



BILL SUMMARY

HF 2650 Health Insurance Mandate Commission

Status of Bill: House Calendar
Committee: Commerce (16-5)
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HF 2650 establishes a state health insurance mandate commission to review legislation that proposes to mandate health care benefits in order to ensure that legislative decisions are based on the best data available regarding the impact of the proposed benefit.

"Mandated health care benefit" is defined as coverage required or required to be offered by state law in an individual or group health insurance policy, if it does any of the following:

1. Stipulates coverage for specific health care services, benefits, technologies, or treatments.
2. Limits or restricts deductibles, coinsurance, copayments, or annual or lifetime maximum amounts.
3. Designates a specific category of provider from whom an insured is entitled to receive care.
4. Requires coverage for all services recommended by a health care provider that are consistent with "generally accepted principles of professional medicine" or a similar standard.
5. Requires a specific level of payment or rate of reimbursement.

"Carrier" means an entity subject to Iowa insurance laws, regulations or the Insurance Commissioner's jurisdiction, that contracts or offers to contract to provide, deliver, arrange or pay for, or reimburse any health care service costs, including an insurance company offering sickness and accident plans, a health maintenance organization (HMO), a nonprofit health service corporation, an organized delivery system, or any other entity that provides a plan of health insurance, health benefits, or health services.

"Small employer" is defined the same as in Chapter 513B (Small Group Coverage) as a person actively engaged in business who, on at least 50% of the employer's working days during the preceding year, employed not less than two and not more than 50 full-time employees.

The State Health Insurance Mandate Commission (SHIMC)

1. The commission has 14 members, four non-voting members and 10 voting members, as follows:
 - The Chairs and Ranking Members of both the House and Senate Commerce Committees or their designees, who shall be ex officio, nonvoting members.
 - The Insurance Commissioner or the commissioner's designee – who shall serve as chair.
 - Four members appointed by the Insurance Commissioner:
 - An expert in the field of health insurance.
 - An expert in medical research.
 - An expert in the field of social sciences.
 - An actuary.
 - Five members appointed by the governor:
 - One representing a small employer.
 - One representing a large employer.

- One member of a collective bargaining unit.
 - One person with individual health insurance coverage.
 - One person representing the general public.
2. Appointed members shall serve three-year terms and be politically balanced. Members receive a per diem and mileage at the same rate as paid to members of the General Assembly.
 3. A majority of the members constitutes a quorum, but the commission shall not conduct business until all members have been appointed or selected.
 4. The commission shall hold public hearings on bills prior to issuing its written report.
 5. The commission may do all of the following:
 - Conduct research.
 - Receive testimony from experts.
 - Review, for purposes of comparison, the health benefits mandated in other states and the jurisdiction and effect of such mandates.
 - Contract with experts to develop needed data concerning a proposed mandate.
 - Perform other necessary actions to accomplish its assigned tasks.
 6. The Insurance Division provides staff and administrative support and the Insurance Commissioner may adopt rules as necessary and shall propose the first budget for SHIMC, subject to its approval. Beginning with FY 10, SHIMC shall review its operating costs for the preceding year and develop a budget for the current fiscal year.

Procedure for Bills Containing a Health Care Benefit Mandate.

1. When a bill is requested, the Legislative Services Agency will determine whether it contains a mandated health care benefit and, if so, include this information in the bill’s explanation.
2. Such a bill shall not be assigned to a House or Senate standing committee until it has been referred to the Insurance Commissioner for review and evaluation by SHIMC and a report regarding the proposal has been received by the House and Senate.
3. Upon referral, the Insurance Commissioner shall convene SHIMC for its review and evaluation.
4. Upon receipt of the SHIMC report, the bill may be assigned to a standing committee and be considered in the same manner as a bill sponsored by the majority and minority leaders of one house.
5. The SHIMC evaluation and recommendation regarding a specific proposed benefit is conclusive and may be used in support of or in opposition to any proposals regarding that specific benefit for three years from the date of the report.
 - No bill mandating that benefit shall be referred to SHIMC during that three-year period.
 - However, if SHIMC determines that new health care data would significantly change its findings, it may amend its report prior to the end of the three-year period.
 - At the conclusion of the three-year period, a bill to mandate that specific benefit shall be referred to the SHIMC for a new evaluation and recommendation.

SHIMC Reports. The commission shall prepare a written report, with the assistance of the Insurance Commissioner, that sets forth the commission’s findings, evaluations, and recommendations.

- The final report must be sent to the House and Senate within 45 days of the date the bill was referred to the Insurance Commissioner.
- The report shall include a financial impact analysis performed by an actuary who is a member of the American Academy of Actuaries and who certifies that the analysis is consistent with accepted actuarial techniques.
- The report shall include, but is not limited to, a review and evaluation of all of the following, to the extent that the information is available:
 1. Public impact, including all of the following:
 - The extent to which the benefit is generally utilized by a significant portion of the population.

- The extent to which insurance coverage for the benefit is already generally available, and if not generally available, the extent to which lack of coverage results in persons foregoing necessary health care treatments or results in unreasonable financial hardship to patients.
 - The extent to which the benefit is covered by self-funded employers' groups.
 - The level of public demand for the benefit.
 - The extent to which the benefit has previously been covered by Iowa carriers and the specific plans offered by Iowa carriers that provide coverage for the benefit.
 - The level of public demand for insurance coverage of the benefit.
 - The level of interest of collective bargaining agents in negotiating privately for inclusion of the coverage in group health insurance contracts.
2. Medical impact, including all of the following:
- The extent to which the benefit is recognized by the appropriate American health care specialty society as being effective in the treatment of patients.
 - The extent to which the benefit is recognized by the appropriate American health care specialty society as being effective as demonstrated by a review of scientific and peer-reviewed literature.
 - The extent to which the benefit is available and utilized by health care providers in the state.
 - The extent to which the benefit makes a positive contribution to the health status of the population, including the ramifications of using alternatives to or not providing the mandated health care benefit.
 - The extent to which the mandated health care benefit would diminish or eliminate access to currently available health care services.
3. Financial impact, including all of the following:
- The extent to which the benefit will increase or decrease the cost of health care benefits over the next five years.
 - The extent to which the benefit will increase the appropriate use of the health care benefit over the next five years.
 - The extent to which the benefit will be a substitute for a more expensive health care benefit over the next five years.
 - The impact of the mandated health care benefit on small employers.
 - The extent to which the costs resulting from lack of coverage for the benefit are currently paid by or will be shifted to other payers, including both public and private entities.
 - The extent to which the benefit will increase or decrease administrative expenses of carriers and the premiums and administrative expenses of policyholders.
 - The impact of the benefit on the total cost of health care over the next five years.

Sunset Date. December 31, 2018.

Effective Date. Upon enactment.

Transition. A bill containing a mandated benefit that is on the calendar or assigned to a standing committee of either house on the last day of the 2008 session shall be referred to SHIMC for evaluation and recommendation and a written report. The determination as to whether the bill does contain such a mandate shall be made by the Speaker of the House or the President of the Senate.