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Place On Calendar

HOUSE FILE 701
BY COMMITTEE ON COMMERCE AND
REGULATION

(SUCCESSOR TO HSB 235)

(P.1194)

Passed House, Date 3/25/97 (p.804) Passed Senate, Date 4-16-97
Vote: Ayes 99 Nays 0 Vote: Ayes 46 Nays 0
Approved May 1, 1997

A BILL FOR

1 An Act relating to the requirements for portability and
2 continuity of health care coverage for individuals among
3 certain types of health care coverage, and related matters.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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HF 701

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1 Section 1. Section 509.3, Code 1997, is amended by adding
2 the following new unnumbered paragraph:

3 NEW UNNUMBERED PARAGRAPH. In addition to the provisions
4 required in subsections 1 through 8, the commissioner shall
5 require provisions through the adoption of rules implementing
6 the federal Health Insurance Portability and Accountability
7 Act, Pub. L. No. 104-191.

8 Sec. 2. Section 513B.2, subsection 4, Code 1997, is
9 amended by striking the subsection and inserting in lieu
10 thereof the following:

11 4. "Carrier" means an entity subject to the insurance laws
12 and regulations of this state, or subject to the jurisdiction
13 of the commissioner, that contracts or offers to contract to
14 provide, deliver, arrange for, pay for, or reimburse any of
15 the costs of health care services, including an insurance
16 company offering sickness and accident plans, a health
17 maintenance organization, a nonprofit health service
18 corporation, or any other entity providing a plan of health
19 insurance, health benefits, or health services.

20 Sec. 3. Section 513B.2, subsection 10, Code 1997, is
21 amended by striking the subsection and inserting in lieu
22 thereof the following:

23 10. a. "Health insurance coverage" means benefits
24 consisting of health care provided directly, through insurance
25 or reimbursement, or otherwise and including items and
26 services paid for as health care under a hospital or health
27 service policy or certificate, hospital or health service plan
28 contract, or health maintenance organization contract offered
29 by a carrier.

30 b. "Health insurance coverage" does not include any of the
31 following:

32 (1) Coverage for accident-only, or disability income
33 insurance.

34 (2) Coverage issued as a supplement to liability
35 insurance.

- 1 (3) Liability insurance, including general liability
2 insurance and automobile liability insurance.
3 (4) Workers' compensation or similar insurance.
4 (5) Automobile medical-payment insurance.
5 (6) Credit-only insurance.
6 (7) Coverage for on-site medical clinic care.
7 (8) Other similar insurance coverage, specified in federal
8 regulations, under which benefits for medical care are
9 secondary or incidental to other insurance coverage or
10 benefits.

11 c. "Health insurance coverage" does not include benefits
12 provided under a separate policy as follows:

- 13 (1) Limited scope dental or vision benefits.
14 (2) Benefits for long-term care, nursing home care, home
15 health care, or community-based care.
16 (3) Any other similar limited benefits as provided by rule
17 of the commissioner.

18 d. "Health insurance coverage" does not include benefits
19 offered as independent noncoordinated benefits as follows:

- 20 (1) Coverage only for a specified disease or illness.
21 (2) A hospital indemnity or other fixed indemnity
22 insurance.

23 e. "Health insurance coverage" does not include Medicare
24 supplemental health insurance as defined under § 1882(g)(1) of
25 the federal Social Security Act, coverage supplemental to the
26 coverage provided under 10 U.S.C. ch. 55, and similar
27 supplemental coverage provided to coverage under group health
28 insurance coverage.

29 f. "Group health insurance coverage" means health
30 insurance coverage offered in connection with a group health
31 plan.

32 Sec. 4. Section 513B.2, subsection 12, paragraph a, Code
33 1997, is amended to read as follows:

34 a. The individual meets all of the following:

- 35 (1) The individual was covered under ~~qualifying-previous~~

1 creditable coverage at the time of the initial enrollment.

2 (2) The individual lost creditable coverage under
3 qualifying-previous-coverage as a result of termination of the
4 individual's employment or eligibility, the involuntary
5 termination of the qualifying-previous creditable coverage,
6 death of the individual's spouse, or the individual's divorce.

7 (3) The individual requests enrollment within thirty days
8 after termination of the qualifying-previous creditable
9 coverage.

10 Sec. 5. Section 513B.2, subsection 12, Code 1997, is
11 amended by adding the following new paragraphs:

12 NEW PARAGRAPH. d. The individual changes status and
13 becomes an eligible employee and requests enrollment within
14 sixty-three days after the date of the change in status.

15 NEW PARAGRAPH. e. The individual was covered under a
16 mandated continuation of group health plan or group health
17 insurance coverage plan until the coverage under that plan was
18 exhausted.

19 Sec. 6. Section 513B.2, Code 1997, is amended by adding
20 the following new subsections:

21 NEW SUBSECTION. 7A. "Creditable coverage" means health
22 benefits or coverage provided to an individual under any of
23 the following:

24 a. A group health plan.

25 b. Health insurance coverage.

26 c. Part A or Part B Medicare pursuant to Title XVIII of
27 the federal Social Security Act.

28 d. Medicaid pursuant to Title XIX of the federal Social
29 Security Act, other than coverage consisting solely of
30 benefits under section 1928 of that Act.

31 e. 10 U.S.C. ch. 55.

32 f. A health or medical care program provided through the
33 Indian health service or a tribal organization.

34 g. A state health benefits risk pool.

35 h. A health plan offered under 5 U.S.C. ch. 89.

1 i. A public health plan as defined under federal
2 regulations.

3 j. A health benefit plan under section 5(e) of the federal
4 Peace Corps Act, 22 U.S.C. § 2504(e).

5 k. An organized delivery system licensed by the director
6 of public health.

7 NEW SUBSECTION. 9A. a. "Group health plan" means an
8 employee welfare benefit plan as defined in section 3(1) of
9 the federal Employee Retirement Income Security Act of 1974,
10 to the extent that the plan provides medical care including
11 items and services paid for as medical care to employees or
12 their dependents as defined under the terms of the plan
13 directly or through insurance, reimbursement, or otherwise.

14 b. For purposes of this subsection, "medical care" means
15 amounts paid for any of the following:

16 (1) The diagnosis, cure, mitigation, treatment, or
17 prevention of disease, or amounts paid for the purpose of
18 affecting a structure or function of the body.

19 (2) Transportation primarily for and essential to medical
20 care referred to in subparagraph (1).

21 (3) Insurance covering medical care referred to in
22 subparagraph (1) or (2).

23 NEW SUBSECTION. 13A. "Preexisting conditions exclusion"
24 means, with respect to health insurance coverage, a limitation
25 or exclusion of benefits relating to a condition based on the
26 fact that the condition was present before the date of
27 enrollment for such coverage, whether or not any medical
28 advice, diagnosis, care, or treatment was recommended or
29 received before such date.

30 Sec. 7. Section 513B.2, subsection 14, Code 1997, is
31 amended by striking the subsection.

32 Sec. 8. Section 513B.5, Code 1997, is amended by striking
33 the section and inserting in lieu thereof the following:

34 513B.5 PROVISIONS ON RENEWABILITY OF COVERAGE.

35 1. Health insurance coverage subject to this chapter is

1 renewable with respect to all eligible employees or their
2 dependents, at the option of the small employer, except for
3 one or more of the following reasons:

4 a. The health insurance coverage sponsor fails to pay, or
5 to make timely payment of, premiums or contributions pursuant
6 to the terms of the health insurance coverage.

7 b. The health insurance coverage sponsor performs an act
8 or practice constituting fraud or makes an intentional
9 misrepresentation of a material fact under the terms of the
10 coverage.

11 c. Noncompliance with the carrier's or organized delivery
12 system's minimum participation requirements.

13 d. Noncompliance with the carrier's or organized delivery
14 system's employer contribution requirements.

15 e. A decision by the carrier or organized delivery system
16 to discontinue offering a particular type of health insurance
17 coverage in the state's small employer market. Health
18 insurance coverage may be discontinued by the carrier or
19 organized delivery system in that market only if the carrier
20 or organized delivery system does all of the following:

21 (1) Provides advance notice of its decision to discontinue
22 such plan to the commissioner or director of public health.
23 Notice to the commissioner or director, at a minimum, shall be
24 no less than three days prior to the notice provided for in
25 subparagraph (2) to affected small employers, participants,
26 and beneficiaries.

27 (2) Provides notice of its decision not to renew such plan
28 to all affected small employers, participants, and
29 beneficiaries no less than ninety days prior to the nonrenewal
30 of the plan.

31 (3) Offers to each plan sponsor of the discontinued
32 coverage, the option to purchase any other coverage currently
33 offered by the carrier or organized delivery system to other
34 employers in this state.

35 (4) Acts uniformly, in opting to discontinue the coverage

1 and in offering the option under subparagraph (3), without
2 regard to the claims experience of the sponsors under the
3 discontinued coverage or to a health status-related factor
4 relating to any participants or beneficiaries covered or new
5 participants or beneficiaries who may become eligible for the
6 coverage.

7 f. A decision by the carrier or organized delivery system
8 to discontinue offering and to cease to renew all of its
9 health insurance coverage delivered or issued for delivery to
10 small employers in this state. A carrier or organized
11 delivery system making such decision shall do all of the
12 following:

13 (1) Provide advance notice of its decision to discontinue
14 such coverage to the commissioner or director of public
15 health. Notice to the commissioner or director, at a minimum,
16 shall be no less than three days prior to the notice provided
17 for in subparagraph (2) to affected small employers,
18 participants, and beneficiaries.

19 (2) Provide notice of its decision not to renew such
20 coverage to all affected small employers, participants, and
21 beneficiaries no less than one hundred eighty days prior to
22 the nonrenewal of the coverage.

23 (3) Discontinue all health insurance coverage issued or
24 delivered for issuance to small employers in this state and
25 cease renewal of such coverage.

26 g. The membership of an employer in an association, which
27 is the basis for the coverage which is provided through such
28 association, ceases, but only if the termination of coverage
29 under this paragraph occurs uniformly without regard to any
30 health status-related factor relating to any covered
31 individual.

32 h. The commissioner or director of public health finds
33 that the continuation of the coverage is not in the best
34 interests of the policyholders or certificate holders, or
35 would impair the carrier's or organized delivery system's

1 ability to meet its contractual obligations.

2 i. At the time of coverage renewal, a carrier or organized
3 delivery system may modify the health insurance coverage for a
4 product offered under group health insurance coverage in the
5 small group market, for coverage that is available in such
6 market other than only through one or more bona fide
7 associations, if such modification is consistent with the laws
8 of this state, and is effective on a uniform basis among group
9 health insurance coverage with that product.

10 2. A carrier or organized delivery system that elects not
11 to renew health insurance coverage under subsection 1,
12 paragraph "f", shall not write any new business in the small
13 employer market in this state for a period of five years after
14 the date of notice to the commissioner or director of public
15 health.

16 3. This section, with respect to a carrier or organized
17 delivery system doing business in one established geographic
18 service area of the state, applies only to such carrier's or
19 organized delivery system's operations in that service area.

20 Sec. 9. NEW SECTION. 513B.9A ELIGIBILITY TO ENROLL.

21 1. A group health plan or a carrier offering group health
22 insurance coverage in connection with a group health plan
23 shall not establish rules for eligibility, including continued
24 eligibility, of an individual to enroll under the terms of the
25 plan based on any of the following health status-related
26 factors in relation to the individual or a dependent of the
27 individual:

28 a. Health status.

29 b. Medical condition, including both physical and mental
30 conditions.

31 c. Claims experience.

32 d. Receipt of health care.

33 e. Medical history.

34 f. Genetic information.

35 g. Evidence of insurability, including conditions arising

1 out of acts of domestic violence.

2 h. Disability.

3 2. Subsection 1 does not require a group health plan or
4 group health insurance coverage to provide particular benefits
5 other than those provided under the terms of the plan or
6 coverage, and does not prevent a plan or coverage from
7 establishing limitations or restrictions on the amount, level,
8 extent, or nature of the benefits or coverage for similarly
9 situated individuals enrolled in the plan or coverage.

10 3. Rules for eligibility to enroll under a group health
11 plan or group health insurance coverage include rules defining
12 any applicable waiting periods for such enrollment.

13 4. a. A group health plan or carrier offering health
14 insurance coverage in connection with a group health plan
15 shall not require an individual, as a condition of enrollment
16 or continued enrollment under the plan, to pay a premium or
17 contribution which is greater than a premium or contribution
18 for a similarly situated individual enrolled in the plan on
19 the basis of a health status-related factor in relation to the
20 individual or to a dependent of an individual enrolled under
21 the plan.

22 b. Paragraph "a" shall not be construed to do either of
23 the following:

24 (1) Restrict the amount that an employer may be charged
25 for coverage under a group health plan.

26 (2) Prevent a carrier or organized delivery system
27 offering group health insurance coverage from establishing
28 premium discounts or rebates or modifying otherwise applicable
29 copayments or deductibles in return for adherence to programs
30 of health promotion and disease prevention.

31 Sec. 10. Section 513B.10, Code 1997, is amended by
32 striking the section and inserting in lieu thereof the
33 following:

34 513B.10 AVAILABILITY OF COVERAGE.

35 1. a. A carrier or an organized delivery system that

1 offers health insurance coverage in the small group market
2 shall accept every small employer that applies for health
3 insurance coverage and shall accept for enrollment under such
4 coverage every eligible individual who applies for enrollment
5 during the period in which the individual first becomes
6 eligible to enroll under the terms of the group health plan
7 and shall not place any restriction which is inconsistent with
8 eligibility rules established under this chapter. A carrier
9 or organized delivery system shall offer health insurance
10 coverage which constitutes a basic health benefit plan and
11 which constitutes a standard health benefit plan.

12 b. A carrier or organized delivery system that offers
13 health insurance coverage in the small group market through a
14 network plan may do either of the following:

15 (1) Limit employers that may apply for such coverage to
16 those with eligible individuals who live, work, or reside in
17 the service area for such network plan.

18 (2) Deny such coverage to such employers within the
19 service area of such plan if the carrier or organized delivery
20 system has demonstrated, if required, to the applicable state
21 authority, both of the following:

22 (a) The carrier or organized delivery system will not have
23 the capacity to deliver services adequately to enrollees of
24 any additional groups because of its obligations to existing
25 group contract holders and enrollees.

26 (b) The carrier or organized delivery system is applying
27 this subparagraph uniformly to all employers without regard to
28 the claims experience of those employers and their employees
29 and their dependents, or any health status-related factor
30 relating to such employees or dependents.

31 c. A carrier or organized delivery system, upon denying
32 health insurance coverage in any service area pursuant to
33 paragraph "b", subparagraph (2), shall not offer coverage in
34 the small group market within such service area for a period
35 of one hundred eighty days after the date such coverage is

1 denied.

2 d. A carrier or organized delivery system may deny health
3 insurance coverage in the small group market if the issuer has
4 demonstrated, if required, to the commissioner or director of
5 public health both of the following:

6 (1) The carrier or organized delivery system does not have
7 the financial reserves necessary to underwrite additional
8 coverage.

9 (2) The carrier or organized delivery system is applying
10 the provisions of this subparagraph uniformly to all employers
11 in the small group market in this state consistent with state
12 law and without regard to the claims experience of those
13 employers and the employees and dependents of such employers,
14 or any health status-related factor relating to such employees
15 and their dependents.

16 e. A carrier or organized delivery system, upon denying
17 health insurance coverage in connection with group health
18 plans pursuant to paragraph "d", shall not offer coverage in
19 connection with group health plans in the small group market
20 in this state for a period of one hundred eighty days after
21 the date such coverage is denied or until the carrier or
22 organized delivery system has demonstrated to the commissioner
23 or director of public health that the carrier or organized
24 delivery system has sufficient financial reserves to
25 underwrite additional coverage, whichever is later. The
26 commissioner or director may provide for the application of
27 this paragraph on a service area-specific basis.

28 f. Paragraph "a" shall not be construed to preclude a
29 carrier or organized delivery system from establishing
30 employer contribution rules or group participation rules for
31 the offering of health insurance coverage in connection with a
32 group health plan in the small group market.

33 2. A carrier or organized delivery system, subject to
34 subsection 1, shall issue health insurance coverage to an
35 eligible small employer that applies for the coverage and

1 agrees to make the required premium payments and satisfy the
2 other reasonable provisions of the health insurance coverage
3 not inconsistent with this chapter. A carrier or organized
4 delivery system is not required to issue health insurance
5 coverage to a self-employed individual who is covered by, or
6 is eligible for coverage under, health insurance coverage
7 offered by an employer.

8 3. a. A carrier or organized delivery system shall file
9 with the commissioner or director of public health, in a form
10 and manner prescribed by the commissioner or director, the
11 basic health benefit plans and the standard health benefit
12 plans to be used by the carrier. Health insurance coverage
13 filed pursuant to this paragraph may be used by a carrier or
14 organized delivery system beginning thirty days after it is
15 filed unless the commissioner or director of public health
16 disapproves its use.

17 b. The commissioner or director of public health, at any
18 time after providing notice and opportunity for hearing to the
19 carrier or organized delivery system, may disapprove the
20 continued use of a basic or standard health benefit plan by a
21 carrier or organized delivery system on the grounds that the
22 plan does not meet the requirements of this chapter.

23 4. Health insurance coverage for small employers shall
24 satisfy all of the following:

25 a. A carrier or organized delivery system offering group
26 health insurance coverage, with respect to a participant or
27 beneficiary, may impose a preexisting condition exclusion only
28 as follows:

29 (1) The exclusion relates to a condition, whether physical
30 or mental, regardless of the cause of the condition, for which
31 medical advice, diagnosis, care, or treatment was recommended
32 or received within the six-month period ending on the
33 enrollment date. However, genetic information shall not be
34 treated as a condition under this subparagraph in the absence
35 of a diagnosis of the condition related to such information.

1 (2) The exclusion extends for a period of not more than
2 twelve months, or eighteen months in the case of a late
3 enrollee, after the enrollment date.

4 (3) The period of any such preexisting condition exclusion
5 is reduced by the aggregate of the periods of creditable
6 coverage applicable to the participant or beneficiary as of
7 the enrollment date.

8 b. A group health plan and a carrier or organized delivery
9 system offering group health insurance coverage shall not
10 impose any preexisting condition as follows:

11 (1) In the case of a child who is adopted or placed for
12 adoption before attaining eighteen years of age and who, as of
13 the last day of the thirty-day period beginning on the date of
14 the adoption or placement for adoption, is covered under
15 creditable coverage. This subparagraph shall not apply to
16 coverage before the date of such adoption or placement for
17 adoption.

18 (2) In the case of an individual who, as of the last day
19 of the thirty-day period beginning with the date of birth, is
20 covered under creditable coverage.

21 (3) Relating to pregnancy as a preexisting condition.

22 c. A carrier or organized delivery system shall waive any
23 waiting period applicable to a preexisting condition exclusion
24 or limitation period with respect to particular services under
25 health insurance coverage for the period of time an individual
26 was covered by creditable coverage, provided that the
27 creditable coverage was continuous to a date not more than
28 sixty-three days prior to the effective date of the new
29 coverage. Any period that an individual is in a waiting
30 period for any coverage under group health insurance coverage,
31 or is in an affiliation period, shall not be taken into
32 account in determining the period of continuous coverage. A
33 health maintenance organization that does not use preexisting
34 condition limitations in any of its health insurance coverage
35 may impose an affiliation period. For purposes of this

1 section, "affiliation period" means a period of time not to
2 exceed sixty days for new entrants and not to exceed ninety
3 days for late enrollees during which no premium shall be
4 collected and coverage issued is not effective, so long as the
5 affiliation period is applied uniformly, without regard to any
6 health status-related factors. This paragraph does not
7 preclude application of a waiting period applicable to all new
8 enrollees under the health insurance coverage, provided that
9 any carrier or organized delivery system-imposed waiting
10 period is no longer than sixty days and is used in lieu of a
11 preexisting condition exclusion.

12 d. Health insurance coverage may exclude coverage for late
13 enrollees for preexisting conditions for a period not to
14 exceed eighteen months.

15 e. (1) Requirements used by a carrier or organized
16 delivery system in determining whether to provide coverage to
17 a small employer shall be applied uniformly among all small
18 employers applying for coverage or receiving coverage from the
19 carrier or organized delivery system.

20 (2) In applying minimum participation requirements with
21 respect to a small employer, a carrier or organized delivery
22 system shall not consider employees or dependents who have
23 other creditable coverage in determining whether the
24 applicable percentage of participation is met.

25 (3) A carrier or organized delivery system shall not
26 increase any requirement for minimum employee participation or
27 modify any requirement for minimum employer contribution
28 applicable to a small employer at any time after the small
29 employer has been accepted for coverage.

30 f. (1) If a carrier or organized delivery system offers
31 coverage to a small employer, the carrier or organized
32 delivery system shall offer coverage to all eligible employees
33 of the small employer and the employees' dependents. A
34 carrier or organized delivery system shall not offer coverage
35 to only certain individuals or dependents in a small employer

1 group or to only part of the group.

2 (2) Except as provided under paragraphs "a" and "d", a
3 carrier or organized delivery system shall not modify health
4 insurance coverage with respect to a small employer or any
5 eligible employee or dependent through riders, endorsements,
6 or other means, to restrict or exclude coverage or benefits
7 for certain diseases, medical conditions, or services
8 otherwise covered by the health insurance coverage.

9 c. A carrier or organized delivery system offering
10 coverage through a network plan shall not be required to offer
11 coverage or accept applications pursuant to subsection 1 with
12 respect to a small employer where any of the following apply:

13 (1) The small employer does not have eligible individuals
14 who live, work, or reside in the service area for the network
15 plan.

16 (2) The small employer does have eligible individuals who
17 live, work, or reside in the service area for the network
18 plan, but the carrier or organized delivery system, if
19 required, has demonstrated to the commissioner or the director
20 of public health that it will not have the capacity to deliver
21 services adequately to enrollees of any additional groups
22 because of its obligations to existing group contract holders
23 and enrollees and that it is applying the requirements of this
24 lettered paragraph uniformly to all employers without regard
25 to the claims experience of those employers and their
26 employees and the employees' dependents, or any health status-
27 related factor relating to such employees and dependents.

28 (3) A carrier or organized delivery system, upon denying
29 health insurance coverage in a service area pursuant to
30 subparagraph (2), shall not offer coverage in the small
31 employer market within such service area for a period of one
32 hundred eighty days after the coverage is denied.

33 5. A carrier or organized delivery system shall not be
34 required to offer coverage to small employers pursuant to
35 subsection 1 for any period of time where the commissioner or

1 director of public health determines that the acceptance of
2 the offers by small employers in accordance with subsection 1
3 would place the carrier or organized delivery system in a
4 financially impaired condition.

5 6. A carrier or organized delivery system shall not be
6 required to provide coverage to small employers pursuant to
7 subsection 1 if the carrier or organized delivery system
8 elects not to offer new coverage to small employers in this
9 state. However, a carrier or organized delivery system that
10 elects not to offer new coverage to small employers under this
11 subsection shall be allowed to maintain its existing policies
12 in the state, subject to the requirements of section 513B.5.

13 7. A carrier or organized delivery system that elects not
14 to offer new coverage to small employers pursuant to
15 subsection 6 shall provide notice to the commissioner or
16 director of public health and is prohibited from writing new
17 business in the small employer market in this state for a
18 period of five years from the date of notice to the
19 commissioner or director.

20 Sec. 11. Section 513B.17, subsection 3, Code 1997, is
21 amended to read as follows:

22 3. The commissioner may adopt, by rule or order,
23 transition provisions to facilitate ~~the orderly and~~
24 ~~coordinated implementation of 1992 Iowa Acts, chapter 1167~~ the
25 implementation and administration of this chapter.

26 Sec. 12. Section 513C.6, Code 1997, is amended by striking
27 the section and inserting in lieu thereof the following:

28 513C.6 PROVISIONS ON RENEWABILITY OF COVERAGE.

29 1. An individual health benefit plan subject to this
30 chapter is renewable with respect to an eligible individual or
31 dependents, at the option of the individual, except for one or
32 more of the following reasons:

33 a. The individual fails to pay, or to make timely payment
34 of, premiums or contributions pursuant to the terms of the
35 individual health benefit plan.

1 b. The individual performs an act or practice constituting
2 fraud or makes an intentional misrepresentation of a material
3 fact under the terms of the individual health benefit plan.

4 c. A decision by the individual carrier or organized
5 delivery system to discontinue offering a particular type of
6 individual health benefit plan in the state's individual
7 insurance market. An individual health benefit plan may be
8 discontinued by the carrier or organized delivery system in
9 that market with the approval of the commissioner or the
10 director and only if the carrier or organized delivery system
11 does all of the following:

12 (1) Provides advance notice of its decision to discontinue
13 such plan to the commissioner or director. Notice to the
14 commissioner or director, at a minimum, shall be no less than
15 three days prior to the notice provided for in subparagraph
16 (2) to affected individuals.

17 (2) Provides notice of its decision not to renew such plan
18 to all affected individuals no less than ninety days prior to
19 the nonrenewal date of any discontinued individual health
20 benefit plans.

21 (3) Offers to each individual of the discontinued plan the
22 option to purchase any other health plan currently offered by
23 the carrier or organized delivery system to individuals in
24 this state.

25 (4) Acts uniformly in opting to discontinue the plan and
26 in offering the option under subparagraph (3), without regard
27 to the claims experience of any affected eligible individual
28 or beneficiary under the discontinued plan or to a health
29 status-related factor relating to any covered individuals or
30 beneficiaries who may become eligible for the coverage.

31 d. A decision by the carrier or organized delivery system
32 to discontinue offering and to cease to renew all of its
33 individual health benefit plans delivered or issued for
34 delivery to individuals in this state. A carrier or organized
35 delivery system making such decision shall do all of the

1 following:

2 (1) Provide advance notice of its decision to discontinue
3 such plan to the commissioner or director. Notice to the
4 commissioner or director, at a minimum, shall be no less than
5 three days prior to the notice provided for in subparagraph
6 (2) to affected individuals.

7 (2) Provide notice of its decision not to renew such plan
8 to all individuals and to the commissioner or director in each
9 state in which an individual under the discontinued plan is
10 known to reside no less than one hundred eighty days prior to
11 the nonrenewal of the plan.

12 e. The commissioner or director finds that the
13 continuation of the coverage is not in the best interests of
14 the individuals, or would impair the carrier's or organized
15 delivery system's ability to meet its contractual obligations.

16 2. At the time of coverage renewal, a carrier or organized
17 delivery system may modify the health insurance coverage for a
18 policy form offered to individuals in the individual market so
19 long as such modification is consistent with state law and
20 effective on a uniform basis among all individuals with that
21 policy form.

22 3. An individual carrier or organized delivery system that
23 elects not to renew an individual health benefit plan under
24 subsection 1, paragraph "d", shall not write any new business
25 in the individual market in this state for a period of five
26 years after the date of notice to the commissioner or
27 director.

28 4. This section, with respect to a carrier or organized
29 delivery system doing business in one established geographic
30 service area of the state, applies only to such carrier's or
31 organized delivery system's operations in that service area.

32 5. A carrier or organized delivery system offering
33 coverage through a network plan is not required to renew or
34 continue in force coverage or to accept applications from an
35 individual who no longer resides or lives in, or is no longer

1 employed in, the service area of such carrier or organized
2 delivery system, or no longer resides or lives in, or is no
3 longer employed in, a service area for which the carrier is
4 authorized to do business, but only if coverage is not offered
5 or terminated uniformly without regard to health status-
6 related factors of a covered individual.

7 Sec. 13. Section 513C.7, subsection 1, paragraph b, Code
8 1997, is amended to read as follows:

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

13 Sec. 14. Section 513C.7, subsection 2, Code 1997, is
14 amended to read as follows:

15 2. A carrier or an organized delivery system shall issue
16 the basic or standard health benefit plan to an individual
17 currently covered by an underwritten benefit plan issued by
18 that carrier or an organized delivery system at the option of
19 the individual. This option must be exercised within thirty
20 sixty-three days of notification of a premium rate increase
21 applicable to the underwritten benefit plan.

22 Sec. 15. Section 513C.7, subsection 4, paragraph b, Code
23 1997, is amended to read as follows:

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

33 Sec. 16. Section 513C.9, Code 1997, is amended by adding
34 the following new subsection:

35 NEW SUBSECTION. 4A. Notwithstanding subsection 4, a

1 commission shall be paid to an agent related to the sale of a
2 basic or standard health benefit plan under this chapter. A
3 commission paid pursuant to this subsection shall not be
4 considered by the board for purposes of section 513C.10,
5 subsection 9.

6 Sec. 17. NEW SECTION. 513C.12 COMMISSIONER'S DUTIES.

7 The commissioner shall adopt rules administering this
8 chapter.

9 Sec. 18. Section 514E.1, Code 1997, is amended by adding
10 the following new subsections:

11 NEW SUBSECTION. 3A. "Church plan" means as the same
12 defined in the federal Employee Retirement Income Security Act
13 of 1974, 29 U.S.C. § 3(33).

14 NEW SUBSECTION. 4A. "Creditable coverage" means health
15 benefits or coverage provided to an individual under any of
16 the following:

17 a. A group health plan.

18 b. Health insurance coverage.

19 c. Part A or Part B Medicare pursuant to Title XVIII of
20 the federal Social Security Act.

21 d. Medicaid pursuant to Title XIX of the federal Social
22 Security Act, other than coverage consisting solely of
23 benefits under section 1928 of that Act.

24 e. 10 U.S.C. ch. 55.

25 f. A health or medical care program provided through the
26 Indian health service or a tribal organization.

27 g. A state health benefits risk pool.

28 h. A health plan offered under 5 U.S.C. ch. 89.

29 i. A public health plan as defined under federal
30 regulations.

31 j. A health benefit plan under section 5(e) of the federal
32 Peace Corps Act, 22 U.S.C. § 2504(e).

33 k. An organized delivery system licensed by the director
34 of public health.

35 NEW SUBSECTION. 4B. "Director" means the director of

1 public health.

2 NEW SUBSECTION. 5A. "Federally eligible individual" means
3 an individual who satisfies any of the following:

4 a. For whom, as of the date on which the individual seeks
5 coverage under this chapter, the aggregate of the periods of
6 creditable coverage is eighteen or more months with no more
7 than a sixty-three day lapse of coverage, and whose most
8 recent prior creditable coverage was under a group health
9 plan, governmental plan, or church plan, or health insurance
10 coverage offered in connection with any such plan.

11 b. Who is not eligible for coverage under a group health
12 plan, Part A or Part B of Title XVIII of the federal Social
13 Security Act, or a state plan under Title XIX of that Act, or
14 any successor program, and does not have other health
15 insurance coverage.

16 c. With respect to whom the most recent coverage within
17 the coverage period described in paragraph "a" was not
18 terminated based on a nonpayment of premiums or fraud.

19 d. If the individual had been offered the option of
20 continuation coverage under a COBRA continuation provision or
21 under a similar state program, and elected such coverage.

22 e. Who, if the individual elected continuation coverage as
23 provided in paragraph "d", has exhausted the continuation
24 coverage under the provision or program.

25 NEW SUBSECTION. 5B. "Governmental plan" means as defined
26 under section 3(32) of the federal Employee Retirement Income
27 Security Act of 1974 and any federal governmental plan.

28 NEW SUBSECTION. 5C. a. "Group health plan" means an
29 employee welfare benefit plan as defined in section 3(1) of
30 the federal Employee Retirement Income Security Act of 1974,
31 to the extent that the plan provides medical care including
32 items and services paid for as medical care to employees or
33 their dependents as defined under the terms of the plan
34 directly or through insurance, reimbursement, or otherwise.

35 b. For purposes of this subsection, "medical care" means

1 amounts paid for any of the following:

2 (1) The diagnosis, cure, mitigation, treatment, or
3 prevention of disease, or amounts paid for the purpose of
4 affecting a structure or function of the body.

5 (2) Transportation primarily for and essential to medical
6 care referred to in subparagraph (1).

7 (3) Insurance covering medical care referred to in
8 subparagraph (1) or (2).

9 c. For purposes of this chapter, the following apply:

10 (1) A plan, fund, or program established or maintained by
11 a partnership which, but for this subsection, would not be an
12 employee welfare benefit plan, shall be treated as an employee
13 welfare benefit plan which is a group health plan to the
14 extent that the plan, fund, or program provides medical care,
15 including items and services paid for as medical care for
16 present or former partners in the partnership or to the
17 dependents of such partners, as defined under the terms of the
18 plan, fund, or program, either directly or through insurance,
19 reimbursement, or otherwise.

20 (2) With respect to a group health plan, the term
21 "employer" includes a partnership with respect to a partner.

22 (3) With respect to a group health plan, the term
23 participant includes the following:

24 (a) With respect to a group health plan maintained by a
25 partnership, an individual who is a partner in the
26 partnership.

27 (b) With respect to a group health plan maintained by a
28 self-employed individual under which one or more of the self-
29 employed individual's employees are participants, the self-
30 employed individual, if that individual is, or may become,
31 eligible to receive benefits under the plan or the
32 individual's dependents may be eligible to receive benefits
33 under the plan.

34 NEW SUBSECTION. 8A. a. "Health insurance coverage" means
35 health insurance coverage offered to individuals in the

1 individual market, but does not include short-term limited
2 duration insurance.

3 b. "Individual health insurance coverage" does not include
4 any of the following:

5 (1) Coverage for accident-only, or disability income
6 insurance.

7 (2) Coverage issued as a supplement to liability
8 insurance.

9 (3) Liability insurance, including general liability
10 insurance and automobile liability insurance.

11 (4) Workers' compensation or similar insurance.

12 (5) Automobile medical-payment insurance.

13 (6) Credit-only insurance.

14 (7) Coverage for on-site medical clinic care.

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

19 c. "Individual health insurance coverage" does not include
20 benefits provided under a separate policy as follows:

21 (1) Limited-scope dental or vision benefits.

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

24 (3) Any other similar limited benefits as provided by rule
25 of the commissioner.

26 d. "Individual health insurance coverage" does not include
27 benefits offered as independent noncoordinated benefits as
28 follows:

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

30 (2) A hospital indemnity or other fixed indemnity
31 insurance.

32 e. "Individual health insurance coverage" does not include
33 Medicare supplemental health insurance as defined under
34 section 1882(g)(1) of the federal Social Security Act,
35 coverage supplemental to the coverage provided under 10 U.S.C.

1 ch. 55 and similar supplemental coverage provided to coverage
2 under group health insurance coverage.

3 NEW SUBSECTION. 10A. "Involuntary termination" includes,
4 but is not limited to, termination of coverage when a
5 conversion policy is not available or where benefits under a
6 state or federal law providing for continuation of coverage
7 upon termination of employment will cease or have ceased.

8 NEW SUBSECTION. 12A. "Organized delivery system" means an
9 organized delivery system as licensed by the director of the
10 department of public health.

11 NEW SUBSECTION. 15. "Preexisting condition exclusion",
12 with respect to coverage, means a limitation or exclusion of
13 benefits relating to a condition based on the fact that the
14 condition was present before the date of enrollment for such
15 coverage, whether or not any medical advice, diagnosis, care,
16 or treatment was recommended or received before such date.

17 Sec. 19. Section 514E.1, subsection 9, Code 1997, is
18 amended by striking the subsection.

19 Sec. 20. Section 514E.2, subsection 1, Code 1997, is
20 amended to read as follows:

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

34 Sec. 21. Section 514E.2, subsection 12, Code 1997, is
35 amended by striking the subsection.

1 Sec. 22. Section 514E.6, subsection 3, paragraph e, Code
2 1997, is amended by striking the paragraph and inserting in
3 lieu thereof the following:

4 e. An amount as determined by the association for any
5 other association policy offered.

6 Sec. 23. Section 514E.6, subsection 6, Code 1997, is
7 amended by striking the subsection and inserting in lieu
8 thereof the following:

9 6. The association, in addition to other policies, shall
10 offer one which is comparable to the standard health benefit
11 plan as defined in section 513B.2.

12 Sec. 24. Section 514E.7, subsections 1, 2, and 5, Code
13 1997, are amended by striking the subsections and inserting in
14 lieu thereof the following:

15 1. An individual who is and continues to be a resident is
16 eligible for plan coverage if evidence is provided of any of
17 the following:

18 a. A notice of rejection or refusal to issue substantially
19 similar insurance for health reasons by one carrier.

20 b. A refusal by a carrier to issue insurance except at a
21 rate exceeding the plan rate.

22 c. That the individual is a federally defined eligible
23 individual.

24 A rejection or refusal by a carrier offering only stoploss,
25 excess of loss, or reinsurance coverage with respect to an
26 applicant under paragraphs "a" and "b" is not sufficient
27 evidence for purposes of this subsection.

28 5. a. A preexisting condition exclusion shall not apply
29 to a federally defined eligible individual.

30 b. Plan coverage shall not impose any preexisting
31 condition as follows:

32 (1) In the case of a child who is adopted or placed for
33 adoption before attaining eighteen years of age and who, as of
34 the last day of the thirty-day period beginning on the date of
35 the adoption or placement for adoption, is covered under

1 creditable coverage. This subparagraph shall not apply to
2 coverage before the date of such adoption or placement for
3 adoption.

4 (2) In the case of an individual who, as of the last day
5 of the thirty-day period beginning with the date of birth, is
6 covered under creditable coverage.

7 (3) Relating to pregnancy as a preexisting condition.

8 c. Plan coverage shall exclude charges or expenses
9 incurred during the first six months following the effective
10 date of coverage for preexisting conditions. Such preexisting
11 condition exclusions shall be waived to the extent that
12 similar exclusions, if any, have been satisfied under any
13 prior health insurance coverage which was involuntarily
14 terminated, provided both of the following apply:

15 (1) Application for association coverage is made no later
16 than sixty-three days following such involuntary termination
17 and, in such case, coverage under the plan is effective from
18 the date on which such prior coverage was terminated.

19 (2) The applicant is not eligible for continuation or
20 conversion rights that would provide coverage substantially
21 similar to plan coverage.

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

26 If the association policy contains a waiting period for
27 preexisting conditions, an insured may retain any existing
28 coverage the insured has under an insurance plan that has
29 coverage equivalent to the association policy for the duration
30 of the waiting period only.

31 Sec. 25. Section 514E.7, subsection 6, Code 1997, is
32 amended to read as follows:

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

35 a. The individual is at the time of application eligible

1 for health care benefits under chapter 249A.

2 b. The individual has terminated coverage by the
3 association within the past twelve months, except that this
4 paragraph does not apply to an applicant who is a federally
5 eligible individual.

6 c. The individual is an inmate of a public institution or
7 ~~is-eligible-for-public-programs-for-which-medical-care-is~~
8 provided, except that this paragraph does not apply to an
9 applicant who is a federally defined eligible individual.

10 d. The individual premiums are paid for or reimbursed
11 under any government sponsored program or by any government
12 agency or health care provider, except as an otherwise
13 qualifying full-time employee, or dependent of the employee,
14 of a government agency or health care provider.

15 e. The individual, on the effective date of the coverage
16 applied for, has not been rejected for, already has, or will
17 have coverage similar to an association policy as an insured
18 or covered dependent. This paragraph does not apply to an
19 applicant who is a federally eligible individual.

20 Sec. 26. Section 514E.9, Code 1997, is amended to read as
21 follows:

22 514E.9 RULES.

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

28 Sec. 27. Section 514E.11, Code 1997, is amended to read as
29 follows:

30 514E.11 NOTICE OF ASSOCIATION POLICY.

31 ~~Commencing July 17, 1986, every~~ Every carrier, including a
32 health maintenance organization subject to chapter 514B and an
33 organized delivery system, authorized to provide health care
34 insurance or coverage for health care services in Iowa, shall
35 provide a notice and-an-application-for of the availability of

1 coverage by the association to any person who receives a
2 rejection of coverage for health insurance or health care
3 services, or a notice to any person who is informed that a
4 rate for health insurance or coverage for health care services
5 will exceed the rate of an association policy, ~~that-effective~~
6 ~~January-17-1987~~, that person is eligible to apply for health
7 insurance provided by the association. Application for the
8 health insurance shall be on forms prescribed by the board and
9 made available to the carriers and organized delivery systems.

10

EXPLANATION

11 This bill enacts changes required as a result of passage of
12 the federal Health Insurance Portability and Accountability
13 Act, which was enacted in 1996 and provides for continuity of
14 coverage between self-funded plans and insured health care
15 plans. Provisions of Code chapters 509, 513B, 513C, and 514E
16 are amended.

17 The bill amends Code section 509.3 to authorize the
18 commissioner to adopt rules to conform the group health
19 insurance statute, Code chapter 509, to the health care
20 requirements of the federal law.

21 The bill creates new definitions in Code chapter 513B,
22 small group coverage, for key terms used, including "health
23 insurance coverage", "group health insurance coverage",
24 "creditable coverage", "group health plan", and "preexisting
25 conditions exclusion". The bill amends several definitions,
26 including the definitions of "carrier" and "late enrollee".

27 The bill extends the time period a person may go without
28 coverage and still be eligible upon application for subsequent
29 coverage from 30 days to 63 days. The bill also amends
30 provisions relating to renewability and availability of small
31 group coverage.

32 The bill provides that a small group policy is guaranteed
33 renewable with certain exceptions for nonpayment of premium,
34 fraud, noncompliance, or discontinuance of the plan or all
35 small group plans. The bill provides that all small group

1 policies will be guaranteed issue.

2 The bill amends provisions of Code chapter 513C, individual
3 health insurance market reform. The bill extends the time
4 which an eligible individual may go without coverage and still
5 be eligible for coverage from 30 days to 63 days. The bill
6 provides for the termination of a government health benefit
7 plan to be a qualifying event for portability to the
8 individual health care market. The bill amends provisions
9 relating to the renewability of health care coverage.

10 The bill provides that a commission shall be paid to an
11 agent related to the sale of an individual basic and standard
12 health benefit plan under chapter 513C.

13 The bill amends provisions of Code chapter 514E relating to
14 the Iowa comprehensive health insurance association. The bill
15 adds new definitions for key terms including "church plan",
16 "creditable coverage", "director", "federally eligible
17 individual", "governmental plan", "group health plan", "health
18 insurance coverage", "involuntary termination", "organized
19 delivery system", and "preexisting condition exclusion". The
20 bill also amends provisions relating to the availability of
21 coverage under the association.

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HOUSE FILE 701

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1 Amend House File 701 as follows:

2 1. Page 1, by inserting after line 7 the
3 following:

4 "Sec. ____ . Section 513B.2, subsection 1, Code
5 1997, is amended to read as follows:

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

16 2. Page 1, by inserting after line 19 the
17 following:

18 "Sec. ____ . Section 513B.2, subsection 6, paragraph
19 a, Code 1997, is amended to read as follows:

20 a. A distinct grouping may only be established by
21 the small employer carrier on the basis that the
22 applicable health ~~benefit-plans~~ insurance coverages
23 meet one or more of the following requirements:

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

29 (2) The ~~plans coverages~~ have been acquired from
30 another small employer carrier as a distinct grouping
31 of plans.

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

36 Sec. ____ . Section 513B.2, subsection 9, Code 1997,
37 is amended to read as follows:

38 9. "Eligible employee" means an employee who works
39 on a full-time basis and has a normal work week of
40 thirty or more hours. The term includes a sole
41 proprietor, a partner of a partnership, and an
42 independent contractor, if the sole proprietor,
43 partner, or independent contractor is included as an
44 employee under a ~~health-benefit-plan~~ health insurance
45 coverage of a small employer, but does not include an
46 employee who works on a part-time, temporary, or
47 substitute basis."

48 3. Page 2, lines 32 and 33, by striking the words
49 and figure "paragraph a, Code 1997, is" and inserting
50 the following: "paragraphs a, b, and c, Code 1997,

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1 are".

2 4. Page 3, by inserting after line 9 the
3 following:

4 "b. The individual is employed by an employer that
5 offers multiple health benefit-plans insurance
6 coverages and the individual elects a different plan
7 coverage during an open enrollment period.

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

13 5. Page 3, by inserting after line 18 the
14 following:

15 "Sec. ____ . Section 513B.2, subsection 13, Code
16 1997, is amended to read as follows:

17 13. "New business premium rate" means, for each
18 class of business as to a rating period, the lowest
19 premium rate charged or offered by the small employer
20 carrier to small employers with similar case
21 characteristics for newly issued health benefit-plans
22 insurance coverages with the same or similar
23 coverage."

24 6. Page 4, by inserting after line 22 the
25 following:

26 "c. For purposes of this subsection, a partnership
27 which establishes and maintains a plan, fund, or
28 program to provide medical care to present or former
29 partners in the partnership or to their dependents
30 directly or through insurance, reimbursement, or other
31 method, which would not be an employee benefit welfare
32 plan but for this paragraph, shall be treated as an
33 employee benefit welfare plan which is a group health
34 plan.

35 (1) For purposes of a group health plan, an
36 employer includes the partnership in relation to any
37 partner.

38 (2) For purposes of a group health plan, the term
39 "participant" also includes both of the following:

40 (a) An individual who is a partner in relation to
41 a partnership which maintains a group health plan.

42 (b) An individual who is a self-employed
43 individual in connection with a group health plan
44 maintained by the self-employed individual where one
45 or more employees are participants, if the individual
46 is or may become eligible to receive a benefit under
47 the plan or the individual's beneficiaries may be
48 eligible to receive a benefit."

49 7. Page 4, by inserting after line 31 the
50 following:

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1 "Sec. ____ . Section 513B.3, subsection 3, Code
2 1997, is amended to read as follows:

3 3. The health ~~benefit-plan~~ insurance coverage is
4 treated by the employer or any of the eligible
5 employees or dependents as part of a plan coverage or
6 program for the purposes of section 106, 125, or 162
7 of the Internal Revenue Code as defined in section
8 422.3.

9 Sec. ____ . Section 513B.3, subsection 4, paragraphs
10 a and c, Code 1997, are amended to read as follows:

11 a. Except as provided in paragraph "b", for
12 purposes of this subchapter, carriers that are
13 affiliated companies or that are eligible to file a
14 consolidated tax return shall be treated as one
15 carrier and any restrictions or limitations imposed by
16 this subchapter shall apply as if all health benefit
17 plans insurance coverages delivered or issued for
18 delivery to small employers in this state by such
19 carriers were issued by one carrier.

20 c. Unless otherwise authorized by the
21 commissioner, a small employer carrier shall not enter
22 into one or more ceding arrangements with respect to
23 health ~~benefit-plans~~ insurance coverages delivered or
24 issued for delivery to small employers in this state
25 if the arrangements would result in less than fifty
26 percent of the insurance obligation or risk for such
27 health ~~benefit-plans~~ insurance coverages being
28 retained by the ceding carrier.

29 Sec. ____ . Section 513B.4, subsection 1, paragraph
30 c, subparagraph (1), Code 1997, is amended to read as
31 follows:

32 (1) The percentage change in the new business
33 premium rate measured from the first day of the prior
34 rating period to the first day of the new rating
35 period. In the case of a class of business for which
36 the small employer carrier is not issuing new
37 policies, the small employer carrier shall use the
38 percentage change in the base premium rate, provided
39 that the change does not exceed, on a percentage
40 basis, the change in the new business premium rate for
41 the most similar health ~~benefit-plan~~ insurance
42 coverage into which the small employer carrier is
43 actively enrolling new insureds who are small
44 employers.

45 Sec. ____ . Section 513B.4, subsection 1, paragraph
46 d, Code 1997, is amended to read as follows:

47 d. In the case of health ~~benefit-plans~~ insurance
48 coverages issued prior to July 1, 1991, a premium rate
49 for a rating period may exceed the ranges described in
50 subsection 1, paragraph "a" or "b", for a period of

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1 three years following July 1, 1992. In such case, the
2 percentage increase in the premium rate charged to a
3 small employer in such a class of business for a new
4 rating period may not exceed the sum of the following:

5 (1) The percentage change in the new business
6 premium rate measured from the first day of the prior
7 rating period to the first day of the new rating
8 period. In the case of a class of business for which
9 the small employer carrier is not issuing new
10 policies, the small employer carrier shall use the
11 percentage change in the base premium rate, provided
12 that the change does not exceed, on a percentage
13 basis, the change in the new business premium rate for
14 the most similar health benefit-plan insurance
15 coverage into which the small employer carrier is
16 actively enrolling new insureds who are small
17 employers.

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

22 Sec. ____ . Section 513B.4, subsection 3, unnumbered
23 paragraph 3, Code 1997, is amended to read as follows:

24 Rating factors shall produce premiums for identical
25 groups which differ only by amounts attributable to
26 plan coverage design and do not reflect differences
27 due to the nature of the groups assumed to select
28 particular health benefit plans. A small employer
29 carrier shall treat all health benefit-plans insurance
30 coverages issued or renewed in the same calendar month
31 as having the same rating period.

32 Sec. ____ . Section 513B.4, subsection 4, Code 1997,
33 is amended to read as follows:

34 4. For purposes of this section, a health benefit
35 plan insurance coverage that contains a restricted
36 network provision shall not be considered similar
37 coverage to a health benefit-plan insurance coverage
38 that does not contain such a provision, if the
39 restriction of benefits to network providers results
40 in substantial differences in claims costs.

41 Sec. ____ . Section 513B.4A, Code 1997, is amended
42 to read as follows:

43 513B.4A EXEMPTION FROM PREMIUM RATE RESTRICTIONS.

44 A Taft-Hartley trust or a carrier with the written
45 authorization of such a trust may make a written
46 request to the commissioner for an exemption from the
47 application of any provisions of section 513B.4 with
48 respect to a health-benefit-plan health insurance
49 coverage provided to such a trust. The commissioner
50 may grant an exemption if the commissioner finds that

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1 application of section 513B.4 with respect to the
2 trust would have a substantial adverse effect on the
3 participants and beneficiaries of such trust, and
4 would require significant modifications to one or more
5 collective bargaining arrangements under which the
6 trust is established or maintained. An exemption
7 granted under this section shall not apply to an
8 individual if the individual participates in a trust
9 as an associate member of an employee organization."

10 8. Page 7, by inserting after line 19 the
11 following:

12 "Sec. _____. Section 513B.6, unnumbered paragraph 1,
13 Code 1997, is amended to read as follows:

14 A small employer carrier or organized delivery
15 system shall make reasonable disclosure in
16 solicitation and sales materials provided to small
17 employers of all of the following:

18 Sec. _____. Section 513B.6, subsection 2, Code 1997,
19 is amended to read as follows:

20 2. The provisions concerning the small employer
21 carrier's or organized delivery system's right to
22 change premium rates and factors, including case
23 characteristics, which affect changes in premium
24 rates.

25 Sec. _____. Section 513B.7, Code 1997, is amended to
26 read as follows:

27 513B.7 MAINTENANCE OF RECORDS.

28 1. A small employer carrier or organized delivery
29 system shall maintain at its principal place of
30 business a complete and detailed description of its
31 rating practices and renewal underwriting practices,
32 including information and documentation which
33 demonstrate that its rating methods and practices are
34 based upon commonly accepted actuarial assumptions and
35 are in accordance with sound actuarial principles.

36 2. A small employer carrier or organized delivery
37 system shall file each March 1 with the commissioner
38 or director an actuarial certification that the small
39 employer carrier or organized delivery system is in
40 compliance with this section and that the rating
41 methods of the small employer carrier or organized
42 delivery system are actuarially sound. A copy of the
43 certification shall be retained by the small employer
44 carrier or organized delivery system at its principal
45 place of business.

46 3. A small employer carrier or organized delivery
47 system shall make the information and documentation
48 described in subsection 1 available to the
49 commissioner or organized delivery system upon
50 request. The information is not a public record or

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- 1 otherwise subject to disclosure under chapter 22, and
2 is considered proprietary and trade secret information
3 and is not subject to disclosure by the commissioner
4 or director to persons outside of the division or
5 department except as agreed to by the small employer
6 carrier or organized delivery system or as ordered by
7 a court of competent jurisdiction."
- 8 9. Page 7, by striking lines 21 and 22 and
9 inserting the following:
10 "A carrier or organized delivery system offering
11 group health insurance coverage".
- 12 10. Page 7, line 25, by striking the word "plan"
13 and inserting the following: "coverage".
- 14 11. Page 8, by striking line 3, and inserting the
15 following:
16 "2. Subsection 1 does not require".
- 17 12. Page 8, line 5, by striking the words "plan
18 or".
- 19 13. Page 8, line 6, by striking the words "plan
20 or".
- 21 14. Page 8, line 9, by striking the words "plan
22 or".
- 23 15. Page 8, by striking lines 10 and 11 and
24 inserting the following:
25 "3. Rules for eligibility to enroll under group
26 health insurance coverage include rules defining".
- 27 16. Page 8, by striking lines 13 and 14 and
28 inserting the following:
29 "4. a. A carrier or organized delivery system
30 offering health insurance coverage".
- 31 17. Page 8, line 16, by striking the word "plan"
32 and inserting the following: "coverage".
- 33 18. Page 8, line 18, by striking the word "plan"
34 and inserting the following: "coverage".
- 35 19. Page 8, line 21, by striking the word "plan"
36 and inserting the following: "coverage".
- 37 20. Page 8, by striking line 25 and inserting the
38 following: "for health insurance coverage."
- 39 21. Page 9, line 6, by striking the words "group
40 health plan" and inserting the following: "health
41 insurance coverage".
- 42 22. Page 9, line 20, by striking the words ", if
43 required,".
- 44 23. Page 10, line 4, by striking the words ", if
45 required,".
- 46 24. Page 10, lines 17 and 18, by striking the
47 words "in connection with group health plans".
- 48 25. Page 10, line 19, by striking the words
49 "group health plans" and inserting the following:
50 "health insurance coverages".

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1 26. Page 10, lines 31 and 32, by striking the
2 words "in connection with a group health plan".

3 27. Page 11, line 12, by inserting after the word
4 "carrier" the following: "or organized delivery
5 system".

6 28. Page 12, line 8, by striking the words "group
7 health plan and a".

8 29. Page 15, by inserting after line 19 the
9 following:

10 "Sec. _____. Section 513B.11, subsection 2, Code
11 1997, is amended to read as follows:

12 2. A reinsuring carrier that applies and is
13 approved to operate as a risk-assuming carrier shall
14 not be permitted to continue to reinsure any health
15 ~~benefit-plan~~ insurance coverage with the program. The
16 carrier shall pay a prorated assessment based upon
17 business issued as a reinsuring carrier for any
18 portion of the year that the business was reinsured.

19 Sec. _____. Section 513B.13, subsection 7,
20 unnumbered paragraph 1, Code 1997, is amended to read
21 as follows:

22 The same general powers and authority granted under
23 the laws of this state to insurance companies and
24 health maintenance organizations licensed to transact
25 business in this state may be exercised by the board
26 under the program, except the power to issue health
27 ~~benefit-plans~~ insurance coverages directly to either
28 groups or individuals. Additionally, the board is
29 granted the specific authority to do all or any of the
30 following:

31 Sec. _____. Section 513B.13, subsection 7, paragraph
32 d, Code 1997, is amended to read as follows:

33 d. Define the health ~~benefit-plans~~ insurance
34 coverages for which reinsurance will be provided, and
35 issue reinsurance policies, pursuant to this
36 subchapter.

37 Sec. _____. Section 513B.13, subsection 8, paragraph
38 b, Code 1997, is amended to read as follows:

39 b. A small employer carrier may reinsure an entire
40 employer group within sixty days of the commencement
41 of the group's coverage under ~~a-health-benefit-plan~~
42 health insurance coverage.

43 Sec. _____. Section 513B.13, subsection 9, paragraph
44 a, Code 1997, is amended to read as follows:

45 a. The board, as part of the plan of operation,
46 shall establish a methodology for determining premium
47 rates to be charged by the program for reinsuring
48 small employers and individuals pursuant to this
49 section. The methodology shall include a system for
50 classification of small employers that reflects the

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1 types of case characteristics commonly used by small
2 employer carriers in the state. The methodology shall
3 provide for the development of base reinsurance
4 premium rates, which shall be multiplied by the
5 factors set forth in paragraph "b" to determine the
6 premium rates for the program. The base reinsurance
7 premium rates shall be established by the board,
8 subject to the approval of the commissioner, and shall
9 be set at levels which reasonably approximate gross
10 premiums charged to small employers by small employer
11 carriers for health ~~benefit-plans~~ insurance coverages
12 with benefits similar to the standard health benefit
13 plan.

14 Sec. _____. Section 513B.13, subsection 10, Code
15 1997, is amended to read as follows:

16 10. If ~~a-health-benefit-plan~~ health insurance
17 coverage for a small employer is entirely or partially
18 reinsured with the program, the premium charged to the
19 small employer for any rating period for the coverage
20 issued shall meet the requirements relating to premium
21 rates set forth in section 513B.4.

22 Sec. _____. Section 513B.13, subsection 11,
23 paragraph b, subparagraphs (1), (2), and (3), Code
24 1997, are amended to read as follows:

25 (1) The board shall establish, as part of the plan
26 of operation, a formula by which to make assessments
27 against reinsuring carriers. The assessment formula
28 shall be based on both of the following:

29 (a) Each reinsuring carrier's share of the total
30 premiums earned in the preceding calendar year from
31 health ~~benefit-plans~~ insurance coverages delivered or
32 issued for delivery to small employers in this state
33 by reinsuring carriers.

34 (b) Each reinsuring carrier's share of the
35 premiums earned in the preceding calendar year from
36 newly issued health ~~benefit-plans~~ insurance coverages
37 delivered or issued for delivery during such calendar
38 year to small employers in this state by reinsuring
39 carriers.

40 (2) The formula established pursuant to
41 subparagraph (1) shall not result in any reinsuring
42 carrier having an assessment share that is less than
43 fifty percent nor more than one hundred fifty percent
44 of an amount which is based on the proportion of the
45 reinsuring carrier's total premiums earned in the
46 preceding calendar year from health ~~benefit-plans~~
47 insurance coverages delivered or issued for delivery
48 to small employers in this state by reinsuring
49 carriers to total premiums earned in the preceding
50 calendar year from health ~~benefit-plans~~ insurance

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1 coverages delivered or issued for delivery to small
2 employers in this state by all reinsuring carriers.

3 (3) The board, with approval of the commissioner,
4 may change the assessment formula established pursuant
5 to subparagraph (1) from time to time as appropriate.
6 The board may provide for the shares of the assessment
7 base attributable to premiums from all health ~~benefit~~
8 ~~plans~~ insurance coverages and to premiums from newly
9 issued health ~~benefit-plans~~ insurance coverages to
10 vary during a transition period.

11 Sec. _____. Section 513B.13, subsection 11,
12 paragraph c, subparagraph (3), Code 1997, is amended
13 to read as follows:

14 (3) For any calendar year, the amount specified in
15 this subparagraph is five percent of total premiums
16 earned in the previous year from health ~~benefit-plans~~
17 insurance coverages delivered or issued for delivery
18 to small employers in this state by reinsuring
19 carriers.

20 Sec. _____. Section 513B.15, Code 1997, is amended
21 to read as follows:

22 513B.15 PERIODIC MARKET EVALUATION.

23 The board shall study and report at least every
24 three years to the commissioner on the effectiveness
25 of this subchapter. The report shall analyze the
26 effectiveness of the subchapter in promoting rate
27 stability, product availability, and coverage
28 affordability. The report may contain recommendations
29 for actions to improve the overall effectiveness,
30 efficiency, and fairness of the small group health
31 insurance marketplace. The report shall address
32 whether carriers and producers are fairly and actively
33 marketing or issuing health ~~benefit-plans~~ insurance
34 coverages to small employers in fulfillment of the
35 purposes of this subchapter. The report may contain
36 recommendations for market conduct or other regulatory
37 standards or action."

38 30. Page 15, by inserting after line 25 the
39 following:

40 "Sec. _____. Section 513B.17A, Code 1997, is amended
41 to read as follows:

42 513B.17A RESTORATION OF TERMINATED COVERAGE.

43 The commissioner may adopt rules to require small
44 employer carriers, as a condition of transacting
45 business with small employers in this state after July
46 1, 1993, to reissue a ~~health-benefit-plan~~ health
47 insurance coverage to any small employer whose health
48 ~~benefit-plan~~ insurance coverage is terminated or not
49 renewed by a carrier after January 1, 1993, unless the
50 carrier's termination is pursuant to section 513B.5.

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1 The commissioner may prescribe such terms for the
2 reissuance of coverage as the commissioner finds are
3 reasonable and necessary to provide continuity of
4 coverage to such employers."

5 31. Page 18, by inserting after line 6 the
6 following:

7 "6. A carrier or organized delivery system
8 offering coverage through a bona fide association is
9 not required to renew a continue in force coverage or
10 to accept applications from an individual through an
11 association if the membership of the individual in the
12 association on which the basis of coverage is provided
13 ceases, but only if the coverage is not offered or
14 terminated under this paragraph uniformly without
15 regard to health status-related factors of a covered
16 individual."

17 32. Page 19, line 11, by striking the words "as
18 the same" and inserting the following: "the same as".

19 33. Page 20, line 3, by striking the words "any
20 of".

21 34. Page 21, line 35, by striking the words "in
22 the".

23 35. Page 22, line 1, by striking the words
24 "individual market".

25 36. Page 22, line 3, by striking the words
26 "Individual health" and inserting the following:
27 "Health".

28 37. Page 22, line 19, by striking the words
29 "Individual health" and inserting the following:
30 "Health".

31 38. Page 22, line 26, by striking the words
32 "Individual health" and inserting the following:
33 "Health".

34 39. Page 22, line 32, by striking the words
35 "Individual health" and inserting the following:
36 "Health".

37 40. Page 23, by inserting after line 33 the
38 following:

39 "Sec. ____ . Section 514E.2, subsection 2,
40 unnumbered paragraph 1, Code 1997, is amended to read
41 as follows:

42 The board of directors of the association shall
43 consist of four members selected by the members of the
44 association, two of whom shall be representatives from
45 corporations operating pursuant to chapter 514 on July
46 1, 1989, or any successors in interest, and two of
47 whom shall be representatives of organized delivery
48 systems or insurers providing coverage pursuant to
49 chapter 509 or 514A; four public members selected by
50 the governor; the commissioner or the commissioner's

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1 designee from the division of insurance; and two
2 members of the general assembly, one of whom shall be
3 appointed by the speaker of the house and one of whom
4 shall be appointed by the president of the senate,
5 after consultation with the majority leader and the
6 minority leader of the senate, who shall be ex officio
7 and nonvoting members. The composition of the board
8 of directors shall be in compliance with sections
9 69.16 and 69.16A. The governor's appointees shall be
10 chosen from a broad cross-section of the residents of
11 this state.

12 Sec. _____. Section 514E.2, subsection 3, paragraph
13 f, Code 1997, is amended by striking the paragraph.

14 Sec. _____. Section 514E.2, subsection 7, Code 1997,
15 is amended to read as follows:

16 7. Following the close of each calendar year, the
17 association shall determine the net premiums and
18 payments, the expenses of administration, and the
19 incurred losses of the association for the year. The
20 association shall certify the amount of any net loss
21 for the preceding calendar year to the commissioner of
22 insurance and director of revenue and finance who
23 ~~shall make payment to the association according to~~
24 ~~procedures established under subsection 3, paragraph~~
25 ~~"f". Any remaining loss, after payment to the~~
26 ~~association from the health insurance trust fund,~~
27 shall be assessed by the association to all members in
28 proportion to their respective shares of total health
29 insurance premiums or payments for subscriber
30 contracts received in Iowa during the second preceding
31 calendar year, or with paid losses in the year,
32 coinciding with or ending during the calendar year or
33 on any other equitable basis as provided in the plan
34 of operation. In sharing losses, the association may
35 abate or defer in any part the assessment of a member,
36 if, in the opinion of the board, payment of the
37 assessment would endanger the ability of the member to
38 fulfill its contractual obligations. The association
39 may also provide for an initial or interim assessment
40 against members of the association if necessary to
41 assure the financial capability of the association to
42 meet the incurred or estimated claims expenses or
43 operating expenses of the association until the next
44 calendar year is completed. Net gains, if any, must
45 be held at interest to offset future losses or
46 allocated to reduce future premiums."

47 41. Page 23, by inserting after line 35 the
48 following:

49 "Sec. _____. Section 514E.5, subsection 2, Code
50 1997, is amended to read as follows:

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

9 However, the association policy shall pay benefits
10 as a primary payer in any case where benefit coverage
11 provided under the laws of the United States,
12 ~~including-Medicare-and-Medicaid~~, or under the laws of
13 this state is, by rule or statute, secondary to all
14 other coverages."

15 42. Page 24, line 19, by inserting after the word
16 "carrier" the following: "or organized delivery
17 system".

18 43. Page 24, line 20, by inserting after the word
19 "carrier" the following: "or organized delivery
20 system".

21 44. Page 24, line 24, by inserting after the word
22 "carrier" the following: "or organized delivery
23 system".

24 45. Page 27, by inserting after line 9 the
25 following:

26 "Sec. ____ . Section 514E.3, Code 1997, is
27 repealed."

28 46. By renumbering as necessary.

By DIX of Butler

H-1326 FILED MARCH 24, 1997

Adopted 3/25/97 (p. 804)

4/197 Revised to De
5-400/97 Unfinished Bus. Calendar

HOUSE FILE 701
BY COMMITTEE ON COMMERCE AND
REGULATION

(SUCCESSOR TO HSB 235)

(As Amended and Passed by the House, March 25, 1997)

Passed House, Date _____ Passed Senate, Date 4-16-97 (p. 1194)
Vote: Ayes _____ Nays _____ Vote: Ayes 46 Nays 0
Approved May 1, 1997

A BILL FOR

1 An Act relating to the requirements for portability and
2 continuity of health care coverage for individuals among
3 certain types of health care coverage, and related matters.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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House Amendments _____

Deleted Language *

1 Section 1. Section 509.3, Code 1997, is amended by adding
2 the following new unnumbered paragraph:

3 NEW UNNUMBERED PARAGRAPH. In addition to the provisions
4 required in subsections 1 through 8, the commissioner shall
5 require provisions through the adoption of rules implementing
6 the federal Health Insurance Portability and Accountability
7 Act, Pub. L. No. 104-191.

8 Sec. 2. Section 513B.2, subsection 1, Code 1997, is
9 amended to read as follows:

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

19 Sec. 3. Section 513B.2, subsection 4, Code 1997, is
20 amended by striking the subsection and inserting in lieu
21 thereof the following:

22 4. "Carrier" means an entity subject to the insurance laws
23 and regulations of this state, or subject to the jurisdiction
24 of the commissioner, that contracts or offers to contract to
25 provide, deliver, arrange for, pay for, or reimburse any of
26 the costs of health care services, including an insurance
27 company offering sickness and accident plans, a health
28 maintenance organization, a nonprofit health service
29 corporation, or any other entity providing a plan of health
30 insurance, health benefits, or health services.

31 Sec. 4. Section 513B.2, subsection 6, paragraph a, Code
32 1997, is amended to read as follows:

33 a. A distinct grouping may only be established by the
34 small employer carrier on the basis that the applicable health
35 benefit-plans insurance coverages meet one or more of the

1 following requirements:

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

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

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

12 Sec. 5. Section 513B.2, subsection 9, Code 1997, is
13 amended to read as follows:

14 9. "Eligible employee" means an employee who works on a
15 full-time basis and has a normal work week of thirty or more
16 hours. The term includes a sole proprietor, a partner of a
17 partnership, and an independent contractor, if the sole
18 proprietor, partner, or independent contractor is included as
19 an employee under a health-benefit-plan health insurance
20 coverage of a small employer, but does not include an employee
21 who works on a part-time, temporary, or substitute basis.

22 Sec. 6. Section 513B.2, subsection 10, Code 1997, is
23 amended by striking the subsection and inserting in lieu
24 thereof the following:

25 10. a. "Health insurance coverage" means benefits
26 consisting of health care provided directly, through insurance
27 or reimbursement, or otherwise and including items and
28 services paid for as health care under a hospital or health
29 service policy or certificate, hospital or health service plan
30 contract, or health maintenance organization contract offered
31 by a carrier.

32 b. "Health insurance coverage" does not include any of the
33 following:

34 (1) Coverage for accident-only, or disability income
35 insurance.

- 1 (2) Coverage issued as a supplement to liability
2 insurance.
- 3 (3) Liability insurance, including general liability
4 insurance and automobile liability insurance.
- 5 (4) Workers' compensation or similar insurance.
- 6 (5) Automobile medical-payment insurance.
- 7 (6) Credit-only insurance.
- 8 (7) Coverage for on-site medical clinic care.
- 9 (8) Other similar insurance coverage, specified in federal
10 regulations, under which benefits for medical care are
11 secondary or incidental to other insurance coverage or
12 benefits.

13 c. "Health insurance coverage" does not include benefits
14 provided under a separate policy as follows:

- 15 (1) Limited scope dental or vision benefits.
- 16 (2) Benefits for long-term care, nursing home care, home
17 health care, or community-based care.
- 18 (3) Any other similar limited benefits as provided by rule
19 of the commissioner.

20 d. "Health insurance coverage" does not include benefits
21 offered as independent noncoordinated benefits as follows:

- 22 (1) Coverage only for a specified disease or illness.
- 23 (2) A hospital indemnity or other fixed indemnity
24 insurance.

25 e. "Health insurance coverage" does not include Medicare
26 supplemental health insurance as defined under § 1882(g)(1) of
27 the federal Social Security Act, coverage supplemental to the
28 coverage provided under 10 U.S.C. ch. 55, and similar
29 supplemental coverage provided to coverage under group health
30 insurance coverage.

31 f. "Group health insurance coverage" means health
32 insurance coverage offered in connection with a group health
33 plan.

34 Sec. 7. Section 513B.2, subsection 12, paragraphs a, b,
35 and c, Code 1997, are amended to read as follows:

1 a. The individual meets all of the following:

2 (1) The individual was covered under qualifying-previous
3 creditable coverage at the time of the initial enrollment.

4 (2) The individual lost creditable coverage under
5 qualifying-previous-coverage as a result of termination of the
6 individual's employment or eligibility, the involuntary
7 termination of the qualifying-previous creditable coverage,
8 death of the individual's spouse, or the individual's divorce.

9 (3) The individual requests enrollment within thirty days
10 after termination of the qualifying-previous creditable
11 coverage.

12 b. The individual is employed by an employer that offers
13 multiple health benefit-plans insurance coverages and the
14 individual elects a different plan coverage during an open
15 enrollment period.

16 c. A court has ordered that coverage be provided for a
17 spouse or minor or dependent child under a covered employee's
18 health benefit-plan insurance coverage and the request for
19 enrollment is made within thirty days after issuance of the
20 court order.

21 Sec. 8. Section 513B.2, subsection 12, Code 1997, is
22 amended by adding the following new paragraphs:

23 NEW PARAGRAPH. d. The individual changes status and
24 becomes an eligible employee and requests enrollment within
25 sixty-three days after the date of the change in status.

26 NEW PARAGRAPH. e. The individual was covered under a
27 mandated continuation of group health plan or group health
28 insurance coverage plan until the coverage under that plan was
29 exhausted.

30 Sec. 9. Section 513B.2, subsection 13, Code 1997, is
31 amended to read as follows:

32 13. "New business premium rate" means, for each class of
33 business as to a rating period, the lowest premium rate
34 charged or offered by the small employer carrier to small
35 employers with similar case characteristics for newly issued

1 health ~~benefit-plans~~ insurance coverages with the same or
2 similar coverage.

3 Sec. 10. Section 513B.2, Code 1997, is amended by adding
4 the following new subsections:

5 NEW SUBSECTION. 7A. "Creditable coverage" means health
6 benefits or coverage provided to an individual under any of
7 the following:

8 a. A group health plan.

9 b. Health insurance coverage.

10 c. Part A or Part B Medicare pursuant to Title XVIII of
11 the federal Social Security Act.

12 d. Medicaid pursuant to Title XIX of the federal Social
13 Security Act, other than coverage consisting solely of
14 benefits under section 1928 of that Act.

15 e. 10 U.S.C. ch. 55.

16 f. A health or medical care program provided through the
17 Indian health service or a tribal organization.

18 g. A state health benefits risk pool.

19 h. A health plan offered under 5 U.S.C. ch. 89.

20 i. A public health plan as defined under federal
21 regulations.

22 j. A health benefit plan under section 5(e) of the federal
23 Peace Corps Act, 22 U.S.C. § 2504(e).

24 k. An organized delivery system licensed by the director
25 of public health.

26 NEW SUBSECTION. 9A. a. "Group health plan" means an
27 employee welfare benefit plan as defined in section 3(1) of
28 the federal Employee Retirement Income Security Act of 1974,
29 to the extent that the plan provides medical care including
30 items and services paid for as medical care to employees or
31 their dependents as defined under the terms of the plan
32 directly or through insurance, reimbursement, or otherwise.

33 b. For purposes of this subsection, "medical care" means
34 amounts paid for any of the following:

35 (1) The diagnosis, cure, mitigation, treatment, or

1 prevention of disease, or amounts paid for the purpose of
2 affecting a structure or function of the body.

3 (2) Transportation primarily for and essential to medical
4 care referred to in subparagraph (1).

5 (3) Insurance covering medical care referred to in
6 subparagraph (1) or (2).

7 c. For purposes of this subsection, a partnership which
8 establishes and maintains a plan, fund, or program to provide
9 medical care to present or former partners in the partnership
10 or to their dependents directly or through insurance,
11 reimbursement, or other method, which would not be an employee
12 benefit welfare plan but for this paragraph, shall be treated
13 as an employee benefit welfare plan which is a group health
14 plan.

15 (1) For purposes of a group health plan, an employer
16 includes the partnership in relation to any partner.

17 (2) For purposes of a group health plan, the term
18 "participant" also includes both of the following:

19 (a) An individual who is a partner in relation to a
20 partnership which maintains a group health plan.

21 (b) An individual who is a self-employed individual in
22 connection with a group health plan maintained by the self-
23 employed individual where one or more employees are
24 participants, if the individual is or may become eligible to
25 receive a benefit under the plan or the individual's
26 beneficiaries may be eligible to receive a benefit.

27 NEW SUBSECTION. 13A. "Preexisting conditions exclusion"
28 means, with respect to health insurance coverage, a limitation
29 or exclusion of benefits relating to a condition based on the
30 fact that the condition was present before the date of
31 enrollment for such coverage, whether or not any medical
32 advice, diagnosis, care, or treatment was recommended or
33 received before such date.

34 Sec. 11. Section 513B.2, subsection 14, Code 1997, is
35 amended by striking the subsection.

1 Sec. 12. Section 513B.3, subsection 3, Code 1997, is
2 amended to read as follows:

3 3. The health benefit-plan insurance coverage is treated
4 by the employer or any of the eligible employees or dependents
5 as part of a plan coverage or program for the purposes of
6 section 106, 125, or 162 of the Internal Revenue Code as
7 defined in section 422.3.

8 Sec. 13. Section 513B.3, subsection 4, paragraphs a and c,
9 Code 1997, are amended to read as follows:

10 a. Except as provided in paragraph "b", for purposes of
11 this subchapter, carriers that are affiliated companies or
12 that are eligible to file a consolidated tax return shall be
13 treated as one carrier and any restrictions or limitations
14 imposed by this subchapter shall apply as if all health
15 benefit-plans insurance coverages delivered or issued for
16 delivery to small employers in this state by such carriers
17 were issued by one carrier.

18 c. Unless otherwise authorized by the commissioner, a
19 small employer carrier shall not enter into one or more ceding
20 arrangements with respect to health benefit-plans insurance
21 coverages delivered or issued for delivery to small employers
22 in this state if the arrangements would result in less than
23 fifty percent of the insurance obligation or risk for such
24 health benefit-plans insurance coverages being retained by the
25 ceding carrier.

26 Sec. 14. Section 513B.4, subsection 1, paragraph c,
27 subparagraph (1), Code 1997, is amended to read as follows:

28 (1) The percentage change in the new business premium rate
29 measured from the first day of the prior rating period to the
30 first day of the new rating period. In the case of a class of
31 business for which the small employer carrier is not issuing
32 new policies, the small employer carrier shall use the
33 percentage change in the base premium rate, provided that the
34 change does not exceed, on a percentage basis, the change in
35 the new business premium rate for the most similar health

1 benefit-plan insurance coverage into which the small employer
2 carrier is actively enrolling new insureds who are small
3 employers.

4 Sec. 15. Section 513B.4, subsection 1, paragraph d, Code
5 1997, is amended to read as follows:

6 d. In the case of health benefit-plans insurance coverages
7 issued prior to July 1, 1991, a premium rate for a rating
8 period may exceed the ranges described in subsection 1,
9 paragraph "a" or "b", for a period of three years following
10 July 1, 1992. In such case, the percentage increase in the
11 premium rate charged to a small employer in such a class of
12 business for a new rating period may not exceed the sum of the
13 following:

14 (1) The percentage change in the new business premium rate
15 measured from the first day of the prior rating period to the
16 first day of the new rating period. In the case of a class of
17 business for which the small employer carrier is not issuing
18 new policies, the small employer carrier shall use the
19 percentage change in the base premium rate, provided that the
20 change does not exceed, on a percentage basis, the change in
21 the new business premium rate for the most similar health
22 benefit-plan insurance coverage into which the small employer
23 carrier is actively enrolling new insureds who are small
24 employers.

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

29 Sec. 16. Section 513B.4, subsection 3, unnumbered
30 paragraph 3, Code 1997, is amended to read as follows:

31 Rating factors shall produce premiums for identical groups
32 which differ only by amounts attributable to plan coverage
33 design and do not reflect differences due to the nature of the
34 groups assumed to select particular health benefit plans. A
35 small employer carrier shall treat all health benefit-plans

1 insurance coverages issued or renewed in the same calendar
2 month as having the same rating period.

3 Sec. 17. Section 513B.4, subsection 4, Code 1997, is
4 amended to read as follows:

5 4. For purposes of this section, a health benefit-plan
6 insurance coverage that contains a restricted network
7 provision shall not be considered similar coverage to a health
8 benefit-plan insurance coverage that does not contain such a
9 provision, if the restriction of benefits to network providers
10 results in substantial differences in claims costs.

11 Sec. 18. Section 513B.4A, Code 1997, is amended to read as
12 follows:

13 513B.4A EXEMPTION FROM PREMIUM RATE RESTRICTIONS.

14 A Taft-Hartley trust or a carrier with the written
15 authorization of such a trust may make a written request to
16 the commissioner for an exemption from the application of any
17 provisions of section 513B.4 with respect to a health-benefit
18 plan health insurance coverage provided to such a trust. The
19 commissioner may grant an exemption if the commissioner finds
20 that application of section 513B.4 with respect to the trust
21 would have a substantial adverse effect on the participants
22 and beneficiaries of such trust, and would require significant
23 modifications to one or more collective bargaining
24 arrangements under which the trust is established or
25 maintained. An exemption granted under this section shall not
26 apply to an individual if the individual participates in a
27 trust as an associate member of an employee organization.

28 Sec. 19. Section 513B.5, Code 1997, is amended by striking
29 the section and inserting in lieu thereof the following:

30 513B.5 PROVISIONS ON RENEWABILITY OF COVERAGE.

31 1. Health insurance coverage subject to this chapter is
32 renewable with respect to all eligible employees or their
33 dependents, at the option of the small employer, except for
34 one or more of the following reasons:

35 a. The health insurance coverage sponsor fails to pay, or

1 to make timely payment of, premiums or contributions pursuant
2 to the terms of the health insurance coverage.

3 b. The health insurance coverage sponsor performs an act
4 or practice constituting fraud or makes an intentional
5 misrepresentation of a material fact under the terms of the
6 coverage.

7 c. Noncompliance with the carrier's or organized delivery
8 system's minimum participation requirements.

9 d. Noncompliance with the carrier's or organized delivery
10 system's employer contribution requirements.

11 e. A decision by the carrier or organized delivery system
12 to discontinue offering a particular type of health insurance
13 coverage in the state's small employer market. Health
14 insurance coverage may be discontinued by the carrier or
15 organized delivery system in that market only if the carrier
16 or organized delivery system does all of the following:

17 (1) Provides advance notice of its decision to discontinue
18 such plan to the commissioner or director of public health.
19 Notice to the commissioner or director, at a minimum, shall be
20 no less than three days prior to the notice provided for in
21 subparagraph (2) to affected small employers, participants,
22 and beneficiaries.

23 (2) Provides notice of its decision not to renew such plan
24 to all affected small employers, participants, and
25 beneficiaries no less than ninety days prior to the nonrenewal
26 of the plan.

27 (3) Offers to each plan sponsor of the discontinued
28 coverage, the option to purchase any other coverage currently
29 offered by the carrier or organized delivery system to other
30 employers in this state.

31 (4) Acts uniformly, in opting to discontinue the coverage
32 and in offering the option under subparagraph (3), without
33 regard to the claims experience of the sponsors under the
34 discontinued coverage or to a health status-related factor
35 relating to any participants or beneficiaries covered or new

1 participants or beneficiaries who may become eligible for the
2 coverage.

3 f. A decision by the carrier or organized delivery system
4 to discontinue offering and to cease to renew all of its
5 health insurance coverage delivered or issued for delivery to
6 small employers in this state. A carrier or organized
7 delivery system making such decision shall do all of the
8 following:

9 (1) Provide advance notice of its decision to discontinue
10 such coverage to the commissioner or director of public
11 health. Notice to the commissioner or director, at a minimum,
12 shall be no less than three days prior to the notice provided
13 for in subparagraph (2) to affected small employers,
14 participants, and beneficiaries.

15 (2) Provide notice of its decision not to renew such
16 coverage to all affected small employers, participants, and
17 beneficiaries no less than one hundred eighty days prior to
18 the nonrenewal of the coverage.

19 (3) Discontinue all health insurance coverage issued or
20 delivered for issuance to small employers in this state and
21 cease renewal of such coverage.

22 g. The membership of an employer in an association, which
23 is the basis for the coverage which is provided through such
24 association, ceases, but only if the termination of coverage
25 under this paragraph occurs uniformly without regard to any
26 health status-related factor relating to any covered
27 individual.

28 h. The commissioner or director of public health finds
29 that the continuation of the coverage is not in the best
30 interests of the policyholders or certificate holders, or
31 would impair the carrier's or organized delivery system's
32 ability to meet its contractual obligations.

33 i. At the time of coverage renewal, a carrier or organized
34 delivery system may modify the health insurance coverage for a
35 product offered under group health insurance coverage in the

1 small group market, for coverage that is available in such
2 market other than only through one or more bona fide
3 associations, if such modification is consistent with the laws
4 of this state, and is effective on a uniform basis among group
5 health insurance coverage with that product.

6 2. A carrier or organized delivery system that elects not
7 to renew health insurance coverage under subsection 1,
8 paragraph "f", shall not write any new business in the small
9 employer market in this state for a period of five years after
10 the date of notice to the commissioner or director of public
11 health.

12 3. This section, with respect to a carrier or organized
13 delivery system doing business in one established geographic
14 service area of the state, applies only to such carrier's or
15 organized delivery system's operations in that service area.

16 Sec. 20. Section 513B.6, unnumbered paragraph 1, Code
17 1997, is amended to read as follows:

18 A small employer carrier or organized delivery system shall
19 make reasonable disclosure in solicitation and sales materials
20 provided to small employers of all of the following:

21 Sec. 21. Section 513B.6, subsection 2, Code 1997, is
22 amended to read as follows:

23 2. The provisions concerning the small employer carrier's
24 or organized delivery system's right to change premium rates
25 and factors, including case characteristics, which affect
26 changes in premium rates.

27 Sec. 22. Section 513B.7, Code 1997, is amended to read as
28 follows:

29 513B.7 MAINTENANCE OF RECORDS.

30 1. A small employer carrier or organized delivery system
31 shall maintain at its principal place of business a complete
32 and detailed description of its rating practices and renewal
33 underwriting practices, including information and
34 documentation which demonstrate that its rating methods and
35 practices are based upon commonly accepted actuarial

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

3 2. A small employer carrier or organized delivery system
4 shall file each March 1 with the commissioner or director an
5 actuarial certification that the small employer carrier or
6 organized delivery system is in compliance with this section
7 and that the rating methods of the small employer carrier or
8 organized delivery system are actuarially sound. A copy of
9 the certification shall be retained by the small employer
10 carrier or organized delivery system at its principal place of
11 business.

12 3. A small employer carrier or organized delivery system
13 shall make the information and documentation described in
14 subsection 1 available to the commissioner or organized
15 delivery system upon request. The information is not a public
16 record or otherwise subject to disclosure under chapter 22,
17 and is considered proprietary and trade secret information and
18 is not subject to disclosure by the commissioner or director
19 to persons outside of the division or department except as
20 agreed to by the small employer carrier or organized delivery
21 system or as ordered by a court of competent jurisdiction.

22 Sec. 23. NEW SECTION. 513B.9A ELIGIBILITY TO ENROLL.

23 A carrier or organized delivery system offering group
24 health insurance coverage shall not establish rules for
25 eligibility, including continued eligibility, of an individual
26 to enroll under the terms of the coverage based on any of the
27 following health status-related factors in relation to the
28 individual or a dependent of the individual:

29 a. Health status.

30 b. Medical condition, including both physical and mental
31 conditions.

32 c. Claims experience.

33 d. Receipt of health care.

34 e. Medical history.

35 f. Genetic information.

1 g. Evidence of insurability, including conditions arising
2 out of acts of domestic violence.

3 h. Disability.

4 2. Subsection 1 does not require group health insurance
5 coverage to provide particular benefits other than those
*6 provided under the terms of the coverage, and does not prevent
*7 a coverage from establishing limitations or restrictions on
8 the amount, level, extent, or nature of the benefits or
*9 coverage for similarly situated individuals enrolled in the
10 coverage.

11 3. Rules for eligibility to enroll under group health
12 insurance coverage include rules defining any applicable
13 waiting periods for such enrollment.

14 4. a. A carrier or organized delivery system offering
15 health insurance coverage shall not require an individual, as
16 a condition of enrollment or continued enrollment under the
17 coverage, to pay a premium or contribution which is greater
18 than a premium or contribution for a similarly situated
19 individual enrolled in the coverage on the basis of a health
20 status-related factor in relation to the individual or to a
21 dependent of an individual enrolled under the coverage.

22 b. Paragraph "a" shall not be construed to do either of
23 the following:

24 (1) Restrict the amount that an employer may be charged
25 for health insurance coverage.

26 (2) Prevent a carrier or organized delivery system
27 offering group health insurance coverage from establishing
28 premium discounts or rebates or modifying otherwise applicable
29 copayments or deductibles in return for adherence to programs
30 of health promotion and disease prevention.

31 Sec. 24. Section 513B.10, Code 1997, is amended by
32 striking the section and inserting in lieu thereof the
33 following:

34 513B.10 AVAILABILITY OF COVERAGE.

35 1. a. A carrier or an organized delivery system that

1 offers health insurance coverage in the small group market
2 shall accept every small employer that applies for health
3 insurance coverage and shall accept for enrollment under such
4 coverage every eligible individual who applies for enrollment
5 during the period in which the individual first becomes
6 eligible to enroll under the terms of the health insurance
7 coverage and shall not place any restriction which is
8 inconsistent with eligibility rules established under this
9 chapter. A carrier or organized delivery system shall offer
10 health insurance coverage which constitutes a basic health
11 benefit plan and which constitutes a standard health benefit
12 plan.

13 b. A carrier or organized delivery system that offers
14 health insurance coverage in the small group market through a
15 network plan may do either of the following:

16 (1) Limit employers that may apply for such coverage to
17 those with eligible individuals who live, work, or reside in
18 the service area for such network plan.

19 (2) Deny such coverage to such employers within the
20 service area of such plan if the carrier or organized delivery
* 21 system has demonstrated to the applicable state authority,
22 both of the following:

23 (a) The carrier or organized delivery system will not have
24 the capacity to deliver services adequately to enrollees of
25 any additional groups because of its obligations to existing
26 group contract holders and enrollees.

27 (b) The carrier or organized delivery system is applying
28 this subparagraph uniformly to all employers without regard to
29 the claims experience of those employers and their employees
30 and their dependents, or any health status-related factor
31 relating to such employees or dependents.

32 c. A carrier or organized delivery system, upon denying
33 health insurance coverage in any service area pursuant to
34 paragraph "b", subparagraph (2), shall not offer coverage in
35 the small group market within such service area for a period

1 of one hundred eighty days after the date such coverage is
2 denied.

3 d. A carrier or organized delivery system may deny health
4 insurance coverage in the small group market if the issuer has
* 5 demonstrated to the commissioner or director of public health
6 both of the following:

7 (1) The carrier or organized delivery system does not have
8 the financial reserves necessary to underwrite additional
9 coverage.

10 (2) The carrier or organized delivery system is applying
11 the provisions of this subparagraph uniformly to all employers
12 in the small group market in this state consistent with state
13 law and without regard to the claims experience of those
14 employers and the employees and dependents of such employers,
15 or any health status-related factor relating to such employees
16 and their dependents.

17 e. A carrier or organized delivery system, upon denying
18 health insurance coverage pursuant to paragraph "d", shall not
19 offer coverage in connection with health insurance coverages
20 in the small group market in this state for a period of one
21 hundred eighty days after the date such coverage is denied or
22 until the carrier or organized delivery system has
23 demonstrated to the commissioner or director of public health
24 that the carrier or organized delivery system has sufficient
25 financial reserves to underwrite additional coverage,
26 whichever is later. The commissioner or director may provide
27 for the application of this paragraph on a service area-
28 specific basis.

29 f. Paragraph "a" shall not be construed to preclude a
30 carrier or organized delivery system from establishing
31 employer contribution rules or group participation rules for
* 32 the offering of health insurance coverage in the small group
33 market.

34 2. A carrier or organized delivery system, subject to
35 subsection 1, shall issue health insurance coverage to an

1 eligible small employer that applies for the coverage and
2 agrees to make the required premium payments and satisfy the
3 other reasonable provisions of the health insurance coverage
4 not inconsistent with this chapter. A carrier or organized
5 delivery system is not required to issue health insurance
6 coverage to a self-employed individual who is covered by, or
7 is eligible for coverage under, health insurance coverage
8 offered by an employer.

9 3. a. A carrier or organized delivery system shall file
10 with the commissioner or director of public health, in a form
11 and manner prescribed by the commissioner or director, the
12 basic health benefit plans and the standard health benefit
13 plans to be used by the carrier or organized delivery system.
14 Health insurance coverage filed pursuant to this paragraph may
15 be used by a carrier or organized delivery system beginning
16 thirty days after it is filed unless the commissioner or
17 director of public health disapproves its use.

18 b. The commissioner or director of public health, at any
19 time after providing notice and opportunity for hearing to the
20 carrier or organized delivery system, may disapprove the
21 continued use of a basic or standard health benefit plan by a
22 carrier or organized delivery system on the grounds that the
23 plan does not meet the requirements of this chapter.

24 4. Health insurance coverage for small employers shall
25 satisfy all of the following:

26 a. A carrier or organized delivery system offering group
27 health insurance coverage, with respect to a participant or
28 beneficiary, may impose a preexisting condition exclusion only
29 as follows:

30 (1) The exclusion relates to a condition, whether physical
31 or mental, regardless of the cause of the condition, for which
32 medical advice, diagnosis, care, or treatment was recommended
33 or received within the six-month period ending on the
34 enrollment date. However, genetic information shall not be
35 treated as a condition under this subparagraph in the absence

1 of a diagnosis of the condition related to such information.

2 (2) The exclusion extends for a period of not more than
3 twelve months, or eighteen months in the case of a late
4 enrollee, after the enrollment date.

5 (3) The period of any such preexisting condition exclusion
6 is reduced by the aggregate of the periods of creditable
7 coverage applicable to the participant or beneficiary as of
8 the enrollment date.

* 9 b. A carrier or organized delivery system offering group
10 health insurance coverage shall not impose any preexisting
11 condition as follows:

12 (1) In the case of a child who is adopted or placed for
13 adoption before attaining eighteen years of age and who, as of
14 the last day of the thirty-day period beginning on the date of
15 the adoption or placement for adoption, is covered under
16 creditable coverage. This subparagraph shall not apply to
17 coverage before the date of such adoption or placement for
18 adoption.

19 (2) In the case of an individual who, as of the last day
20 of the thirty-day period beginning with the date of birth, is
21 covered under creditable coverage.

22 (3) Relating to pregnancy as a preexisting condition.

23 c. A carrier or organized delivery system shall waive any
24 waiting period applicable to a preexisting condition exclusion
25 or limitation period with respect to particular services under
26 health insurance coverage for the period of time an individual
27 was covered by creditable coverage, provided that the
28 creditable coverage was continuous to a date not more than
29 sixty-three days prior to the effective date of the new
30 coverage. Any period that an individual is in a waiting
31 period for any coverage under group health insurance coverage,
32 or is in an affiliation period, shall not be taken into
33 account in determining the period of continuous coverage. A
34 health maintenance organization that does not use preexisting
35 condition limitations in any of its health insurance coverage

1 may impose an affiliation period. For purposes of this
2 section, "affiliation period" means a period of time not to
3 exceed sixty days for new entrants and not to exceed ninety
4 days for late enrollees during which no premium shall be
5 collected and coverage issued is not effective, so long as the
6 affiliation period is applied uniformly, without regard to any
7 health status-related factors. This paragraph does not
8 preclude application of a waiting period applicable to all new
9 enrollees under the health insurance coverage, provided that
10 any carrier or organized delivery system-imposed waiting
11 period is no longer than sixty days and is used in lieu of a
12 preexisting condition exclusion.

13 d. Health insurance coverage may exclude coverage for late
14 enrollees for preexisting conditions for a period not to
15 exceed eighteen months.

16 e. (1) Requirements used by a carrier or organized
17 delivery system in determining whether to provide coverage to
18 a small employer shall be applied uniformly among all small
19 employers applying for coverage or receiving coverage from the
20 carrier or organized delivery system.

21 (2) In applying minimum participation requirements with
22 respect to a small employer, a carrier or organized delivery
23 system shall not consider employees or dependents who have
24 other creditable coverage in determining whether the
25 applicable percentage of participation is met.

26 (3) A carrier or organized delivery system shall not
27 increase any requirement for minimum employee participation or
28 modify any requirement for minimum employer contribution
29 applicable to a small employer at any time after the small
30 employer has been accepted for coverage.

31 f. (1) If a carrier or organized delivery system offers
32 coverage to a small employer, the carrier or organized
33 delivery system shall offer coverage to all eligible employees
34 of the small employer and the employees' dependents. A
35 carrier or organized delivery system shall not offer coverage

1 to only certain individuals or dependents in a small employer
2 group or to only part of the group.

3 (2) Except as provided under paragraphs "a" and "d", a
4 carrier or organized delivery system shall not modify health
5 insurance coverage with respect to a small employer or any
6 eligible employee or dependent through riders, endorsements,
7 or other means, to restrict or exclude coverage or benefits
8 for certain diseases, medical conditions, or services
9 otherwise covered by the health insurance coverage.

10 g. A carrier or organized delivery system offering
11 coverage through a network plan shall not be required to offer
12 coverage or accept applications pursuant to subsection 1 with
13 respect to a small employer where any of the following apply:

14 (1) The small employer does not have eligible individuals
15 who live, work, or reside in the service area for the network
16 plan.

17 (2) The small employer does have eligible individuals who
18 live, work, or reside in the service area for the network
19 plan, but the carrier or organized delivery system, if
20 required, has demonstrated to the commissioner or the director
21 of public health that it will not have the capacity to deliver
22 services adequately to enrollees of any additional groups
23 because of its obligations to existing group contract holders
24 and enrollees and that it is applying the requirements of this
25 lettered paragraph uniformly to all employers without regard
26 to the claims experience of those employers and their
27 employees and the employees' dependents, or any health status-
28 related factor relating to such employees and dependents.

29 (3) A carrier or organized delivery system, upon denying
30 health insurance coverage in a service area pursuant to
31 subparagraph (2), shall not offer coverage in the small
32 employer market within such service area for a period of one
33 hundred eighty days after the coverage is denied.

34 5. A carrier or organized delivery system shall not be
35 required to offer coverage to small employers pursuant to

1 subsection 1 for any period of time where the commissioner or
2 director of public health determines that the acceptance of
3 the offers by small employers in accordance with subsection 1
4 would place the carrier or organized delivery system in a
5 financially impaired condition.

6 6. A carrier or organized delivery system shall not be
7 required to provide coverage to small employers pursuant to
8 subsection 1 if the carrier or organized delivery system
9 elects not to offer new coverage to small employers in this
10 state. However, a carrier or organized delivery system that
11 elects not to offer new coverage to small employers under this
12 subsection shall be allowed to maintain its existing policies
13 in the state, subject to the requirements of section 513B.5.

14 7. A carrier or organized delivery system that elects not
15 to offer new coverage to small employers pursuant to
16 subsection 6 shall provide notice to the commissioner or
17 director of public health and is prohibited from writing new
18 business in the small employer market in this state for a
19 period of five years from the date of notice to the
20 commissioner or director.

21 Sec. 25. Section 513B.11, subsection 2, Code 1997, is
22 amended to read as follows:

23 2. A reinsuring carrier that applies and is approved to
24 operate as a risk-assuming carrier shall not be permitted to
25 continue to reinsure any health benefit-plan insurance
26 coverage with the program. The carrier shall pay a prorated
27 assessment based upon business issued as a reinsuring carrier
28 for any portion of the year that the business was reinsured.

29 Sec. 26. Section 513B.13, subsection 7, unnumbered
30 paragraph 1, Code 1997, is amended to read as follows:

31 The same general powers and authority granted under the
32 laws of this state to insurance companies and health
33 maintenance organizations licensed to transact business in
34 this state may be exercised by the board under the program,
35 except the power to issue health benefit-plans insurance

1 coverages directly to either groups or individuals.

2 Additionally, the board is granted the specific authority to
3 do all or any of the following:

4 Sec. 27. Section 513B.13, subsection 7, paragraph d, Code
5 1997, is amended to read as follows:

6 d. Define the health benefit-plans insurance coverages for
7 which reinsurance will be provided, and issue reinsurance
8 policies, pursuant to this subchapter.

9 Sec. 28. Section 513B.13, subsection 8, paragraph b, Code
10 1997, is amended to read as follows:

11 b. A small employer carrier may reinsure an entire
12 employer group within sixty days of the commencement of the
13 group's coverage under a-health-benefit-plan health insurance
14 coverage.

15 Sec. 29. Section 513B.13, subsection 9, paragraph a, Code
16 1997, is amended to read as follows:

17 a. The board, as part of the plan of operation, shall
18 establish a methodology for determining premium rates to be
19 charged by the program for reinsuring small employers and
20 individuals pursuant to this section. The methodology shall
21 include a system for classification of small employers that
22 reflects the types of case characteristics commonly used by
23 small employer carriers in the state. The methodology shall
24 provide for the development of base reinsurance premium rates,
25 which shall be multiplied by the factors set forth in
26 paragraph "b" to determine the premium rates for the program.
27 The base reinsurance premium rates shall be established by the
28 board, subject to the approval of the commissioner, and shall
29 be set at levels which reasonably approximate gross premiums
30 charged to small employers by small employer carriers for
31 health benefit-plans insurance coverages with benefits similar
32 to the standard health benefit plan.

33 Sec. 30. Section 513B.13, subsection 10, Code 1997, is
34 amended to read as follows:

35 10. If a-health-benefit-plan health insurance coverage for

1 a small employer is entirely or partially reinsured with the
2 program, the premium charged to the small employer for any
3 rating period for the coverage issued shall meet the
4 requirements relating to premium rates set forth in section
5 513B.4.

6 Sec. 31. Section 513B.13, subsection 11, paragraph b,
7 subparagraphs (1), (2), and (3), Code 1997, are amended to
8 read as follows:

9 (1) The board shall establish, as part of the plan of
10 operation, a formula by which to make assessments against
11 reinsuring carriers. The assessment formula shall be based on
12 both of the following:

13 (a) Each reinsuring carrier's share of the total premiums
14 earned in the preceding calendar year from health benefit
15 plans insurance coverages delivered or issued for delivery to
16 small employers in this state by reinsuring carriers.

17 (b) Each reinsuring carrier's share of the premiums earned
18 in the preceding calendar year from newly issued health
19 benefit-plans insurance coverages delivered or issued for
20 delivery during such calendar year to small employers in this
21 state by reinsuring carriers.

22 (2) The formula established pursuant to subparagraph (1)
23 shall not result in any reinsuring carrier having an
24 assessment share that is less than fifty percent nor more than
25 one hundred fifty percent of an amount which is based on the
26 proportion of the reinsuring carrier's total premiums earned
27 in the preceding calendar year from health benefit-plans
28 insurance coverages delivered or issued for delivery to small
29 employers in this state by reinsuring carriers to total
30 premiums earned in the preceding calendar year from health
31 benefit-plans insurance coverages delivered or issued for
32 delivery to small employers in this state by all reinsuring
33 carriers.

34 (3) The board, with approval of the commissioner, may
35 change the assessment formula established pursuant to

1 subparagraph (1) from time to time as appropriate. The board
2 may provide for the shares of the assessment base attributable
3 to premiums from all health benefit-plans insurance coverages
4 and to premiums from newly issued health benefit-plans
5 insurance coverages to vary during a transition period.

6 Sec. 32. Section 513B.13, subsection 11, paragraph c,
7 subparagraph (3), Code 1997, is amended to read as follows:

8 (3) For any calendar year, the amount specified in this
9 subparagraph is five percent of total premiums earned in the
10 previous year from health benefit-plans insurance coverages
11 delivered or issued for delivery to small employers in this
12 state by reinsuring carriers.

13 Sec. 33. Section 513B.15, Code 1997, is amended to read as
14 follows:

15 513B.15 PERIODIC MARKET EVALUATION.

16 The board shall study and report at least every three years
17 to the commissioner on the effectiveness of this subchapter.
18 The report shall analyze the effectiveness of the subchapter
19 in promoting rate stability, product availability, and
20 coverage affordability. The report may contain
21 recommendations for actions to improve the overall
22 effectiveness, efficiency, and fairness of the small group
23 health insurance marketplace. The report shall address
24 whether carriers and producers are fairly and actively
25 marketing or issuing health benefit-plans insurance coverages
26 to small employers in fulfillment of the purposes of this
27 subchapter. The report may contain recommendations for market
28 conduct or other regulatory standards or action.

29 Sec. 34. Section 513B.17, subsection 3, Code 1997, is
30 amended to read as follows:

31 3. The commissioner may adopt, by rule or order,
32 transition provisions to facilitate the-orderly-and
33 coordinated-implementation-of-1992-Iowa-Acts,-chapter-1167 the
34 implementation and administration of this chapter.

35 Sec. 35. Section 513B.17A, Code 1997, is amended to read

1 as follows:

2 513B.17A RESTORATION OF TERMINATED COVERAGE.

3 The commissioner may adopt rules to require small employer
4 carriers, as a condition of transacting business with small
5 employers in this state after July 1, 1993, to reissue a
6 health-benefit-plan health insurance coverage to any small
7 employer whose health benefit-plan insurance coverage is
8 terminated or not renewed by a carrier after January 1, 1993,
9 unless the carrier's termination is pursuant to section
10 513B.5. The commissioner may prescribe such terms for the
11 reissuance of coverage as the commissioner finds are
12 reasonable and necessary to provide continuity of coverage to
13 such employers.

14 Sec. 36. Section 513C.6, Code 1997, is amended by striking
15 the section and inserting in lieu thereof the following:

16 513C.6 PROVISIONS ON RENEWABILITY OF COVERAGE.

17 1. An individual health benefit plan subject to this
18 chapter is renewable with respect to an eligible individual or
19 dependents, at the option of the individual, except for one or
20 more of the following reasons:

21 a. The individual fails to pay, or to make timely payment
22 of, premiums or contributions pursuant to the terms of the
23 individual health benefit plan.

24 b. The individual performs an act or practice constituting
25 fraud or makes an intentional misrepresentation of a material
26 fact under the terms of the individual health benefit plan.

27 c. A decision by the individual carrier or organized
28 delivery system to discontinue offering a particular type of
29 individual health benefit plan in the state's individual
30 insurance market. An individual health benefit plan may be
31 discontinued by the carrier or organized delivery system in
32 that market with the approval of the commissioner or the
33 director and only if the carrier or organized delivery system
34 does all of the following:

35 (1) Provides advance notice of its decision to discontinue

1 such plan to the commissioner or director. Notice to the
2 commissioner or director, at a minimum, shall be no less than
3 three days prior to the notice provided for in subparagraph
4 (2) to affected individuals.

5 (2) Provides notice of its decision not to renew such plan
6 to all affected individuals no less than ninety days prior to
7 the nonrenewal date of any discontinued individual health
8 benefit plans.

9 (3) Offers to each individual of the discontinued plan the
10 option to purchase any other health plan currently offered by
11 the carrier or organized delivery system to individuals in
12 this state.

13 (4) Acts uniformly in opting to discontinue the plan and
14 in offering the option under subparagraph (3), without regard
15 to the claims experience of any affected eligible individual
16 or beneficiary under the discontinued plan or to a health
17 status-related factor relating to any covered individuals or
18 beneficiaries who may become eligible for the coverage.

19 d. A decision by the carrier or organized delivery system
20 to discontinue offering and to cease to renew all of its
21 individual health benefit plans delivered or issued for
22 delivery to individuals in this state. A carrier or organized
23 delivery system making such decision shall do all of the
24 following:

25 (1) Provide advance notice of its decision to discontinue
26 such plan to the commissioner or director. Notice to the
27 commissioner or director, at a minimum, shall be no less than
28 three days prior to the notice provided for in subparagraph
29 (2) to affected individuals.

30 (2) Provide notice of its decision not to renew such plan
31 to all individuals and to the commissioner or director in each
32 state in which an individual under the discontinued plan is
33 known to reside no less than one hundred eighty days prior to
34 the nonrenewal of the plan.

35 e. The commissioner or director finds that the

1 continuation of the coverage is not in the best interests of
2 the individuals, or would impair the carrier's or organized
3 delivery system's ability to meet its contractual obligations.

4 2. At the time of coverage renewal, a carrier or organized
5 delivery system may modify the health insurance coverage for a
6 policy form offered to individuals in the individual market so
7 long as such modification is consistent with state law and
8 effective on a uniform basis among all individuals with that
9 policy form.

10 3. An individual carrier or organized delivery system that
11 elects not to renew an individual health benefit plan under
12 subsection 1, paragraph "d", shall not write any new business
13 in the individual market in this state for a period of five
14 years after the date of notice to the commissioner or
15 director.

16 4. This section, with respect to a carrier or organized
17 delivery system doing business in one established geographic
18 service area of the state, applies only to such carrier's or
19 organized delivery system's operations in that service area.

20 5. A carrier or organized delivery system offering
21 coverage through a network plan is not required to renew or
22 continue in force coverage or to accept applications from an
23 individual who no longer resides or lives in, or is no longer
24 employed in, the service area of such carrier or organized
25 delivery system, or no longer resides or lives in, or is no
26 longer employed in, a service area for which the carrier is
27 authorized to do business, but only if coverage is not offered
28 or terminated uniformly without regard to health status-
29 related factors of a covered individual.

30 6. A carrier or organized delivery system offering
31 coverage through a bona fide association is not required to
32 renew a continue in force coverage or to accept applications
33 from an individual through an association if the membership of
34 the individual in the association on which the basis of
35 coverage is provided ceases, but only if the coverage is not

1 offered or terminated under this paragraph uniformly without
2 regard to health status-related factors of a covered
3 individual.

4 Sec. 37. Section 513C.7, subsection 1, paragraph b, Code
5 1997, is amended to read as follows:

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

10 Sec. 38. Section 513C.7, subsection 2, Code 1997, is
11 amended to read as follows:

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

19 Sec. 39. Section 513C.7, subsection 4, paragraph b, Code
20 1997, is amended to read as follows:

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

30 Sec. 40. Section 513C.9, Code 1997, is amended by adding
31 the following new subsection:

32 NEW SUBSECTION. 4A. Notwithstanding subsection 4, a
33 commission shall be paid to an agent related to the sale of a
34 basic or standard health benefit plan under this chapter. A
35 commission paid pursuant to this subsection shall not be

1 considered by the board for purposes of section 513C.10,
2 subsection 9.

3 Sec. 41. NEW SECTION. 513C.12 COMMISSIONER'S DUTIES.

4 The commissioner shall adopt rules administering this
5 chapter.

6 Sec. 42. Section 514E.1, Code 1997, is amended by adding
7 the following new subsections:

8 NEW SUBSECTION. 3A. "Church plan" means the same as
9 defined in the federal Employee Retirement Income Security Act
10 of 1974, 29 U.S.C. § 3(33).

11 NEW SUBSECTION. 4A. "Creditable coverage" means health
12 benefits or coverage provided to an individual under any of
13 the following:

14 a. A group health plan.

15 b. Health insurance coverage.

16 c. Part A or Part B Medicare pursuant to Title XVIII of
17 the federal Social Security Act.

18 d. Medicaid pursuant to Title XIX of the federal Social
19 Security Act, other than coverage consisting solely of
20 benefits under section 1928 of that Act.

21 e. 10 U.S.C. ch. 55.

22 f. A health or medical care program provided through the
23 Indian health service or a tribal organization.

24 g. A state health benefits risk pool.

25 h. A health plan offered under 5 U.S.C. ch. 89.

26 i. A public health plan as defined under federal
27 regulations.

28 j. A health benefit plan under section 5(e) of the federal
29 Peace Corps Act, 22 U.S.C. § 2504(e).

30 k. An organized delivery system licensed by the director
31 of public health.

32 NEW SUBSECTION. 4B. "Director" means the director of
33 public health.

34 NEW SUBSECTION. 5A. "Federally eligible individual" means
* 35 an individual who satisfies the following:

1 a. For whom, as of the date on which the individual seeks
2 coverage under this chapter, the aggregate of the periods of
3 creditable coverage is eighteen or more months with no more
4 than a sixty-three day lapse of coverage, and whose most
5 recent prior creditable coverage was under a group health
6 plan, governmental plan, or church plan, or health insurance
7 coverage offered in connection with any such plan.

8 b. Who is not eligible for coverage under a group health
9 plan, Part A or Part B of Title XVIII of the federal Social
10 Security Act, or a state plan under Title XIX of that Act, or
11 any successor program, and does not have other health
12 insurance coverage.

13 c. With respect to whom the most recent coverage within
14 the coverage period described in paragraph "a" was not
15 terminated based on a nonpayment of premiums or fraud.

16 d. If the individual had been offered the option of
17 continuation coverage under a COBRA continuation provision or
18 under a similar state program, and elected such coverage.

19 e. Who, if the individual elected continuation coverage as
20 provided in paragraph "d", has exhausted the continuation
21 coverage under the provision or program.

22 NEW SUBSECTION. 5B. "Governmental plan" means as defined
23 under section 3(32) of the federal Employee Retirement Income
24 Security Act of 1974 and any federal governmental plan.

25 NEW SUBSECTION. 5C. a. "Group health plan" means an
26 employee welfare benefit plan as defined in section 3(1) of
27 the federal Employee Retirement Income Security Act of 1974,
28 to the extent that the plan provides medical care including
29 items and services paid for as medical care to employees or
30 their dependents as defined under the terms of the plan
31 directly or through insurance, reimbursement, or otherwise.

32 b. For purposes of this subsection, "medical care" means
33 amounts paid for any of the following:

34 (1) The diagnosis, cure, mitigation, treatment, or
35 prevention of disease, or amounts paid for the purpose of

1 affecting a structure or function of the body.

2 (2) Transportation primarily for and essential to medical
3 care referred to in subparagraph (1).

4 (3) Insurance covering medical care referred to in
5 subparagraph (1) or (2).

6 c. For purposes of this chapter, the following apply:

7 (1) A plan, fund, or program established or maintained by
8 a partnership which, but for this subsection, would not be an
9 employee welfare benefit plan, shall be treated as an employee
10 welfare benefit plan which is a group health plan to the
11 extent that the plan, fund, or program provides medical care,
12 including items and services paid for as medical care for
13 present or former partners in the partnership or to the
14 dependents of such partners, as defined under the terms of the
15 plan, fund, or program, either directly or through insurance,
16 reimbursement, or otherwise.

17 (2) With respect to a group health plan, the term
18 "employer" includes a partnership with respect to a partner.

19 (3) With respect to a group health plan, the term
20 participant includes the following:

21 (a) With respect to a group health plan maintained by a
22 partnership, an individual who is a partner in the
23 partnership.

24 (b) With respect to a group health plan maintained by a
25 self-employed individual under which one or more of the self-
26 employed individual's employees are participants, the self-
27 employed individual, if that individual is, or may become,
28 eligible to receive benefits under the plan or the
29 individual's dependents may be eligible to receive benefits
30 under the plan.

31 NEW SUBSECTION. 8A. a. "Health insurance coverage" means
32 health insurance coverage offered to individuals, but does not
33 include short-term limited duration insurance.

34 b. "Health insurance coverage" does not include any of the
35 following:

1 (1) Coverage for accident-only, or disability income
2 insurance.

3 (2) Coverage issued as a supplement to liability
4 insurance.

5 (3) Liability insurance, including general liability
6 insurance and automobile liability insurance.

7 (4) Workers' compensation or similar insurance.

8 (5) Automobile medical-payment insurance.

9 (6) Credit-only insurance.

10 (7) Coverage for on-site medical clinic care.

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

15 c. "Health insurance coverage" does not include benefits
16 provided under a separate policy as follows:

17 (1) Limited-scope dental or vision benefits.

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

20 (3) Any other similar limited benefits as provided by rule
21 of the commissioner.

22 d. "Health insurance coverage" does not include benefits
23 offered as independent noncoordinated benefits as follows:

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

25 (2) A hospital indemnity or other fixed indemnity
26 insurance.

27 e. "Health insurance coverage" does not include Medicare
28 supplemental health insurance as defined under section
29 1882(g)(1) of the federal Social Security Act, coverage
30 supplemental to the coverage provided under 10 U.S.C. ch. 55
31 and similar supplemental coverage provided to coverage under
32 group health insurance coverage.

33 NEW SUBSECTION. 10A. "Involuntary termination" includes,
34 but is not limited to, termination of coverage when a
35 conversion policy is not available or where benefits under a

1 state or federal law providing for continuation of coverage
2 upon termination of employment will cease or have ceased.

3 NEW SUBSECTION. 12A. "Organized delivery system" means an
4 organized delivery system as licensed by the director of the
5 department of public health.

6 NEW SUBSECTION. 15. "Preexisting condition exclusion",
7 with respect to coverage, means a limitation or exclusion of
8 benefits relating to a condition based on the fact that the
9 condition was present before the date of enrollment for such
10 coverage, whether or not any medical advice, diagnosis, care,
11 or treatment was recommended or received before such date.

12 Sec. 43. Section 514E.1, subsection 9, Code 1997, is
13 amended by striking the subsection.

14 Sec. 44. Section 514E.2, subsection 1, Code 1997, is
15 amended to read as follows:

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

29 Sec. 45. Section 514E.2, subsection 2, unnumbered
30 paragraph 1, Code 1997, is amended to read as follows:

31 The board of directors of the association shall consist of
32 four members selected by the members of the association, two
33 of whom shall be representatives from corporations operating
34 pursuant to chapter 514 on July 1, 1989, or any successors in
35 interest, and two of whom shall be representatives of

1 organized delivery systems or insurers providing coverage
2 pursuant to chapter 509 or 514A; four public members selected
3 by the governor; the commissioner or the commissioner's
4 designee from the division of insurance; and two members of
5 the general assembly, one of whom shall be appointed by the
6 speaker of the house and one of whom shall be appointed by the
7 president of the senate, after consultation with the majority
8 leader and the minority leader of the senate, who shall be ex
9 officio and nonvoting members. The composition of the board
10 of directors shall be in compliance with sections 69.16 and
11 69.16A. The governor's appointees shall be chosen from a
12 broad cross-section of the residents of this state.

13 Sec. 46. Section 514E.2, subsection 3, paragraph f, Code
14 1997, is amended by striking the paragraph.

15 Sec. 47. Section 514E.2, subsection 7, Code 1997, is
16 amended to read as follows:

17 7. Following the close of each calendar year, the
18 association shall determine the net premiums and payments, the
19 expenses of administration, and the incurred losses of the
20 association for the year. The association shall certify the
21 amount of any net loss for the preceding calendar year to the
22 commissioner of insurance and director of revenue and finance
23 ~~who shall make payment to the association according to~~
24 ~~procedures established under subsection 37-paragraph "f". Any~~
25 ~~remaining loss, after payment to the association from the~~
26 ~~health insurance trust fund, shall be assessed by the~~
27 association to all members in proportion to their respective
28 shares of total health insurance premiums or payments for
29 subscriber contracts received in Iowa during the second
30 preceding calendar year, or with paid losses in the year,
31 coinciding with or ending during the calendar year or on any
32 other equitable basis as provided in the plan of operation.
33 In sharing losses, the association may abate or defer in any
34 part the assessment of a member, if, in the opinion of the
35 board, payment of the assessment would endanger the ability of

1 the member to fulfill its contractual obligations. The
2 association may also provide for an initial or interim
3 assessment against members of the association if necessary to
4 assure the financial capability of the association to meet the
5 incurred or estimated claims expenses or operating expenses of
6 the association until the next calendar year is completed.
7 Net gains, if any, must be held at interest to offset future
8 losses or allocated to reduce future premiums.

9 Sec. 48. Section 514E.2, subsection 12, Code 1997, is
10 amended by striking the subsection.

11 Sec. 49. Section 514E.5, subsection 2, Code 1997, is
12 amended to read as follows:

13 2. Services and charges made for benefits provided under
14 the laws of the United States, ~~including~~ excluding Medicare
15 and Medicaid, military service-connected disabilities, but
16 including medical services provided for members of the armed
17 forces and their dependents or for employees of the armed
18 forces of the United States, and medical services financed on
19 behalf of all citizens by the United States.

20 However, the association policy shall pay benefits as a
21 primary payer in any case where benefit coverage provided
22 under the laws of the United States, ~~including Medicare and~~
23 Medicaid, or under the laws of this state is, by rule or
24 statute, secondary to all other coverages.

25 Sec. 50. Section 514E.6, subsection 3, paragraph e, Code
26 1997, is amended by striking the paragraph and inserting in
27 lieu thereof the following:

28 e. An amount as determined by the association for any
29 other association policy offered.

30 Sec. 51. Section 514E.6, subsection 6, Code 1997, is
31 amended by striking the subsection and inserting in lieu
32 thereof the following:

33 6. The association, in addition to other policies, shall
34 offer one which is comparable to the standard health benefit
35 plan as defined in section 513B.2.

1 Sec. 52. Section 514E.7, subsections 1, 2, and 5, Code
2 1997, are amended by striking the subsections and inserting in
3 lieu thereof the following:

4 1. An individual who is and continues to be a resident is
5 eligible for plan coverage if evidence is provided of any of
6 the following:

7 a. A notice of rejection or refusal to issue substantially
8 similar insurance for health reasons by one carrier or
9 organized delivery system.

10 b. A refusal by a carrier or organized delivery system to
11 issue insurance except at a rate exceeding the plan rate.

12 c. That the individual is a federally defined eligible
13 individual.

14 A rejection or refusal by a carrier or organized delivery
15 system offering only stoploss, excess of loss, or reinsurance
16 coverage with respect to an applicant under paragraphs "a" and
17 "b" is not sufficient evidence for purposes of this
18 subsection.

19 5. a. A preexisting condition exclusion shall not apply
20 to a federally defined eligible individual.

21 b. Plan coverage shall not impose any preexisting
22 condition as follows:

23 (1) In the case of a child who is adopted or placed for
24 adoption before attaining eighteen years of age and who, as of
25 the last day of the thirty-day period beginning on the date of
26 the adoption or placement for adoption, is covered under
27 creditable coverage. This subparagraph shall not apply to
28 coverage before the date of such adoption or placement for
29 adoption.

30 (2) In the case of an individual who, as of the last day
31 of the thirty-day period beginning with the date of birth, is
32 covered under creditable coverage.

33 (3) Relating to pregnancy as a preexisting condition.

34 c. Plan coverage shall exclude charges or expenses
35 incurred during the first six months following the effective

1 date of coverage for preexisting conditions. Such preexisting
2 condition exclusions shall be waived to the extent that
3 similar exclusions, if any, have been satisfied under any
4 prior health insurance coverage which was involuntarily
5 terminated, provided both of the following apply:

6 (1) Application for association coverage is made no later
7 than sixty-three days following such involuntary termination
8 and, in such case, coverage under the plan is effective from
9 the date on which such prior coverage was terminated.

10 (2) The applicant is not eligible for continuation or
11 conversion rights that would provide coverage substantially
12 similar to plan coverage.

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

17 If the association policy contains a waiting period for
18 preexisting conditions, an insured may retain any existing
19 coverage the insured has under an insurance plan that has
20 coverage equivalent to the association policy for the duration
21 of the waiting period only.

22 Sec. 53. Section 514E.7, subsection 6, Code 1997, is
23 amended to read as follows:

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

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

28 b. The individual has terminated coverage by the
29 association within the past twelve months, except that this
30 paragraph does not apply to an applicant who is a federally
31 eligible individual.

32 c. The individual is an inmate of a public institution ~~or~~
33 ~~is-eligible-for-public-programs-for-which-medical-care-is~~
34 ~~provided, except that this paragraph does not apply to an~~
35 applicant who is a federally defined eligible individual.

1 d. The individual premiums are paid for or reimbursed
2 under any government sponsored program or by any government
3 agency or health care provider, except as an otherwise
4 qualifying full-time employee, or dependent of the employee,
5 of a government agency or health care provider.

6 e. The individual, on the effective date of the coverage
7 applied for, has not been rejected for, already has, or will
8 have coverage similar to an association policy as an insured
9 or covered dependent. This paragraph does not apply to an
10 applicant who is a federally eligible individual.

11 Sec. 54. Section 514E.9, Code 1997, is amended to read as
12 follows:

13 514E.9 RULES.

14 Pursuant to chapter 17A, the commissioner and the director
15 of public health shall adopt rules to provide for disclosure
16 by carriers and organized delivery systems of the availability
17 of insurance coverage from the association, and to otherwise
18 implement this chapter.

19 Sec. 55. Section 514E.11, Code 1997, is amended to read as
20 follows:

21 514E.11 NOTICE OF ASSOCIATION POLICY.

22 ~~Commencing July 1, 1986, every~~ Every carrier, including a
23 health maintenance organization subject to chapter 514B and an
24 organized delivery system, authorized to provide health care
25 insurance or coverage for health care services in Iowa, shall
26 provide a notice ~~and an application for~~ of the availability of
27 coverage by the association to any person who receives a
28 rejection of coverage for health insurance or health care
29 services, or a notice to any person who is informed that a
30 rate for health insurance or coverage for health care services
31 will exceed the rate of an association policy, ~~that effective~~
32 ~~January 1, 1987,~~ that person is eligible to apply for health
33 insurance provided by the association. Application for the
34 health insurance shall be on forms prescribed by the board and
35 made available to the carriers and organized delivery systems.

Sec. 56. Section 514E.3, Code 1997, is repealed.

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DIX CHAIR

METCALF

HOLUECK

HSB 235

COMMERCE AND REGULATION

SENATE/HOUSE FILE ^{S.} ^{or} ^{By} 701
BY (PROPOSED DEPARTMENT OF
COMMERCE/INSURANCE DIVISION
BILL)

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

A BILL FOR

1 An Act relating to the requirements for portability and
2 continuity of health care coverage for individuals among
3 certain types of health care coverage, and related matters.

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

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1 Section 1. Section 509.3, Code 1997, is amended by adding
2 the following new unnumbered paragraph:

3 NEW UNNUMBERED PARAGRAPH. In addition to the provisions
4 required in subsections 1 through 8, the commissioner shall
5 require provisions through the adoption of rules implementing
6 the federal Health Insurance Portability and Accountability
7 Act, Pub. L. No. 104-191.

8 Sec. 2. Section 513B.2, subsection 4, Code 1997, is
9 amended by striking the subsection and inserting in lieu
10 thereof the following:

11 4. "Carrier" means an entity subject to the insurance laws
12 and regulations of this state, or subject to the jurisdiction
13 of the commissioner, that contracts or offers to contract to
14 provide, deliver, arrange for, pay for, or reimburse any of
15 the costs of health care services, including an insurance
16 company offering sickness and accident plans, a health
17 maintenance organization, a nonprofit health service
18 corporation, or any other entity providing a plan of health
19 insurance, health benefits, or health services.

20 Sec. 3. Section 513B.2, subsection 9, Code 1997, is
21 amended to read as follows:

22 9. "Eligible employee" means an employee who works ~~on-a~~
23 ~~full-time-basis-and-has-a-normal-work-week-of-thirty-or-more~~
24 hours for a small employer. The term includes a sole
25 proprietor, a partner of a partnership, and an independent
26 contractor, if the sole proprietor, partner, or independent
27 contractor is included as an employee under a health benefit
28 plan of a small employer, ~~but does not include an employee who~~
29 ~~works-on-a-part-time, temporary, or substitute basis.~~

30 Sec. 4. Section 513B.2, subsection 10, Code 1997, is
31 amended by striking the subsection and inserting in lieu
32 thereof the following:

33 10. a. "Health insurance coverage" means benefits
34 consisting of health care provided directly, through insurance
35 or reimbursement, or otherwise and including items and

1 services paid for as health care under a hospital or health
2 service policy or certificate, hospital or health service plan
3 contract, or health maintenance organization contract offered
4 by a carrier.

5 b. "Health insurance coverage" does not include any of the
6 following:

7 (1) Coverage for accident-only, or disability income
8 insurance.

9 (2) Coverage issued as a supplement to liability
10 insurance.

11 (3) Liability insurance, including general liability
12 insurance and automobile liability insurance.

13 (4) Workers' compensation or similar insurance.

14 (5) Automobile medical-payment insurance.

15 (6) Credit-only insurance.

16 (7) Coverage for on-site medical clinic care.

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

21 c. "Health insurance coverage" does not include benefits
22 provided under a separate policy as follows:

23 (1) Limited scope dental or vision benefits.

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

26 (3) Any other similar limited benefits as provided by rule
27 of the commissioner.

28 d. "Health insurance coverage" does not include benefits
29 offered as independent noncoordinated benefits as follows:

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

31 (2) A hospital indemnity or other fixed indemnity
32 insurance.

33 e. "Health insurance coverage" does not include Medicare
34 supplemental health insurance as defined under § 1882(g)(1) of
35 the federal Social Security Act, coverage supplemental to the

1 coverage provided under 10 U.S.C. ch. 55, and similar
2 supplemental coverage provided to coverage under group health
3 insurance coverage.

4 f. "Group health insurance coverage" means health
5 insurance coverage offered in connection with a group health
6 plan.

7 Sec. 5. Section 513B.2, subsection 12, paragraph a, Code
8 1997, is amended to read as follows:

9 a. The individual meets all of the following:

10 (1) The individual was covered under ~~qualifying-previous~~
11 creditable coverage at the time of the initial enrollment.

12 (2) The individual lost creditable coverage under
13 ~~qualifying-previous-coverage~~ as a result of termination of the
14 individual's employment or eligibility, the involuntary
15 termination of the ~~qualifying-previous~~ creditable coverage,
16 death of the individual's spouse, or the individual's divorce.

17 (3) The individual requests enrollment within thirty days
18 after termination of the ~~qualifying-previous~~ creditable
19 coverage.

20 Sec. 6. Section 513B.2, subsection 12, Code 1997, is
21 amended by adding the following new paragraphs:

22 NEW PARAGRAPH. d. The individual changes status and
23 becomes an eligible employee and requests enrollment within
24 sixty-three days after the date of the change in status.

25 NEW PARAGRAPH. e. The individual was covered under a
26 mandated continuation of group health plan or group health
27 insurance coverage plan until the coverage under that plan was
28 exhausted.

29 Sec. 7. Section 513B.2, Code 1997, is amended by adding
30 the following new subsections:

31 NEW SUBSECTION. 7A. "Creditable coverage" means health
32 benefits or coverage provided to an individual under any of
33 the following:

34 a. A group health plan.

35 b. Health insurance coverage.

1 c. Part A or Part B Medicare pursuant to Title XVIII of
2 the federal Social Security Act.

3 d. Medicaid pursuant to Title XIX of the federal Social
4 Security Act, other than coverage consisting solely of
5 benefits under section 1928 of that Act.

6 e. 10 U.S.C. ch. 55.

7 f. A health or medical care program provided through the
8 Indian health service or a tribal organization.

9 g. A state health benefits risk pool.

10 h. A health plan offered under 5 U.S.C. ch. 89.

11 i. A public health plan as defined under federal
12 regulations.

13 j. A health benefit plan under section 5(e) of the federal
14 Peace Corps Act, 22 U.S.C. § 2504(e).

15 k. An organized delivery system licensed by the director
16 of public health.

17 NEW SUBSECTION. 9A. a. "Group health plan" means an
18 employee welfare benefit plan as defined in section 3(1) of
19 the federal Employee Retirement Income Security Act of 1974,
20 to the extent that the plan provides medical care including
21 items and services paid for as medical care to employees or
22 their dependents as defined under the terms of the plan
23 directly or through insurance, reimbursement, or otherwise.

24 b. For purposes of this subsection, "medical care" means
25 amounts paid for any of the following:

26 (1) The diagnosis, cure, mitigation, treatment, or
27 prevention of disease, or amounts paid for the purpose of
28 affecting a structure or function of the body.

29 (2) Transportation primarily for and essential to medical
30 care referred to in subparagraph (1).

31 (3) Insurance covering medical care referred to in
32 subparagraph (1) or (2).

33 NEW SUBSECTION. 13A. "Preexisting conditions exclusion"
34 means, with respect to health insurance coverage, a limitation
35 or exclusion of benefits relating to a condition based on the

1 fact that the condition was present before the date of
2 enrollment for such coverage, whether or not any medical
3 advice, diagnosis, care, or treatment was recommended or
4 received before such date.

5 Sec. 8. Section 513B.2, subsection 14, Code 1997, is
6 amended by striking the subsection.

7 Sec. 9. Section 513B.5, Code 1997, is amended by striking
8 the section and inserting in lieu thereof the following:

9 513B.5 PROVISIONS ON RENEWABILITY OF COVERAGE.

10 1. Health insurance coverage subject to this chapter is
11 renewable with respect to all eligible employees or their
12 dependents, at the option of the small employer, except for
13 one or more of the following reasons:

14 a. The health insurance coverage sponsor fails to pay, or
15 to make timely payment of, premiums or contributions pursuant
16 to the terms of the health insurance coverage.

17 b. The health insurance coverage sponsor performs an act
18 or practice constituting fraud or makes an intentional
19 misrepresentation of a material fact under the terms of the
20 coverage.

21 c. Noncompliance with the carrier's or organized delivery
22 system's minimum participation requirements.

23 d. Noncompliance with the carrier's or organized delivery
24 system's employer contribution requirements.

25 e. A decision by the carrier or organized delivery system
26 to discontinue offering a particular type of health insurance
27 coverage in the state's small employer market. Health
28 insurance coverage may be discontinued by the carrier or
29 organized delivery system in that market only if the carrier
30 or organized delivery system does all of the following:

31 (1) Provides advance notice of its decision to discontinue
32 such plan to the commissioner or director of public health.
33 Notice to the commissioner or director, at a minimum, shall be
34 no less than three days prior to the notice provided for in
35 subparagraph (2) to affected small employers, participants,

1 and beneficiaries.

2 (2) Provides notice of its decision not to renew such plan
3 to all affected small employers, participants, and
4 beneficiaries no less than ninety days prior to the nonrenewal
5 of the plan.

6 (3) Offers to each plan sponsor of the discontinued
7 coverage, the option to purchase any other coverage currently
8 offered by the carrier or organized delivery system to other
9 employers in this state.

10 (4) Acts uniformly, in opting to discontinue the coverage
11 and in offering the option under subparagraph (3), without
12 regard to the claims experience of the sponsors under the
13 discontinued coverage or to a health status-related factor
14 relating to any participants or beneficiaries covered or new
15 participants or beneficiaries who may become eligible for the
16 coverage.

17 f. A decision by the carrier or organized delivery system
18 to discontinue offering and to cease to renew all of its
19 health insurance coverage delivered or issued for delivery to
20 small employers in this state. A carrier or organized
21 delivery system making such decision shall do all of the
22 following:

23 (1) Provide advance notice of its decision to discontinue
24 such coverage to the commissioner or director of public
25 health. Notice to the commissioner or director, at a minimum,
26 shall be no less than three days prior to the notice provided
27 for in subparagraph (2) to affected small employers,
28 participants, and beneficiaries.

29 (2) Provide notice of its decision not to renew such
30 coverage to all affected small employers, participants, and
31 beneficiaries no less than one hundred eighty days prior to
32 the nonrenewal of the coverage.

33 (3) Discontinue all health insurance coverage issued or
34 delivered for issuance to small employers in this state and
35 cease renewal of such coverage.

1 g. The membership of an employer in an association, which
2 is the basis for the coverage which is provided through such
3 association, ceases, but only if the termination of coverage
4 under this paragraph occurs uniformly without regard to any
5 health status-related factor relating to any covered
6 individual.

7 h. The commissioner or director of public health finds
8 that the continuation of the coverage is not in the best
9 interests of the policyholders or certificate holders, or
10 would impair the carrier's or organized delivery system's
11 ability to meet its contractual obligations.

12 i. At the time of coverage renewal, a carrier or organized
13 delivery system may modify the health insurance coverage for a
14 product offered under group health insurance coverage in the
15 small group market, for coverage that is available in such
16 market other than only through one or more bona fide
17 associations, if such modification is consistent with the laws
18 of this state, and is effective on a uniform basis among group
19 health insurance coverage with that product.

20 2. A carrier or organized delivery system that elects not
21 to renew health insurance coverage under subsection 1,
22 paragraph "f", shall not write any new business in the small
23 employer market in this state for a period of five years after
24 the date of notice to the commissioner or director of public
25 health.

26 3. This section, with respect to a carrier or organized
27 delivery system doing business in one established geographic
28 service area of the state, applies only to such carrier's or
29 organized delivery system's operations in that service area.

30 Sec. 10. NEW SECTION. 513B.9A ELIGIBILITY TO ENROLL.

31 1. A group health plan or a carrier offering group health
32 insurance coverage in connection with a group health plan
33 shall not establish rules for eligibility, including continued
34 eligibility, of an individual to enroll under the terms of the
35 plan based on any of the following health status-related

1 factors in relation to the individual or a dependent of the
2 individual:

3 a. Health status.

4 b. Medical condition, including both physical and mental
5 conditions.

6 c. Claims experience.

7 d. Receipt of health care.

8 e. Medical history.

9 f. Genetic information.

10 g. Evidence of insurability, including conditions arising
11 out of acts of domestic violence.

12 h. Disability.

13 2. Subsection 1 does not require a group health plan or
14 group health insurance coverage to provide particular benefits
15 other than those provided under the terms of the plan or
16 coverage, and does not prevent a plan or coverage from
17 establishing limitations or restrictions on the amount, level,
18 extent, or nature of the benefits or coverage for similarly
19 situated individuals enrolled in the plan or coverage.

20 3. Rules for eligibility to enroll under a group health
21 plan or group health insurance coverage include rules defining
22 any applicable waiting periods for such enrollment.

23 4. a. A group health plan or carrier offering health
24 insurance coverage in connection with a group health plan
25 shall not require an individual, as a condition of enrollment
26 or continued enrollment under the plan, to pay a premium or
27 contribution which is greater than a premium or contribution
28 for a similarly situated individual enrolled in the plan on
29 the basis of a health status-related factor in relation to the
30 individual or to a dependent of an individual enrolled under
31 the plan.

32 b. Paragraph "a" shall not be construed to do either of
33 the following:

34 (1) Restrict the amount that an employer may be charged
35 for coverage under a group health plan.

1 (2) Prevent a carrier or organized delivery system
2 offering group health insurance coverage from establishing
3 premium discounts or rebates or modifying otherwise applicable
4 copayments or deductibles in return for adherence to programs
5 of health promotion and disease prevention.

6 Sec. 11. Section 513B.10, Code 1997, is amended by
7 striking the section and inserting in lieu thereof the
8 following:

9 513B.10 AVAILABILITY OF COVERAGE.

10 1. a. A carrier or an organized delivery system that
11 offers health insurance coverage in the small group market
12 shall accept every small employer that applies for health
13 insurance coverage and shall accept for enrollment under such
14 coverage every eligible individual who applies for enrollment
15 during the period in which the individual first becomes
16 eligible to enroll under the terms of the group health plan
17 and shall not place any restriction which is inconsistent with
18 eligibility rules established under this chapter. A carrier
19 or organized delivery system shall offer health insurance
20 coverage which constitutes a basic health benefit plan and
21 which constitutes a standard health benefit plan.

22 b. A carrier or organized delivery system that offers
23 health insurance coverage in the small group market through a
24 network plan may do either of the following:

25 (1) Limit employers that may apply for such coverage to
26 those with eligible individuals who live, work, or reside in
27 the service area for such network plan.

28 (2) Deny such coverage to such employers within the
29 service area of such plan if the carrier or organized delivery
30 system has demonstrated, if required, to the applicable state
31 authority, both of the following:

32 (a) The carrier or organized delivery system will not have
33 the capacity to deliver services adequately to enrollees of
34 any additional groups because of its obligations to existing
35 group contract holders and enrollees.

1 (b) The carrier or organized delivery system is applying
2 this subparagraph uniformly to all employers without regard to
3 the claims experience of those employers and their employees
4 and their dependents, or any health status-related factor
5 relating to such employees or dependents.

6 c. A carrier or organized delivery system, upon denying
7 health insurance coverage in any service area pursuant to
8 paragraph "b", subparagraph (2), shall not offer coverage in
9 the small group market within such service area for a period
10 of one hundred eighty days after the date such coverage is
11 denied.

12 d. A carrier or organized delivery system may deny health
13 insurance coverage in the small group market if the issuer has
14 demonstrated, if required, to the commissioner or director of
15 public health both of the following:

16 (1) The carrier or organized delivery system does not have
17 the financial reserves necessary to underwrite additional
18 coverage.

19 (2) The carrier or organized delivery system is applying
20 the provisions of this subparagraph uniformly to all employers
21 in the small group market in this state consistent with state
22 law and without regard to the claims experience of those
23 employers and the employees and dependents of such employers,
24 or any health status-related factor relating to such employees
25 and their dependents.

26 e. A carrier or organized delivery system, upon denying
27 health insurance coverage in connection with group health
28 plans pursuant to paragraph "d", shall not offer coverage in
29 connection with group health plans in the small group market
30 in this state for a period of one hundred eighty days after
31 the date such coverage is denied or until the carrier or
32 organized delivery system has demonstrated to the commissioner
33 or director of public health that the carrier or organized
34 delivery system has sufficient financial reserves to
35 underwrite additional coverage, whichever is later. The

1 commissioner or director may provide for the application of
2 this paragraph on a service area-specific basis.

3 f. Paragraph "a" shall not be construed to preclude a
4 carrier or organized delivery system from establishing
5 employer contribution rules or group participation rules for
6 the offering of health insurance coverage in connection with a
7 group health plan in the small group market.

8 2. A carrier or organized delivery system, subject to
9 subsection 1, shall issue health insurance coverage to an
10 eligible small employer that applies for the coverage and
11 agrees to make the required premium payments and satisfy the
12 other reasonable provisions of the health insurance coverage
13 not inconsistent with this chapter. A carrier or organized
14 delivery system is not required to issue health insurance
15 coverage to a self-employed individual who is covered by, or
16 is eligible for coverage under, health insurance coverage
17 offered by an employer.

18 3. a. A carrier or organized delivery system shall file
19 with the commissioner or director of public health, in a form
20 and manner prescribed by the commissioner or director, the
21 basic health benefit plans and the standard health benefit
22 plans to be used by the carrier. Health insurance coverage
23 filed pursuant to this paragraph may be used by a carrier or
24 organized delivery system beginning thirty days after it is
25 filed unless the commissioner or director of public health
26 disapproves its use.

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

33 4. Health insurance coverage for small employers shall
34 satisfy all of the following:

35 a. A carrier or organized delivery system offering group

1 health insurance coverage, with respect to a participant or
2 beneficiary, may impose a preexisting condition exclusion only
3 as follows:

4 (1) The exclusion relates to a condition, whether physical
5 or mental, regardless of the cause of the condition, for which
6 medical advice, diagnosis, care, or treatment was recommended
7 or received within the six-month period ending on the
8 enrollment date. However, genetic information shall not be
9 treated as a condition under this subparagraph in the absence
10 of a diagnosis of the condition related to such information.

11 (2) The exclusion extends for a period of not more than
12 twelve months, or eighteen months in the case of a late
13 enrollee, after the enrollment date.

14 (3) The period of any such preexisting condition exclusion
15 is reduced by the aggregate of the periods of creditable
16 coverage applicable to the participant or beneficiary as of
17 the enrollment date.

18 b. A group health plan and a carrier or organized delivery
19 system offering group health insurance coverage shall not
20 impose any preexisting condition as follows:

21 (1) In the case of a child who is adopted or placed for
22 adoption before attaining eighteen years of age and who, as of
23 the last day of the thirty-day period beginning on the date of
24 the adoption or placement for adoption, is covered under
25 creditable coverage. This subparagraph shall not apply to
26 coverage before the date of such adoption or placement for
27 adoption.

28 (2) In the case of an individual who, as of the last day
29 of the thirty-day period beginning with the date of birth, is
30 covered under creditable coverage.

31 (3) Relating to pregnancy as a preexisting condition.

32 c. A carrier or organized delivery system shall waive any
33 waiting period applicable to a preexisting condition exclusion
34 or limitation period with respect to particular services under
35 health insurance coverage for the period of time an individual

1 was covered by creditable coverage, provided that the
2 creditable coverage was continuous to a date not more than
3 sixty-three days prior to the effective date of the new
4 coverage. Any period that an individual is in a waiting
5 period for any coverage under group health insurance coverage,
6 or is in an affiliation period, shall not be taken into
7 account in determining the period of continuous coverage. A
8 health maintenance organization that does not use preexisting
9 condition limitations in any of its health insurance coverage
10 may impose an affiliation period. For purposes of this
11 section, "affiliation period" means a period of time not to
12 exceed sixty days for new entrants and not to exceed ninety
13 days for late enrollees during which no premium shall be
14 collected and coverage issued is not effective, so long as the
15 affiliation period is applied uniformly, without regard to any
16 health status-related factors. This paragraph does not
17 preclude application of a waiting period applicable to all new
18 enrollees under the health insurance coverage, provided that
19 any carrier or organized delivery system-imposed waiting
20 period is no longer than sixty days and is used in lieu of a
21 preexisting condition exclusion.

22 d. Health insurance coverage may exclude coverage for late
23 enrollees for preexisting conditions for a period not to
24 exceed eighteen months.

25 e. (1) Requirements used by a carrier or organized
26 delivery system in determining whether to provide coverage to
27 a small employer shall be applied uniformly among all small
28 employers applying for coverage or receiving coverage from the
29 carrier or organized delivery system.

30 (2) In applying minimum participation requirements with
31 respect to a small employer, a carrier or organized delivery
32 system shall not consider employees or dependents who have
33 other creditable coverage in determining whether the
34 applicable percentage of participation is met.

35 (3) A carrier or organized delivery system shall not

1 increase any requirement for minimum employee participation or
2 modify any requirement for minimum employer contribution
3 applicable to a small employer at any time after the small
4 employer has been accepted for coverage.

5 f. (1) If a carrier or organized delivery system offers
6 coverage to a small employer, the carrier or organized
7 delivery system shall offer coverage to all eligible employees
8 of the small employer and the employees' dependents. A
9 carrier or organized delivery system shall not offer coverage
10 to only certain individuals or dependents in a small employer
11 group or to only part of the group.

12 (2) Except as provided under paragraphs "a" and "d", a
13 carrier or organized delivery system shall not modify health
14 insurance coverage with respect to a small employer or any
15 eligible employee or dependent through riders, endorsements,
16 or other means, to restrict or exclude coverage or benefits
17 for certain diseases, medical conditions, or services
18 otherwise covered by the health insurance coverage.

19 g. A carrier or organized delivery system offering
20 coverage through a network plan shall not be required to offer
21 coverage or accept applications pursuant to subsection 1 with
22 respect to a small employer where any of the following apply:

23 (1) The small employer does not have eligible individuals
24 who live, work, or reside in the service area for the network
25 plan.

26 (2) The small employer does have eligible individuals who
27 live, work, or reside in the service area for the network
28 plan, but the carrier or organized delivery system, if
29 required, has demonstrated to the commissioner or the director
30 of public health that it will not have the capacity to deliver
31 services adequately to enrollees of any additional groups
32 because of its obligations to existing group contract holders
33 and enrollees and that it is applying the requirements of this
34 lettered paragraph uniformly to all employers without regard
35 to the claims experience of those employers and their

1 employees and the employees' dependents, or any health status-
2 related factor relating to such employees and dependents.

3 (3) A carrier or organized delivery system, upon denying
4 health insurance coverage in a service area pursuant to
5 subparagraph (2), shall not offer coverage in the small
6 employer market within such service area for a period of one
7 hundred eighty days after the coverage is denied.

8 5. A carrier or organized delivery system shall not be
9 required to offer coverage to small employers pursuant to
10 subsection 1 for any period of time where the commissioner or
11 director of public health determines that the acceptance of
12 the offers by small employers in accordance with subsection 1
13 would place the carrier or organized delivery system in a
14 financially impaired condition.

15 6. A carrier or organized delivery system shall not be
16 required to provide coverage to small employers pursuant to
17 subsection 1 if the carrier or organized delivery system
18 elects not to offer new coverage to small employers in this
19 state. However, a carrier or organized delivery system that
20 elects not to offer new coverage to small employers under this
21 subsection shall be allowed to maintain its existing policies
22 in the state, subject to the requirements of section 513B.5.

23 7. A carrier or organized delivery system that elects not
24 to offer new coverage to small employers pursuant to
25 subsection 6 shall provide notice to the commissioner or
26 director of public health and is prohibited from writing new
27 business in the small employer market in this state for a
28 period of five years from the date of notice to the
29 commissioner or director.

30 Sec. 12. Section 513B.17, subsection 3, Code 1997, is
31 amended to read as follows:

32 3. The commissioner may adopt, by rule or order,
33 transition provisions to facilitate ~~the orderly and~~
34 ~~coordinated implementation of 1992 Iowa Acts, chapter 1167~~ the
35 implementation and administration of this chapter.

1 Sec. 13. Section 513C.6, Code 1997, is amended by striking
2 the section and inserting in lieu thereof the following:

3 513C.6 PROVISIONS ON RENEWABILITY OF COVERAGE.

4 1. An individual health benefit plan subject to this
5 chapter is renewable with respect to an eligible individual or
6 dependents, at the option of the individual, except for one or
7 more of the following reasons:

8 a. The individual fails to pay, or to make timely payment
9 of, premiums or contributions pursuant to the terms of the
10 individual health benefit plan.

11 b. The individual performs an act or practice constituting
12 fraud or makes an intentional misrepresentation of a material
13 fact under the terms of the individual health benefit plan.

14 c. A decision by the individual carrier or organized
15 delivery system to discontinue offering a particular type of
16 individual health benefit plan in the state's individual
17 insurance market. An individual health benefit plan may be
18 discontinued by the carrier or organized delivery system in
19 that market with the approval of the commissioner or the
20 director and only if the carrier or organized delivery system
21 does all of the following:

22 (1) Provides advance notice of its decision to discontinue
23 such plan to the commissioner or director. Notice to the
24 commissioner or director, at a minimum, shall be no less than
25 three days prior to the notice provided for in subparagraph
26 (2) to affected individuals.

27 (2) Provides notice of its decision not to renew such plan
28 to all affected individuals no less than ninety days prior to
29 the nonrenewal date of any discontinued individual health
30 benefit plans.

31 (3) Offers to each individual of the discontinued plan the
32 option to purchase any other health plan currently offered by
33 the carrier or organized delivery system to individuals in
34 this state.

35 (4) Acts uniformly in opting to discontinue the plan and

1 in offering the option under subparagraph (3), without regard
2 to the claims experience of any affected eligible individual
3 or beneficiary under the discontinued plan or to a health
4 status-related factor relating to any covered individuals or
5 beneficiaries who may become eligible for the coverage.

6 d. A decision by the carrier or organized delivery system
7 to discontinue offering and to cease to renew all of its
8 individual health benefit plans delivered or issued for
9 delivery to individuals in this state. A carrier or organized
10 delivery system making such decision shall do all of the
11 following:

12 (1) Provide advance notice of its decision to discontinue
13 such plan to the commissioner or director. Notice to the
14 commissioner or director, at a minimum, shall be no less than
15 three days prior to the notice provided for in subparagraph
16 (2) to affected individuals.

17 (2) Provide notice of its decision not to renew such plan
18 to all individuals and to the commissioner or director in each
19 state in which an individual under the discontinued plan is
20 known to reside no less than one hundred eighty days prior to
21 the nonrenewal of the plan.

22 e. The commissioner or director finds that the
23 continuation of the coverage is not in the best interests of
24 the individuals, or would impair the carrier's or organized
25 delivery system's ability to meet its contractual obligations.

26 2. At the time of coverage renewal, a carrier or organized
27 delivery system may modify the health insurance coverage for a
28 policy form offered to individuals in the individual market so
29 long as such modification is consistent with state law and
30 effective on a uniform basis among all individuals with that
31 policy form.

32 3. An individual carrier or organized delivery system that
33 elects not to renew an individual health benefit plan under
34 subsection 1, paragraph "d", shall not write any new business
35 in the individual market in this state for a period of five

1 years after the date of notice to the commissioner or
2 director.

3 4. This section, with respect to a carrier or organized
4 delivery system doing business in one established geographic
5 service area of the state, applies only to such carrier's or
6 organized delivery system's operations in that service area.

7 5. A carrier or organized delivery system offering
8 coverage through a network plan is not required to renew or
9 continue in force coverage or to accept applications from an
10 individual who no longer resides or lives in, or is no longer
11 employed in, the service area of such carrier or organized
12 delivery system, or no longer resides or lives in, or is no
13 longer employed in, a service area for which the carrier is
14 authorized to do business, but only if coverage is not offered
15 or terminated uniformly without regard to health status-
16 related factors of a covered individual.

17 Sec. 14. Section 513C.7, subsection 1, paragraph b, Code
18 1997, is amended to read as follows:

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

23 Sec. 15. Section 513C.7, subsection 2, Code 1997, is
24 amended to read as follows:

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

32 Sec. 16. Section 513C.7, subsection 4, paragraph b, Code
33 1997, is amended to read as follows:

34 b. A carrier or an organized delivery system shall waive
35 any time period applicable to a preexisting condition

1 exclusion or limitation period with respect to particular
2 services in an individual health benefit plan for the period
3 of time an individual was previously covered by qualifying
4 previous coverage that provided benefits with respect to such
5 services, provided that the qualifying previous coverage was
6 continuous to a date not more than ~~thirty~~ sixty-three days
7 prior to the effective date of the new coverage.

8 Sec. 17. NEW SECTION. 513C.12 COMMISSIONER'S DUTIES.

9 The commissioner shall adopt rules administering this
10 chapter.

11 Sec. 18. Section 514E.1, Code 1997, is amended by adding
12 the following new subsections:

13 NEW SUBSECTION. 3A. "Church plan" means as the same
14 defined in the federal Employee Retirement Income Security Act
15 of 1974, 29 U.S.C. § 3(33).

16 NEW SUBSECTION. 4A. "Creditable coverage" means health
17 benefits or coverage provided to an individual under any of
18 the following:

19 a. A group health plan.

20 b. Health insurance coverage.

21 c. Part A or Part B Medicare pursuant to Title XVIII of
22 the federal Social Security Act.

23 d. Medicaid pursuant to Title XIX of the federal Social
24 Security Act, other than coverage consisting solely of
25 benefits under section 1928 of that Act.

26 e. 10 U.S.C. ch. 55.

27 f. A health or medical care program provided through the
28 Indian health service or a tribal organization.

29 g. A state health benefits risk pool.

30 h. A health plan offered under 5 U.S.C. ch. 89.

31 i. A public health plan as defined under federal
32 regulations.

33 j. A health benefit plan under section 5(e) of the federal
34 Peace Corps Act, 22 U.S.C. § 2504(e).

35 k. An organized delivery system licensed by the director

1 of public health.

2 NEW SUBSECTION. 4B. "Director" means the director of
3 public health.

4 NEW SUBSECTION. 5A. "Federally eligible individual" means
5 an individual who satisfies any of the following:

6 a. For whom, as of the date on which the individual seeks
7 coverage under this chapter, the aggregate of the periods of
8 creditable coverage is eighteen or more months with no more
9 than a sixty-three day lapse of coverage, and whose most
10 recent prior creditable coverage was under a group health
11 plan, governmental plan, or church plan, or health insurance
12 coverage offered in connection with any such plan.

13 b. Who is not eligible for coverage under a group health
14 plan, Part A or Part B of Title XVIII of the federal Social
15 Security Act, or a state plan under Title XIX of that Act, or
16 any successor program, and does not have other health
17 insurance coverage.

18 c. With respect to whom the most recent coverage within
19 the coverage period described in paragraph "a" was not
20 terminated based on a nonpayment of premiums or fraud.

21 d. If the individual had been offered the option of
22 continuation coverage under a COBRA continuation provision or
23 under a similar state program, and elected such coverage.

24 e. Who, if the individual elected continuation coverage as
25 provided in paragraph "d", has exhausted the continuation
26 coverage under the provision or program.

27 NEW SUBSECTION. 5B. "Governmental plan" means as defined
28 under section 3(32) of the federal Employee Retirement Income
29 Security Act of 1974 and any federal governmental plan.

30 NEW SUBSECTION. 5C. a. "Group health plan" means an
31 employee welfare benefit plan as defined in section 3(1) of
32 the federal Employee Retirement Income Security Act of 1974,
33 to the extent that the plan provides medical care including
34 items and services paid for as medical care to employees or
35 their dependents as defined under the terms of the plan

1 directly or through insurance, reimbursement, or otherwise.

2 b. For purposes of this subsection, "medical care" means
3 amounts paid for any of the following:

4 (1) The diagnosis, cure, mitigation, treatment, or
5 prevention of disease, or amounts paid for the purpose of
6 affecting a structure or function of the body.

7 (2) Transportation primarily for and essential to medical
8 care referred to in subparagraph (1).

9 (3) Insurance covering medical care referred to in
10 subparagraph (1) or (2).

11 c. For purposes of this chapter, the following apply:

12 (1) A plan, fund, or program established or maintained by
13 a partnership which, but for this subsection, would not be an
14 employee welfare benefit plan, shall be treated as an employee
15 welfare benefit plan which is a group health plan to the
16 extent that the plan, fund, or program provides medical care,
17 including items and services paid for as medical care for
18 present or former partners in the partnership or to the
19 dependents of such partners, as defined under the terms of the
20 plan, fund, or program, either directly or through insurance,
21 reimbursement, or otherwise.

22 (2) With respect to a group health plan, the term
23 "employer" includes a partnership with respect to a partner.

24 (3) With respect to a group health plan, the term
25 participant includes the following:

26 (a) With respect to a group health plan maintained by a
27 partnership, an individual who is a partner in the
28 partnership.

29 (b) With respect to a group health plan maintained by a
30 self-employed individual under which one or more of the self-
31 employed individual's employees are participants, the self-
32 employed individual, if that individual is, or may become,
33 eligible to receive benefits under the plan or the
34 individual's dependents may be eligible to receive benefits
35 under the plan.

1 NEW SUBSECTION. 8A. a. "Health insurance coverage" means
2 health insurance coverage offered to individuals in the
3 individual market, but does not include short-term limited
4 duration insurance.

5 b. "Individual health insurance coverage" does not include
6 any of the following:

7 (1) Coverage for accident-only, or disability income
8 insurance.

9 (2) Coverage issued as a supplement to liability
10 insurance.

11 (3) Liability insurance, including general liability
12 insurance and automobile liability insurance.

13 (4) Workers' compensation or similar insurance.

14 (5) Automobile medical-payment insurance.

15 (6) Credit-only insurance.

16 (7) Coverage for on-site medical clinic care.

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

21 c. "Individual health insurance coverage" does not include
22 benefits provided under a separate policy as follows:

23 (1) Limited-scope dental or vision benefits.

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

26 (3) Any other similar limited benefits as provided by rule
27 of the commissioner.

28 d. "Individual health insurance coverage" does not include
29 benefits offered as independent noncoordinated benefits as
30 follows:

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

32 (2) A hospital indemnity or other fixed indemnity
33 insurance.

34 e. "Individual health insurance coverage" does not include
35 Medicare supplemental health insurance as defined under

1 section 1882(g)(1) of the federal Social Security Act,
2 coverage supplemental to the coverage provided under 10 U.S.C.
3 ch. 55 and similar supplemental coverage provided to coverage
4 under group health insurance coverage.

5 NEW SUBSECTION. 10A. "Involuntary termination" includes,
6 but is not limited to, termination of coverage when a
7 conversion policy is not available or where benefits under a
8 state or federal law providing for continuation of coverage
9 upon termination of employment will cease or have ceased.

10 NEW SUBSECTION. 12A. "Organized delivery system" means an
11 organized delivery system as licensed by the director of the
12 department of public health.

13 NEW SUBSECTION. 15. "Preexisting condition exclusion",
14 with respect to coverage, means a limitation or exclusion of
15 benefits relating to a condition based on the fact that the
16 condition was present before the date of enrollment for such
17 coverage, whether or not any medical advice, diagnosis, care,
18 or treatment was recommended or received before such date.

19 Sec. 19. Section 514E.1, subsection 9, Code 1997, is
20 amended by striking the subsection.

21 Sec. 20. Section 514E.2, subsection 1, Code 1997, is
22 amended to read as follows:

23 1. There is established a nonprofit corporation known as
24 the Iowa comprehensive health insurance association which
25 shall assure that health insurance, as limited by sections
26 514E.4 and 514E.5, is made available to each eligible Iowa
27 resident and each federally eligible individual applying to
28 the association for coverage. All carriers as defined in
29 section 514E.1, subsection 3, and all organized delivery
30 systems licensed by the director of public health providing
31 health insurance or health care services in Iowa shall be
32 members of the association. The association shall operate
33 under a plan of operation established and approved under
34 subsection 3 and shall exercise its powers through a board of
35 directors established under this section.

1 Sec. 21. Section 514E.2, subsection 12, Code 1997, is
2 amended by striking the subsection.

3 Sec. 22. Section 514E.6, subsection 3, paragraph e, Code
4 1997, is amended by striking the paragraph and inserting in
5 lieu thereof the following:

6 e. An amount as determined by the association for any
7 other association policy offered.

8 Sec. 23. Section 514E.6, subsection 6, Code 1997, is
9 amended by striking the subsection and inserting in lieu
10 thereof the following:

11 6. The association, in addition to other policies, shall
12 offer one which is comparable to the standard health benefit
13 plan as defined in section 513B.2.

14 Sec. 24. Section 514E.7, subsections 1, 2, and 5, Code
15 1997, are amended by striking the subsections and inserting in
16 lieu thereof the following:

17 1. An individual who is and continues to be a resident is
18 eligible for plan coverage if evidence is provided of any of
19 the following:

20 a. A notice of rejection or refusal to issue substantially
21 similar insurance for health reasons by one carrier.

22 b. A refusal by a carrier to issue insurance except at a
23 rate exceeding the plan rate.

24 c. That the individual is a federally defined eligible
25 individual.

26 A rejection or refusal by a carrier offering only stoploss,
27 excess of loss, or reinsurance coverage with respect to an
28 applicant under paragraphs "a" and "b" is not sufficient
29 evidence for purposes of this subsection.

30 5. a. A preexisting condition exclusion shall not apply
31 to a federally defined eligible individual.

32 b. Plan coverage shall not impose any preexisting
33 condition as follows:

34 (1) In the case of a child who is adopted or placed for
35 adoption before attaining eighteen years of age and who, as of

1 the last day of the thirty-day period beginning on the date of
2 the adoption or placement for adoption, is covered under
3 creditable coverage. This subparagraph shall not apply to
4 coverage before the date of such adoption or placement for
5 adoption.

6 (2) In the case of an individual who, as of the last day
7 of the thirty-day period beginning with the date of birth, is
8 covered under creditable coverage.

9 (3) Relating to pregnancy as a preexisting condition.

10 c. Plan coverage shall exclude charges or expenses
11 incurred during the first six months following the effective
12 date of coverage for preexisting conditions. Such preexisting
13 condition exclusions shall be waived to the extent that
14 similar exclusions, if any, have been satisfied under any
15 prior health insurance coverage which was involuntarily
16 terminated, provided both of the following apply:

17 (1) Application for association coverage is made no later
18 than sixty-three days following such involuntary termination
19 and, in such case, coverage under the plan is effective from
20 the date on which such prior coverage was terminated.

21 (2) The applicant is not eligible for continuation or
22 conversion rights that would provide coverage substantially
23 similar to plan coverage.

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

28 If the association policy contains a waiting period for
29 preexisting conditions, an insured may retain any existing
30 coverage the insured has under an insurance plan that has
31 coverage equivalent to the association policy for the duration
32 of the waiting period only.

33 Sec. 25. Section 514E.7, subsection 6, Code 1997, is
34 amended to read as follows:

35 6. An individual is not eligible for coverage by the

1 association if any of the following apply:

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

4 b. The individual has terminated coverage by the
5 association within the past twelve months, except that this
6 paragraph does not apply to an applicant who is a federally
7 eligible individual.

8 c. The individual is an inmate of a public institution or
9 ~~is-eligible-for-public-programs-for-which-medical-care-is~~
10 provided, except that this paragraph does not apply to an
11 applicant who is a federally defined eligible individual.

12 d. The individual premiums are paid for or reimbursed
13 under any government sponsored program or by any government
14 agency or health care provider, except as an otherwise
15 qualifying full-time employee, or dependent of the employee,
16 of a government agency or health care provider.

17 e. The individual, on the effective date of the coverage
18 applied for, has not been rejected for, already has, or will
19 have coverage similar to an association policy as an insured
20 or covered dependent. This paragraph does not apply to an
21 applicant who is a federally eligible individual.

22 Sec. 26. Section 514E.9, Code 1997, is amended to read as
23 follows:

24 514E.9 RULES.

25 Pursuant to chapter 17A, the commissioner and the director
26 of public health shall adopt rules to provide for disclosure
27 by carriers and organized delivery systems of the availability
28 of insurance coverage from the association, and to otherwise
29 implement this chapter.

30 Sec. 27. Section 514E.11, Code 1997, is amended to read as
31 follows:

32 514E.11 NOTICE OF ASSOCIATION POLICY.

33 ~~Commencing July 17, 1986, every~~ Every carrier, including a
34 health maintenance organization subject to chapter 514B and an
35 organized delivery system, authorized to provide health care

1 insurance or coverage for health care services in Iowa, shall
2 provide a notice ~~and an application for~~ of the availability of
3 coverage by the association to any person who receives a
4 rejection of coverage for health insurance or health care
5 services, or a notice to any person who is informed that a
6 rate for health insurance or coverage for health care services
7 will exceed the rate of an association policy, ~~that-effective~~
8 ~~January-17-1987~~, that person is eligible to apply for health
9 insurance provided by the association. Application for the
10 health insurance shall be on forms prescribed by the board and
11 made available to the carriers and organized delivery systems.

12 Sec. 28. Section 514E.3, Code 1997, is repealed.

13 EXPLANATION

14 This bill enacts changes required as a result of passage of
15 the federal Health Insurance Portability and Accountability
16 Act, which was enacted in 1996 and provides for continuity of
17 coverage between self-funded plans and insured health care
18 plans. Provisions of Code chapters 509, 513B, 513C, and 514E
19 are amended.

20 The bill amends Code section 509.3 to authorize the
21 commissioner to adopt rules to conform the group health
22 insurance statute, Code chapter 509, to the health care
23 requirements of the federal law.

24 The bill creates new definitions in Code chapter 513B,
25 small group coverage, for key terms used, including "health
26 insurance coverage", "group health insurance coverage",
27 "creditable coverage", "group health plan", and "preexisting
28 conditions exclusion". The bill amends several definitions,
29 including the definitions of "carrier", "eligible employee",
30 and "late enrollee".

31 The bill extends the time period a person may go without
32 coverage and still be eligible upon application for subsequent
33 coverage from 30 days to 63 days.

34 The bill provides that a small group policy is guaranteed
35 renewable with certain exceptions for nonpayment of premium,

1 fraud, noncompliance, or discontinuance of the plan or all
2 small group plans. The bill provides that all small group
3 policies will be guaranteed issue.

4 The bill amends provisions of Code chapter 513C, individual
5 health insurance market reform. The bill extends the time
6 which an eligible individual may go without coverage and still
7 be eligible for coverage from 30 days to 63 days. The bill
8 provides for the termination of a government health benefit
9 plan to be a qualifying event for portability to the
10 individual health care market. The bill amends provisions
11 relating to the renewability of health care coverage.

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HOUSE FILE 701

AN ACT

RELATING TO THE REQUIREMENTS FOR PORTABILITY AND
CONTINUITY OF HEALTH CARE COVERAGE FOR INDIVIDUALS
AMONG CERTAIN TYPES OF HEALTH CARE COVERAGE, AND
RELATED MATTERS.

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

Section 1. Section 509.3, Code 1997, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. In addition to the provisions required in subsections 1 through 8, the commissioner shall require provisions through the adoption of rules implementing the federal Health Insurance Portability and Accountability Act, Pub. L. No. 104-191.

Sec. 2. Section 513B.2, subsection 1, Code 1997, is amended to read as follows:

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

Sec. 3. Section 513B.2, subsection 4, Code 1997, is amended by striking the subsection and inserting in lieu thereof the following:

4. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of

the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

Sec. 4. Section 513B.2, subsection 6, paragraph a, Code 1997, is amended to read as follows:

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

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

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

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

Sec. 5. Section 513B.2, subsection 9, Code 1997, is amended to read as follows:

9. "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a-health-benefit-plan health insurance coverage of a small employer, but does not include an employee who works on a part-time, temporary, or substitute basis.

Sec. 6. Section 513B.2, subsection 10, Code 1997, is amended by striking the subsection and inserting in lieu thereof the following:

10. a. "Health insurance coverage" means benefits consisting of health care provided directly, through insurance

or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

b. "Health insurance coverage" does not include any of the following:

- (1) Coverage for accident-only, or disability income insurance.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Liability insurance, including general liability insurance and automobile liability insurance.
- (4) Workers' compensation or similar insurance.
- (5) Automobile medical-payment insurance.
- (6) Credit-only insurance.
- (7) Coverage for on-site medical clinic care.
- (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

- (1) Limited scope dental or vision benefits.
- (2) Benefits for long-term care, nursing home care, home health care, or community-based care.
- (3) Any other similar limited benefits as provided by rule of the commissioner.

d. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

- (1) Coverage only for a specified disease or illness.
- (2) A hospital indemnity or other fixed indemnity insurance.

e. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under § 1882(g)(1) of the federal Social Security Act, coverage supplemental to the

coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided to coverage under group health insurance coverage.

f. "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan.

Sec. 7. Section 513B.2, subsection 12, paragraphs a, b, and c, Code 1997, are amended to read as follows:

a. The individual meets all of the following:

- (1) The individual was covered under qualifying-previous creditable coverage at the time of the initial enrollment.
- (2) The individual lost creditable coverage under qualifying-previous-coverage as a result of termination of the individual's employment or eligibility, the involuntary termination of the qualifying-previous creditable coverage, death of the individual's spouse, or the individual's divorce.
- (3) The individual requests enrollment within thirty days after termination of the qualifying-previous creditable coverage.

b. The individual is employed by an employer that offers multiple health benefit-plans insurance coverages and the individual elects a different plan coverage during an open enrollment period.

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 insurance coverage and the request for enrollment is made within thirty days after issuance of the court order.

Sec. 8. Section 513B.2, subsection 12, Code 1997, is amended by adding the following new paragraphs:

NEW PARAGRAPH. d. The individual changes status and becomes an eligible employee and requests enrollment within sixty-three days after the date of the change in status.

NEW PARAGRAPH. e. The individual was covered under a mandated continuation of group health plan or group health insurance coverage plan until the coverage under that plan was exhausted.

Sec. 9. Section 513B.2, subsection 13, Code 1997, is amended to read as follows:

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

Sec. 10. Section 513B.2, Code 1997, is amended by adding the following new subsections:

NEW SUBSECTION. 7A. "Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

- a. A group health plan.
- b. Health insurance coverage.
- c. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.
- d. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.
- e. 10 U.S.C. ch. 55.
- f. A health or medical care program provided through the Indian health service or a tribal organization.
- g. A state health benefits risk pool.
- h. A health plan offered under 5 U.S.C. ch. 89.
- i. A public health plan as defined under federal regulations.
- j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. § 2504(e).
- k. An organized delivery system licensed by the director of public health.

NEW SUBSECTION. 9A. a. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or

their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

b. For purposes of this subsection, "medical care" means amounts paid for any of the following:

- (1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.
- (2) Transportation primarily for and essential to medical care referred to in subparagraph (1).
- (3) Insurance covering medical care referred to in subparagraph (1) or (2).

c. For purposes of this subsection, a partnership which establishes and maintains a plan, fund, or program to provide medical care to present or former partners in the partnership or to their dependents directly or through insurance, reimbursement, or other method, which would not be an employee benefit welfare plan but for this paragraph, shall be treated as an employee benefit welfare plan which is a group health plan.

(1) For purposes of a group health plan, an employer includes the partnership in relation to any partner.

(2) For purposes of a group health plan, the term "participant" also includes both of the following:

(a) An individual who is a partner in relation to a partnership which maintains a group health plan.

(b) An individual who is a self-employed individual in connection with a group health plan maintained by the self-employed individual where one or more employees are participants, if the individual is or may become eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive a benefit.

NEW SUBSECTION. 13A. "Preexisting conditions exclusion" means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical

advice, diagnosis, care, or treatment was recommended or received before such date.

Sec. 11. Section 513B.2, subsection 14, Code 1997, is amended by striking the subsection.

Sec. 12. Section 513B.3, subsection 3, Code 1997, is amended to read as follows:

3. The health benefit-plan insurance coverage is treated by the employer or any of the eligible employees or dependents as part of a plan coverage or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code as defined in section 422.3.

Sec. 13. Section 513B.3, subsection 4, paragraphs a and c, Code 1997, are amended to read as follows:

a. Except as provided in paragraph "b", for purposes of this subchapter, 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 subchapter shall apply as if all health benefit-plans insurance coverages delivered or issued for delivery to small employers in this state by such carriers were issued by one carrier.

c. Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit-plans insurance coverages delivered or issued for delivery to small employers in this state if the arrangements would result in less than fifty percent of the insurance obligation or risk for such health benefit-plans insurance coverages being retained by the ceding carrier.

Sec. 14. Section 513B.4, subsection 1, paragraph c, subparagraph (1), Code 1997, is amended to read as follows:

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

percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit-plan insurance coverage into which the small employer carrier is actively enrolling new insureds who are small employers.

Sec. 15. Section 513B.4, subsection 1, paragraph d, Code 1997, is amended to read as follows:

d. In the case of health benefit-plans insurance coverages issued prior to July 1, 1991, a premium rate for a rating period may exceed the ranges described in subsection 1, paragraph "a" or "b", for a period of three years following July 1, 1992. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit-plan insurance coverage into which the small employer carrier is actively enrolling new insureds who are small employers.

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

Sec. 16. Section 513B.4, subsection 3, unnumbered paragraph 3, Code 1997, is amended to read as follows:

Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan coverage design and do not reflect differences due to the nature of the

groups assumed to select particular health benefit plans. A small employer carrier shall treat all health benefit-plans insurance coverages issued or renewed in the same calendar month as having the same rating period.

Sec. 17. Section 513B.4, subsection 4, Code 1997, is amended to read as follows:

4. For purposes of this section, a health benefit-plan insurance coverage that contains a restricted network provision shall not be considered similar coverage to a health benefit-plan insurance coverage that does not contain such a provision, if the restriction of benefits to network providers results in substantial differences in claims costs.

Sec. 18. Section 513B.4A, Code 1997, is amended to read as follows:

513B.4A EXEMPTION FROM PREMIUM RATE RESTRICTIONS.

A Taft-Hartley trust or a carrier with the written authorization of such a trust may make a written request to the commissioner for an exemption from the application of any provisions of section 513B.4 with respect to a health-benefit plan health insurance coverage provided to such a trust. The commissioner may grant an exemption if the commissioner finds that application of section 513B.4 with respect to the trust would have a substantial adverse effect on the participants and beneficiaries of such trust, and would require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained. An exemption granted under this section shall not apply to an individual if the individual participates in a trust as an associate member of an employee organization.

Sec. 19. Section 513B.5, Code 1997, is amended by striking the section and inserting in lieu thereof the following:

513B.5 PROVISIONS ON RENEWABILITY OF COVERAGE.

1. Health insurance coverage subject to this chapter is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except for one or more of the following reasons:

a. The health insurance coverage sponsor fails to pay, or to make timely payment of, premiums or contributions pursuant to the terms of the health insurance coverage.

b. The health insurance coverage sponsor performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's or organized delivery system's minimum participation requirements.

d. Noncompliance with the carrier's or organized delivery system's employer contribution requirements.

e. A decision by the carrier or organized delivery system to discontinue offering a particular type of health insurance coverage in the state's small employer market. Health insurance coverage may be discontinued by the carrier or organized delivery system in that market only if the carrier or organized delivery system does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner or director of public health. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provides notice of its decision not to renew such plan to all affected small employers, participants, and beneficiaries no less than ninety days prior to the nonrenewal of the plan.

(3) Offers to each plan sponsor of the discontinued coverage, the option to purchase any other coverage currently offered by the carrier or organized delivery system to other employers in this state.

(4) Acts uniformly, in opting to discontinue the coverage and in offering the option under subparagraph (3), without regard to the claims experience of the sponsors under the discontinued coverage or to a health status-related factor relating to any participants or beneficiaries covered or new

participants or beneficiaries who may become eligible for the coverage.

f. A decision by the carrier or organized delivery system to discontinue offering and to cease to renew all of its health insurance coverage delivered or issued for delivery to small employers in this state. A carrier or organized delivery system making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such coverage to the commissioner or director of public health. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provide notice of its decision not to renew such coverage to all affected small employers, participants, and beneficiaries no less than one hundred eighty days prior to the nonrenewal of the coverage.

(3) Discontinue all health insurance coverage issued or delivered for issuance to small employers in this state and cease renewal of such coverage.

g. The membership of an employer in an association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage under this paragraph occurs uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner or director of public health finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's or organized delivery system's ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier or organized delivery system may modify the health insurance coverage for a product offered under group health insurance coverage in the small group market, for coverage that is available in such

market other than only through one or more bona fide associations, if such modification is consistent with the laws of this state, and is effective on a uniform basis among group health insurance coverage with that product.

2. A carrier or organized delivery system that elects not to renew health insurance coverage under subsection 1, paragraph "f", shall not write any new business in the small employer market in this state for a period of five years after the date of notice to the commissioner or director of public health.

3. This section, with respect to a carrier or organized delivery system doing business in one established geographic service area of the state, applies only to such carrier's or organized delivery system's operations in that service area.

Sec. 20. Section 513B.6, unnumbered paragraph 1, Code 1997, is amended to read as follows:

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

Sec. 21. Section 513B.6, subsection 2, Code 1997, is amended to read as follows:

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

Sec. 22. Section 513B.7, Code 1997, is amended to read as follows:

513B.7 MAINTENANCE OF RECORDS.

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

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

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

Sec. 23. NEW SECTION. 513B.9A ELIGIBILITY TO ENROLL.

A carrier or organized delivery system offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- a. Health status.
- b. Medical condition, including both physical and mental conditions.
- c. Claims experience.
- d. Receipt of health care.
- e. Medical history.
- f. Genetic information.
- g. Evidence of insurability, including conditions arising out of acts of domestic violence.
- h. Disability.

2. Subsection 1 does not require group health insurance coverage to provide particular benefits other than those provided under the terms of the coverage, and does not prevent a coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

3. Rules for eligibility to enroll under group health insurance coverage include rules defining any applicable waiting periods for such enrollment.

4. a. A carrier or organized delivery system offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage.

b. Paragraph "a" shall not be construed to do either of the following:

- (1) Restrict the amount that an employer may be charged for health insurance coverage.
- (2) Prevent a carrier or organized delivery system offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Sec. 24. Section 513B.10, Code 1997, is amended by striking the section and inserting in lieu thereof the following:

513B.10 AVAILABILITY OF COVERAGE.

1. a. A carrier or an organized delivery system that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment

during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter. A carrier or organized delivery system shall offer health insurance coverage which constitutes a basic health benefit plan and which constitutes a standard health benefit plan.

b. A carrier or organized delivery system that offers health insurance coverage in the small group market through a network plan may do either of the following:

(1) Limit employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan.

(2) Deny such coverage to such employers within the service area of such plan if the carrier or organized delivery system has demonstrated to the applicable state authority, both of the following:

(a) The carrier or organized delivery system will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees.

(b) The carrier or organized delivery system is applying this subparagraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents, or any health status-related factor relating to such employees or dependents.

c. A carrier or organized delivery system, upon denying health insurance coverage in any service area pursuant to paragraph "b", subparagraph (2), shall not offer coverage in the small group market within such service area for a period of one hundred eighty days after the date such coverage is denied.

d. A carrier or organized delivery system may deny health insurance coverage in the small group market if the issuer has demonstrated to the commissioner or director of public health both of the following:

(1) The carrier or organized delivery system does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier or organized delivery system is applying the provisions of this subparagraph uniformly to all employers in the small group market in this state consistent with state law and without regard to the claims experience of those employers and the employees and dependents of such employers, or any health status-related factor relating to such employees and their dependents.

e. A carrier or organized delivery system, upon denying health insurance coverage pursuant to paragraph "d", shall not offer coverage in connection with health insurance coverages in the small group market in this state for a period of one hundred eighty days after the date such coverage is denied or until the carrier or organized delivery system has demonstrated to the commissioner or director of public health that the carrier or organized delivery system has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner or director may provide for the application of this paragraph on a service area-specific basis.

f. Paragraph "a" shall not be construed to preclude a carrier or organized delivery system from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in the small group market.

2. A carrier or organized delivery system, subject to subsection 1, shall issue health insurance coverage to an eligible small employer that applies for the coverage and agrees to make the required premium payments and satisfy the other reasonable provisions of the health insurance coverage not inconsistent with this chapter. A carrier or organized delivery system is not required to issue health insurance coverage to a self-employed individual who is covered by, or is eligible for coverage under, health insurance coverage offered by an employer.

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

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

4. Health insurance coverage for small employers shall satisfy all of the following:

a. A carrier or organized delivery system offering group health insurance coverage, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.

(2) The exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

b. A carrier or organized delivery system offering group health insurance coverage shall not impose any preexisting condition as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. A carrier or organized delivery system shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this section, "affiliation period" means a period of time not to exceed sixty days for new entrants and not to exceed ninety days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors. This paragraph does not preclude application of a waiting period applicable to all new enrollees under the health insurance coverage, provided that

any carrier or organized delivery system-imposed waiting period is no longer than sixty days and is used in lieu of a preexisting condition exclusion.

d. Health insurance coverage may exclude coverage for late enrollees for preexisting conditions for a period not to exceed eighteen months.

e. (1) Requirements used by a carrier or organized delivery system in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier or organized delivery system.

(2) In applying minimum participation requirements with respect to a small employer, a carrier or organized delivery system shall not consider employees or dependents who have other creditable coverage in determining whether the applicable percentage of participation is met.

(3) A carrier or organized delivery system shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

f. (1) If a carrier or organized delivery system offers coverage to a small employer, the carrier or organized delivery system shall offer coverage to all eligible employees of the small employer and the employees' dependents. A carrier or organized delivery system shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(2) Except as provided under paragraphs "a" and "d", a carrier or organized delivery system shall not modify health insurance coverage with respect to a small employer or any eligible employee or dependent through riders, endorsements, or other means, to restrict or exclude coverage or benefits for certain diseases, medical conditions, or services otherwise covered by the health insurance coverage.

g. A carrier or organized delivery system offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection 1 with respect to a small employer where any of the following apply:

(1) The small employer does not have eligible individuals who live, work, or reside in the service area for the network plan.

(2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier or organized delivery system, if required, has demonstrated to the commissioner or the director of public health that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying the requirements of this lettered paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and the employees' dependents, or any health status-related factor relating to such employees and dependents.

(3) A carrier or organized delivery system, upon denying health insurance coverage in a service area pursuant to subparagraph (2), shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the coverage is denied.

5. A carrier or organized delivery system shall not be required to offer coverage to small employers pursuant to subsection 1 for any period of time where the commissioner or director of public health determines that the acceptance of the offers by small employers in accordance with subsection 1 would place the carrier or organized delivery system in a financially impaired condition.

6. A carrier or organized delivery system shall not be required to provide coverage to small employers pursuant to subsection 1 if the carrier or organized delivery system elects not to offer new coverage to small employers in this state. However, a carrier or organized delivery system that

elects not to offer new coverage to small employers under this subsection shall be allowed to maintain its existing policies in the state, subject to the requirements of section 513B.5.

7. A carrier or organized delivery system that elects not to offer new coverage to small employers pursuant to subsection 6 shall provide notice to the commissioner or director of public health and is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner or director.

Sec. 25. Section 513B.11, subsection 2, Code 1997, is amended to read as follows:

2. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health ~~benefit-plan~~ insurance coverage with the program. The carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

Sec. 26. Section 513B.13, subsection 7, unnumbered paragraph 1, Code 1997, is amended to read as follows:

The same general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business in this state may be exercised by the board under the program, except the power to issue health ~~benefit-plans~~ insurance coverages directly to either groups or individuals. Additionally, the board is granted the specific authority to do all or any of the following:

Sec. 27. Section 513B.13, subsection 7, paragraph d, Code 1997, is amended to read as follows:

d. Define the health ~~benefit-plans~~ insurance coverages for which reinsurance will be provided, and issue reinsurance policies, pursuant to this subchapter.

Sec. 28. Section 513B.13, subsection 8, paragraph b, Code 1997, is amended to read as follows:

b. A small employer carrier may reinsure an entire employer group within sixty days of the commencement of the group's coverage under ~~a-health-benefit-plan~~ health insurance coverage.

Sec. 29. Section 513B.13, subsection 9, paragraph a, Code 1997, is amended to read as follows:

a. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in paragraph "b" to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health ~~benefit-plans~~ insurance coverages with benefits similar to the standard health benefit plan.

Sec. 30. Section 513B.13, subsection 10, Code 1997, is amended to read as follows:

10. If ~~a-health-benefit-plan~~ health insurance coverage for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 513B.4.

Sec. 31. Section 513B.13, subsection 11, paragraph b, subparagraphs (1), (2), and (3), Code 1997, are amended to read as follows:

(1) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on both of the following:

(a) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans insurance coverages delivered or issued for delivery to small employers in this state by reinsuring carriers.

(b) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit-plans insurance coverages delivered or issued for delivery during such calendar year to small employers in this state by reinsuring carriers.

(2) The formula established pursuant to subparagraph (1) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit-plans insurance coverages delivered or issued for delivery to small employers in this state by reinsuring carriers to total premiums earned in the preceding calendar year from health benefit-plans insurance coverages delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(3) The board, with approval of the commissioner, may change the assessment formula established pursuant to subparagraph (1) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to premiums from all health benefit-plans insurance coverages and to premiums from newly issued health benefit-plans insurance coverages to vary during a transition period.

Sec. 32. Section 513B.13, subsection 11, paragraph c, subparagraph (3), Code 1997, is amended to read as follows:

(3) For any calendar year, the amount specified in this subparagraph is five percent of total premiums earned in the previous year from health benefit-plans insurance coverages delivered or issued for delivery to small employers in this state by reinsuring carriers.

Sec. 33. Section 513B.15, Code 1997, is amended to read as follows:

513B.15 PERIODIC MARKET EVALUATION.

The board shall study and report at least every three years to the commissioner on the effectiveness of this subchapter. The report shall analyze the effectiveness of the subchapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health benefit-plans insurance coverages to small employers in fulfillment of the purposes of this subchapter. The report may contain recommendations for market conduct or other regulatory standards or action.

Sec. 34. Section 513B.17, subsection 3, Code 1997, is amended to read as follows:

3. The commissioner may adopt, by rule or order, transition provisions to facilitate ~~the orderly and coordinated implementation of 1992 Iowa Acts, chapter 1167~~ the implementation and administration of this chapter.

Sec. 35. Section 513B.17A, Code 1997, is amended to read as follows:

513B.17A RESTORATION OF TERMINATED COVERAGE.

The commissioner may adopt rules to require small employer carriers, as a condition of transacting business with small employers in this state after July 1, 1993, to reissue a health-benefit-plan health insurance coverage to any small employer whose health benefit-plan insurance coverage is terminated or not renewed by a carrier after January 1, 1993, unless the carrier's termination is pursuant to section 513B.5. The commissioner may prescribe such terms for the reissuance of coverage as the commissioner finds are reasonable and necessary to provide continuity of coverage to such employers.

Sec. 36. Section 513C.6, Code 1997, is amended by striking the section and inserting in lieu thereof the following:

513C.6 PROVISIONS ON RENEWABILITY OF COVERAGE.

1. An individual health benefit plan subject to this chapter is renewable with respect to an eligible individual or dependents, at the option of the individual, except for one or more of the following reasons:

a. The individual fails to pay, or to make timely payment of, premiums or contributions pursuant to the terms of the individual health benefit plan.

b. The individual performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the individual health benefit plan.

c. A decision by the individual carrier or organized delivery system to discontinue offering a particular type of individual health benefit plan in the state's individual insurance market. An individual health benefit plan may be discontinued by the carrier or organized delivery system in that market with the approval of the commissioner or the director and only if the carrier or organized delivery system does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner or director. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected individuals.

(2) Provides notice of its decision not to renew such plan to all affected individuals no less than ninety days prior to the nonrenewal date of any discontinued individual health benefit plans.

(3) Offers to each individual of the discontinued plan the option to purchase any other health plan currently offered by the carrier or organized delivery system to individuals in this state.

(4) Acts uniformly in opting to discontinue the plan and in offering the option under subparagraph (3), without regard

to the claims experience of any affected eligible individual or beneficiary under the discontinued plan or to a health status-related factor relating to any covered individuals or beneficiaries who may become eligible for the coverage.

d. A decision by the carrier or organized delivery system to discontinue offering and to cease to renew all of its individual health benefit plans delivered or issued for delivery to individuals in this state. A carrier or organized delivery system making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such plan to the commissioner or director. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected individuals.

(2) Provide notice of its decision not to renew such plan to all individuals and to the commissioner or director in each state in which an individual under the discontinued plan is known to reside no less than one hundred eighty days prior to the nonrenewal of the plan.

e. The commissioner or director finds that the continuation of the coverage is not in the best interests of the individuals, or would impair the carrier's or organized delivery system's ability to meet its contractual obligations.

2. At the time of coverage renewal, a carrier or organized delivery system may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

3. An individual carrier or organized delivery system that elects not to renew an individual health benefit plan under subsection 1, paragraph "d", shall not write any new business in the individual market in this state for a period of five years after the date of notice to the commissioner or director.

4. This section, with respect to a carrier or organized delivery system doing business in one established geographic service area of the state, applies only to such carrier's or organized delivery system's operations in that service area.

5. A carrier or organized delivery system offering coverage through a network plan is not required to renew or continue in force coverage or to accept applications from an individual who no longer resides or lives in, or is no longer employed in, the service area of such carrier or organized delivery system, or no longer resides or lives in, or is no longer employed in, a service area for which the carrier is authorized to do business, but only if coverage is not offered or terminated uniformly without regard to health status-related factors of a covered individual.

6. A carrier or organized delivery system offering coverage through a bona fide association is not required to renew a continue in force coverage or to accept applications from an individual through an association if the membership of the individual in the association on which the basis of coverage is provided ceases, but only if the coverage is not offered or terminated under this paragraph uniformly without regard to health status-related factors of a covered individual.

Sec. 37. Section 513C.7, subsection 1, paragraph b, Code 1997, is amended to read as follows:

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

Sec. 38. Section 513C.7, subsection 2, Code 1997, is amended to read as follows:

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

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

Sec. 39. Section 513C.7, subsection 4, paragraph b, Code 1997, is amended to read as follows:

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 sixty-three days prior to the effective date of the new coverage.

Sec. 40. Section 513C.9, Code 1997, is amended by adding the following new subsection:

NEW SUBSECTION. 4A. Notwithstanding subsection 4, a commission shall be paid to an agent related to the sale of a basic or standard health benefit plan under this chapter. A commission paid pursuant to this subsection shall not be considered by the board for purposes of section 513C.10, subsection 9.

Sec. 41. NEW SECTION. 513C.12 COMMISSIONER'S DUTIES. The commissioner shall adopt rules administering this chapter.

Sec. 42. Section 514E.1, Code 1997, is amended by adding the following new subsections:

NEW SUBSECTION. 3A. "Church plan" means the same as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 3(33).

NEW SUBSECTION. 4A. "Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

- a. A group health plan.
- b. Health insurance coverage.
- c. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.

d. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.

e. 10 U.S.C. ch. 55.

f. A health or medical care program provided through the Indian health service or a tribal organization.

g. A state health benefits risk pool.

h. A health plan offered under 5 U.S.C. ch. 89.

i. A public health plan as defined under federal regulations.

j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. § 2504(e).

k. An organized delivery system licensed by the director of public health.

NEW SUBSECTION. 4B. "Director" means the director of public health.

NEW SUBSECTION. 5A. "Federally eligible individual" means an individual who satisfies the following:

a. For whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage is eighteen or more months with no more than a sixty-three day lapse of coverage, and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan.

b. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the federal Social Security Act, or a state plan under Title XIX of that Act, or any successor program, and does not have other health insurance coverage.

c. With respect to whom the most recent coverage within the coverage period described in paragraph "a" was not terminated based on a nonpayment of premiums or fraud.

d. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, and elected such coverage.

e. Who, if the individual elected continuation coverage as provided in paragraph "d", has exhausted the continuation coverage under the provision or program.

NEW SUBSECTION. 5B. "Governmental plan" means as defined under section 3(32) of the federal Employee Retirement Income Security Act of 1974 and any federal governmental plan.

NEW SUBSECTION. 5C. a. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

b. For purposes of this subsection, "medical care" means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in subparagraph (1).

(3) Insurance covering medical care referred to in subparagraph (1) or (2).

c. For purposes of this chapter, the following apply:

(1) A plan, fund, or program established or maintained by a partnership which, but for this subsection, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care for present or former partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.

(2) With respect to a group health plan, the term "employer" includes a partnership with respect to a partner.

(3) With respect to a group health plan, the term participant includes the following:

(a) With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.

(b) With respect to a group health plan maintained by a self-employed individual under which one or more of the self-employed individual's employees are participants, the self-employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual's dependents may be eligible to receive benefits under the plan.

NEW SUBSECTION. 8A. a. "Health insurance coverage" means health insurance coverage offered to individuals, but does not include short-term limited duration insurance.

b. "Health insurance coverage" does not include any of the following:

- (1) Coverage for accident-only, or disability income insurance.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Liability insurance, including general liability insurance and automobile liability insurance.
- (4) Workers' compensation or similar insurance.
- (5) Automobile medical-payment insurance.
- (6) Credit-only insurance.
- (7) Coverage for on-site medical clinic care.
- (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

- (1) Limited-scope dental or vision benefits.
- (2) Benefits for long-term care, nursing home care, home health care, or community-based care.

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

d. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

- (1) Coverage only for a specified disease or illness.
- (2) A hospital indemnity or other fixed indemnity insurance.

e. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55 and similar supplemental coverage provided to coverage under group health insurance coverage.

NEW SUBSECTION. 10A. "Involuntary termination" includes, but is not limited to, termination of coverage when a conversion policy is not available or where benefits under a state or federal law providing for continuation of coverage upon termination of employment will cease or have ceased.

NEW SUBSECTION. 12A. "Organized delivery system" means an organized delivery system as licensed by the director of the department of public health.

NEW SUBSECTION. 15. "Preexisting condition exclusion", with respect to coverage, means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Sec. 43. Section 514E.1, subsection 9, Code 1997, is amended by striking the subsection.

Sec. 44. Section 514E.2, subsection 1, Code 1997, is amended to read as follows:

1. There is established a nonprofit corporation known as the Iowa comprehensive health insurance association which shall assure that health insurance, as limited by sections 514E.4 and 514E.5, is made available to each eligible Iowa resident and each federally eligible individual applying to

the association for coverage. All carriers as defined in section 514E.1, subsection 3, and all organized delivery systems licensed by the director of public health providing health insurance or health care services in Iowa shall be members of the association. The association shall operate under a plan of operation established and approved under subsection 3 and shall exercise its powers through a board of directors established under this section.

Sec. 45. Section 514E.2, subsection 2, unnumbered paragraph 1, Code 1997, is amended to read as follows:

The board of directors of the association shall consist of four members selected by the members of the association, two of whom shall be representatives from corporations operating pursuant to chapter 514 on July 1, 1989, or any successors in interest, and two of whom shall be representatives of organized delivery systems or insurers providing coverage pursuant to chapter 509 or 514A; four public members selected by the governor; the commissioner or the commissioner's designee from the division of insurance; and two members of the general assembly, one of whom shall be appointed by the speaker of the house and one of whom shall be appointed by the president of the senate, after consultation with the majority leader and the minority leader of the senate, who shall be ex officio and nonvoting members. The composition of the board of directors shall be in compliance with sections 69.16 and 69.16A. The governor's appointees shall be chosen from a broad cross-section of the residents of this state.

Sec. 46. Section 514E.2, subsection 3, paragraph f, Code 1997, is amended by striking the paragraph.

Sec. 47. Section 514E.2, subsection 7, Code 1997, is amended to read as follows:

7. Following the close of each calendar year, the association shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the association for the year. The association shall certify the amount of any net loss for the preceding calendar year to the

commissioner of insurance and director of revenue and finance ~~who shall make payment to the association according to procedures established under subsection 3, paragraph "f".~~ Any remaining loss, ~~after payment to the association from the health insurance trust fund,~~ shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year or on any other equitable basis as provided in the plan of operation. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the next calendar year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums.

Sec. 48. Section 514E.2, subsection 12, Code 1997, is amended by striking the subsection.

Sec. 49. Section 514E.5, subsection 2, Code 1997, is amended to read as follows:

2. Services and charges made for benefits provided under the laws of the United States, ~~including~~ excluding Medicare and Medicaid, military service-connected disabilities, but including medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States.

However, the association policy shall pay benefits as a primary payer in any case where benefit coverage provided under the laws of the United States, ~~including Medicare and~~

Medicaid, or under the laws of this state is, by rule or statute, secondary to all other coverages.

Sec. 50. Section 514E.6, subsection 3, paragraph e, Code 1997, is amended by striking the paragraph and inserting in lieu thereof the following:

e. An amount as determined by the association for any other association policy offered.

Sec. 51. Section 514E.6, subsection 6, Code 1997, is amended by striking the subsection and inserting in lieu thereof the following:

6. The association, in addition to other policies, shall offer one which is comparable to the standard health benefit plan as defined in section 513B.2.

Sec. 52. Section 514E.7, subsections 1, 2, and 5, Code 1997, are amended by striking the subsections and inserting in lieu thereof the following:

1. An individual who is and continues to be a resident is eligible for plan coverage if evidence is provided of any of the following:

a. A notice of rejection or refusal to issue substantially similar insurance for health reasons by one carrier or organized delivery system.

b. A refusal by a carrier or organized delivery system to issue insurance except at a rate exceeding the plan rate.

c. That the individual is a federally defined eligible individual.

A rejection or refusal by a carrier or organized delivery system offering only stoploss, excess of loss, or reinsurance coverage with respect to an applicant under paragraphs "a" and "b" is not sufficient evidence for purposes of this subsection.

5. a. A preexisting condition exclusion shall not apply to a federally defined eligible individual.

b. Plan coverage shall not impose any preexisting condition as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. Plan coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage for preexisting conditions. Such preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, provided both of the following apply:

(1) Application for association coverage is made no later than sixty-three days following such involuntary termination and, in such case, coverage under the plan is effective from the date on which such prior coverage was terminated.

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

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

If the association policy contains a waiting period for preexisting conditions, an insured may retain any existing coverage the insured has under an insurance plan that has coverage equivalent to the association policy for the duration of the waiting period only.

Sec. 53. Section 514E.7, subsection 6, Code 1997, is amended to read as follows:

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

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

b. The individual has terminated coverage by the association within the past twelve months, except that this paragraph does not apply to an applicant who is a federally eligible individual.

c. The individual is an inmate of a public institution ~~or is eligible for public programs for which medical care is provided~~, except that this paragraph does not apply to an applicant who is a federally defined eligible individual.

d. The individual premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of the employee, of a government agency or health care provider.

e. The individual, on the effective date of the coverage applied for, has not been rejected for, already has, or will have coverage similar to an association policy as an insured or covered dependent. This paragraph does not apply to an applicant who is a federally eligible individual.

Sec. 54. Section 514E.9, Code 1997, is amended to read as follows:

514E.9 RULES.

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

Sec. 55. Section 514E.11, Code 1997, is amended to read as follows:

514E.11 NOTICE OF ASSOCIATION POLICY.

~~Commencing July 17, 1986, every~~ Every carrier, including a health maintenance organization subject to chapter 514B and an organized delivery system, authorized to provide health care

insurance or coverage for health care services in Iowa, shall provide a notice ~~and an application for~~ of the availability of coverage by the association to any person who receives a rejection of coverage for health insurance or health care services, or a notice to any person who is informed that a rate for health insurance or coverage for health care services will exceed the rate of an association policy, ~~that effective January 17, 1987,~~ that person is eligible to apply for health insurance provided by the association. Application for the health insurance shall be on forms prescribed by the board and made available to the carriers and organized delivery systems.

Sec. 56. Section 514E.3, Code 1997, is repealed.

RON J. CORBETT
Speaker of the House

MARY E. KRAMER
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 701, Seventy-seventh General Assembly.

ELIZABETH ISAACSON
Chief Clerk of the House

Approved May 1, 1997

TERRY E. BRANSTAD
Governor