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SENATE FILE 2215

BY WIECK

COMMERCE

Passed Senate, Date _____ Passed House, Date _____

Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____

Approved _____

A BILL FOR

An Act creating a healthy Iowa individual health care insurance and reinsurance program for certain uninsured Iowans.

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

COMMERCE SF 2215

TLSB 5684XS 81

av/gg/14

S.F. 2215 H.F. _____

Section 1. NEW SECTION. 513C.11A HEALTHY IOWA INDIVIDUAL HEALTH CARE INSURANCE AND REINSURANCE PROGRAM -- FUND.

1. DEFINITIONS.

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

a. "Fund" means the healthy Iowa individual health care reinsurance fund.

b. "Program" means the healthy Iowa individual health care insurance and reinsurance program created in this section.

c. "Qualified contract" means a health insurance contract issued pursuant to this section by a qualified insurer that complies with the requirements for such a contract as set forth in subsection 3.

d. "Qualified individual" means an individual who meets all of the criteria for enrollment in the program as set forth in subsection 2.

e. "Qualified insurer" means a carrier as defined in section 513C.3.

2. QUALIFIED INDIVIDUALS -- ENROLLMENT.

a. An individual is qualified to apply for health insurance provided under the program if the individual meets all of the following criteria or is the dependent of an individual who meets all of the following criteria:

(1) Is employed and has been employed during the twelve-month period prior to the individual's application for health insurance under the program.

(2) Does not have and has not had health insurance with benefits on an expense reimbursed or prepaid basis during the twelve-month period prior to the individual's application for health insurance under the program.

(3) Is employed and has been employed by an employer that does not provide group health insurance and has not provided group health insurance with benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve-month period prior to the individual's application for

health insurance under the program.

(4) Has a net household income that is not less than two hundred percent and not greater than three hundred percent of the federal poverty level, as defined and updated by the federal department of health and human services, or the gross equivalent of such net income at the time of the individual's application for health insurance under the program.

(5) Is ineligible for Medicare.

b. The requirements set forth in paragraph "a", subparagraphs (1) and (2), are not applicable to an individual or a dependent of an individual who had health insurance during the twelve-month period prior to the individual's application for health insurance under the program if the coverage was terminated for any of the following reasons:

(1) Loss of employment due to factors other than voluntary separation.

(2) Death of a family member which resulted in termination of coverage under a health insurance contract under which the individual was covered.

(3) Change of employment to an employer that does not provide group health insurance with benefits on an expense reimbursed or prepaid basis covering the individual as an employee or a dependent.

(4) Change of residence so that health insurance is not available from an employer on an expense reimbursed or prepaid basis covering the individual as an employee or a dependent.

(5) Discontinuation of a group health insurance contract with benefits on an expense reimbursed or prepaid basis covering the individual as an employee or a dependent.

(6) Expiration of the coverage periods established by the continuation provisions of the federal Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq., and the federal Public Health Service Act, 42 U.S.C. § 300bb-1 et seq., established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(7) Legal separation, divorce, or annulment which resulted in termination of coverage under a health insurance contract under which the individual was covered.

(8) Loss of eligibility under a group health plan.

3. QUALIFIED HEALTH INSURANCE CONTRACTS.

a. A qualified health insurance contract issued by a qualified insurer pursuant to the program established by this section shall do all of the following:

(1) Be issued directly to a qualified individual.

(2) Include coverage for dependents of the qualified individual, at the option of the individual.

(3) Be approved by the commissioner prior to issuance.

(4) Provide only in-plan benefits, except for emergency care or where services are not available through a plan provider.

b. A qualified health insurance contract shall include only the following covered services:

(1) Inpatient hospital services consisting of daily room and board, general nursing care, special diets, and miscellaneous hospital services and supplies.

(2) Outpatient hospital services consisting of diagnostic and treatment services.

(3) Physician services consisting of diagnostic and treatment services, consultant and referral services, surgical services, including breast reconstruction after a mastectomy, anesthesia services, a second surgical opinion, and a second opinion for cancer treatment.

(4) Outpatient surgical facility charges related to a covered surgical procedure.

(5) Preadmission testing.

(6) Prenatal and maternity care.

(7) Adult preventive health services consisting of mammography screening, cervical cytology screening, periodic physical examinations no more than once every three years, and adult immunizations.

(8) Preventive and primary health care services for dependent children, including routine well-child visits and necessary immunizations.

(9) Equipment, supplies, and self-management education for the treatment of diabetes.

(10) Diagnostic x-ray and laboratory services.

(11) Emergency services.

(12) Therapeutic services consisting of radiologic services, chemotherapy, and hemodialysis.

(13) Blood and blood products furnished in connection with surgery or inpatient hospital services.

c. A prescription drug benefit may be offered in a qualified health insurance contract. If such a benefit is offered, prescription drugs obtained at a participating pharmacy shall be covered. In addition or alternatively, prescription drugs may be provided pursuant to a mail order prescription drug program or pursuant to a drug formulary. If a drug formulary is used, the contract shall provide for an appeals process that allows a physician to request the use of nonformulary prescription drugs.

(1) Prescription drug benefits provided under a qualified contract shall have a one hundred dollar deductible per calendar year for each individual. The maximum coverage for prescription drugs under a qualified contract is three thousand dollars per calendar year for each individual.

(2) After the deductible is satisfied, each thirty-day supply of a prescription drug shall be subject to a copayment of ten dollars if the drug is generic or twenty dollars if the drug is a brand name drug plus the difference in cost between the brand name drug and the equivalent generic drug. In no event shall the copayment exceed the cost of the prescribed drug.

(3) If a mail order drug program is utilized, each ninety-day supply of a prescription drug shall be subject to a copayment of twenty dollars if the drug is generic, or forty

dollars if the drug is a brand name drug plus the difference in cost between the brand name drug and the equivalent generic drug. In no event shall the copayment exceed the cost of the prescribed drug.

d. Drugs, procedures, and supplies for the treatment of erectile dysfunction may be subject to prior authorization requirements in a qualified contract. If coverage is denied, the contract shall provide for an appeals process that allows the enrollee to obtain additional information concerning the denial and a means to challenge the denial.

(1) Covered services shall not include drugs, procedures, and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to chapter 692A. In addition, the commissioner shall remove any drug, procedure, or supply from covered services available under a qualified contract to a person required to register as a sex offender pursuant to chapter 692A, upon a finding by the director of public health directing such removal.

(2) The commissioner shall adopt rules pursuant to chapter 17A setting forth the criteria for denial of such coverage and requirements for the appeals process.

e. Coverage for benefits for drugs, procedures, and supplies provided in a qualified contract under this section shall be subject to the following copayments:

(1) In-patient hospital services shall have a five hundred dollar copayment for each continuous hospital confinement.

(2) Surgical services shall be subject to a copayment of the lesser of twenty percent of the cost of such services or two hundred dollars per occurrence.

(3) Outpatient surgical facility charges shall be subject to a facility copayment charge of seventy-five dollars per occurrence.

(4) Emergency services shall have a fifty dollar copayment, which shall be waived if the emergency room visit

results in a hospital admission.

f. A qualified insurer that provides coverage pursuant to a qualified contract shall not be subject to any civil or criminal liability for damages for any decision or action made under this section if the qualified insurer acted reasonably and in good faith.

g. Special health and accident insurance coverages required under chapter 514C are not applicable to qualified health insurance contracts issued pursuant to this section, except as otherwise required by this section.

h. Unless otherwise specified in this section, all covered services included in a qualified health insurance contract issued pursuant to this section shall be subject to a twenty dollar copayment, except prenatal services which shall be subject to a ten dollar copayment.

i. Premiums for all coverage offered shall be community rated and shall include rate tiers for individuals, families with two adult members, and at least one other type of family unit. Premium rate differences shall be based upon the cost differences between the different types of family units and the rate tiers shall be uniformly applied.

j. If geographic rating areas are utilized to determine premium rates for the coverages offered, such geographic areas shall be reasonable and may include a single county. The commissioner shall not require the inclusion of any specific geographic area within a proposed community rated region selected by a qualified insurer so long as the proposed regions do not contain configurations designed to avoid or segregate particular areas of a county covered by the qualified insurer's community rates.

k. Claims experience under qualified health insurance contracts issued pursuant to the program shall be pooled for rate setting purposes.

l. The commissioner may, by rule, modify the copayment and deductible amounts set forth in this section as necessary to

facilitate implementation of the program.

m. On or after January 1, 2007, the commissioner may, by rule, establish one or more additional standardized health insurance benefit packages to be offered pursuant to the program with different levels of coverage as the commissioner deems necessary to meet public needs.

4. QUALIFIED INSURERS -- PARTICIPATION.

a. Participation in the program established by this section is limited to qualified insurers.

b. Participation in the program is mandatory for all health maintenance organizations organized and licensed in this state pursuant to chapter 514B, provided that participation is not required for health maintenance organizations that exclusively serve individuals enrolled in the medical assistance program as defined in chapter 249A.

c. A health maintenance organization participating in the program that is providing comprehensive health insurance coverage to an individual prior to the effective date of this section shall not discontinue that coverage if the individual is ineligible to purchase a qualified contract offered pursuant to this section.

d. A health maintenance organization, or an insurer that voluntarily participates in the program, shall participate by offering qualified contracts without changes or additional benefits. The qualified contracts offered shall be issued to all qualified individuals who apply for the contracts.

e. A qualified insurer shall require an individual applying for coverage under the program to certify in writing to the insurer that the individual is qualified to participate in the program at the time of the application and ninety days prior to the contract renewal date each year. A qualified insurer may also require such an individual to submit appropriate documentation in support of the individual's certification.

f. A qualified insurer that participates in the program is

required to submit reports, as required by the commissioner, by rules adopted under chapter 17A, to enable the commissioner to evaluate the operations and results of the program established pursuant to this section.

g. In order to qualify for participation in the reinsurance program, a qualified insurer shall certify to the commissioner that the premium rates for qualified health insurance contracts offered by the insurer pursuant to this section reflect the fact that reimbursement from the fund is available for certain claims that will be paid under those contracts according to accepted actuarial guidelines adopted by the commissioner by rule under chapter 17A.

5. REINSURANCE FUND.

a. A healthy Iowa individual health care reinsurance fund is created as a separate fund in the state treasury under the control of the commissioner of insurance.

b. The treasurer of state shall act as custodian of the fund and shall disburse amounts contained in the fund as directed by the commissioner.

c. The commissioner shall keep accounts in relation to the appropriation of moneys to the fund and all amounts of approved vouchers for reimbursement to qualified insurers chargeable to the fund.

6. REINSURANCE PROGRAM.

a. A reinsurance program is created in the insurance division of the department of commerce to administer the fund and to make expenditures from the fund pursuant to this section.

b. Moneys in the fund shall be used to reimburse a qualified insurer for claims paid by the qualified insurer for individuals covered under qualified health insurance contracts issued pursuant to this section. The amount of reimbursement shall be ninety percent of the cost of claims paid for any covered individual that amount to at least thirty thousand dollars but not more than one hundred thousand dollars in a

calendar year. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a covered individual exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such individual in that calendar year shall be eligible for reimbursement.

c. Claims shall be reported and funds shall be distributed from the fund on a calendar year basis. The commissioner shall adopt rules under chapter 17A establishing procedures for the operation of the fund and the distribution of moneys from the fund.

d. Each qualified insurer participating in the program shall submit a request for reimbursement from the fund on forms prescribed by the commissioner. Such requests shall be submitted no later than April 1 following the end of the calendar year during which reimbursement is sought and shall include claims data as the commissioner requires, by rule, to enable the commissioner to distribute moneys and oversee the operation of the program and fund.

e. The commissioner may require the submission of data by participating qualified insurers on a per member, aggregate, or categorical basis. The commissioner shall calculate the total claims reimbursement amount for all qualified insurers for the calendar year in which the claims are reported.

(1) In the event that the total amount requested for reimbursement for a calendar year exceeds the funds available for distribution for claims paid during that same calendar year, the commissioner shall provide for the pro rata distribution of the available funds. Each qualified insurer shall be eligible to receive only the proportionate amount of the available funds as the qualified insurer's total eligible claims paid bears to the total eligible claims paid by all qualified insurers.

(2) In the event that funds available for distribution for claims paid by all qualified insurers exceeds the total amount

requested for reimbursement by all qualified insurers during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year and shall be in addition to the moneys appropriated for the fund in the next calendar year.

f. Each qualified insurer participating in the program shall provide the commissioner with monthly reports of the total enrollment under qualified contracts issued by the insurer and the total number of such contracts issued, in a form prescribed by the commissioner, by rules adopted under chapter 17A.

g. The commissioner shall separately estimate the per enrollee annual cost of total claims reimbursement from the fund for qualified contracts issued based upon available data and appropriate actuarial assumptions. Upon request, each participating qualified insurer shall furnish claims experience data to the commissioner for use in such estimations.

h. The commissioner shall estimate the total enrollment eligible for reimbursement under qualified contracts by dividing the total moneys available for distribution from the fund by the estimated per individual annual cost of total claims reimbursement from the fund. The commissioner shall suspend the enrollment of new individuals under qualified contracts if the commissioner determines that the total eligible enrollment will result in anticipated annual expenditures from the fund in excess of the total funds available for distribution from the fund.

(1) The commissioner shall provide participating qualified insurers with notification of any suspension of enrollment as soon as practicable after receipt of all enrollment data.

(2) If at any point during a suspension of enrollment the commissioner determines that funds are sufficient to support the addition of new enrollments, the commissioner may reactivate new enrollments and notify all participating

qualified insurers that enrollment of new individuals may commence.

(3) The suspension of issuance of new qualified contracts shall not preclude the addition of new dependents to a qualified contract that has already been issued.

EXPLANATION

This bill creates a healthy Iowa individual health care insurance and reinsurance program for certain uninsured Iowans.

The bill provides that an individual is qualified to apply for health care insurance provided under the healthy Iowa program if the individual meets specified criteria at the time of the application of being employed for the previous 12 months without health insurance and without the availability of health insurance through the individual's employer, having a gross household income not less than 200 percent and not greater than 300 percent of the federal poverty level, and ineligibility for Medicare.

The requirements that the applicant has been employed and without health insurance for the 12 months previous to the application for such insurance, are not applicable to certain individuals and dependents of individuals who do not have health insurance coverage because of loss of employment due to factors other than voluntary termination; death of a family member which resulted in termination of coverage; change of employment to an employer that does not provide health insurance benefits; change of residence so that health insurance is not available from an employer; discontinuation of a group health insurance contract by an employer; expiration of coverage continuation under ERISA; legal separation, divorce, or annulment resulting in loss of coverage; or loss of eligibility under a group health plan.

A health insurance contract qualifies to be issued under the healthy Iowa program if the contract is issued by a qualified insurer and complies with the requirements of the

bill.

A qualified health insurance contract must be issued directly to a qualified individual, offer optional coverage for dependents of the qualified individual, be approved by the commissioner of insurance prior to issuance, and provide only in-plan benefits, except for emergency care or where services are not available through a plan provider.

A qualified health insurance contract shall include only the services specified in the bill but may offer an optional prescription drug benefit. If a drug benefit is offered, the drug benefit must have a $100 annual deductible per individual with maximum annual coverage of $3,000 per individual. After the deductible is satisfied, the drug benefit must include a copayment for a 30-day supply of a drug, which is $10 for a generic drug and $20 for a brand name drug plus the difference in cost between the brand name drug and the equivalent generic drug. If a mail order drug program is utilized, the drug benefit must include a copayment for a 90-day supply of a drug, which is $20 for a generic drug and $40 for a brand name drug plus the difference in cost between the brand name drug and the equivalent generic drug. In no event can the copayment exceed the cost of the prescribed drug.

The bill also provides that drugs, procedures, and supplies for the treatment of erectile dysfunction may be subject to prior authorization requirements and that treatment of this condition is not covered for an individual who is required to register as a sex offender pursuant to Code chapter 692A.

Coverage under qualified health insurance contracts issued pursuant to the healthy Iowa program is required to be subject to copayments of $500 for each continuous hospital confinement, the lesser of 20 percent or $200 for each surgical service, $75 for each outpatient surgical facility charge, and $50 for each emergency room visit except where the visit results in a hospital admission. Except as otherwise specified, copayments for all other covered services under the

contracts must be $20, except that copayments for prenatal services are $10.

A qualified insurer that provides such coverage is not subject to civil or criminal liability for any decision or action made under the program if the insurer acted reasonably and in good faith.

The bill requires that premiums for the coverage offered under the healthy Iowa program shall be community rated and shall include rate tiers for individuals, families with two adult members, and at least one other type of family unit. Premium rate differences must be based upon the cost differences between the different types of family units and the rates tiers must be uniformly applied. The bill specifies how geographic rating areas may be used and allows claims experience under the contracts to be pooled for rate setting purposes. The bill allows the commissioner of insurance, by rule, to modify the copayments and deductibles contained in the bill to facilitate implementation of the program and on or after January 1, 2007, to establish additional standardized health insurance benefits packages that can be offered under the program, as necessary to meet public needs.

The bill provides that participation in the healthy Iowa program is limited to carriers defined in Code section 513C.3, which includes any entity that provides individual health benefit plans in this state. Participation in the program is mandatory for all health maintenance organizations in the state except for those that exclusively serve individuals enrolled in the state's medical assistance program as defined in Code chapter 249A.

A health maintenance organization participating in the program that is providing coverage to an individual prior to the effective date of the program cannot discontinue that coverage if the individual is ineligible to purchase a qualified contract under the healthy Iowa program.

A qualified insurer that participates in the healthy Iowa

program must offer contracts that comply with the requirements of the bill and do not include changes or additional benefits. The contracts must be issued to all qualified individuals who apply for them. An insurer may require applicants for the contracts to certify that they are qualified to participate in the program at the time of application and 90 days prior to the annual contract renewal date.

A participating insurer is required to submit reports to the commissioner of insurance to enable evaluation of the program. An insurer is required to certify to the commissioner that the premium rates for the health insurance contracts offered by the insurer under the healthy Iowa program reflect the fact that reimbursement is available for payment of certain claims under the contracts according to accepted actuarial guidelines adopted by the commissioner by rule.

The bill creates a healthy Iowa individual health care reinsurance fund as a separate fund in the state treasury under the control of the commissioner of insurance.

The bill also creates a reinsurance program to be administered by the commissioner of insurance. The bill provides that moneys in the reinsurance fund shall be used to reimburse a participating insurer for claims paid for individuals covered under health insurance contracts issued pursuant to the healthy Iowa program in an amount that is 90 percent of the cost of claims paid for any covered individual of at least $30,000 but not more than $100,000 in a calendar year. Once claims paid on behalf of a covered individual exceed $100,000 in a given calendar year, no further reimbursement as to that individual is available.

The bill provides that requests for reimbursement by insurers shall be made to the commissioner no later than April 1 following the end of the calendar year during which reimbursement is sought, by procedures established by the commissioner by rule.

The bill requires the commissioner to calculate the total claims reimbursement amount for all participating insurers for the calendar year in which the claims are reported and if the total amount requested exceeds the funds available in the reinsurance fund, the commissioner shall provide for pro rata distribution of the available funds based on the proportionate amount each insurer's eligible claims bears to the total of all eligible claims paid by participating insurers. If available funds exceed the reimbursement requests, the excess funds remain in the reinsurance fund for distribution in the next calendar year, in addition to any moneys appropriated to the reinsurance fund in the next year.

The bill also requires each participating insurer to provide the commissioner with monthly reports of the total number of healthy Iowa contracts issued and the enrollment under those contracts so that the commissioner can estimate the projected annual cost of total claims reimbursement from the fund for that year. If the commissioner determines that total eligible enrollment in the program will result in reimbursements from the reinsurance fund in excess of the moneys available, the commissioner is required to suspend enrollment of new individuals in the healthy Iowa program, except that such suspension does not preclude the addition of new dependents to contracts that have already been issued. If the commissioner later determines that funds are sufficient to support new enrollments in the program, the enrollment suspension for that year may be lifted.