Senate Study Bill 1063 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE ON STATE GOVERNMENT BILL BY CHAIRPERSON DANIELSON)

A BILL FOR

An Act relating to establishment of an Iowa health benefit exchange, abolishment of the Iowa insurance information exchange, and including effective date provisions.

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

DIVISION I

IOWA HEALTH BENEFIT EXCHANGE

Section 1. NEW SECTION. **514M.1 Short title.**

This Act shall be known and may be cited as the "*Iowa Health Benefit Exchange Act*".

Sec. 2. NEW SECTION. **514M.2 Findings.**

The general assembly finds the following:

1. The cost of health insurance for individuals and employers in Iowa is increasing.

2. The cost of health insurance for state and local governments in Iowa is increasing.

3. The number of uninsured and underinsured persons in Iowa is increasing.

4. The federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, requires each state, by January 1, 2014, to establish an American health benefit exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified, and meets certain other requirements. The federal Act also requires each state to inform the secretary by January 1, 2013, that the state has the ability to implement the exchange by January 1, 2014.

5. The establishment of the Iowa health benefit exchange provides an opportunity to increase access to health care, expand health care coverage, lower the costs of health care, and provide the foundation for a sustainable health care system for Iowa citizens and employers.

Sec. 3. NEW SECTION. **514M.3 Purpose and intent.**

It is the purpose of this chapter to do all of the following:

1. Enact the necessary state laws to be consistent with the federal Act.

2. Provide for the establishment of an American health benefit exchange as required by the federal Act to facilitate the purchase and sale of qualified health benefit plans in

the individual market in this state and to provide for the establishment of a small business health options program, known as a small business health options program exchange, to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health benefit plans offered in the small group market.

3. Reduce the number of uninsured Iowans by creating an organized, transparent, and easy-to-navigate health insurance marketplace with low administrative costs that offers a choice of high-value health benefit plans for individuals and employers.

4. Provide qualified individuals and employers with the ability to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal Act.

Sec. 4. NEW SECTION. **514M.4 Definitions.**

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

1. *"Board"* means the board of directors of the Iowa health benefit exchange.

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

3. *"Defined contribution arrangement health benefit plan"* means an employer group health benefit plan individually selected by an employee of a small employer, within the actuarial tier of platinum, gold, silver, or bronze, as defined in the federal Act, selected by the small employer.

4. *"Exchange"* means the Iowa health benefit exchange established pursuant to section 514M.5.

5. *"Federal Act"* means the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under, those acts.

6. *a. "Health benefit plan"* means a policy, contract, certificate, or agreement offered or issued by a health carrier

to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

b. "Health benefit plan" does not include any of the following:

(1) Coverage only for accident, or disability income insurance, or any combination thereof.

(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 clinics.

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to Tit. XXVII of the federal Public Health Service Act, as enacted by the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and amended by the federal Act, under which benefits for health care services are secondary or incidental to other insurance benefits.

c. "Health benefit plan" does not include any of the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits.

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(3) Other similar, limited benefits specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

d. "Health benefit plan" does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits

and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(2) Hospital indemnity or other fixed indemnity insurance.

e. "Health benefit plan" does not include any of the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act.

(2) Coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, by the civilian health and medical program of the uniformed services.

(3) Supplemental coverage similar to that provided under a group health plan.

7. *"Health carrier"* means an entity subject to the insurance laws and rules 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 hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

8. *"Insurance producer"* means a person required to be licensed under chapter 522B to sell, solicit, or negotiate insurance.

9. *"Qualified dental plan"* means a limited scope dental plan that has been certified in accordance with section 514M.10.

10. *"Qualified employer"* means a small employer that elects to make its full-time employees eligible for one or more qualified health benefit plans offered through the small business health options program exchange, and at the option of

the employer, some or all of its part-time employees, provided that the employer does either of the following:

a. Has its principal place of business in this state and elects to provide coverage through the small business health options program exchange to all of its eligible employees wherever employed.

b. Elects to provide coverage through the small business health options program exchange to all of its eligible employees who are principally employed in this state.

11. *"Qualified health benefit plan"* means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal Act and section 514M.10.

12. *"Qualified individual"* means an individual, including a minor, who is all of the following:

a. Is seeking to enroll in a qualified health plan offered to individuals through the exchange.

b. Is a resident of this state.

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges.

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

13. *"Resident"* means a person who is a resident of this state for state income tax purposes.

14. *"Secretary"* means the secretary of the United States department of health and human services.

15. *"Small business health options program exchange"* means the small business health options program exchange established under section 514M.9.

16. *a. "Small employer"* means an employer that employed an average of one to fifty employees during the preceding calendar year.

b. For the purposes of this subsection:

(1) All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(2) An employer and any predecessor employer shall be treated as a single employer.

(3) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

(4) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year.

(5) An employer that makes enrollment in qualified health plans available to its employees through the small business health options program exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the small business health options program exchange available to its employees.

Sec. 5. NEW SECTION. **514M.5 Iowa health benefit exchange established.**

1. The Iowa health benefit exchange is established as a nonprofit corporation under the purview of the office of the governor.

2. The exchange shall operate under a plan of operation established and approved under section 514M.8 and shall exercise its powers through a board of directors established under section 514M.6. The board shall implement and direct the activities of the exchange, whose purpose is to create and administer a state-based exchange, as described in section 1311 of the federal Act and this chapter.

3. The exchange shall facilitate the availability, choice, and adoption of private health benefit plans to eligible

individuals and groups as described in this chapter and in the federal Act.

4. The exchange shall make individual and small employer group coverage available to Iowa residents no later than January 1, 2014.

5. The exchange shall be considered a governmental body for the purposes of chapter 21 and a government body for the purposes of chapter 22.

Sec. 6. NEW SECTION. **514M.6 Board of directors.**

1. There is a board of directors of the exchange which shall carry out the powers and duties of the exchange as set forth in this chapter.

2. The board of directors of the exchange shall consist of seven voting members and two nonvoting members. The voting members shall be appointed by the governor, subject to confirmation by the senate. The governor shall designate one voting member as chairperson and one as vice chairperson. The nonvoting members shall be the commissioner of insurance and the director of human services or their designees.

3. Each member of the board appointed by the governor shall be a resident of this state and the composition of the voting members of the board shall be in compliance with sections 69.16, 69.16A, and 69.16C.

4. The voting members of the board shall be appointed for staggered terms of three years within sixty days after the effective date of this Act and by December 15 of each year thereafter. The initial terms of the voting members of the board shall be staggered at the discretion of the governor. A voting member of the board is eligible for reappointment. The governor shall fill a vacancy on the board in the same manner as the original appointment for the remainder of the term. A voting member of the board may be removed by the governor for misfeasance, malfeasance, willful neglect of duty, failure to actively participate in the affairs of the board, or other cause after notice and a public hearing unless the notice and

hearing are waived by the member in writing.

5. The voting members of the board shall include representatives of consumers and small employers as well as individuals that are knowledgeable about health insurance, health finance, and health systems.

6. A voting member of the board shall not be an employee of, a consultant to, a member of the board of directors of, affiliated with, have an ownership interest in, or otherwise be a representative of any health carrier, insurance producer agency, insurance consultant organization, trade association of insurers, or association offering health insurance coverage to its members, while serving on the board.

7. Voting members of the board may be reimbursed from the moneys of the exchange for expenses incurred by them as members, but shall not be otherwise compensated by the exchange for their services.

8. A majority of the voting members of the board constitutes a quorum. The affirmative vote of a majority of the voting members is necessary for any action taken by the board. The majority shall not include a member who has a conflict of interest and a statement by a member of a conflict of interest is conclusive for this purpose. A vacancy in the membership of the board does not impair the right of a quorum to exercise the rights and perform the duties of the board. An action taken by the board under this chapter may be authorized by resolution at a regular or special meeting and each resolution shall take effect immediately and need not be published or posted. Meetings of the board shall be held at the call of the chairperson or at the request of a majority of the voting members.

9. The voting members of the board shall give bond as required for public officers in chapter 64.

10. The voting members of the board are subject to and are officials within the meaning of chapter 68B.

Sec. 7. NEW SECTION. **514M.7 Executive director —— staff.**

1. The voting members of the board shall meet, and within forty-five days of their appointment to the board, appoint an executive director to supervise the administrative affairs and general management and operations of the exchange. The executive director shall not be a member of the board, shall serve at the pleasure of the board, and shall receive compensation as fixed by the board.

2. The executive director of the exchange shall keep a record of the proceedings of the board and shall be the custodian of all books, documents, and papers filed with the board, the minute book or journal of the board, and the official seal of the board. The executive director may cause copies to be made of minutes and other records and documents of the board and may give certificates under the official seal of the board that the copies are true copies, and persons dealing with the board may rely upon the certificates.

3. The executive director shall, with the approval of the board, do all of the following:

a. Plan, direct, coordinate, and execute administrative functions of the exchange in conformity with the policies and directives of the board.

b. Employ professional and clerical staff as necessary.

c. Report to the board on all operations under the executive director's control and supervision.

d. Prepare an annual budget and manage the administrative expenses of the exchange.

e. Undertake any other activities necessary to implement the powers and duties of the board.

Sec. 8. NEW SECTION. **514M.8 General requirements for the exchange — plan of operation.**

1. The exchange shall be organized as a nonprofit corporation and shall submit to the commissioner a plan of operation for the exchange within ninety days after the appointment of the board of directors. After notice and hearing, the commissioner shall approve the plan of operation

if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the exchange and to meet the requirements of federal and state law for a state health benefit exchange. In addition to other requirements, the plan of operation shall provide for all of the following:

a. The handling and accounting of assets and moneys of the exchange, including the power to borrow money, and to establish lines of credit and cash and investment accounts.

b. The amount and method of reimbursing members of the board for expenses incurred by them as members.

c. Regular times and places for meetings of the board.

d. Records to be kept of all financial transactions, and the annual audit and fiscal reporting to the secretary, the governor, the commissioner, the general assembly, and the public.

e. Hiring independent consultants as necessary.

f. Procedures and criteria detailing the implementation of the activities and duties assigned to the exchange pursuant to this chapter and applicable federal law.

g. Adoption of bylaws to regulate the affairs and the conduct of the exchange's business.

h. Maintenance of an office within the state at such place or places as the exchange may designate.

i. The power to approve the use of trademarks, brand names, seals, logos, and other similar instruments by participating health carriers, employers, or organizations.

j. Additional provisions necessary or proper for the execution of the powers and duties of the exchange.

k. The assessment of health carriers in the state to fund the operation of the exchange as provided in section 514M.12.

2. The exchange has the power to enter into agreements with other state and federal agencies.

3. The exchange shall do the following:

a. Beginning no later than January 1, 2014, make qualified health benefit plans available to qualified individuals and

qualified employers and facilitate the purchase and sale of such plans.

b. Beginning no later than January 1, 2014, provide for the establishment of a small business health options program exchange that is designed to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health benefit plans offered in the small group market in this state.

c. Beginning no later than January 1, 2014, provide an option for an eligible small employer to choose to participate in a defined contribution arrangement health benefit plan made available by the exchange.

d. Within sixty days of appointment of the board of directors, begin to collaborate with the commissioner to integrate the functions of the Iowa insurance information exchange established in section 505.32 into the Iowa health benefit exchange in order to ensure the most seamless transition possible from an insurance information exchange to the Iowa health benefit exchange within the time period prescribed by the federal Act.

4. The exchange may contract with an eligible entity for any of its functions described in this chapter, not otherwise delegated to the commissioner or the board. An eligible entity includes but is not limited to the department of public health, the department of human services, or an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities of the exchange. However, a health carrier or an affiliate of a health carrier is not an eligible entity for the purposes of this subsection.

5. The exchange shall not make available any health benefit plan that is not a qualified health benefit plan.

6. The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue

Code of 1986 through the exchange, either separately or in conjunction with a qualified health benefit plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the federal Act.

7. The exchange or a health carrier offering health benefit plans through the exchange shall not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of the federal Act, to be codified at section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Sec. 9. NEW SECTION. **514M.9 Powers and duties of the exchange.**

1. The exchange shall, according to the provisions of this chapter, applicable rules, and applicable federal laws and regulations do all of the following:

a. Implement procedures for the certification, recertification, and decertification of health benefit plans as qualified health benefit plans, consistent with guidelines developed by the secretary under section 1311(c) of the federal Act and applicable state law.

b. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

c. Provide for enrollment periods, as determined by the secretary under section 1311(c)(6) of the federal Act and applicable state law.

d. Maintain an internet site through which enrollees, employers, and prospective enrollees of qualified health benefit plans, at a minimum, may obtain standardized comparative information on such plans. In developing the electronic clearinghouse, the board may require health carriers participating in the exchange to make available and regularly update an electronic directory of contracting health care

providers so individuals seeking coverage through the exchange can search by health care provider name to determine which health benefit plans in the exchange include that health care provider in their network, and whether that health care provider is accepting new patients for that particular health benefit plan.

e. Assign a rating to each qualified health benefit plan offered through the exchange in accordance with criteria developed by the secretary under section 1311(c)(3) of the federal Act, and determine the level of coverage of each qualified health benefit plan in accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the federal Act and applicable state law.

f. Utilize a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act and applicable state law.

g. In accordance with section 1413 of the federal Act and applicable state law, inform individuals of eligibility requirements for the Medicaid program under Tit. XIX of the federal Social Security Act, the children's health insurance program under Tit. XXI of the federal Social Security Act, or any applicable state or local public program and if through screening of an application by the exchange, the exchange determines that any individual is eligible for any such program, enroll that individual in that program.

h. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under the standards of the federal Act to be codified at section 36B(c)(2)(C) of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the federal Act.

i. Establish a small business health options program exchange through which individuals employed by qualified employers may enroll in any qualified health benefit plan

offered through the small business health options program exchange at the level of coverage specified by the employer. In establishing a small business health options program exchange, the exchange shall do all of the following:

(1) Provide consolidated billing and premium payment by employers including detailed information to employers on health benefit plans and costs chosen by their employees.

(2) Establish an electronic interface and facilitate the flow of funds between health carriers, employers, and employees, including subsidies and the use of free choice vouchers as provided in the federal Act.

(3) Provide plan enrollment information to employers.

j. Establish guidelines consistent with procedures established pursuant to the federal Act that allow insurance producers to assist individuals and small employers in purchasing qualified health benefit plans from the exchange and receive a commission from the exchange for the services provided by them. If an insurance producer receives a commission from the carrier that issues a qualified health benefit plan, the producer shall not collect a commission from the exchange.

k. Subject to section 1411 of the federal Act and applicable state law, grant a certification attesting that, for purposes of the individual responsibility penalty under the standards of the federal Act to be codified at section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of any of the following:

(1) There is no affordable qualified health benefit plan available through the exchange, or the individual's employer, covering the individual.

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

l. Transfer to the United States secretary of the treasury

all of the following:

(1) A list of the individuals who are issued a certification under paragraph "*k*", subparagraph (1), including the name and taxpayer identification number of each individual.

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under the standards of the federal Act to be codified at section 36B(c)(2)(C) of the Internal Revenue Code of 1986 because of either of the following:

(a) The employer did not provide minimum essential health benefits coverage.

(b) The employer provided the minimum essential health benefits coverage, but it was determined under the standards of the federal Act to be codified at section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

(3) The name and taxpayer identification number of all of the following:

(a) Each individual who notifies the exchange under section 1411(b)(4) of the federal Act that the individual has changed employers.

(b) Each individual who ceases coverage under a qualified health benefit plan during a plan year and the effective date of that cessation.

m. Provide to each employer the name of each employee of the employer described in paragraph "*l*", subparagraph (2), who ceases coverage under a qualified health benefit plan during a plan year and the effective date of the cessation.

n. Perform duties required of, or delegated to, the exchange by the secretary, the United States secretary of the treasury, or the commissioner related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

o. Select entities qualified to serve as navigators

in accordance with section 1311(i) of the federal Act and applicable state law and award grants to enable navigators to do the following:

(1) Conduct public education activities for individuals and small employers to raise awareness of the availability of qualified health benefit plans.

(2) Distribute fair and impartial information concerning enrollment in qualified health benefit plans, and the availability of premium tax credits under the standards of the federal Act to be codified at section 36B(c)(2)(C) of the Internal Revenue Code of 1986, cost-sharing reductions under section 1402 of the federal Act, federal employer health tax credits, and state employer health tax credits and subsidies.

(3) Facilitate enrollment in qualified health benefit plans.

(4) Provide referrals to the office of health insurance consumer assistance established under the federal Act pursuant to section 2793 of the federal Public Health Service Act and the office of the commissioner or any other appropriate state agency, for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan, coverage, or a determination under that plan or coverage.

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

p. In consultation with the commissioner, review the rate of premium growth within the exchange and outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

q. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the federal Act, and collect the amount credited from the offering employer.

r. Consult with stakeholders who are relevant to carrying

out the activities required under this chapter including but not limited to the following:

(1) Educated health care consumers who are individuals that are knowledgeable about the health care system, have a background or experience in making informed decisions regarding health, medical, and scientific matters, and who are enrollees in qualified health benefit plans.

(2) Individuals and entities with experience in facilitating enrollment in qualified health benefit plans.

(3) Representatives of small businesses and self-employed individuals.

(4) The department of human services.

(5) The commissioner.

(6) The department of public health.

(7) Advocates for enrolling hard-to-reach populations.

s. Seek and receive federal grants available pursuant to section 1311 of the federal Act and other grant funding available from private or government sources.

t. Require qualified health benefit plans to provide information and make disclosures to enrollees required by state and federal law.

u. Require qualified health benefit plans to implement activities to reduce health care access disparities, including the use of language services, community outreach, and cultural competency training for employees of such plans.

v. Assist in the implementation of reinsurance and risk adjustment mechanisms, as required by state and federal law.

w. Publicize the existence of the exchange, the eligibility and enrollment requirements of the exchange, and the benefits and advantages of purchasing coverage through the exchange.

x. Develop services that aid small employers in the administration of their group health benefit plans.

y. Facilitate the development of cafeteria plans pursuant to section 125 of the Internal Revenue Code of 1986, for use by employers participating in the exchange.

z. Establish guidelines for determining what state licensure requirements for insurance producers are applicable, if any, to the exchange and to exchange employees and entities or persons who are qualified as navigators.

aa. Examine methods to limit health benefit plan design options to create adequate consumer choice and value, while avoiding unnecessary, duplicative, and confusing plan designs.

ab. Encourage the development of health benefit plans that promote wellness, preventative health care, and new innovations in health care delivery systems that promote efficiency, curb health care costs, and provide value to health care consumers.

ac. Develop strategies that encourage the participation of health carriers in the exchange, including cooperatives and multistate plans, that offer good value to consumers and have high-quality ratings.

ad. Develop strategies to ensure the viability of the exchange by minimizing adverse risk selection.

ae. Meet all of the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts, and expenditures of the exchange and annually submit to the secretary, the governor, the commissioner, the general assembly, and the public, a report concerning such accountings as provided in section 514M.12.

(2) Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the federal Act and allow the secretary, in coordination with the inspector general of the United States department of health and human services to do all of the following:

(a) Investigate the affairs of the exchange.

(b) Examine the properties and records of the exchange.

(c) Require periodic reports in relation to the activities undertaken by the exchange.

(3) In carrying out its activities under this chapter, not use any funds intended for the administrative and operational

expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

2. The exchange has the power to enter into agreements with other state and federal agencies.

3. The exchange shall encourage cross-agency consultation and coordination and shall consult regularly with the commissioner, department of human services, department of public health, and where appropriate, the attorney general, all of which shall be required to lend expertise and resources to the exchange as needed.

4. The exchange shall coordinate its activities with the Iowa Medicaid enterprise of the department of human services, the department of revenue, and the insurance division of the department of commerce to ensure that the state fulfills the requirements of the federal Act and to ensure that there is a seamless integration of the functions of the exchange, the Medicaid program, and the hawk-i program including eligibility determinations and distribution of premium subsidies and other cost-sharing assistance.

5. The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this chapter provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

6. The exchange may establish and manage a system of aggregating all moneys paid as tax credits, premium subsidies, and premium payments made by, or on behalf of, individuals obtaining coverage through the exchange, including any premium payments made by employers, enrollees, employees, unions, or other organizations and paying those moneys to the health carrier.

Sec. 10. NEW SECTION. **514M.10 Health benefit plan certification.**

1. The exchange may certify a health benefit plan as a qualified health benefit plan if the plan meets all of the following criteria:

a. The plan provides the essential health benefit package described in section 1302(a) of the federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection 7, if all of the following occur:

(1) The exchange determines that at least one qualified dental plan is available to supplement the plan's coverage.

(2) The health carrier makes a prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange.

b. The premium rates and contract language have been approved by the commissioner.

c. The plan provides at least a bronze level of coverage, as that level is defined by the federal Act, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

d. The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the federal Act, and if the plan is offered through the small business health options program exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the federal Act.

e. The health carrier offering the plan meets all of the following criteria:

(1) Is licensed and in good standing to offer health insurance coverage in this state.

(2) Has received form and rate prior approval from the

commissioner for that health benefit plan as required by statute.

(3) Offers at least one qualified health benefit plan in the silver level and at least one qualified health plan in the gold level, as those levels are defined in the federal Act, through each component of the exchange in which the health carrier participates, where component refers to the small business health options program exchange and to the exchange for individual coverage.

(4) Charges the same premium rate for each qualified health benefit plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the health carrier or through an insurance producer.

(5) Does not charge any termination of coverage fees or penalties in violation of section 514M.8.

(6) Offers at least one qualified health benefit plan in the silver level and at least one qualified health benefit plan in the gold level, as those levels are defined in the federal Act, outside the exchange, unless the health carrier does not offer any health benefit plans outside the exchange.

(7) Complies with the regulations developed by the secretary under section 1311(d) of the federal Act, applicable state laws, and such other requirements as the exchange may establish.

f. The plan meets the requirements of certification as adopted by rule pursuant to this section and by the secretary under section 1311(c) of the federal Act, which include but are not limited to minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health benefit plan performance.

g. The exchange determines that making the health benefit plan available through the exchange is in the interest of

qualified individuals and qualified employers in the state.

2. The exchange shall not exclude a health benefit plan from certification for any of the following reasons:

a. On the basis that the plan is a fee-for-service plan.

b. Through the imposition of premium price controls.

c. On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

3. The exchange has the authority to limit participation in the exchange, to the extent permitted by the federal Act and by the United States department of health and human services, to the health benefit plans that the exchange determines offer the best value, meaning the best combination of price and quality. In making a determination of which health benefit plans offer the best value, the exchange should consider all of the following:

a. Rates and rate increases of the health benefit plan.

b. Health care effectiveness data, and information set and consumer assessment of health care providers and systems scores.

c. Implementation of payment mechanisms by the plan to reduce medical errors and preventable hospitalizations, reduce disparities in access to and quality of health care, and improve language access.

d. The extent to which cost-sharing creates barriers to treatment for lower-income enrollees.

4. The exchange shall require each health carrier seeking certification of a health benefit plan as a qualified health benefit plan to do the following:

a. Provide notice of any proposed premium increase and a justification for the increase to the exchange and to affected policyholders before implementation of that increase. The health carrier shall prominently post the information on its internet site. The exchange shall take this information, along

with the information and the recommendations provided to the exchange by the commissioner under the federal Act pursuant to section 2794(b) of the federal Public Health Service Act and applicable state law, into consideration when determining whether to allow the health carrier to make health benefit plans available through the exchange.

b. Make available to the public, in the format described in paragraph "*c*", and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of all of the following:

(1) Claims payment policies and practices.

(2) Periodic financial disclosures.

(3) Data on enrollment.

(4) Data on disenrollment.

(5) Data on the number of claims that are denied.

(6) Data on rating practices.

(7) Information on cost-sharing and payments with respect to any out-of-network coverage.

(8) Information on enrollee and participant rights under Tit. I of the federal Act and applicable state law.

(9) Other information as determined appropriate by the secretary, the exchange, or the commissioner.

c. The information required in paragraph "*b*" shall be provided in plain language, as that term is defined in section 1311(e) of the federal Act, as amended by section 10104 of the federal Act, and applicable state law.

5. The exchange shall permit individuals to learn, in a timely manner upon the request of an individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an internet site and through other means for individuals without access to the

internet.

6. The exchange shall not exempt any health carrier seeking certification of a health benefit plan, regardless of the type or size of the health carrier, from applicable state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

7. *a.* The provisions of this chapter that are applicable to qualified health benefit plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs *"b"*, *"c"*, and *"d"* or by rules adopted by the exchange.

b. A health carrier shall be licensed to offer dental coverage, but is not required to be licensed to offer other health benefits.

c. A qualified dental plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the federal Act, and such other dental benefits as the exchange or the secretary may specify by regulation or rule.

d. Health carriers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a health carrier through a qualified dental plan and the other benefits are provided by a health carrier through a qualified health benefit plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

Sec. 11. NEW SECTION. **514M.11 Advisory committees.**

1. The board shall establish one or more advisory committees consisting of representatives from the insurance industry, producer organizations, consumer advocacy groups, labor unions, employers, health care providers, and other interested parties.

The advisory committees shall meet when requested by the board.

2. An advisory committee may offer input to the board regarding proposed rules, the plan of operation for the exchange, and any other topics relevant to the exchange.

3. Public participation and comment, including written comments, shall be encouraged by an advisory committee.

Sec. 12. NEW SECTION. **514M.12 Funding for the exchange — assessments — annual financial report.**

1. Funding to operate the exchange shall come from federal and private grants and from assessment fees charged to health carriers. The exchange shall charge an assessment fee to all health carriers in this state, as necessary to support the operations of the exchange as provided under this chapter. No state funding shall be appropriated or allocated for the operation or administration of the exchange. The assessment shall provide for the sharing of exchange losses and expenses on an equitable and proportionate basis among health carriers in the state as provided in this section.

2. Following the close of each calendar year, the exchange shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the exchange for the year. The exchange shall certify the amount of any net loss for the preceding calendar year to the commissioner and director of revenue. Any loss shall be assessed by the exchange to all health carriers in proportion to the health carriers' respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or to their 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 exchange may abate or defer in any part the assessment of a health carrier, if, in the opinion of the board, payment of the assessment would endanger the ability of the health carrier to fulfill its contractual obligations. The exchange may also provide for an initial or

interim assessment against health carriers if necessary to assure the financial capability of the exchange to meet the incurred or estimated claims expenses or operating expenses of the exchange until the next calendar year is completed. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future expenses of the exchange.

a. For purposes of this subsection, *"total health insurance premiums"* and *"payments for subscriber contracts"* include, without limitation, premiums or other amounts paid to or received by a health carrier for individual and group health benefit plan coverage provided under any chapter of the Code or of any Iowa Acts, and *"paid losses"* includes, without limitation, claims paid by a health carrier operating on a self-funded basis for individual and group health benefit plan coverage provided under any chapter of the Code or of any Iowa Acts.

b. For purposes of calculating and conducting the assessment, the exchange shall have the express authority to require health carriers to report on an annual basis each health carrier's total health insurance premiums and payments for subscriber contracts and paid losses. A health carrier is liable for its share of the assessment calculated in accordance with this section regardless of whether it participates in the individual insurance market.

3. The exchange is subject to examination by the commissioner. The exchange shall conduct periodic audits to assure the general accuracy of the financial data submitted to the exchange, and the exchange shall have an annual audit of its operations made by an independent certified public accountant. The results of that audit shall be provided to the governor, the commissioner, the general assembly, and the public. Not later than April 30 of each year, the board of directors shall submit to the secretary, the governor, the commissioner, the general assembly, and the public a financial report for the preceding calendar year in a form approved by

the commissioner and in compliance with federal law.

4. The exchange is subject to oversight by the legislative fiscal committee of the legislative council. Not later than April 30 of each year, the board of directors shall submit to the legislative fiscal committee a financial report for the preceding year in a form approved by the committee.

5. The exchange is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

6. The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the exchange, on the exchange internet site to educate consumers and employers about the costs of operating the exchange. This information shall include moneys lost to waste, fraud, and abuse.

Sec. 13. NEW SECTION. **514M.13 Annual exchange status report.**

1. Every year the board shall examine the operations of the exchange and the demographics of the persons enrolled in the exchange and submit a written exchange status report to the secretary, the governor, the commissioner, the general assembly, and the public. The exchange status report shall include a review of the following:

a. The operation and administration of the exchange, including but not limited to:

(1) Surveys and reports of health benefit plans available to eligible individuals and employers and the experience of the plans.

(2) Administrative costs, claims statistics, complaint data, and goals defined and achieved by the board during the preceding year.

b. Information about the experience of health benefit plans available through the exchange including data on enrollees inside the exchange and on enrollees purchasing health benefit plans outside the exchange.

c. Any other significant observations regarding the utilization of the individual exchange and the small business health options program exchange.

2. The first exchange report shall be due on April 15, 2015, and annually on that date thereafter.

3. On or before August 1, 2012, the board shall research, investigate, produce, and submit one or more reports as described in subsection 1 on the following topics:

a. Feasibility of merging the nongroup and small group health insurance markets and risk pools, and the resulting impact on premiums charged to individuals and small employer groups.

b. Feasibility of establishing a multistate exchange and the effects of a multistate exchange on health carriers and health care consumers in the state.

c. Development of strategies to reduce health care costs, such as encouraging the use of accountable care organizations and the medical home model, and the effect of such changes on health care costs and health insurance premiums for exchange enrollees.

d. Development of strategies to avoid adverse risk selection inside the exchange.

e. Feasibility of establishing a basic plan as described in the federal Act for individuals whose income levels fall between one hundred thirty-three percent and two hundred percent of the federal poverty level based on the number of people in the individual's household as defined by the most recently revised poverty income guidelines published by the United States department of health and human services and the possible impact of such a plan on the exchange, the health insurance market, and health care consumers in the state.

f. Feasibility of incorporating certain government-sponsored health benefit plans, such as state employee plans and school district plans, in the exchange and the possible impact on those plans, the exchange, and the

health insurance market in the state.

Sec. 14. NEW SECTION. **514M.14 Relation to other laws.**

Nothing in this chapter, and no action taken by the exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance in this state. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health benefit plans in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

Sec. 15. EFFECTIVE UPON ENACTMENT. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

DIVISION II

COORDINATING PROVISIONS

IOWA INSURANCE INFORMATION EXCHANGE

Sec. 16. REPEAL. Section 505.32, Code 2011, is repealed.

Sec. 17. EFFECTIVE DATE. This division of this Act takes effect December 31, 2013.

EXPLANATION

This bill relates to establishment of an Iowa health benefit exchange, and repeal of a provision establishing the Iowa health insurance information exchange.

DIVISION I —— IOWA HEALTH BENEFIT EXCHANGE. Division I of the bill contains new Code chapter 514M, which establishes the Iowa health benefit exchange (exchange) to comply with the requirement of the federal Patient Protection and Affordable Care Act (PPACA) that each state establish a health benefit exchange by January 1, 2014, to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers and meet other requirements specified in state and federal law.

The exchange is established as a nonprofit corporation under the purview of the governor. The exchange operates under bylaws and a plan of operation approved by the commissioner of

insurance. The exchange is subject to the Iowa open meetings and open records laws.

The exchange exercises its powers through a nine-member board of directors, seven of whom are voting members and are appointed by the governor and confirmed by the senate, and the commissioner of insurance and director of human services, or their designees, who are nonvoting members. The composition of the board is subject to state requirements of equality in political affiliation, gender balance, and minority representation. The voting members of the board may be reimbursed from the moneys of the exchange only for expenses and do not receive any other compensation for their services.

The members of the board must be appointed by the governor within 60 days after enactment of division I of the bill. The plan of operation of the exchange must be submitted to the commissioner within 90 days after the appointment of the board. The board must meet, and within 45 days of their appointment, appoint an executive director to supervise the administrative affairs and general management and operations of the exchange. The executive director may also employ professional and clerical staff for the exchange as necessary.

Beginning no later than January 1, 2014, the exchange is required to make qualified health benefit plans available to qualified individuals and qualified employers, and facilitate the purchase and sale of such plans; provide for the establishment of a small business health options program (SHOP) exchange to assist qualified small employers in Iowa in facilitating the enrollment of their employees in qualified health benefit plans offered in the small group market in this state; and provide an option for an eligible small employer to choose to participate in a defined contribution arrangement health benefit plan made available by the exchange. Within 60 days of appointment of the board of directors, the exchange is required to begin to collaborate with the commissioner of insurance to integrate the functions of the Iowa insurance

information exchange into the new Iowa health benefit exchange consistent with state and federal law. The bill specifies the powers and duties of the exchange to carry out the intent of the chapter consistent with the PPACA and state law.

The exchange is given parameters for certifying health benefit plans as qualified health benefit plans. Under the PPACA, only qualified health benefit plans can be sold through the exchange and a health benefit plan must be certified as meeting certain minimum standards specified in the PPACA and in this bill to be certified as a qualified health benefit plan. Also, a health carrier must meet certain standards in order to have its plans certified so that the plans can be offered through the exchange. Licensed insurance producers are allowed to assist individuals and small employers with purchasing qualified health benefit plans through the exchange and to receive a commission for doing so.

The board of the exchange is authorized to establish one or more advisory committees consisting of various stakeholders to offer input to the board concerning the exchange and topics relevant to the exchange.

Funding to operate the exchange comes from federal and private grants and from assessment fees charged to health carriers in the state. Pursuant to federal law, no state funding can be appropriated or allocated for the operation or administration of the exchange. The amount of the assessment for each health carrier to pay the exchange losses and expenses is to be shared on an equitable and proportionate basis based on the health carrier's respective share of total health insurance premiums or payments for subscriber contracts received in Iowa. The assessment formula to be utilized is similar to that used by HIPIowa.

The exchange is required to file an annual financial report including the results of an audit of the exchange by an independent certified public accountant to the secretary of the United States department of health and human services, the

governor, the commissioner of insurance, the general assembly, the legislative fiscal committee of the legislative council, and the public. The exchange is also required to file an annual exchange status report that examines the operations of the exchange and the demographics of the persons enrolled in the exchange with the secretary of the United States department of health and human services, the governor, the commissioner of insurance, the general assembly, and the public. On or before August 1, 2012, the board of the exchange is required to submit one or more reports to these same persons on topics involving the feasibility of various strategies to reduce health care costs in the state.

Division I of the bill, establishing the Iowa health benefit exchange, takes effect upon enactment.

DIVISION II —— IOWA INSURANCE INFORMATION EXCHANGE. In division II of the bill, Code section 505.32, which established the Iowa insurance information exchange, is repealed effective December 31, 2013.