Senate Study Bill 53

Conference Committee Text

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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 insurance for the taxpayer or taxpayer's spouse or dependent.

Sec. 2. NEW SECTION. 505.22 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. 3. Section 507B.4, subsection 1, Code 1995, is amended by adding the following new paragraph:

NEW PARAGRAPH. k. Misrepresents the access to health care practitioners under a managed care health plan. The commissioner shall adopt rules providing for monitoring of such plans.

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

(3) The individual requests enrollment within

~~thirty~~ sixty days after termination of the qualifying previous coverage.

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

c. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and the request for enrollment is made within

~~thirty~~ sixty days after issuance of the court order.

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

a. What benefits or direct pay requirements must be

minimally included in a basic or standard benefit coverage policy or subscription contract.

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

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

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

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

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

1. The division shall adopt rules to implement and administer the premium credit authorized by this section, which rules shall include the minimum standard application form for premium credit eligibility. Forms shall be printed by participating insurance companies, health maintenance organizations, or health insurance purchasing cooperatives and provided to individuals wishing to apply for premium credit eligibility.

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

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

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

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

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

a. A basic benefit plan approved by the commissioner.

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

7. The policy shall also satisfy any conditions imposed by rules adopted pursuant to subsection 1 which the commissioner determines are necessary or convenient to implement and

administer the premium credit.

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

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

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

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

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

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

Sec. 10. 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. 11. 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.

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 providing hospital or medical expense incurred coverage to individuals. 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 or other objective 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. 12. NEW SECTION. 513C.4 APPLICABILITY AND SCOPE.

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

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. 13. 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 July 1, 1995, by a carrier subject to this chapter are subject to the composite effect of all of 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. Rating characteristics other than age, geographic area, and family composition shall not be used by a carrier without the prior approval of the commissioner.

e. 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.

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

g. 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 "f", 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. 14. 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. 15. NEW SECTION. 513C.7 AVAILABILITY OF COVERAGE.

1. A carrier or an organized delivery system issuing an individual health benefit plan in this state shall issue 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 to be used by the carrier. 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. 16. 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 be substantially similar to those as provided for under chapter 513B with respect to small group coverage.

Sec. 17. 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. 18. 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 carriers of individual health insurance in the state, excluding medicare supplement coverage premiums, as of the calendar year ending December 31, 1994.

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

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 rate 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 the organized delivery system.

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

9. The 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 members of the association if necessary to assure the financial viability of the association to meet the operating expenses of the association until the next calendar year is completed.

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

11. 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 the state for health benefit plans. Upon a finding that a carrier or an organized delivery system has written a disproportionate share, the board may agree to compensate the carrier or the organized delivery system either by paying to the carrier or the 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.

12. 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 individual health insurance 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 require the organized delivery system to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.

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

1. The insurance division shall annually provide a written report to the general assembly beginning January 1, 1996, which evaluates the effect of this chapter on providing universal coverage for all Iowans. This report may be completed in conjunction with the report required by section 505.21 relating to the establishment of a requirement that an employer provide access to health care to the employer's employees.

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

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

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

Sec. 21. INTERIM STUDY REQUEST. The legislative council is requested to establish an interim study committee to review the potential for adoption of a variety of plans which may be formed to enable an individual or family to participate in financial instruments which provide for accumulation of deposits for the potential payment of health care expenditures. In particular, the committee should review the potential offered by family health accounts and their applicability in the provision of health security for individuals and families. Issues to be reviewed shall include limitations on deposits, extent of usage for health care expenditures, tax consequences, extent to which deposits can be used, the role of financial institutions, withdrawal parameters, and penalties. A report with recommendations shall be presented to the general assembly no later than January 3, 1996.

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

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

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

EXPLANATION

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

Section 422.7 is amended to implement the deduction of 100 percent of a taxpayer's cost for the purchase of health insurance from adjusted gross income in computing state individual income tax.

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

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

Section 513B.2, subsection 12, which defines a late

enrollee for purposes of small group health coverage, is amended to not include an individual, or a spouse or minor dependent child under a court order requiring coverage, who, in addition to existing requirements, requests enrollment within 60 days after termination of qualifying previous coverage for an individual, or within 60 days after the issuance of the court order. Currently, such request for coverage must be made within 30 days.

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

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

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

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

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

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

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

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

New section 513C.6 relates to the renewal of an individual health benefit plan. Such plan is renewable at the option of the individual, except under certain enumerated circumstances. The section also provides that 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 required to be provided to the commissioner of such election.

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

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

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

New section 513C.10 establishes an Iowa individual health benefit reinsurance association to 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.

New section 513C.11 is established requiring the insurance division to annually report to the general assembly regarding the effect of new chapter 513C on providing universal coverage

for all Iowans, and regarding the number of aggregate number of insureds who have coverage through an individual health benefit plan issued under chapter 513C.

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

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

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

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