.11 is established requiring the insurance  
13 division to annually report to the general assembly regarding  
14 the effect of new chapter 513C on providing universal coverage  
15 for all Iowans, and regarding the number of aggregate number  
16 of insureds who have coverage through an individual health  
17 benefit plan issued under chapter 513C.

18 The bill directs the insurance division to review, develop,  
19 and submit a plan for the establishment of an individual  
20 health coverage reinsurance program. The division is also to  
21 provide a written proposal on or before September 1, 1995,  
22 detailing all available financing and cost containment  
23 mechanisms which might assist in attaining universal coverage.  
24 for all Iowans.

25 The bill also provides that the tax deduction established  
26 in chapter 422 is effective for tax years beginning on or  
27 after January 1, 1996.

28 The bill requests the legislative council to establish an  
29 interim committee to review the potential for adoption of a  
30 variety of plans which may be formed to enable an individual  
31 or family to participate in financial instruments which  
32 provide for accumulation of deposits for the potential payment  
33 of health care expenditures.

34  
35

SENATE FILE 84

AN ACT

RELATING TO INDIVIDUAL HEALTH INSURANCE AND INDIVIDUAL HEALTH  
BENEFIT PLAN REFORMS, AND ESTABLISHING AN INCOME TAX CREDIT  
FOR CERTAIN INDIVIDUALS.

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

Section 1. Section 422.7, Code 1995, is amended by adding  
the following new subsection:

NEW SUBSECTION. 32. Subtract, to the extent not otherwise  
deducted in computing adjusted gross income, the amounts paid  
by the taxpayer for the purchase of health benefits coverage  
or insurance for the taxpayer or taxpayer's spouse or  
dependent.

Sec. 2. Section 422.9, subsection 2, Code 1995, is amended  
by adding the following new paragraph:

NEW PARAGRAPH. i. If the taxpayer has a deduction for  
medical care expenses under section 213 of the Internal  
Revenue Code, the taxpayer shall recompute for the purposes of  
this subsection the amount of the deduction under section 213  
by excluding from medical care, as defined in section 213, the  
amount subtracted under section 422.7, subsection 32.

Sec. 3. NEW SECTION. 513C.1 SHORT TITLE.

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

Sec. 4. NEW SECTION. 513C.2 PURPOSE.

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

efficiency of the individual health insurance market.

Sec. 5. NEW SECTION. 513C.3 DEFINITIONS.

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

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

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

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

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

5. "Carrier" means any entity that provides individual  
health benefit plans in this state. For purposes of this  
chapter, carrier includes an insurance company, a group  
hospital or medical service corporation, a fraternal benefit  
society, a health maintenance organization, and any other  
entity providing an individual plan of health insurance or  
health benefits subject to state insurance regulation.  
"Carrier" does not include an organized delivery system.

6. "Commissioner" means the commissioner of insurance.

7. "Director" means the director of public health  
appointed pursuant to section 135.2.

8. "Eligible individual" means an individual who is a  
resident of this state and who either has qualifying existing  
coverage or has had qualifying existing coverage within the

immediately preceding thirty days, or an individual who has had a qualifying event occur within the immediately preceding thirty days.

9. "Established service area" means a geographic area, as approved by the commissioner and based upon the carrier's certificate of authority to transact business in this state, within which the carrier is authorized to provide coverage or a geographic area, as approved by the director and based upon the organized delivery system's license to transact business in this state, within which the organized delivery system is authorized to provide coverage.

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

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

12. "Organized delivery system" means an organized delivery system licensed by the director.

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

14. "Qualifying event" means any of the following:

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

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

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

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

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

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

c. An organized delivery system that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, provided that the benefits provided by the organized delivery system have been in effect for a period of at least one year.

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

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

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

Sec. 6. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

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

2. An affiliated carrier that is a health maintenance organization having a certificate of authority under section 513C.5 shall be considered to be a separate carrier for the purposes of this chapter.

Sec. 7. NEW SECTION. 513C.5 RESTRICTIONS RELATING TO PREMIUM RATES.

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

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

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

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

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

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

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

2. Notwithstanding subsection 1, the commissioner, with the concurrence of the board of the Iowa individual health benefit reinsurance association established in section 513C.10, may by order reduce or eliminate the allowed rating bands provided under subsection 1, paragraphs "a", "b", "c", and "e", or otherwise limit or eliminate the use of experience rating. The commissioner shall also develop a recommendation for the elimination of age as a rating characteristic, and shall submit such recommendation by January 8, 1996.

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

4. The commissioner may suspend for a specified period the application of subsection 1, paragraph "a", as to the premium

rates applicable to one or more blocks of business of a carrier for one or more rating periods upon a filing by the carrier requesting the suspension and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the carrier.

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

- a. The extent to which premium rates for a specified individual are established or adjusted based upon rating characteristics.
  - b. The carrier's right to change premium rates, and the factors, other than claim experience, that affect changes in premium rates.
  - c. The provisions relating to the renewal of policies and contracts.
  - d. Any provisions relating to any preexisting condition.
  - e. All plans offered by the carrier, the prices of such plans, and the availability of such plans to the individual.
6. A carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

7. A carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner and shall contain information as specified by the commissioner. A copy of the certification shall be retained by the carrier at its principal place of business. Rate adjustments made in order to comply with this section are exempt from loss ratio requirements.

8. A carrier shall make the information and documentation maintained pursuant to subsection 5 available to the commissioner upon request. The information and documentation shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

Sec. 8. NEW SECTION. 513C.6 RENEWAL OF COVERAGE.

1. An individual health benefit plan is renewable at the option of the individual, except in any of the following cases:
- a. Nonpayment of the required premiums.
  - b. Fraud or misrepresentation.
  - c. The insured individual becomes eligible for Medicare coverage under Title XVIII of the federal Social Security Act.
  - d. The carrier elects not to renew all of its individual health benefit plans in the state. In such case, the carrier shall provide notice of the decision not to renew coverage to all affected individuals and to the commissioner in each state in which an affected insured individual is known to reside at least ninety days prior to the nonrenewal of the health benefit plan by the carrier. Notice to the commissioner under this paragraph shall be provided at least three working days prior to the notice to the affected individuals.
  - e. The commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders, or would impair the carrier's ability to meet its contractual obligations.
2. A carrier that elects not to renew all of its individual health benefit plans in this state shall be prohibited from writing new individual health benefit plans in this state for a period of five years from the date of the notice to the commissioner.
3. With respect to a carrier doing business in an established geographic service area of the state, this section applies only to the carrier's operations in the service area.

Sec. 9. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

1. A carrier or an organized delivery system, as a condition of issuing individual health benefit plans in this state, shall make available a basic or standard health benefit plan to an eligible individual who applies for a plan and agrees to make the required premium payments and to satisfy other reasonable provisions of the basic or standard health benefit plan. A carrier or an organized delivery system is not required to issue a basic or standard health benefit plan to an individual who meets any of the following criteria:

a. The individual is covered or is eligible for coverage under a health benefit plan provided by the individual's employer.

b. An eligible individual who does not apply for a basic or standard health benefit plan within thirty days of a qualifying event or within thirty days upon becoming ineligible for qualifying existing coverage.

c. The individual is covered or is eligible for any continued group coverage under section 4980b of the Internal Revenue Code, sections 601 through 608 of the federal Employee Retirement Income Security Act of 1974, sections 2201 through 2208 of the federal Public Health Service Act, or any state-required continued group coverage. For purposes of this subsection, an individual who would have been eligible for such continuation of coverage, but is not eligible solely because the individual or other responsible party failed to make the required coverage election during the applicable time period, is deemed to be eligible for such group coverage until the date on which the individual's continuing group coverage would have expired had an election been made.

2. A carrier or an organized delivery system shall issue the basic or standard health benefit plan to an individual currently covered by an underwritten benefit plan issued by that carrier or an organized delivery system at the option of the individual. This option must be exercised within thirty

days of notification of a premium rate increase applicable to the underwritten benefit plan.

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

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

b. An organized delivery system shall file with the director, in a form and manner prescribed by the director, the basic or standard health benefit plan to be used by the organized delivery system. A basic or standard health benefit plan filed pursuant to this paragraph may be used by the organized delivery system beginning thirty days after it is filed unless the director disapproves of its use.

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

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

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

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

(3) A pregnancy existing on the effective date of coverage.

b. A carrier or an organized delivery system shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage.

5. A carrier or an organized delivery system is not required to offer coverage or accept applications pursuant to subsection 1 from any individual not residing in the carrier's or the organized delivery system's established geographic access area.

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

Sec. 10. NEW SECTION. 513C.8 HEALTH BENEFIT PLAN STANDARDS.

The commissioner shall adopt by rule the form and level of coverage of the basic health benefit plan and the standard health benefit plan for the individual market which shall provide benefits substantially similar to those as provided for under chapter 513B with respect to small group coverage, but which shall be appropriately adjusted to reflect the individual market.

Sec. 11. NEW SECTION. 513C.9 STANDARDS TO ASSURE FAIR MARKETING.

1. A carrier or an organized delivery system issuing individual health benefit plans in this state shall make available the basic or standard health benefit plan to residents of this state. If a carrier or an organized delivery system denies other individual health benefit plan coverage to an eligible individual on the basis of the health status or claims experience of the eligible individual, or the individual's dependents, the carrier or the organized delivery system shall offer the individual the opportunity to purchase a basic or standard health benefit plan.

2. A carrier, or an organized delivery system, or an agent shall not do either of the following:

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

b. Encourage or direct individuals to seek coverage from another carrier or another organized delivery system because of the health status, claims experience, industry, occupation, or geographic location of the individuals.

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

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



5. Subsection 4 does not apply with respect to the compensation paid to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status or other permitted rating characteristics of the individual or the individual's dependents.

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

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

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

Sec. 12. NEW SECTION. 513C.10 IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE ASSOCIATION.

1. A nonprofit corporation is established to be known as the Iowa individual health benefit reinsurance association. All persons that provide health benefit plans in this state including insurers providing accident and sickness insurance under chapter 509, 514, or 514A; fraternal benefit societies providing hospital, medical, or nursing benefits under chapter 512B; health maintenance organizations, organized delivery systems, and all other entities providing health insurance or health benefits subject to state insurance regulation shall be members of this association. The association shall be incorporated under chapter 504A, shall operate under a plan of operation established and approved pursuant to chapter 504A, and shall exercise its powers through a board of directors established under this section.

2. The initial board of directors of the association shall consist of seven members appointed by the commissioner as follows:

a. Four members shall be representatives of the four largest domestic carriers of individual health insurance in the state as of the calendar year ending December 31, 1994.

b. Three members shall be representatives of the three largest carriers of health insurance in the state, excluding Medicare supplement coverage premiums, which are not otherwise represented. In the event a carrier to be represented pursuant to this paragraph does not appoint a representative, the board member shall be a representative of the next largest carrier which satisfies the criteria.

After an initial term, board members shall be nominated and elected by the members of the association.

Members of the board may be reimbursed from the funds of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

3. The association shall submit to the commissioner a plan of operation for the association and any amendments to the association's articles of incorporation necessary and appropriate to assure the fair, reasonable, and equitable administration of the association. The plan shall provide for the sharing of losses related to basic and standard plans, if any, on an equitable and proportional basis among the members of the association. If the association fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, the commissioner shall adopt rules necessary to implement this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

a. The handling and accounting of assets and funds of the association.

- b. The amount of and method for reimbursing the expenses of board members.
  - c. Regular times and places for meetings of the board of directors.
  - d. Records to be kept relating to all financial transactions, and annual fiscal reporting to the commissioner.
  - e. Procedures for selecting the board of directors.
  - f. Additional provisions necessary or proper for the execution of the powers and duties of the association.
4. The plan of operation may provide that the powers and duties of the association may be delegated to a person who will perform functions similar to those of the association. A delegation under this section takes effect only upon the approval of the board of directors.
5. The association has the general powers and authority enumerated by this section and executed in accordance with the plan of operation approved by the commissioner under subsection 3. In addition, the association may do any of the following:
- a. Enter into contracts as necessary or proper to administer this chapter.
  - b. Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments for, on behalf of, or against members of the association or other participating persons.
  - c. Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, including the hiring of independent consultants as necessary.
  - d. Perform any other functions within the authority of the association.
6. Rates for basic and standard coverages as provided in this chapter shall be determined by each carrier or organized delivery system as the average of the lowest rate available for issuance by that carrier or organized delivery system

adjusted for rating characteristics and benefits and the maximum rate allowable by law after adjustments for rate characteristics and benefits.

7. Following the close of each calendar year, the association, in conjunction with the commissioner, shall require each carrier or organized delivery system to report the amount of earned premiums and the associated paid losses for all basic and standard plans issued by the carrier or organized delivery system. The reporting of these amounts must be certified by an officer of the carrier or organized delivery system.

8. The board shall develop procedures and make assessments and distributions as required to equalize the individual carrier and organized delivery system gains or losses so that each carrier or organized delivery system receives the same ratio of paid claims to ninety percent of earned premiums as the aggregate of all basic and standard plans insured by all carriers and organized delivery systems in the state.

9. If the statewide aggregate ratio of paid claims to ninety percent of earned premiums is greater than one, the dollar difference between ninety percent of earned premiums and the paid claims shall represent an assessable loss.

10. The assessable loss plus necessary operating expenses for the association, plus any additional expenses as provided by law, shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year, or on any other equitable basis as provided in the plan of operation. In sharing losses, the association may abate or defer any part of the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial

or interim assessment against the members of the association to meet the operating expenses of the association until the next calendar year is completed.

11. The board shall develop procedures for distributing the assessable loss assessments to each carrier and organized delivery system in proportion to the carrier's and organized delivery system's respective share of premium for basic and standard plans to the statewide total premium for all basic and standard plans.

12. The board shall ensure that procedures for collecting and distributing assessments are as efficient as possible for carriers and organized delivery systems. The board may establish procedures which combine, or offset, the assessment from, and the distribution due to, a carrier or organized delivery system.

13. A carrier or an organized delivery system may petition the association board to seek remedy from writing a significantly disproportionate share of basic and standard policies in relation to total premiums written in this state for health benefit plans. Upon a finding that a carrier or organized delivery system has written a disproportionate share, the board may agree to compensate the carrier or organized delivery system either by paying to the carrier or organized delivery system an additional fee not to exceed two percent of earned premiums from basic and standard policies for that carrier or organized delivery system or by petitioning the commissioner or director, as appropriate for remedy.

14. a. The commissioner, upon a finding that the acceptance of the offer of basic and standard coverage by individuals pursuant to this chapter would place the carrier in a financially impaired condition, shall not require the carrier to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.

b. The director, upon a finding that the acceptance of the offer of basic and standard coverage by individuals pursuant to this chapter would place the organized delivery system in a financially impaired condition, shall not required the organized delivery system to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.

Sec. 13. NEW SECTION. 513C.11 SELF-FUNDED EMPLOYER-SPONSORED HEALTH BENEFIT PLAN PARTICIPATION IN IOWA INDIVIDUAL HEALTH BENEFIT REINSURANCE ASSOCIATION.

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

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

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

Sec. 14. EFFECTIVE DATE. Sections 1 and 2 of this Act, which amend section 422.7 by adding a new subsection 32, and section 422.9, subsection 2, by adding a new paragraph "i",

are effective January 1, 1996, for tax years beginning on or after that date.

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LEONARD L. BOSWELL  
President of the Senate

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RON J. CORBETT  
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 84, Seventy-sixth General Assembly.

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JOHN F. DWYER  
Secretary of the Senate

Approved March 2, 1995

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TERRY E. BRANSTAD  
Governor