Senate File 48 - Introduced

SENATE FILE ______
BY HATCH

Passed Senate, Date ____________ Passed House, Date ____________
Vote: Ayes ______ Nays _______ Vote: Ayes ______ Nays ________
Approved ____________________________

A BILL FOR

1 An Act relating to health care, health care providers, and health
2 care coverage, providing for appropriations, providing
3 penalties, and providing retroactive and other effective
4 dates.
5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
6 TLSB 1747XS 83
7 pf/rj/14

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1 1 DIVISION I
1 2 IOWA HEALTH CARE COVERAGE PARTNERSHIP PROGRAM
1 3 PART 5
1 4 IOWA HEALTH CARE COVERAGE PARTNERSHIP PROGRAM
1 5 Section 1. NEW SECTION. 8A.459 DEFINITIONS.
1 6 As used in this part, unless the context otherwise
1 7 requires:
1 8 1. "Nonprofit employer" means a nonprofit corporation that
1 9 is either of the following and does not include a nonstate
1 10 public employer:
1 11 a. A corporation subject to chapter 504.
1 12 b. A corporation which qualifies under 26 U.S.C. } 1.
1 13 2. "Nonstate public employee" means any employee or
1 14 elected official of a nonstate public employer.
1 15 3. "Nonstate public employer" means a political
1 16 subdivision of this state, including a quasi=public agency but
1 17 not including a school district.
1 18 4. "Political subdivision of the state" means a political
1 19 subdivision of the state or its offices or units, including
1 20 but not limited to a county, city, or community college.
1 21 5. "Small employer" means a person, firm, corporation,
1 22 limited liability company, partnership, or association
1 23 actively engaged in business or self=employed for at least
1 24 three consecutive months who, on at least fifty percent of the
1 25 entity's working days during the preceding twelve months,
1 26 employed not more than fifty full=time equivalent eligible
1 27 employees, the majority of whom were employed within this
1 28 state. "Small employer" does not include any nonstate public
1 29 employer. In determining the number of eligible employees,
1 30 companies which are affiliated companies or which are eligible
1 31 to file a combined tax return for purposes of state taxation
1 32 are considered one employer.
1 33 6. "State health or medical group insurance plan" or
1 34 "state plan" means a health or medical group insurance plan
1 35 for employees of the state.
2 1 Sec. 2. NEW SECTION. 8A.460 ELIGIBILITY.
2 2 1. Nonstate public employees and employees of a nonprofit
2 3 employer and small employer shall be considered state
2 4 employees for purposes of eligibility to obtain employee
2 5 health or medical insurance from a state health or medical
2 6 group insurance plan as provided to state employees by the
2 7 department of administrative services through the Iowa state
2 8 health care coverage partnership program.
2 9 2. A nonstate public employer, nonprofit employer, or
2 10 small employer is not eligible to participate in a state
2 11 health or medical group insurance plan through the Iowa state
2 12 health care coverage partnership program unless all employees
2 13 and officials of the nonstate public employer and all
2 14 employees of the nonprofit employer or small employer elect to
2 15 enroll in the state plan pursuant to the program.
2 16 3. If a nonstate public employer, nonprofit employer, or

2 17 small employer elects to participate in a state health or
2 18 medical group insurance plan through the Iowa state health
2 19 care coverage partnership program, the nonstate public
2 20 employer, nonprofit employer, or small employer shall pay the
2 21 costs of participation in the plan as provided in this part.
2 22   4. An employee or official of a nonstate public employer,
2 23 or an employee of a nonprofit employer or small employer shall
2 24 not be enrolled in the state plan through the Iowa state
2 25 health care coverage partnership program if such employee is
2 26 covered through the employee's employer by health insurance
2 27 plans or insurance arrangements issued to or in accordance
2 28 with a trust established pursuant to collective bargaining
2 29 subject to the federal Labor Management Relations Act.
2 30   Sec. 3. NEW SECTION. 8A.461 IOWA STATE HEALTH CARE
2 31 COVERAGE PARTNERSHIP PROGRAM == COVERAGE OFFERED.
2 32   1. The Iowa state health care coverage partnership program
2 33 is established in the department of administrative services.
2 34 Pursuant to the program, the department shall offer coverage
2 35 under the state health or medical group insurance plan to
3 1 nonstate public employees, and employees of nonprofit
3 2 employers and small employers, and shall pool such employees
3 3 with the state plan, provided the department received an
3 4 application from an employer of such employees and the
3 5 application is approved in accordance with the provisions of
3 6 this part 5. Employees and officials of such employers shall
3 7 be covered under the state plan pursuant to the Iowa state
3 8 health care coverage partnership program under the same
3 9 conditions that state employees are covered under the state
3 10 plan and shall not be denied coverage on the basis of risk,
3 11 cost, preexisting conditions, or other factors not applicable
3 12 to state employees.
3 13   a. Premium payments for such coverage shall be remitted by
3 14 the employer to the department and shall be the same as those
3 15 paid by the state inclusive of any premiums paid by state
3 16 employees, except as otherwise provided in this part 5.
3 17   b. The department shall offer participation in the state
3 18 plan pursuant to the Iowa state health care coverage
3 19 partnership program for no shorter than three=year intervals,
3 20 and at the end of any such interval, an employer may apply for
3 21 coverage for an additional interval.
3 22   c. The department, by rule, shall develop procedures by
3 23 which employers obtaining coverage for their employees
3 24 pursuant to the Iowa state health care coverage partnership
3 25 program may withdraw from such coverage. Any such procedures
3 26 shall provide that nonstate public employees covered by
3 27 collective bargaining shall withdraw from such coverage in
3 28 accordance with the provisions of their collective bargaining
3 29 agreements and applicable statutes.
3 30   2. The department is not required to offer coverage to
3 31 every employer seeking coverage pursuant to the Iowa health
3 32 care coverage partnership program from every vendor providing
3 33 coverage under the state plan.
3 34   3. The department, in collaboration with the Iowa choice
3 35 insurance exchange, may procure coverage to be offered
4 1 pursuant to the Iowa health care coverage partnership program
4 2 to nonstate public employees and employees of nonprofit
4 3 employers and small employers from vendors other than those
4 4 providing coverage to state employees and may offer insurance
4 5 plans different from those available to state employees.
4 6   4. The department shall collaborate with the Iowa choice
4 7 insurance exchange to develop and procure coverage to be
4 8 offered pursuant to the Iowa health care coverage partnership
4 9 program that meets minimum standards of quality and
4 10 affordability.
4 11   5. The department, in collaboration with the Iowa choice
4 12 insurance exchange, shall implement and administer the Iowa
4 13 health care coverage partnership program including but not
4 14 limited to creating applications and application procedures,
4 15 enrollment periods and procedures, and procedures for
4 16 withdrawal from the program.
4 17   6. Notwithstanding any other provision of state or federal
4 18 law, the state plan or the Iowa health care coverage
4 19 partnership program shall not be deemed an unauthorized
4 20 insurer or a multiple employer welfare arrangement. Any
4 21 licensed insurer in this state is eligible to conduct business
4 22 with the state plan and the Iowa health care coverage
4 23 partnership program.
4 24   Sec. 4. NEW SECTION. 8A.462 NONSTATE PUBLIC EMPLOYEES ==
4 25 COVERAGE.
4 26   1. Nonstate public employees and officials may obtain
4 27 coverage under the state plan pursuant to the Iowa health care

4 28 coverage partnership program in accordance with this section.
4 29 2. A nonstate public employer may submit an application to
4 30 the department for coverage under the state plan of all of
4 31 such employer's employees and officials. If a nonstate public
4 32 employer submits such an application for coverage, the
4 33 department shall provide such coverage no later than the first
4 34 day of the third calendar month following such application.
4 35 3. Notwithstanding any other provisions of state law,
5 1 initial participation in the state plan shall be a permissive
5 2 subject of collective bargaining and shall be subject to
5 3 binding interest arbitration only if the collective bargaining
5 4 agent and the nonstate public employer mutually agree to
5 5 bargain over such initial participation. Such mutual
5 6 agreement shall be in writing and signed by the authorized
5 7 representatives of the collective bargaining agent and the
5 8 nonstate public employer. Continuation in the state plan,
5 9 after initial participation, shall be a mandatory subject of
5 10 bargaining, and shall be subject to binding interest
5 11 arbitration in accordance with the same procedures and
5 12 standards that apply to any other mandatory subject of
5 13 bargaining pursuant to state law.
5 14 4. Premium rates for nonstate public employers shall be
5 15 the total premium rate paid by the state inclusive of any
5 16 premiums paid by state employees for the particular state
5 17 health care product offered by the state plan.
5 18 Sec. 5. NEW SECTION. 8A.463 EMPLOYEES OF SMALL EMPLOYERS
5 19 == COVERAGE.
5 20 1. Employees of small employers may obtain coverage under
5 21 the state plan pursuant to the Iowa health care coverage
5 22 partnership program in accordance with this section.
5 23 2. A small employer may submit an application to the
5 24 department for coverage under the state plan of all of such
5 25 employer's employees. If a small employer submits such an
5 26 application for coverage, the department shall provide such
5 27 coverage no later than the first day of the third calendar
5 28 month following such application. However, the department
5 29 shall not approve an application for coverage under the state
5 30 plan if the department determines that approval of such
5 31 coverage would cause the state plan to be subject to the
5 32 requirements of the federal Employee Retirement Income
5 33 Security Act of 1974, as codified at 29 U.S.C. } 1001 et seq.
5 34 If the department determines that the state plan is compliant
5 35 with such federal requirements, the department shall resume
6 1 approval of applications for coverage under the state plan as
6 2 provided in this section.
6 3 3. Premium rates for small employers shall be the total
6 4 premium rate paid by the state inclusive of any premiums paid
6 5 by state employees for the particular state health care
6 6 product offered by the state plan, except that an insurance
6 7 carrier offering coverage under the state plan pursuant to the
6 8 Iowa health care coverage partnership program to small
6 9 employers may adjust the premium rate to reflect one or more
6 10 of the characteristics identified in section 513B.4.
6 11 Sec. 6. NEW SECTION. 8A.464 EMPLOYEES OF NONPROFIT
6 12 EMPLOYERS == COVERAGE.
6 13 1. Employees of nonprofit employers which are not small
6 14 employers may obtain coverage under the state plan pursuant to
6 15 the Iowa health care coverage partnership program in
6 16 accordance with this section.
6 17 2. A nonprofit employer may submit an application to the
6 18 department for coverage under the state plan of all of such
6 19 employer's employees. If a nonprofit employer submits such an
6 20 application for coverage, the department shall provide such
6 21 coverage no later than the first day of the third calendar
6 22 month following such application. However, the department
6 23 shall not approve an application for coverage under the state
6 24 plan if the department determines that approval of such
6 25 coverage would cause the state plan to be subject to the
6 26 requirements of the federal Employee Retirement Income
6 27 Security Act of 1974, as codified at 29 U.S.C. } 1001 et seq.
6 28 If the department determines that the state plan is compliant
6 29 with such federal requirements, the department shall resume
6 30 approval of applications for coverage under the state plan as
6 31 provided in this section.
6 32 3. Premium rates for nonprofit employers shall be the
6 33 total premium rate paid by the state inclusive of any premiums
6 34 paid by state employees for the particular state health care
6 35 product offered by the state plan.
7 1 Sec. 7. NEW SECTION. 8A.465 RETIREES == COVERAGE.
7 2 1. Employers eligible to obtain coverage for their
7 3 employees under the state plan pursuant to the Iowa health

7 4 care coverage partnership program may obtain such coverage for
7 5 all of their retirees as provided in this part. Premium
7 6 payments for such coverage shall be remitted by the employer
7 7 to the department and shall be the same as those paid by the
7 8 employer for employees who are not retired.
7 9 2. Nothing in this part 5 shall diminish any right to
7 10 retiree health insurance pursuant to a collective bargaining
7 11 agreement or pursuant to any other provision of state or
7 12 federal law.
7 13 Sec. 8. NEW SECTION. 8A.466 PREMIUM PAYMENTS ==
7 14 ADMINISTRATIVE FEES.
7 15 1. Each employer participating in the state plan pursuant
7 16 to the Iowa health care coverage partnership program shall pay
7 17 the monthly amount determined by the department, for coverage
7 18 of its employees and officials, or its employees and retirees,
7 19 as appropriate under the state plan. An employer may require
7 20 each covered employee or official to contribute a portion of
7 21 the cost of such coverage under the state plan, subject to any
7 22 collective bargaining obligation applicable to such employer.
7 23 If any payment due by an employer under this section is not
7 24 paid after the due date, interest shall be added to such
7 25 payment at the prevailing rate of interest, as determined by
7 26 the department. Such interest shall be paid by the employer.
7 27 2. The department shall charge each employer participating
7 28 in the state plan pursuant to the Iowa state health care
7 29 coverage partnership program, an administrative fee calculated
7 30 on a per=month basis per covered employee or official.
7 31 3. Payments made pursuant to this section shall be
7 32 deposited in the health insurance administration fund created
7 33 in section 8A.454. Moneys deposited in the health insurance
7 34 administration fund pursuant to this section shall be
7 35 separately accounted for and shall be expended for payment of
8 1 insurance premiums for employees and officials covered under
8 2 the Iowa health care coverage partnership program.
8 3 4. If a nonstate public employer fails to make premium
8 4 payments as required under this section, the department may
8 5 direct the treasurer of state, or any other office of the
8 6 state that is the custodian of any moneys made available by
8 7 reason of any grant, allocation, or appropriation by the state
8 8 or state agencies payable to a nonstate public employer at any
8 9 time subsequent to the failure of such nonstate public
8 10 employer, to pay such premiums and interest that are due and
8 11 unpaid and to withhold payment of moneys payable to the
8 12 nonstate public employer until the amount of the premiums and
8 13 interest then due and unpaid by the nonstate public employer
8 14 has been paid to the state or until the treasurer determines
8 15 that arrangements, satisfactory to the treasurer, have been
8 16 made for the payment of such premiums and interest. However,
8 17 such moneys shall not be withheld from a nonstate public
8 18 employer if such withholding will adversely affect the receipt
8 19 of any federal grant or aid in connection with such moneys.
8 20 If a small employer or nonprofit employer fails to make
8 21 premium payments, the department may terminate that employer's
8 22 employee participation in the state plan pursuant to the Iowa
8 23 health care coverage partnership program and request the
8 24 attorney general to recover any premium and interest costs due
8 25 and unpaid.
8 26 Sec. 9. EFFECTIVE DATE. This division is effective on and
8 27 after January 1, 2010.
8 28 DIVISION II
8 29 IOWA CHOICE INSURANCE EXCHANGE
8 30 Sec. 10. NEW SECTION. 514M.1 SHORT TITLE.
8 31 This chapter shall be known and may be cited as the "Iowa
8 32 Choice Insurance Exchange Act".
8 33 Sec. 11. NEW SECTION. 514M.2 PURPOSE.
8 34 It is the purpose of this chapter to:
8 35 1. Ensure that all children in the state have affordable,
9 1 quality health care coverage with the following priorities:
9 2 a. Provide funding to cover all children who are eligible
9 3 for Medicaid, Medicaid expansion, and hawk=i by December 31,
9 4 2009.
9 5 b. As funding becomes available, provide subsidized
9 6 coverage which meets certain standards of quality and
9 7 affordability to the remaining uninsured children less than
9 8 nineteen years of age under a sliding scale based on family
9 9 income.
9 10 c. Require all parents of children less than nineteen
9 11 years of age to indicate on their Iowa tax returns whether
9 12 their children have health care coverage.
9 13 d. Require that all parents of children less than nineteen
9 14 years of age with a family income that is less than three

9 15 hundred percent of the federal poverty level must provide
9 16 proof of qualified health care coverage for their children
9 17 which meets certain standards of quality and affordability.
9 18 e. Move towards a future requirement that all parents of
9 19 children must provide proof of qualified health care coverage
9 20 for their children which meets certain standards of quality
9 21 and affordability.
9 22 2. Ensure that all Iowans have qualified health care
9 23 coverage which meets certain standards of quality and
9 24 affordability with the following priorities:
9 25 a. Continue to expand options for individuals who are
9 26 dually eligible for Medicare and Medicaid, typically the
9 27 chronically disabled, by utilizing evidence=based medical
9 28 treatments.
9 29 b. Ensure that all health and long=term care workers have
9 30 qualified health care coverage which meets certain standards
9 31 of quality and affordability.
9 32 c. Maximize eligibility of low=income adults nineteen
9 33 years of age and older for public health care coverage.
9 34 d. As funding becomes available, provide subsidized
9 35 coverage which meets certain standards of quality and
10 1 affordability to the remaining low=income adults.
10 2 e. Move towards a future requirement that all Iowans must
10 3 provide proof of qualified health care coverage which meets
10 4 certain standards of quality and affordability.
10 5 3. Decrease health care costs and health care coverage
10 6 costs by:
10 7 a. Instituting insurance reforms that assure the
10 8 availability of private insurance coverage for all Iowans by
10 9 addressing issues involving guaranteed availability and issue
10 10 of insurance to applicants; preexisting condition exclusions;
10 11 portability; and allowable or required pooling and rating
10 12 classifications.
10 13 b. Requiring every child who has public health care
10 14 coverage or is insured by a plan created by the Iowa health
10 15 care coverage exchange to have a medical home.
10 16 c. Establishing a statewide telehealth system.
10 17 d. Implementing cost containment strategies such as
10 18 disease management programs, advance medical directives or end
10 19 of life planning initiatives, transparency in health care cost
10 20 and quality information, and an expanded certificate of need
10 21 process.
10 22 Sec. 12. NEW SECTION. 514M.3 DEFINITIONS.
10 23 As used in this chapter, unless the context otherwise
10 24 requires:
10 25 1. "Board" means the board of directors of the Iowa choice
10 26 insurance exchange.
10 27 2. "Carrier" means an insurer providing accident and
10 28 sickness insurance under chapter 509, 514, or 514A and
10 29 includes a health maintenance organization established under
10 30 chapter 514B if payments received by the health maintenance
10 31 organization are considered premiums pursuant to section
10 32 514B.31 and are taxed under chapter 432. "Carrier" also
10 33 includes a corporation which becomes a mutual insurer pursuant
10 34 to section 514.23 and any other person as defined in section
10 35 4.1, subsection 20, who is or may become liable for the tax
11 1 imposed by chapter 432.
11 2 3. "Commissioner" means the commissioner of insurance.
11 3 4. "Creditable coverage" means health benefits or coverage
11 4 provided to an individual under any of the following:
11 5 a. A group health plan.
11 6 b. Health insurance coverage.
11 7 c. Part A or part B Medicare pursuant to Title XVIII of
11 8 the federal Social Security Act.
11 9 d. Medicaid pursuant to Title XIX of the federal Social
11 10 Security Act, other than coverage consisting solely of
11 11 benefits under section 1928 of that Act.
11 12 e. 10 U.S.C. ch. 55.
11 13 f. A health or medical care program provided through the
11 14 Indian health service or a tribal organization.
11 15 g. A state health benefits risk pool.
11 16 h. A health plan offered under 5 U.S.C. ch. 89.
11 17 i. A public health plan as defined under federal
11 18 regulations.
11 19 j. A health benefit plan under section 5(e) of the federal
11 20 Peace Corps Act, 22 U.S.C. } 2504(e).
11 21 k. An organized delivery system licensed by the director
11 22 of public health.
11 23 l. The hawk=i program authorized by chapter 514I.
11 24 5. "Director" means the director of revenue.
11 25 6. "Exchange" means the Iowa choice insurance exchange.

11 26   7. "Executive director" means the executive director of
11 27 the Iowa choice insurance exchange.
11 28   8. "Federal poverty level" means the most recently revised
11 29 income guidelines published by the United States department of
11 30 health and human services.
11 31   9. a. "Group health plan" means an employee welfare
11 32 benefit plan as defined in section 3(1) of the federal
11 33 Employee Retirement Income Security Act of 1974, to the extent
11 34 that the plan provides medical care including items and
11 35 services paid for as medical care to employees or their
12 1 dependents as defined under the terms of the plan directly or
12 2 through insurance, reimbursement, or otherwise.
12 3   b. For purposes of this subsection, "medical care" means
12 4 amounts paid for any of the following:
12 5   (1) The diagnosis, cure, mitigation, treatment, or
12 6 prevention of disease, or amounts paid for the purpose of
12 7 affecting a structure or function of the body.
12 8   (2) Transportation primarily for and essential to medical
12 9 care referred to in subparagraph (1).
12 10   (3) Insurance covering medical care referred to in
12 11 subparagraph (1) or (2).
12 12   c. For purposes of this subsection, the following apply:
12 13   (1) A plan, fund, or program established or maintained by
12 14 a partnership which, but for this subsection, would not be an
12 15 employee welfare benefit plan, shall be treated as an employee
12 16 welfare benefit plan which is a group health plan to the
12 17 extent that the plan, fund, or program provides medical care,
12 18 including items and services paid for as medical care for
12 19 present or former partners in the partnership or to the
12 20 dependents of such partners, as defined under the terms of the
12 21 plan, fund, or program, either directly or through insurance,
12 22 reimbursement, or otherwise.
12 23   (2) With respect to a group health plan, the term
12 24 "employer" includes a partnership with respect to a partner.
12 25   (3) With respect to a group health plan, the term
12 26 "participant" includes the following:
12 27   (a) With respect to a group health plan maintained by a
12 28 partnership, an individual who is a partner in the
12 29 partnership.
12 30   (b) With respect to a group health plan maintained by a
12 31 self=employed individual under which one or more of the
12 32 self=employed individual's employees are participants, the
12 33 self=employed individual, if that individual is, or may
12 34 become, eligible to receive benefits under the plan or the
12 35 individual's dependents may be eligible to receive benefits
13 1 under the plan.
13 2   10. "Health care services" means services, the coverage of
13 3 which is authorized under chapter 509, 514, 514A, or 514B as
13 4 limited by benefit plans established by the exchange's board
13 5 of directors, with the approval of the commissioner and
13 6 includes services for the purposes of preventing, alleviating,
13 7 curing, or healing human illness, injury, or physical
13 8 disability.
13 9   11. "Health insurance" means accident and sickness
13 10 insurance authorized by chapter 509, 514, or 514A.
13 11   12. a. "Health insurance coverage" means health insurance
13 12 coverage offered to individuals, including group conversion
13 13 coverage.
13 14   b. "Health insurance coverage" does not include any of the
13 15 following:
13 16   (1) Coverage for accident=only or disability income
13 17 insurance.
13 18   (2) Coverage issued as a supplement to liability
13 19 insurance.
13 20   (3) Liability insurance, including general liability
13 21 insurance and automobile liability insurance.
13 22   (4) Workers' compensation or similar insurance.
13 23   (5) Automobile medical=payment insurance.
13 24   (6) Credit=only insurance.
13 25   (7) Coverage for on=site medical clinic care.
13 26   (8) Other similar insurance coverage, specified in federal
13 27 regulations, under which benefits for medical care are
13 28 secondary or incidental to other insurance coverage or
13 29 benefits.
13 30   c. "Health insurance coverage" does not include benefits
13 31 provided under a separate policy as follows:
13 32   (1) Limited=scope dental or vision benefits.
13 33   (2) Benefits for long=term care, nursing home care, home
13 34 health care, or community=based care.
13 35   (3) Any other similar limited benefits as provided by rule
14 1 of the commissioner.

14 2 d. "Health insurance coverage" does not include benefits
14 3 offered as independent noncoordinated benefits as follows:
14 4 (1) Coverage only for a specified disease or illness.
14 5 (2) A hospital indemnity or other fixed indemnity
14 6 insurance.
14 7 e. "Health insurance coverage" does not include Medicare
14 8 supplemental health insurance as defined under section
14 9 1882(g)(1) of the federal Social Security Act, coverage
14 10 supplemental to the coverage provided under 10 U.S.C. ch. 55
14 11 and similar supplemental coverage provided to coverage under
14 12 group health insurance coverage.
14 13 13. "Insured" means an individual who is provided
14 14 qualified health care coverage under a policy, which policy
14 15 may include dependents and other covered persons.
14 16 14. "Medical assistance program" means the federal=state
14 17 assistance program established under Title XIX of the federal
14 18 Social Security Act and chapter 249A.
14 19 15. "Medicare" means the federal government health
14 20 insurance program established under Title XVIII of the federal
14 21 Social Security Act.
14 22 16. "Organized delivery system" means an organized
14 23 delivery system as licensed by the director of public health.
14 24 17. "Policy" means a contract, policy, or plan of health
14 25 insurance.
14 26 18. "Policy year" means a consecutive twelve=month period
14 27 during which a policy provides or obligates the carrier to
14 28 provide health insurance.
14 29 19. "Qualified health care coverage" means creditable
14 30 coverage which meets minimum standards of quality and
14 31 affordability as determined by the board by rule.
14 32 20. "Resident" means a person who is a resident of this
14 33 state for state income tax purposes.
14 34 21. "Secretary" means the secretary of the board of the
14 35 exchange.
15 1 Sec. 13. NEW SECTION. 514M.4 IOWA CHOICE INSURANCE
15 2 EXCHANGE CREATED == BOARD OF DIRECTORS.
15 3 1. The Iowa choice insurance exchange is created as a
15 4 nonprofit corporation.
15 5 a. All carriers and all organized delivery systems
15 6 licensed by the director of public health providing health
15 7 insurance or health care services in Iowa, whether on an
15 8 individual or group basis, and all other insurers designated
15 9 by the exchange's board of directors and approved by the
15 10 commissioner shall be members of the exchange.
15 11 b. The exchange shall operate under a plan of operation
15 12 established and approved under section 514M.5 and shall
15 13 exercise its powers through a board of directors established
15 14 under this section.
15 15 2. The board of directors of the exchange shall consist of
15 16 the following members:
15 17 a. Persons who are voting members of the board appointed
15 18 by the governor and subject to confirmation by the senate:
15 19 (1) A practicing physician licensed to practice medicine
15 20 and surgery or osteopathic medicine and surgery.
15 21 (2) A practicing nurse licensed as a registered nurse or a
15 22 licensed practical nurse or vocational nurse.
15 23 (3) A representative of the federation of Iowa insurers.
15 24 (4) A health economist who resides in Iowa.
15 25 (5) A health benefit manager.
15 26 (6) A consumer who is a representative of a children's
15 27 advocacy organization.
15 28 (7) A consumer who is a representative of the state's
15 29 adult uninsured population.
15 30 (8) A consumer who is a member of a racial or ethnic
15 31 minority group.
15 32 (9) A representative of organized labor.
15 33 (10) A representative of an organization of small
15 34 businesses.
15 35 b. Persons who are ex officio, nonvoting members of the
16 1 board:
16 2 (1) The commissioner of insurance, or a designee.
16 3 (2) The director of human services, or a designee.
16 4 (3) The director of public health, or a designee.
16 5 (4) Four members of the general assembly, one appointed by
16 6 the speaker of the house of representatives, one appointed by
16 7 the minority leader of the house of representatives, one
16 8 appointed by the majority leader of the senate, and one
16 9 appointed by the minority leader of the senate.
16 10 (5) The secretary of the board.
16 11 c. Each member of the board appointed by the governor
16 12 shall be a resident of this state and the composition of

16 13 voting members of the board shall be in compliance with
16 14 sections 69.16, 69.16A, and 69.16C.
16 15 d. The voting members of the board shall be appointed for
16 16 terms of six years beginning and ending as provided in section
16 17 69.19. A member of the board is eligible for reappointment.
16 18 The governor shall fill a vacancy for the remainder of the
16 19 unexpired term. A member of the board may be removed by the
16 20 governor for misfeasance, malfeasance, or willful neglect of
16 21 duty or other cause after notice and a public hearing unless
16 22 the notice and hearing are waived by the member in writing.
16 23 e. The voting members of the board shall annually elect
16 24 one of the members as chairperson and one as vice chairperson.
16 25 f. A majority of the voting members of the board
16 26 constitutes a quorum. The affirmative vote of a majority of
16 27 the voting members is necessary for any action taken by the
16 28 board. The majority shall not include a member who has a
16 29 conflict of interest and a statement by a member of a conflict
16 30 of interest is conclusive for this purpose. A vacancy in the
16 31 voting membership of the board does not impair the right of a
16 32 quorum to exercise the rights and perform the duties of the
16 33 board. An action taken by the board under this chapter may be
16 34 authorized by resolution at a regular or special meeting and
16 35 each resolution shall take effect immediately and need not be
17 1 published or posted. Meetings of the board shall be held at
17 2 the call of the chairperson or at the request of a majority of
17 3 the voting members.
17 4 g. Members of the board may be reimbursed from the moneys
17 5 of the exchange for expenses incurred by them as members, but
17 6 shall not be otherwise compensated by the exchange for their
17 7 services.
17 8 h. The voting members of the board shall give bond as
17 9 required for public officers in chapter 64.
17 10 i. The members of the board are subject to and are
17 11 officials within the meaning of chapter 68B.
17 12 j. All employees of the exchange are exempt from chapter
17 13 8A, subchapter IV, and chapter 97B.
17 14 3. The voting members of the board shall appoint an
17 15 executive director, subject to confirmation by the senate, to
17 16 supervise the administrative affairs and general management
17 17 and operations of the exchange. The board may appoint an
17 18 assistant executive director, and other officers as the voting
17 19 members of the board deem necessary. The officers shall not
17 20 be members of the board, shall serve at the pleasure of the
17 21 board, and shall receive compensation as fixed by the board.
17 22 4. The governor shall appoint a secretary of the board,
17 23 subject to confirmation by the senate. The secretary of the
17 24 board shall keep a record of the proceedings of the board and
17 25 shall be custodian of all books, documents, and papers filed
17 26 with the board, the minute book or journal of the board, and
17 27 the official seal of the board. The secretary may cause
17 28 copies to be made of minutes and other records and documents
17 29 of the board and may give certificates under the official seal
17 30 of the board that the copies are true copies, and persons
17 31 dealing with the board may rely upon the certificates.
17 32 Sec. 14. NEW SECTION. 514M.5 PLAN OF OPERATION ==
17 33 ASSESSMENTS.
17 34 1. The exchange shall submit to the commissioner a plan of
17 35 operation for the exchange and any amendments necessary or
18 1 suitable to assure the fair, reasonable, and equitable
18 2 administration of the exchange. The plan of operation shall
18 3 include provisions for the development of a comprehensive
18 4 health care coverage plan as provided in section 514M.6. The
18 5 plan of operation becomes effective upon approval in writing
18 6 by the commissioner prior to the date on which the coverage
18 7 under this chapter must be made available. After notice and
18 8 hearing, the commissioner shall approve the plan of operation
18 9 if the plan is determined to be suitable to assure the fair,
18 10 reasonable, and equitable administration of the exchange, and
18 11 provides for the sharing of exchange losses, if any, on an
18 12 equitable and proportionate basis among the member carriers.
18 13 If the exchange fails to submit a suitable plan of operation
18 14 within one hundred eighty days after the appointment of the
18 15 board of directors, or if at any later time the exchange fails
18 16 to submit suitable amendments to the plan, the commissioner
18 17 shall adopt, pursuant to chapter 17A, rules necessary to
18 18 administer this section. The rules shall continue in force
18 19 until modified by the commissioner or superseded by a plan
18 20 submitted by the exchange and approved by the commissioner.
18 21 In addition to other requirements, the plan of operation shall
18 22 provide for all of the following:
18 23 a. The handling and accounting of assets and moneys of the

18 24 exchange.
18 25   b. The amount and method of reimbursing members of the
18 26 board.
18 27   c. Regular times and places for meetings of the board.
18 28   d. Records to be kept of all financial transactions, and
18 29 the annual fiscal reporting to the commissioner.
18 30   e. The periodic advertising of the general availability of
18 31 health insurance coverage from the exchange.
18 32   f. Additional provisions necessary or proper for the
18 33 execution of the powers and duties of the exchange.
18 34   2. The plan of operation may provide that the powers and
18 35 duties of the exchange may be delegated to a person who will
19 1 perform functions similar to those of the exchange. A
19 2 delegation under this section takes effect only upon the
19 3 approval of both the board and the commissioner. The
19 4 commissioner shall not approve a delegation unless the
19 5 protections afforded to the insureds are substantially
19 6 equivalent to or greater than those provided under this
19 7 chapter.
19 8   3. The exchange has the general powers and authority
19 9 enumerated by this section and executed in accordance with the
19 10 plan of operation approved by the commissioner under
19 11 subsection 1. The exchange has the general powers and
19 12 authority granted under the laws of this state to carriers
19 13 licensed to issue health insurance coverage. In addition, the
19 14 exchange may do any of the following:
19 15   a. Enter into contracts as necessary or proper to carry
19 16 out this chapter.
19 17   b. Sue or be sued, including taking any legal action
19 18 necessary or proper for recovery of any assessments for, on
19 19 behalf of, or against participating carriers.
19 20   c. Take legal action necessary to avoid the payment of
19 21 improper claims against the exchange or the coverage provided
19 22 by or through the exchange.
19 23   d. Establish or utilize a medical review committee to
19 24 determine the reasonably appropriate level and extent of
19 25 health care services in each instance.
19 26   e. Establish appropriate rates, scales of rates, rate
19 27 classifications, and rating adjustments, which rates shall not
19 28 be unreasonable in relation to the health care coverage
19 29 provided and the reasonable operations expenses of the
19 30 exchange.
19 31   f. Pool risks among members.
19 32   g. Issue exchange policies on an indemnity or provision of
19 33 service basis providing the health care coverage required by
19 34 this chapter.
19 35   h. Administer separate pools, separate accounts, or other
20 1 plans or arrangements considered appropriate for separate
20 2 members or groups of members.
20 3   i. Operate and administer any combination of plans, pools,
20 4 or other mechanisms considered appropriate to best accomplish
20 5 the fair and equitable operation of the exchange.
20 6   j. Appoint from among members appropriate legal,
20 7 actuarial, and other committees as necessary to provide
20 8 technical assistance in the operation of the exchange, policy
20 9 and other contract design, and any other functions within the
20 10 authority of the exchange.
20 11   k. Hire independent consultants as necessary.
20 12   l. Develop a method of advising applicants of the
20 13 availability of other health care coverages outside the
20 14 exchange.
20 15   m. Include in its policies a provision providing for
20 16 subrogation rights by the exchange in a case in which the
20 17 exchange pays expenses on behalf of an individual who is
20 18 injured or suffers a disease under circumstances creating a
20 19 liability upon another person to pay damages to the extent of
20 20 the expenses paid by the exchange but only to the extent the
20 21 damages exceed the policy deductible and coinsurance amounts
20 22 paid by the insured. The exchange may waive its subrogation
20 23 rights if it determines that the exercise of the rights would
20 24 be impractical, uneconomical, or would work a hardship on the
20 25 insured.
20 26   n. Establish lines of credit, and establish one or more
20 27 cash and investment accounts to receive payments for services
20 28 rendered, appropriations from the state, and all other
20 29 business activity granted by this chapter except to the extent
20 30 otherwise limited by any applicable provision of the federal
20 31 Employee Retirement Income Security Act of 1974.
20 32   o. Design and approve the use of its trademarks, brand
20 33 names, seals, logos, and similar instruments by participating
20 34 carriers, employers, or organizations.

20 35   p. Enter into agreements with the department of revenue,
21 1 the department of human services, the division of insurance,
21 2 and any other state agencies the exchange deems necessary to
21 3 administer its duties under this chapter.
21 4   q. Seek and receive any grant funding from the federal
21 5 government, departments or agencies of the state, and private
21 6 foundations.
21 7   4. Policy rates for health insurance coverage issued by
21 8 the exchange shall reflect rating characteristics used in the
21 9 individual insurance market. The rates for a given
21 10 classification shall not be more than one hundred fifty
21 11 percent of the average premium or payment rate for the
21 12 classification charged by the five carriers with the largest
21 13 health insurance premium or payment volume in the state during
21 14 the preceding calendar year. In determining the average rate
21 15 of the five largest carriers, the rates or payments charged by
21 16 the carriers shall be actuarially adjusted to determine the
21 17 rate or payment that would have been charged for benefits
21 18 similar to those issued by the exchange.
21 19   5. Following the close of each calendar year, the exchange
21 20 shall determine the net premiums and payments, the expenses of
21 21 administration, and the incurred losses of the exchange for
21 22 the year. The exchange shall certify the amount of any net
21 23 loss for the preceding calendar year to the commissioner and
21 24 director of revenue. Any loss shall be assessed by the
21 25 exchange to all members of the exchange in proportion to their
21 26 respective shares of total health insurance premiums or
21 27 payments for subscriber contracts received in Iowa during the
21 28 second preceding calendar year, or with paid losses in the
21 29 year, coinciding with or ending during the calendar year or on
21 30 any other equitable basis as provided in the plan of
21 31 operation. In sharing losses, the exchange may abate or defer
21 32 in any part the assessment of a member, if, in the opinion of
21 33 the board, payment of the assessment would endanger the
21 34 ability of the member to fulfill its contractual obligations.
21 35 The exchange may also provide for an initial or interim
22 1 assessment against members of the exchange if necessary to
22 2 assure the financial capability of the exchange to meet the
22 3 incurred or estimated claims expenses or operating expenses of
22 4 the exchange until the next calendar year is completed. Net
22 5 gains, if any, must be held at interest to offset future
22 6 losses or allocated to reduce future premiums.
22 7   a. For purposes of this subsection, "total health
22 8 insurance premiums" and "payments for subscriber contracts"
22 9 include, without limitation, premiums or other amounts paid to
22 10 or received by a member for individual and group health plan
22 11 coverage provided under any chapter of the Code or Acts, and
22 12 "paid losses" includes, without limitation, claims paid by a
22 13 member operating on a self=funded basis for individual and
22 14 group health plan coverage provided under any chapter of the
22 15 Code or Acts.
22 16   b. For purposes of calculating and conducting the
22 17 assessment under this subsection, the exchange shall have the
22 18 express authority to require members to report on an annual
22 19 basis each member's total health insurance premiums and
22 20 payments for subscriber contracts and paid losses. A member
22 21 is liable for its share of the assessment calculated in
22 22 accordance with this section regardless of whether it
22 23 participates in the individual insurance market.
22 24   6. The exchange shall conduct periodic audits to assure
22 25 the general accuracy of the financial data submitted to the
22 26 exchange, and the exchange shall have an annual audit of its
22 27 operations, made by an independent certified public
22 28 accountant.
22 29   7. The exchange is subject to examination by the
22 30 commissioner. Not later than April 30 of each year, the board
22 31 shall submit to the commissioner a financial report for the
22 32 preceding calendar year in a form approved by the
22 33 commissioner.
22 34   8. The exchange is subject to oversight by the legislative
22 35 fiscal committee of the legislative council. Not later than
23 1 April 30 of each year, the board shall submit to the governor,
23 2 the speaker of the house of representatives, the majority
23 3 leader of the senate, and the legislative fiscal committee a
23 4 financial report for the preceding year in a form approved by
23 5 the committee.
23 6   9. All policy forms issued by the exchange must be filed
23 7 with and approved by the commissioner before their use.
23 8   10. The exchange is exempt from payment of all fees and
23 9 all taxes levied by this state or any of its political
23 10 subdivisions.

23 11   11. A member may offset an assessment made pursuant to
23 12 this chapter against its premium tax liability pursuant to
23 13 chapter 432 to the extent of twenty percent of the amount of
23 14 the assessment for each of the five calendar years following
23 15 the year in which the assessment was paid. If a member ceases
23 16 doing business, all uncredited assessments may be credited
23 17 against its premium tax liability for the year it ceases doing
23 18 business.
23 19   12. The exchange shall develop and implement a plan and
23 20 corresponding timeline detailing action steps toward
23 21 implementing this chapter, by rules adopted pursuant to
23 22 chapter 17A as provided in section 514M.7.
23 23   Sec. 15. NEW SECTION. 514M.6 IOWA CHOICE INSURANCE
23 24 EXCHANGE COVERAGE.
23 25   1. The exchange shall develop a comprehensive health care
23 26 coverage plan to provide health care coverage to all children
23 27 without such coverage, that utilizes and modifies existing
23 28 public programs including the medical assistance program,
23 29 hawk=i program, and hawk=i expansion program, and to provide
23 30 access to private unsubsidized, affordable, qualified health
23 31 care coverage to children who are not otherwise eligible for
23 32 health care coverage through public programs.
23 33   2. The comprehensive plan developed by the exchange shall
23 34 also consider and recommend options to provide access to
23 35 private unsubsidized, affordable, qualified health care
24 1 coverage to all Iowa children less than nineteen years of age
24 2 with a family income that is more than three hundred percent
24 3 of the federal poverty level and to adults and families with a
24 4 family income that is up to four hundred percent of the
24 5 federal poverty level who are not otherwise eligible for
24 6 health care coverage through public programs.
24 7   3. The exchange shall have broad authority to accomplish
24 8 the purposes of this chapter, including but not limited to:
24 9   a. Establishing, by rule, what constitutes qualified
24 10 health care coverage within parameters set by statute which
24 11 may include consideration of the following factors:
24 12   (1) Setting parameters for what is affordable by creating
24 13 an affordability schedule that is conservative to prevent harm
24 14 to people who are struggling financially and that utilizes a
24 15 progressive scale of subsidization by the state that decreases
24 16 as incomes increase and requires people with very low incomes
24 17 to pay only small amounts for health care coverage with no
24 18 financial penalties.
24 19   (2) Setting the maximum limit for affordability of
24 20 coverage at approximately six and one=half percent of an
24 21 individual's or family's income, including consideration of
24 22 assets held.
24 23   b. Establishing what constitutes qualified health care
24 24 coverage which meets certain standards of quality and
24 25 affordability. For purposes of defining qualified health care
24 26 coverage, the board may consider requirements for coverage and
24 27 benefits that include but are not limited to:
24 28   (1) No underwriting requirements and no preexisting
24 29 condition exclusions.
24 30   (2) Portability.
24 31   (3) Coverage of physical, behavioral, and dental health
24 32 services, vision services, and prescription drugs.
24 33   (4) Copayments and deductibles that do not exceed
24 34 specified amounts, with no copayments or deductibles for
24 35 wellness, prevention, disease, and chronic care management
25 1 services.
25 2   (5) No reimbursement of providers for an otherwise covered
25 3 service if the service is required solely on account of the
25 4 provider's avoidable medical error.
25 5   (6) A requirement that all insureds have a medical home.
25 6   (7) Coverage of wellness, prevention, disease management,
25 7 and chronic care management services including, without
25 8 limitation, physical and psycho=social screenings for children
25 9 which satisfy the Medicaid early periodic screening,
25 10 diagnosis, and treatment standards.
25 11   (8) Coverage of emergency mental health services when
25 12 provided by a state=certified emergency mental health services
25 13 provider.
25 14   (9) Premium discounts for nonsmokers and for insureds who
25 15 successfully lose weight through participation in a diet and
25 16 exercise program prescribed by a qualified health care
25 17 professional.
25 18   (10) A requirement that all participating health care
25 19 providers:
25 20   (a) Utilize electronic prescriptions.
25 21   (b) Utilize electronic medical records.

25 22 (c) Provide rate schedules of all services provided to the
25 23 board.
25 24 c. Establishing threshold requirements for a future
25 25 mandate to provide health care coverage that must be met by
25 26 parents of children less than nineteen years of age with
25 27 family incomes greater than three hundred percent of the
25 28 federal poverty level.
25 29 d. Collaborating with carriers to do the following,
25 30 including but not limited to:
25 31 (1) Assuring the availability of private health insurance
25 32 coverage to all Iowans by designing solutions to issues
25 33 related to guaranteed issuance of insurance, preexisting
25 34 condition exclusions, portability, and allowable pooling and
25 35 rating classifications.
26 1 (2) Formulating principles that ensure fair and
26 2 appropriate practices related to issues involving individual
26 3 health insurance policies such as recision and preexisting
26 4 condition clauses, and that provide for a binding third party
26 5 review process to resolve disputes related to such issues.
26 6 (3) Designing affordable, portable health insurance plans
26 7 that meet the needs of low=income populations.
26 8 4. The exchange shall design and implement a health care
26 9 coverage program called Iowa choice which offers private
26 10 qualified health care coverage through the exchange with
26 11 options to purchase at least three levels of benefits
26 12 including a gold plan which offers a comprehensive benefits
26 13 package, a silver plan which offers a medium benefits package,
26 14 and a bronze plan which offers a basic benefits package. The
26 15 Iowa choice care plans shall be available for purchase by
26 16 individuals and families. The purchase of Iowa choice health
26 17 care coverage may be publicly subsidized for low=income
26 18 individuals and families who do not meet eligibility
26 19 guidelines for any other public program. Iowa choice health
26 20 care coverage shall also provide affordable, unsubsidized
26 21 qualified health care coverage options for purchase by any
26 22 person who wishes to purchase them, including individuals,
26 23 families, and employees of small businesses.
26 24 5. The exchange shall design and administer a subsidy
26 25 program for payment of premiums for health care coverage for
26 26 low=income people that complements, not supplants, Medicaid
26 27 and includes cost=sharing by the insured using a sliding scale
26 28 based on income utilizing the federal poverty level
26 29 guidelines. The subsidy program may include subsidizing an
26 30 employee's purchase of health insurance offered by that
26 31 person's employer. The subsidy program may be implemented
26 32 incrementally as funding becomes available and may include
26 33 rolling implementation of the program to specified subgroups
26 34 of low=income children, adults, and families with incomes up
26 35 to four hundred percent of the federal poverty level.
27 1 6. The exchange shall provide for the coordination of a
27 2 children's health care network in the state that acts as a
27 3 resource for consumers to transition seamlessly among public
27 4 and private health care coverage options, including but not
27 5 limited to medical assistance, hawk=i, and Iowa choice care
27 6 programs.
27 7 7. The exchange shall implement initiatives such as
27 8 uniform insurance applications, uniform billing and coding
27 9 procedures in Iowa choice plans, and other standardized
27 10 administrative procedures that make the purchase of insurance
27 11 easier and lower administrative costs. The board may
27 12 determine what constitutes an equitable administrative formula
27 13 for carriers.
27 14 8. The exchange shall encourage initiatives that allow
27 15 portability of insurance plans offered by the exchange.
27 16 9. The exchange may set and control premiums by
27 17 establishing what constitutes reasonable rates to ensure
27 18 affordability of coverage.
27 19 10. The exchange shall study the ramifications of
27 20 requiring each employer with more than ten employees in the
27 21 state to adopt and maintain a cafeteria plan that satisfies
27 22 section 125 of the federal Internal Revenue Code of 1986, and
27 23 the rules adopted by the exchange.
27 24 11. The exchange shall establish procedures for the
27 25 selection and approval of qualified health care coverage plans
27 26 to be offered through the exchange.
27 27 12. The exchange shall establish procedures for the
27 28 enrollment of eligible individuals and groups.
27 29 13. The exchange shall establish procedures for appeals of
27 30 eligibility decisions for the Iowa choice insurance exchange.
27 31 14. The exchange shall operate a health insurance service
27 32 center that collects and distributes information to consumers

27 33 about all health insurance policies, contracts, and plans
27 34 available in the state and provides information to eligible
27 35 Iowans about the exchange.
28 1 15. The exchange shall establish and manage a system of
28 2 collecting all premium payments made by, or on behalf of,
28 3 individuals obtaining health insurance through the exchange,
28 4 including any premium payments made by enrollees, employers,
28 5 unions, or other organizations.
28 6 16. The exchange shall establish and manage a system of
28 7 remitting premium assistance payments to the carriers.
28 8 17. The exchange shall establish a plan for publicizing
28 9 the existence of the exchange and the exchange's requirements
28 10 and enrollment procedures.
28 11 18. The exchange shall develop criteria for determining
28 12 that certain health insurance plans shall no longer be made
28 13 available through the exchange, and develop a plan to
28 14 decertify and remove exchange approval from certain health
28 15 benefit plans.
28 16 19. The exchange shall develop criteria for health
28 17 insurance plans eligible for premium assistance payments
28 18 through the Iowa choice insurance exchange.
28 19 20. The exchange shall establish criteria for determining
28 20 each applicant's eligibility to purchase health insurance
28 21 offered by the exchange, including eligibility for premium
28 22 assistance payments.
28 23 21. The exchange may contract with professional service
28 24 firms as deemed necessary to carry out the requirements of
28 25 this section, and fix their compensation.
28 26 22. The exchange may contract with companies which provide
28 27 third=party administrative and billing services for health
28 28 insurance products.
28 29 23. The exchange shall design a premium schedule to be
28 30 published by the exchange by December 1 of each year, which,
28 31 accounting for maximum pricing in all rating factors with an
28 32 exception for age, includes the lowest premium on the market
28 33 for which an individual would be eligible for qualified health
28 34 care coverage as determined by the board. The schedule shall
28 35 publish premiums allowing variance for age and rate basis
29 1 type.
29 2 24. The exchange shall commission a study to examine and
29 3 model the effect of merging the individual and small group
29 4 health insurance markets in this state.
29 5 25. The exchange shall commission a study to examine and
29 6 model the effect of merging the Iowa comprehensive health
29 7 insurance association pool and the Iowa choice insurance
29 8 exchange pool and modifying the pool to improve accessibility
29 9 to qualified coverage at affordable rates prior to complete
29 10 implementation of universal health care coverage in the state.
29 11 26. The exchange may consider changing pooling and rating
29 12 classifications, including age rating, to better reflect
29 13 principles of equity, fairness, and cost=sharing and that best
29 14 facilitate the goal of achieving quality, affordable health
29 15 care coverage for all Iowans.
29 16 Sec. 16. NEW SECTION. 514M.7 RULES.
29 17 Pursuant to chapter 17A, the commissioner shall adopt rules
29 18 to administer this chapter.
29 19 Sec. 17. NEW SECTION. 514M.8 IOWA CHOICE INSURANCE
29 20 EXCHANGE POOL == APPROPRIATION.
29 21 1. The Iowa choice insurance exchange pool is created in
29 22 the state treasury as a separate fund under the control of the
29 23 exchange. There shall be credited to the pool all moneys
29 24 collected from premiums paid for health care plans offered by
29 25 the exchange, and any other funds that are appropriated or
29 26 transferred to the pool. All moneys deposited or paid into
29 27 the pool are appropriated and made available to the exchange
29 28 to be used for the purposes set forth in this chapter.
29 29 2. Notwithstanding section 8.33, any balance in the fund
29 30 on June 30 of each fiscal year shall not revert to the general
29 31 fund of the state, but shall be available for purposes of this
29 32 chapter in subsequent fiscal years.
29 33 Sec. 18. NEW SECTION. 514M.9 COLLECTIVE ACTION ==
29 34 IMMUNITY.
29 35 Neither the participation by carriers or members in the
30 1 exchange, the establishment of rates, forms, or procedures for
30 2 coverage issued by the exchange, nor any joint or collective
30 3 action required by this chapter shall be the basis of any
30 4 legal civil action, or criminal liability against the exchange
30 5 or members of it either jointly or separately.
30 6 Sec. 19. NEW SECTION. 514M.10 UNIVERSAL HEALTH CARE
30 7 COVERAGE == TRANSITION == IMPLEMENTATION.
30 8 1. To protect the health of all Iowans, the board shall

30 9 design and implement a program, including a timetable and
30 10 procedures for implementation, to ensure that all children in
30 11 the state have qualified health care coverage by maximizing
30 12 the use of state and private financial support as follows:
30 13 a. All children who are eligible for Medicaid, Medicaid
30 14 expansion, and hawk=i shall have coverage by December 31,
30 15 2009. Parents of such children shall provide proof that each
30 16 child has qualified health care coverage at a time and in a
30 17 manner as specified by the board by rule. Implementation of
30 18 this requirement may include a reporting requirement on Iowa
30 19 income tax returns or during school registration.
30 20 b. As funding becomes available, the state shall provide a
30 21 subsidy to assist with the purchase of qualified health care
30 22 coverage for the remaining uninsured children up to nineteen
30 23 years of age with a family income of up to four hundred
30 24 percent of the federal poverty level, using a sliding scale
30 25 based on family income. Parents of such children who are
30 26 eligible for subsidies shall provide proof that each child has
30 27 qualified health care coverage, at a time and in a manner as
30 28 specified by the board by rule. Implementation of this
30 29 requirement may include a reporting requirement on Iowa income
30 30 tax returns or during school registration.
30 31 c. All parents of children less than nineteen years of age
30 32 shall be required to provide proof that each child has
30 33 qualified health care coverage, at a time and in a manner as
30 34 specified by the board by rule. Implementation of this
30 35 requirement shall include a reporting requirement on Iowa
31 1 income tax returns or during school registration.
31 2 2. To protect the health of all Iowans, the board shall
31 3 design and implement a program, including a timetable and
31 4 procedures for implementation after all children have
31 5 qualified health care coverage, to ensure that all adults in
31 6 the state have qualified health care coverage as follows:
31 7 a. The state shall continue to expand options for
31 8 individuals who are dually eligible for Medicare and Medicaid
31 9 by utilizing evidence=based care.
31 10 b. As funding becomes available, the state shall provide a
31 11 subsidy to assist uninsured health and long=term care workers
31 12 with the purchase of qualified health care coverage. "Health
31 13 and long=term care workers" shall be defined by the board by
31 14 rules adopted under chapter 17A. A health or long=term care
31 15 worker who is eligible for the subsidy shall provide proof of
31 16 qualified health care coverage, at a time and in a manner as
31 17 specified by the board by rule. Implementation of this
31 18 requirement may include a reporting requirement on Iowa income
31 19 tax returns.
31 20 c. As funding becomes available, the state shall provide a
31 21 subsidy to assist with the purchase of qualified health care
31 22 coverage by the remaining uninsured adults with a family
31 23 income of up to four hundred percent of the federal poverty
31 24 level, using a sliding scale based on income. A person who is
31 25 eligible for the subsidy shall provide proof of qualified
31 26 health care coverage, at a time and in a manner as specified
31 27 by the board by rule. Implementation of this requirement may
31 28 include a reporting requirement on Iowa income tax returns.
31 29 d. All adults shall be required to provide proof of
31 30 qualified health care coverage, at a time and in a manner as
31 31 specified by the board by rule. Implementation of this
31 32 requirement may include a reporting requirement on Iowa income
31 33 tax returns.
31 34 3. An adult or parent of a child who is required to
31 35 provide proof of qualified health care coverage of the adult
32 1 or child and does not do so shall automatically be assigned
32 2 and enrolled in the appropriate health care coverage program
32 3 at a cost and in a time and manner determined by the board by
32 4 rule.
32 5 4. The board shall collaborate with members of the
32 6 exchange to institute health insurance reforms that may become
32 7 effective once universal health coverage of all Iowans has
32 8 been achieved. Such reforms may include:
32 9 a. Carriers will enroll any applicant rated up to two
32 10 hundred percent of standard at a maximum premium rate of one
32 11 hundred fifty percent of the standard rate.
32 12 b. Any applicant rated over two hundred percent of
32 13 standard will be enrolled in a plan offered by the state, such
32 14 as the Iowa comprehensive health insurance association pool or
32 15 the Iowa choice insurance exchange pool or a combination
32 16 thereof at one hundred fifty percent of standard premium rates
32 17 with the state subsidizing any cost over that amount.
32 18 c. Carriers will offer open enrollment periods where any
32 19 applicant may enroll with no preexisting condition exclusions.

32 20 d. Carriers will guarantee issuance of insurance with no
32 21 preexisting condition exclusions if an applicant has no more
32 22 than sixty=three days of lapse of coverage.
32 23 5. The Iowa choice insurance exchange program shall be
32 24 implemented by the board by rule pursuant to chapter 17A in
32 25 accordance with parameters and schedules established by
32 26 statute. The administrative rules review committee may
32 27 provide oversight of the rules through the administrative
32 28 rulemaking process.
32 29 COORDINATING AMENDMENTS
32 30 Sec. 20. Section 514E.1, subsections 15 and 22, Code 2009,
32 31 are amended by striking the subsections.
32 32 Sec. 21. Section 514E.2, subsection 3, unnumbered
32 33 paragraph 1, Code 2009, is amended to read as follows:
32 34 The association shall submit to the commissioner a plan of
32 35 operation for the association and any amendments necessary or
33 1 suitable to assure the fair, reasonable, and equitable
33 2 administration of the association. ~~The plan of operation~~
~~33 3 shall include provisions for the development of a~~
~~33 4 comprehensive health care coverage plan as provided in section~~
~~33 5 514E.5. In developing the comprehensive plan the association~~
~~33 6 shall give deference to the recommendations made by the~~
~~33 7 advisory council as provided in section 514E.6, subsection 1.~~
~~33 8 The association shall approve or disapprove but shall not~~
~~33 9 modify recommendations made by the advisory council.~~
~~33 10 Recommendations that are approved shall be included in the~~
~~33 11 plan of operation submitted to the commissioner.~~
~~33 12 Recommendations that are disapproved shall be submitted to the~~
~~33 13 commissioner with reasons for the disapproval.~~ The plan of
33 14 operation becomes effective upon approval in writing by the
33 15 commissioner prior to the date on which the coverage under
33 16 this chapter must be made available. After notice and
33 17 hearing, the commissioner shall approve the plan of operation
33 18 if the plan is determined to be suitable to assure the fair,
33 19 reasonable, and equitable administration of the association,
33 20 and provides for the sharing of association losses, if any, on
33 21 an equitable and proportionate basis among the member
33 22 carriers. If the association fails to submit a suitable plan
33 23 of operation within one hundred eighty days after the
33 24 appointment of the board of directors, or if at any later time
33 25 the association fails to submit suitable amendments to the
33 26 plan, the commissioner shall adopt, pursuant to chapter 17A,
33 27 rules necessary to implement this section. The rules shall
33 28 continue in force until modified by the commissioner or
33 29 superseded by a plan submitted by the association and approved
33 30 by the commissioner. In addition to other requirements, the
33 31 plan of operation shall provide for all of the following:
33 32 Sec. 22. Sections 514E.5 and 514E.6, Code 2009, are
33 33 repealed.
33 34 DIVISION III
33 35 HEALTH CARE COVERAGE OF ADULT CHILDREN
34 1 Sec. 23. Section 422.7, Code 2009, is amended by adding
34 2 the following new subsection:
34 3 NEW SUBSECTION. 29A. If the health benefits coverage or
34 4 insurance of the taxpayer includes coverage of a nonqualified
34 5 tax dependent as determined by the federal internal revenue
34 6 service, subtract, to the extent included, the amount of the
34 7 value of such coverage attributable to the nonqualified tax
34 8 dependent.
34 9 Sec. 24. Section 509.3, subsection 8, Code 2009, is
34 10 amended to read as follows:
34 11 8. A provision that the insurer will permit continuation
34 12 of existing coverage or reenrollment in previously existing
34 13 coverage for an unmarried child of an insured or enrollee who
34 14 so elects, at least through the policy anniversary date on or
34 15 after the date the child marries, ceases to be a resident of
34 16 this state, or attains the age of twenty=five years old,
34 17 whichever occurs first, or so long as the unmarried child
34 18 maintains full=time status as a student in an accredited
34 19 institution of postsecondary education.
34 20 In addition to the provisions required in subsections 1
34 21 through 7, the commissioner shall require provisions through
34 22 the adoption of rules implementing the federal Health
34 23 Insurance Portability and Accountability Act, Pub. L. No.
34 24 104=191.
34 25 Sec. 25. Section 509A.13B, Code 2009, is amended to read
34 26 as follows:
34 27 509A.13B ~~CONTINUATION OF DEPENDENT~~ COVERAGE OF CHILDREN ==
34 28 CONTINUATION OR REENROLLMENT.
34 29 If a governing body, a county board of supervisors, or a
34 30 city council has procured accident or health care coverage for

34 31 its employees under this chapter such coverage shall permit
34 32 continuation of existing coverage or reenrollment in
34 33 previously existing coverage for an unmarried child of an
34 34 insured or enrollee who so elects, at least through the policy
34 35 anniversary date on or after the date the child marries,
35 1 ceases to be a resident of this state, or attains the age of
35 2 twenty=five years old, whichever occurs first, or so long as
35 3 the unmarried child maintains full=time status as a student in
35 4 an accredited institution of postsecondary education.
35 5 Sec. 26. Section 514A.3B, subsection 2, Code 2009, is
35 6 amended to read as follows:
35 7 2. An insurer issuing an individual policy or contract of
35 8 accident and health insurance which provides coverage for
35 9 children of the insured shall permit continuation of existing
35 10 coverage or reenrollment in previously existing coverage for
35 11 an unmarried child of an insured or enrollee who so elects, at
35 12 least through the policy anniversary date on or after the date
35 13 the child marries, ceases to be a resident of this state, or
35 14 attains the age of twenty=five years old, whichever occurs
35 15 first, or so long as the unmarried child maintains full=time
35 16 status as a student in an accredited institution of
35 17 postsecondary education.
35 18 Sec. 27. APPLICABILITY. The sections of this Act amending
35 19 section 509.3, subsection 8, 509A.13B, and 514A.3B, subsection
35 20 2, apply to policies, contracts, or plans of accident and
35 21 health insurance delivered, issued for delivery, continued, or
35 22 renewed in this state on or after July 1, 2009.
35 23 Sec. 28. RETROACTIVE APPLICABILITY DATE. The section of
35 24 this Act enacting section 422.7, subsection 29A, applies
35 25 retroactively to January 1, 2009, for tax years beginning on
35 26 or after that date.
35 27 DIVISION IV
35 28 MEDICAL ASSISTANCE AND HAWK=I PROVISIONS
35 29 COVERAGE FOR ALL INCOME=ELIGIBLE CHILDREN
35 30 Sec. 29. NEW SECTION. 249A.3A MEDICAL ASSISTANCE == ALL
35 31 INCOME=ELIGIBLE CHILDREN.
35 32 The department shall provide state=only funded medical
35 33 assistance to individuals under nineteen years of age who meet
35 34 the income eligibility requirements for the state medical
35 35 assistance program, notwithstanding that federal financial
36 1 participation is not available for the cost of such medical
36 2 assistance. The department shall take such actions as may be
36 3 necessary to ensure the receipt of federal financial
36 4 participation under Title XIX of the federal Social Security
36 5 Act for the medical assistance program and any other federal
36 6 funding sources that may become available in the future to
36 7 provide coverage to this population.
36 8 Sec. 30. NEW SECTION. 514I.8A HAWK=I == ALL
36 9 INCOME=ELIGIBLE CHILDREN.
36 10 The department shall provide state=only funded coverage to
36 11 individuals under nineteen years of age who meet the income
36 12 eligibility requirements for the hawk=i program,
36 13 notwithstanding that federal financial participation is not
36 14 available for the cost of such coverage. The department shall
36 15 take such actions as may be necessary to ensure the receipt of
36 16 federal financial participation under Title XXI of the federal
36 17 Social Security Act and any other federal funding sources that
36 18 may become available in the future to provide coverage to this
36 19 population.
36 20 REQUIRED APPLICATION FOR DEPENDENT CHILD HEALTH CARE COVERAGE
36 21 Sec. 31. Section 422.12M, Code 2009, is amended to read as
36 22 follows:
36 23 422.12M INCOME TAX FORM == INDICATION OF DEPENDENT CHILD
36 24 HEALTH CARE COVERAGE.
36 25 1. The director shall draft the income tax form to ~~allow~~
36 26 require beginning with the tax returns for tax year ~~2008~~ 2009,
36 27 a person who files an individual or joint income tax return
36 28 with the department under section 422.13 to indicate the
36 29 presence or absence of health care coverage for each dependent
36 30 child for whom an exemption is claimed.
36 31 2. Beginning with the income tax return for tax year ~~2008~~
36 32 2009, a person who files an individual or joint income tax
36 33 return with the department under section 422.13, ~~may~~ shall
36 34 report on the income tax return, in the form required, the
36 35 presence or absence of health care coverage for each dependent
37 1 child for whom an exemption is claimed.
37 2 a. If the taxpayer indicates on the income tax return that
37 3 a dependent child does not have health care coverage, and the
37 4 income of the taxpayer's tax return does not exceed the
37 5 highest level of income eligibility standard for the medical
37 6 assistance program pursuant to chapter 249A or the hawk=i

37 7 program pursuant to chapter 514I, the department shall send a
37 8 notice to the taxpayer indicating that the dependent child may
37 9 be eligible for the medical assistance program or the hawk=i
37 10 program and providing information to the taxpayer about how to
37 11 enroll the dependent child in the ~~programs~~ appropriate
37 12 program. The taxpayer shall submit an application for the
37 13 appropriate program within ninety days of receipt of the
37 14 enrollment information.
~~37 15 b. Notwithstanding any other provision of law to the~~
~~37 16 contrary, a taxpayer shall not be subject to a penalty for not~~
~~37 17 providing the information required under this section.~~
37 18 ~~c.~~ b. The department shall consult with the department of
37 19 human services in developing the tax return form and the
37 20 information to be provided to tax filers under this section.
37 21 3. The department, in cooperation with the department of
37 22 human services, shall adopt rules pursuant to chapter 17A to
37 23 administer this section, including rules defining "health care
37 24 coverage" for the purpose of indicating its presence or
37 25 absence on the tax form and enforcement provisions relating to
37 26 the required indication of a dependent child's health care
37 27 coverage status on the tax form and the required application
37 28 for an appropriate program as specified in this section.
37 29 4. The department, in cooperation with the department of
37 30 human services, shall report, annually, to the governor and
37 31 the general assembly all of the following:
37 32 a. The number of Iowa families, by income level, claiming
37 33 the state income tax exemption for dependent children.
37 34 b. The number of Iowa families, by income level, claiming
37 35 the state income tax exemption for dependent children ~~who also~~
38 1 and whether they indicate the presence or absence of health
38 2 care coverage for the dependent children.
38 3 c. The effect of the reporting requirements and provision
38 4 of information ~~requirements~~ required under this section on the
38 5 number and percentage of children in the state who are
38 6 uninsured.
38 7 d. The number of those indicating the absence of coverage
38 8 who comply or do not comply with the requirement for
38 9 application for an appropriate program, and any enforcement
38 10 action taken.
38 11 PREGNANT WOMEN INCOME ELIGIBILITY FOR MEDICAID
38 12 Sec. 32. Section 249A.3, subsection 1, paragraph l, Code
38 13 2009, is amended to read as follows:
38 14 l. (1) Is an infant whose income is not more than two
38 15 hundred percent of the federal poverty level, as defined by
38 16 the most recently revised income guidelines published by the
38 17 United States department of health and human services.
38 18 (2) Additionally, effective July 1, 2009, medical
38 19 assistance shall be provided to ~~an~~ a pregnant woman or infant
38 20 whose family income is at or below three hundred percent of
38 21 the federal poverty level, as defined by the most recently
38 22 revised poverty income guidelines published by the United
38 23 States department of health and human services, if otherwise
38 24 eligible.
38 25 IMPROVING ACCESS AND RETENTION
38 26 Sec. 33. Section 249A.4, Code 2009, is amended by adding
38 27 the following new subsections:
38 28 NEW SUBSECTION. 16. Provide by rule for presumptive
38 29 eligibility for a child who is eligible for medical assistance
38 30 under this chapter.
38 31 NEW SUBSECTION. 17. Require by rule only one pay stub as
38 32 verification of earned income for the medical assistance
38 33 program when it is indicative of future income.
38 34 NEW SUBSECTION. 18. Allow by rule for an averaging of
38 35 three years of income for self=employed families to establish
39 1 eligibility for the medical assistance program.
39 2 NEW SUBSECTION. 19. Extend by rule the period for annual
39 3 renewal by medical assistance members by mailing the renewal
39 4 form to the member on the first day of the month prior to the
39 5 month of renewal.
39 6 NEW SUBSECTION. 20. Implement by rule passive renewal in
39 7 the medical assistance program.
39 8 Sec. 34. Section 514I.5, subsection 8, paragraph g, Code
39 9 2009, is amended to read as follows:
39 10 g. Presumptive eligibility criteria for the program.
39 11 Beginning July 1, 2009, presumptive eligibility shall be
39 12 provided for an eligible child.
39 13 Sec. 35. Section 514I.5, subsection 8, Code 2009, is
39 14 amended by adding the following new paragraphs:
39 15 NEW PARAGRAPH. o. Requiring only one pay stub as
39 16 verification of earned income when it is indicative of future
39 17 income.

39 18 NEW PARAGRAPH. p. Allowing for an averaging of three
39 19 years of income for self=employed families to establish
39 20 eligibility.
39 21 DIVISION V
39 22 VOLUNTEER HEALTH CARE PROVIDERS
39 23 Sec. 36. Section 135.24, Code 2009, is amended to read as
39 24 follows:
39 25 135.24 VOLUNTEER HEALTH CARE PROVIDER PROGRAM ESTABLISHED
39 26 == IMMUNITY FROM CIVIL LIABILITY.
39 27 1. The director shall establish within the department a
39 28 program to provide to eligible hospitals, clinics, free
39 29 clinics, field dental clinics, health care provider offices,
39 30 or other health care facilities, health care referral
39 31 programs, or charitable organizations, free medical, dental,
39 32 chiropractic, pharmaceutical, nursing, optometric,
39 33 psychological, social work, behavioral science, podiatric,
39 34 physical therapy, occupational therapy, respiratory therapy,
39 35 and emergency medical care services given on a voluntary basis
40 1 by health care providers. A participating health care
40 2 provider shall register with the department and obtain from
40 3 the department a list of eligible, participating hospitals,
40 4 clinics, free clinics, field dental clinics, health care
40 5 provider offices, or other health care facilities, health care
40 6 referral programs, or charitable organizations.
40 7 2. The department, in consultation with the department of
40 8 human services, shall adopt rules to implement the volunteer
40 9 health care provider program which shall include the
40 10 following:
40 11 a. Procedures for registration of health care providers
40 12 deemed qualified by the board of medicine, the board of
40 13 physician assistants, the dental board, the board of nursing,
40 14 the board of chiropractic, the board of psychology, the board
40 15 of social work, the board of behavioral science, the board of
40 16 pharmacy, the board of optometry, the board of podiatry, the
40 17 board of physical and occupational therapy, the board of
40 18 respiratory care, and the Iowa department of public health, as
40 19 applicable.
40 20 b. Procedures for registration of free clinics, ~~and~~ field
40 21 dental clinics, and health care provider offices.
40 22 c. Criteria for and identification of hospitals, clinics,
40 23 free clinics, field dental clinics, health care provider
40 24 offices, or other health care facilities, health care referral
40 25 programs, or charitable organizations, eligible to participate
40 26 in the provision of free medical, dental, chiropractic,
40 27 pharmaceutical, nursing, optometric, psychological, social
40 28 work, behavioral science, podiatric, physical therapy,
40 29 occupational therapy, respiratory therapy, or emergency
40 30 medical care services through the volunteer health care
40 31 provider program. A free clinic, a field dental clinic, a
40 32 health care provider office, a health care facility, a health
40 33 care referral program, a charitable organization, or a health
40 34 care provider participating in the program shall not bill or
40 35 charge a patient for any health care provider service provided
41 1 under the volunteer health care provider program.
41 2 d. Identification of the services to be provided under the
41 3 program. The services provided may include, but shall not be
41 4 limited to, obstetrical and gynecological medical services,
41 5 psychiatric services provided by a physician licensed under
41 6 chapter 148, dental services provided under chapter 153, or
41 7 other services provided under chapter 147A, 148A, 148B, 148C,
41 8 149, 151, 152, 152B, 152E, 154, 154B, 154C, 154D, 154F, or
41 9 155A.
41 10 3. A health care provider providing free care under this
41 11 section shall be considered an employee of the state under
41 12 chapter 669, shall be afforded protection as an employee of
41 13 the state under section 669.21, and shall not be subject to
41 14 payment of claims arising out of the free care provided under
41 15 this section through the health care provider's own
41 16 professional liability insurance coverage, provided that the
41 17 health care provider has done all of the following:
41 18 a. Registered with the department pursuant to subsection
41 19 1.
41 20 b. Provided medical, dental, chiropractic, pharmaceutical,
41 21 nursing, optometric, psychological, social work, behavioral
41 22 science, podiatric, physical therapy, occupational therapy,
41 23 respiratory therapy, or emergency medical care services
41 24 through a hospital, clinic, free clinic, field dental clinic,
41 25 health care provider office, or other health care facility,
41 26 health care referral program, or charitable organization
41 27 listed as eligible and participating by the department
41 28 pursuant to subsection 1.

41 29   4. A free clinic providing free care under this section
41 30 shall be considered a state agency solely for the purposes of
41 31 this section and chapter 669 and shall be afforded protection
41 32 under chapter 669 as a state agency for all claims arising
41 33 from the provision of free care by a health care provider
41 34 registered under subsection 3 who is providing services at the
41 35 free clinic in accordance with this section or from the
42 1 provision of free care by a health care provider who is
42 2 covered by adequate medical malpractice insurance as
42 3 determined by the department, if the free clinic has
42 4 registered with the department pursuant to subsection 1.
42 5   5. A field dental clinic providing free care under this
42 6 section shall be considered a state agency solely for the
42 7 purposes of this section and chapter 669 and shall be afforded
42 8 protection under chapter 669 as a state agency for all claims
42 9 arising from the provision of free care by a health care
42 10 provider registered under subsection 3 who is providing
42 11 services at the field dental clinic in accordance with this
42 12 section or from the provision of free care by a health care
42 13 provider who is covered by adequate medical malpractice
42 14 insurance, as determined by the department, if the field
42 15 dental clinic has registered with the department pursuant to
42 16 subsection 1.
42 17   5A. A health care provider office providing free care
42 18 under this section shall be considered a state agency solely
42 19 for the purposes of this section and chapter 669 and shall be
42 20 afforded protection under chapter 669 as a state agency for
42 21 all claims arising from the provision of free care by a health
42 22 care provider registered under subsection 3 who is providing
42 23 services at the health care provider office in accordance with
42 24 this section or from the provision of free care by a health
42 25 care provider who is covered by adequate medical malpractice
42 26 insurance, as determined by the department, if the health care
42 27 provider office has registered with the department pursuant to
42 28 subsection 1.
42 29   6. For the purposes of this section:
42 30   a. "Charitable organization" means a charitable
42 31 organization within the meaning of section 501(c)(3) of the
42 32 Internal Revenue Code.
42 33   b. "Field dental clinic" means a dental clinic temporarily
42 34 or periodically erected at a location utilizing mobile dental
42 35 equipment, instruments, or supplies, as necessary, to provide
43 1 dental services.
43 2   c. "Free clinic" means a facility, other than a hospital
43 3 or health care provider's office which is exempt from taxation
43 4 under section 501(c)(3) of the Internal Revenue Code and which
43 5 has as its sole purpose the provision of health care services
43 6 without charge to individuals who are otherwise unable to pay
43 7 for the services.
43 8   d. "Health care provider" means a physician licensed under
43 9 chapter 148, a chiropractor licensed under chapter 151, a
43 10 physical therapist licensed pursuant to chapter 148A, an
43 11 occupational therapist licensed pursuant to chapter 148B, a
43 12 podiatrist licensed pursuant to chapter 149, a physician
43 13 assistant licensed and practicing under a supervising
43 14 physician pursuant to chapter 148C, a licensed practical
43 15 nurse, a registered nurse, or an advanced registered nurse
43 16 practitioner licensed pursuant to chapter 152 or 152E, a
43 17 respiratory therapist licensed pursuant to chapter 152B, a
43 18 dentist, dental hygienist, or dental assistant registered or
43 19 licensed to practice under chapter 153, an optometrist
43 20 licensed pursuant to chapter 154, a psychologist licensed
43 21 pursuant to chapter 154B, a social worker licensed pursuant to
43 22 chapter 154C, a mental health counselor or a marital and
43 23 family therapist licensed pursuant to chapter 154D,* a
43 24 pharmacist licensed pursuant to chapter 155A, or an emergency
43 25 medical care provider certified pursuant to chapter 147A.
43 26   e. "Health care provider office" means the private office
43 27 or clinic of an individual health care provider or group of
43 28 health care providers but does not include a field dental
43 29 clinic, a free clinic, or a hospital.
43 30   DIVISION VI
43 31   HEALTH CARE WORKFORCE SUPPORT INITIATIVE
43 32   Sec. 37. Section 261.2, Code 2009, is amended by adding
43 33 the following new subsection:
43 34   NEW SUBSECTION. 10. Administer, in cooperation with the
43 35 health care workforce shortages advisory council established
44 1 in section 261.128, the health care workforce support
44 2 initiative.
44 3   Sec. 38. NEW SECTION. 261.128 HEALTH CARE WORKFORCE
44 4 SUPPORT INITIATIVE == WORKFORCE SHORTAGE FUND.

44 5 1. HEALTH CARE WORKFORCE SHORTAGE FUND.
44 6 a. A health care workforce shortage fund is created in the
44 7 state treasury as a separate fund under the control of the
44 8 college student aid commission. Moneys appropriated from the
44 9 general fund of the state to the fund; moneys received from
44 10 the federal government for the purposes of addressing the
44 11 health care workforce shortage; contributions, grants, and
44 12 other moneys from communities and health care employers; and
44 13 moneys from any other public or private source available to
44 14 the fund, shall be deposited in the fund. The commission may
44 15 receive contributions, grants, and in=kind contributions to
44 16 support the purposes of the fund.
44 17 b. The fund shall be separate from the general fund of the
44 18 state and shall not be considered part of the general fund of
44 19 the state. The moneys in the fund shall not be considered
44 20 revenue of the state, but rather shall be moneys of the fund.
44 21 The moneys in the fund are not subject to section 8.33 and
44 22 shall not be transferred, used, obligated, appropriated, or
44 23 otherwise encumbered, except to provide for the purposes of
44 24 this section. Notwithstanding section 12C.7, subsection 2,
44 25 interest or earnings on moneys deposited in the fund shall be
44 26 credited to the fund.
44 27 c. Moneys in the fund are appropriated to support the
44 28 medical residency training grants program, the health care
44 29 professional loan repayment program, and the nurse educator
44 30 forgivable loan and nursing faculty fellowship programs, as
44 31 specified in this section. However, the total amount provided
44 32 annually for the medical residency training grants program
44 33 shall not exceed eleven million dollars, the total amount
44 34 provided annually for the health care professional loan
44 35 repayment program shall not exceed three million dollars, and
45 1 the total amount provided annually for the nurse educator
45 2 forgivable loan and nursing faculty fellowship programs shall
45 3 not exceed one million dollars.
45 4 d. The commission shall adopt rules pursuant to chapter
45 5 17A to administer the fund.
45 6 2. HEALTH CARE WORKFORCE SHORTAGE ADVISORY COUNCIL.
45 7 a. The commission shall establish a health care workforce
45 8 shortage advisory council. The commission shall adopt rules
45 9 pursuant to chapter 17A to establish policies and procedures
45 10 for the advisory council.
45 11 b. The members of the advisory council shall include one
45 12 representative of each of the following:
45 13 (1) The department of public health.
45 14 (2) The department of human services.
45 15 (3) The department of education.
45 16 (4) The office of the attorney general.
45 17 (5) The university of Iowa college of medicine.
45 18 (6) The university of Iowa hospitals and clinics.
45 19 (7) Iowa health systems.
45 20 (8) Mercy medical center.
45 21 (9) Des Moines university == osteopathic medical center.
45 22 (10) The Iowa hospital association.
45 23 (11) The Iowa medical society.
45 24 (12) The Iowa nurses association.
45 25 c. The advisory council members shall serve without
45 26 compensation or reimbursement for expenses.
45 27 d. The advisory council shall provide oversight for the
45 28 programs established under this section. The advisory council
45 29 shall also make recommendations to the commission regarding
45 30 administration of the programs including prioritization in the
45 31 awarding of grants, loans, and fellowships based upon data
45 32 demonstrating the specific health care provider needs in this
45 33 state.
45 34 e. The advisory council shall also provide recommendations
45 35 to the commission regarding coordination of the programs
46 1 established under this section with other health care
46 2 professional=related financial assistance programs available
46 3 in this state.
46 4 3. MEDICAL RESIDENCY TRAINING GRANTS PROGRAM.
46 5 a. The commission shall establish a medical residency
46 6 training grants program to provide grants to sponsors of
46 7 accredited graduate medical education residency programs in
46 8 this state to establish, expand, or support medical residency
46 9 training programs. For the purposes of this section, unless
46 10 the context otherwise requires, "accredited" means a graduate
46 11 medical education program approved by the accreditation
46 12 council for graduate medical education. The grant funds may
46 13 be used to support medical residency programs through any of
46 14 the following:
46 15 (1) The establishment of new or alternative campus

46 16 accredited medical residency training programs. For the
46 17 purposes of this subparagraph, "new or alternative campus
46 18 accredited medical residency training program" means a program
46 19 that is accredited by a recognized entity approved for such
46 20 purpose by the accreditation council for graduate medical
46 21 education with the exception that a new medical residency
46 22 training program that, by reason of an insufficient period of
46 23 operation is not eligible for accreditation on or before the
46 24 date of submission of an application for a grant, may be
46 25 deemed accredited if the accreditation council for graduate
46 26 medical education finds, after consultation with the
46 27 appropriate accreditation entity, that there is reasonable
46 28 assurance that the program will meet the accreditation
46 29 standards of the entity prior to the date of graduation of the
46 30 initial class in the program.
46 31 (2) The provision of new residency positions within
46 32 existing accredited medical residency or fellowship training
46 33 programs.
46 34 (3) The funding of not more than twenty=five residency
46 35 positions which are in excess of the federal residency cap.
47 1 For the purposes of this subparagraph, "in excess of the
47 2 federal residency cap" means a residency position for which no
47 3 federal Medicare funding is available because the residency
47 4 position is a position beyond the cap for residency positions
47 5 established by the federal Balanced Budget Act of 1997, Pub.
47 6 L. No. 105=33.
47 7 b. The commission, in consultation with the advisory
47 8 council, shall adopt rules pursuant to chapter 17A to provide
47 9 for all of the following:
47 10 (1) Eligibility requirements for and qualifications of a
47 11 sponsor of an accredited graduate medical education residency
47 12 program to receive a grant.
47 13 (2) The application process for a grant.
47 14 (3) Criteria for preference in awarding of grants,
47 15 including preference in the residency specialty.
47 16 (4) Criteria for determining the amount of a grant. Only
47 17 entities that have contributed moneys to the health care
47 18 workforce shortage fund may be awarded grants. The total
47 19 amount of a grant to such an entity shall be limited to no
47 20 more than twice the amount of the contribution by the entity
47 21 to the fund.
47 22 (5) Use of the funds awarded. Funds may be used to pay
47 23 the costs of establishing, expanding, or supporting a graduate
47 24 medical education program including but not limited to costs
47 25 associated with residency stipends and physician faculty
47 26 stipends.
47 27 4. HEALTH CARE PROFESSIONAL LOAN REPAYMENT PROGRAM.
47 28 a. The commission shall establish a health care
47 29 professional loan repayment program to assist health care
47 30 professionals in repaying outstanding qualifying education
47 31 loans.
47 32 b. The commission shall administer the loan repayment
47 33 program with the assistance of Des Moines university ==
47 34 osteopathic medical center. From funds appropriated from the
47 35 health care workforce shortage fund for the purposes of the
48 1 program, the commission shall pay a fee to Des Moines
48 2 university == osteopathic medical center for the
48 3 administration of the program.
48 4 c. The commission, with the assistance of Des Moines
48 5 university == osteopathic medical center and based on
48 6 recommendations from the advisory council, shall adopt rules
48 7 pursuant to chapter 17A relating to the establishment and
48 8 administration of the health care professional loan repayment
48 9 program. The rules adopted shall address all of the
48 10 following:
48 11 (1) Eligibility and qualification requirements for a
48 12 health care professional, medically underserved communities,
48 13 and health care employers to participate in the loan repayment
48 14 program. Any medically underserved community in the state and
48 15 all health care specialties shall be considered for
48 16 participation.
48 17 (a) To be eligible, a health care professional at a
48 18 minimum must not have any unserved obligations to a federal,
48 19 state, or local government or other entity that would prevent
48 20 compliance with obligations under the loan; must have a
48 21 current and unrestricted license to practice the
48 22 professional's respective profession; and must be able to
48 23 begin full=time clinical practice upon signing an agreement
48 24 for a loan repayment.
48 25 (b) To be eligible, a medically underserved community must
48 26 provide a clinical setting for full=time practice of a health

48 27 care professional and must provide a fifty thousand dollar
48 28 matching contribution for a physician and a fifteen thousand
48 29 dollar matching contribution for any other health care
48 30 professional.
48 31 (c) To be eligible, a health care employer must provide a
48 32 clinical setting for full=time practice of a health care
48 33 professional and must contribute to the health care workforce
48 34 shortage fund an amount that is at least twice the amount
48 35 awarded to recipients of loan repayments under the program
49 1 employed by the health care employer.
49 2 (2) The process for awarding loans. The commission shall
49 3 receive recommendations from the advisory council regarding
49 4 selection of loan repayment recipients. The process shall
49 5 require each recipient to enter into an agreement with the
49 6 commission that specifies the obligations of the recipient and
49 7 the commission prior to receiving loan repayment.
49 8 (3) Public awareness regarding the program including
49 9 notification of potential health care professionals, medically
49 10 underserved communities, and health care employers about the
49 11 program and dissemination of applications to appropriate
49 12 entities.
49 13 (4) Measures regarding all of the following:
49 14 (a) The amount of the loan repayment and the specifics of
49 15 obligated service for a loan repayment recipient. A loan
49 16 repayment recipient shall agree to provide service in
49 17 full=time clinical practice for a minimum of four years. If a
49 18 loan repayment recipient is sponsored by a medically
49 19 underserved community partner, the obligated service shall be
49 20 provided in the medically underserved community. A loan
49 21 repayment recipient sponsored by a health care employer shall
49 22 agree to provide health care services as specified in an
49 23 employment agreement.
49 24 (b) Determination of the conditions of loan repayment
49 25 applicable to a loan repayment recipient. At the time of
49 26 approval for participation in the program, a loan repayment
49 27 recipient shall designate the qualifying loan to be repaid
49 28 through the program. The recipient shall be required to
49 29 submit proof that all payments made through the program are
49 30 applied toward the designated qualifying loan. For the
49 31 purposes of this subparagraph division, "qualifying loan"
49 32 means a government or commercial loan for actual costs paid
49 33 for tuition, reasonable education expenses, and reasonable
49 34 living expenses related to the graduate or undergraduate
49 35 education of a health care professional.
50 1 (c) Enforcement of the state's rights under a loan
50 2 repayment agreement, including the commencement of any court
50 3 action. A recipient who fails to fulfill the requirements of
50 4 the loan repayment agreement is subject to payment of the loan
50 5 repayment amount in full or on a pro rata basis for the
50 6 portion of the loan repaid through the fund and any penalty
50 7 established by rule of the commission. A recipient who fails
50 8 to meet the requirements of the loan repayment agreement may
50 9 also be subject to repayment of moneys advanced by a medically
50 10 underserved community or health care employer partner as
50 11 provided in any agreement with the partner.
50 12 (d) Waiver, suspension, or cancellation of a loan
50 13 repayment agreement in appropriate situations.
50 14 (e) A process for monitoring compliance with eligibility
50 15 requirements, obligated service provisions, and use of funds
50 16 by recipients to verify eligibility of recipients and to
50 17 ensure that state and federal funds are used in accordance
50 18 with program requirements.
50 19 d. A recipient is responsible for reporting on federal
50 20 income tax forms any amount received through the program, to
50 21 the extent required by federal law. Loan repayments received
50 22 through the program by a recipient in compliance with the
50 23 requirements of the loan repayment program are exempt from
50 24 state income taxation.
50 25 5. NURSING WORKFORCE SHORTAGE INITIATIVE.
50 26 a. NURSE EDUCATOR FORGIVABLE LOAN PROGRAM.
50 27 (1) The commission shall establish a nurse educator
50 28 forgivable loan program. For the purposes of this paragraph,
50 29 "nurse educator" means a registered nurse who holds a master's
50 30 degree or doctorate degree and is employed as a faculty member
50 31 who teaches nursing in a nursing education program as provided
50 32 in 655 IAC 2.6 at an accredited private institution or an
50 33 institution of higher education governed by the state board of
50 34 regents.
50 35 (2) The program shall consist of loan forgiveness for
51 1 qualifying loans for nurse educators. For the purposes of
51 2 this subparagraph, "qualifying loan" means a government or

51 3 commercial loan for actual costs paid for tuition, reasonable
51 4 education expenses, and reasonable living expenses related to
51 5 the graduate or undergraduate education of a nurse. The
51 6 program shall provide for payment of up to twenty thousand
51 7 dollars for a qualifying loan, if the nurse educator remains
51 8 teaching in a qualifying teaching position for a period of not
51 9 less than four consecutive academic years.
51 10 (3) The nurse educator and the commission shall enter into
51 11 an agreement specifying the obligations of the nurse educator
51 12 and the commission. If the nurse educator leaves the
51 13 qualifying teaching position prior to teaching for four
51 14 consecutive academic years, the nurse educator shall be liable
51 15 to repay the amount of the qualifying loan paid or forgiven
51 16 through the program, plus interest as specified by rule.
51 17 However, if the nurse educator leaves the qualifying teaching
51 18 position involuntarily, the nurse educator shall not be liable
51 19 to repay the amount paid or forgiven, but shall be responsible
51 20 for paying the amount remaining due on a qualifying loan.
51 21 (4) The commission, in consultation with the advisory
51 22 council, shall adopt rules pursuant to chapter 17A relating to
51 23 the establishment and administration of the nurse educator
51 24 forgivable loan program. The rules shall include provisions
51 25 specifying what constitutes a qualifying teaching position.
51 26 b. NURSING FACULTY FELLOWSHIP PROGRAM.
51 27 (1) The commission shall establish a nursing faculty
51 28 fellowship program to provide funds to nursing schools in the
51 29 state for fellowships for individuals employed in qualifying
51 30 positions on the nursing faculty. The program shall be
51 31 designed to assist nursing schools in filling vacancies in
51 32 qualifying positions throughout the state.
51 33 (2) The commission, in consultation with the advisory
51 34 council and in cooperation with nursing schools throughout the
51 35 state, shall develop a distribution formula which shall
52 1 provide that no more than thirty percent of the available
52 2 moneys are awarded to a single nursing school. Additionally,
52 3 the program shall limit funding for a qualifying position in a
52 4 nursing school to no more than ten thousand dollars per year
52 5 for up to three years.
52 6 (3) The commission, in consultation with the advisory
52 7 council, shall adopt rules pursuant to chapter 17A to
52 8 administer the program. The rules shall include provisions
52 9 specifying what constitutes a qualifying position at a nursing
52 10 school.
52 11 (4) In determining eligibility for a fellowship, the
52 12 commission shall consider all of the following:
52 13 (a) The length of time a qualifying position has gone
52 14 unfilled at a nursing school.
52 15 (b) Documented recruiting efforts by a nursing school.
52 16 (c) The geographic location of a nursing school.
52 17 (d) The type of nursing program offered at the nursing
52 18 school, including associate, bachelor's, master's, or doctoral
52 19 degrees in nursing, and the need for the specific nursing
52 20 program in the state.
52 21 6. The commission shall submit an annual report to the
52 22 governor and the general assembly regarding the status of the
52 23 health care workforce support initiative, including the
52 24 balance remaining in and appropriations from the health care
52 25 workforce shortage fund.
52 26 Sec. 39. Sections 261.19 and 261.19B, Code 2009, are
52 27 repealed.
52 28 Sec. 40. CODE EDITOR DIRECTIVE. The Code editor shall
52 29 create a new division in chapter 261 codifying section
52 30 261.128, as enacted in this Act, as the health care workforce
52 31 support initiative.
52 32 DIVISION VII
52 33 PHARMACEUTICAL=RELATED INITIATIVES
52 34 MEDICATION THERAPY MANAGEMENT
52 35 Sec. 41. NEW SECTION. 155A.43 MEDICATION THERAPY
53 1 MANAGEMENT == ADVISORY COMMITTEE.
53 2 1. The director of public health shall appoint a
53 3 medication therapy management advisory committee comprised of
53 4 the following:
53 5 a. Three licensed pharmacists selected by the Iowa
53 6 pharmacy association.
53 7 b. Two licensed physicians.
53 8 c. One consumer representative.
53 9 d. One health insurer.
53 10 2. Members of the committee shall serve three=year terms
53 11 beginning and ending as provided in section 69.19.
53 12 Appointments are subject to the requirements of sections 69.16
53 13 and 69.16A. Any vacancy shall be filled in the same manner as

53 14 regular appointments are made for the unexpired portion of the
53 15 regular term. A member is eligible for reappointment for two
53 16 successive terms. Committee members shall not receive
53 17 compensation or reimbursement for expenses.
53 18 3. The advisory committee shall do all of the following:
53 19 a. Advise the director and the commissioner of insurance
53 20 in the development and administration of the medication
53 21 therapy management benefit coverage pursuant to section
53 22 514C.24, including adoption of rules pursuant to chapter 17A.
53 23 b. Evaluate, annually, the effect of medication therapy
53 24 management on quality of care, patient outcomes, and health
53 25 coverage costs. The advisory committee annually shall compile
53 26 its findings and submit its findings and recommendations to
53 27 the governor and the general assembly. The director of public
53 28 health may contract with an academic institution or other
53 29 appropriate entity that has expertise in evaluating health
53 30 care outcomes for the purpose of completing the evaluation.
53 31 Sec. 42. NEW SECTION. 514C.24 MEDICAL THERAPY MANAGEMENT
53 32 COVERAGE.
53 33 1. As used in this section, unless the context otherwise
53 34 requires:
53 35 a. "Commissioner" means the commissioner of insurance.
54 1 b. "Medication therapy management" means the provision of
54 2 all of the following services by a licensed pharmacist to
54 3 optimize the therapeutic outcomes of a patient's medications:
54 4 (1) Conducting a medication therapy review with the
54 5 patient to identify, resolve, and prevent medication=related
54 6 problems, including adverse drug events.
54 7 (2) Working with the patient to develop a personal
54 8 medication record that contains all prescribed and
54 9 nonprescription drugs, herbal products, and dietary
54 10 supplements taken by the patient.
54 11 (3) Working with the patient to develop a
54 12 medication=related action plan for the patient to use in
54 13 collaborative medication self=management.
54 14 (4) Performing health screenings and laboratory tests
54 15 within the pharmacist's scope of practice.
54 16 (5) Providing consultative services to address
54 17 medication=related issues, and referring the patient to the
54 18 patient's primary health care provider or other health care
54 19 professional for evaluation and additional referrals when
54 20 appropriate.
54 21 (6) Performing all necessary follow=up medication therapy
54 22 management services for the maintenance and support of the
54 23 patient as recommended by the patient's primary health care
54 24 provider or other health care professional.
54 25 (7) Maintaining all necessary documentation, including the
54 26 following and any other records required for compliance with
54 27 state and federal laws and regulations requiring maintenance
54 28 of patient records:
54 29 (a) Patient demographics and basic identifying
54 30 information.
54 31 (b) Pertinent patient=reported subjective information.
54 32 (c) Objective observations regarding known allergies,
54 33 diseases, conditions, laboratory results, vital signs,
54 34 diagnostic signs, physical exam results, and a review of
54 35 internal systems.
55 1 (d) An assessment of medication=related problems.
55 2 (e) A care plan.
55 3 (f) Any collaborative communications with the primary
55 4 health care provider and other health care professionals.
55 5 (g) Patient=centric lists of actions to be followed in
55 6 tracking progress in medication self=management.
55 7 (h) Any relevant transition plan or scheduling of
55 8 follow=up visits.
55 9 (i) Billing information, including level of patient care,
55 10 level of complexity, and charges.
55 11 c. "Medication therapy review" means any of the following:
55 12 (1) Interviewing the patient to gather data, including
55 13 demographic information, general health and activity status,
55 14 medical history, medication history, immunization history, and
55 15 the patient's personal statement about the patient's disease
55 16 or condition and medication use.
55 17 (2) Performing necessary clinical assessments of the
55 18 patient's health status, including current or previous
55 19 diseases or conditions.
55 20 (3) Assessing patient values, preferences, quality of
55 21 life, goals of therapy, cultural issues, education level,
55 22 language barriers, literacy level, and other characteristics
55 23 affecting the patient's communication skills that could affect
55 24 patient outcomes.

55 25 (4) Assessing, identifying, prioritizing, and developing a
55 26 plan for resolving medication=related problems pertaining to
55 27 the clinical appropriateness of each medication, the
55 28 appropriateness of the dosage of each medication, including
55 29 considerations of indications, contra=indications, and
55 30 potential adverse effects, adherence to regimen, untreated
55 31 diseases or conditions, medication costs, and provider access
55 32 considerations.
55 33 (5) Providing education and training on the appropriate
55 34 use of medications and medical devices.
55 35 (6) Coaching patients to manage their own medications.
56 1 (7) Evaluating the patient's ability to detect symptoms
56 2 that could be attributed to adverse reactions or interactions
56 3 from medications.
56 4 (8) Interpreting, monitoring, and assessing the patient's
56 5 laboratory results for those laboratory test results provided
56 6 to a pharmacist.
56 7 (9) Monitoring and evaluating the patient's responses to
56 8 medication therapies, including the safety and effectiveness
56 9 of those therapies.
56 10 (10) Communicating appropriate information to the
56 11 patient's primary health care provider or other health care
56 12 professional, including consultation on the selection of
56 13 medications, suggestions to address identified medication
56 14 problems, updates on the patient's progress, and recommended
56 15 follow=up care.
56 16 2. Notwithstanding the uniformity of treatment
56 17 requirements of section 514C.6, a person who provides an
56 18 individual or group policy of accident or health insurance or
56 19 individual or group hospital or health care service contract
56 20 issued pursuant to chapter 509, 509A, 514, or 514A, or an
56 21 individual or group health maintenance organization contract
56 22 issued and regulated under chapter 514B, which is delivered,
56 23 amended, or renewed on or after July 1, 2009, and which
56 24 provides pharmaceutical benefits, shall provide coverage
56 25 benefits for medication therapy management in accordance with
56 26 rules adopted by the commissioner of insurance.
56 27 3. The commissioner, in consultation with the director of
56 28 public health and the medication therapy management advisory
56 29 committee established in section 155A.43, shall adopt rules in
56 30 accordance with chapter 17A regarding coverage benefits for
56 31 medication therapy management based upon all of the following:
56 32 a. The amount reimbursed under the coverage benefit shall
56 33 be calculated using quarter=hourly rates. The reimbursement
56 34 shall be an amount separate from the reimbursement for a
56 35 prescription drug product or dispensing services to any
57 1 pharmacist participating under the policy or contract.
57 2 b. Medication therapy management shall be a covered
57 3 benefit if provided to any of the following:
57 4 (1) An individual taking four or more prescription drugs
57 5 to treat or prevent two or more chronic medical conditions.
57 6 (2) An individual with a prescription drug therapy problem
57 7 who is identified by the patient's primary health care
57 8 provider or other health care provider and referred to a
57 9 pharmacist for medication therapy management services.
57 10 (3) An individual who meets other criteria established by
57 11 the commissioner by rule in consultation with the director of
57 12 public health and the medication therapy management advisory
57 13 committee.
57 14 c. Medication therapy management shall be a covered
57 15 benefit if provided by a pharmacist who meets all of the
57 16 following criteria:
57 17 (1) Holds a valid and current license issued by the board
57 18 of pharmacy.
57 19 (2) Is a graduate of an accredited school of pharmacy.
57 20 (3) Is trained in pharmaceutical care and medication
57 21 therapy management.
57 22 (4) Has developed a structured patient care process as
57 23 specified by rule.
57 24 (5) Maintains appropriate documentation that meets
57 25 requirements for outcomes analysis and patient care as
57 26 specified by rule.
57 27 EVIDENCE=BASED PRESCRIPTION DRUG EDUCATION PROGRAM
57 28 Sec. 43. NEW SECTION. 155B.1 DEFINITIONS.
57 29 As used in this chapter, unless the context otherwise
57 30 requires:
57 31 1. "Department" means the department of public health.
57 32 2. "Prescription drug" means prescription drug as defined
57 33 in section 155A.3.
57 34 Sec. 44. NEW SECTION. 155B.2 EVIDENCE=BASED PRESCRIPTION
57 35 DRUG EDUCATION PROGRAM.

58 1 1. The department shall establish and administer an
58 2 evidence=based prescription drug education program designed to
58 3 provide health care professionals who are licensed to
58 4 prescribe or dispense prescription drugs with information and
58 5 education regarding the therapeutic and cost=effective
58 6 utilization of prescription drugs.
58 7 2. a. In establishing and administering the program, the
58 8 department shall request input and collaboration from
58 9 physicians, pharmacists, private insurers, hospitals, pharmacy
58 10 benefits managers, the medical assistance drug utilization
58 11 review commission, medical and pharmacy schools, and other
58 12 entities providing evidence=based education to health care
58 13 professionals that are licensed to prescribe or dispense
58 14 prescription drugs.
58 15 b. The department may contract with entities conducting
58 16 independent research into the therapeutic and
58 17 cost=effectiveness of prescription drugs to provide technical
58 18 and clinical support to the department in establishing and
58 19 administering the program.
58 20 3. The department may establish and collect fees from
58 21 private payors for participation in the program. The
58 22 department may seek funding from nongovernmental health
58 23 foundations or other nonprofit charitable foundations to
58 24 establish and administer the program.
58 25 GIFTS TO HEALTH CARE PRACTITIONERS
58 26 Sec. 45. NEW SECTION. 155C.1 PURPOSES.
58 27 The purposes of this chapter are to improve the public
58 28 health and the quality of prescribing and medical decision
58 29 making; promote consumer access to information relating to
58 30 medical care, marketing, and gifts; reduce the inappropriate
58 31 influence of gifts and payments on provider medical decisions;
58 32 limit annual increases in the cost of health care; and assist
58 33 the state in its role as a purchaser of health care services
58 34 and an administrator of health care programs by enabling the
58 35 state to determine the scope of advertising and marketing
59 1 costs and their effect on the cost, utilization, and delivery
59 2 of health care services.
59 3 Sec. 46. NEW SECTION. 155C.2 DEFINITIONS.
59 4 As used in this chapter, unless the context otherwise
59 5 requires:
59 6 1. "Biologic" means a biological product as defined in 42
59 7 U.S.C. } 262.
59 8 2. "Bona fide clinical trial" means any research project
59 9 that prospectively assigns human subjects to intervention and
59 10 comparison groups to study the cause and effect relationship
59 11 between a medical intervention and a health outcome.
59 12 3. "Department" means the department of administrative
59 13 services.
59 14 4. "Gift" means a payment, fee, food, entertainment,
59 15 travel, honorarium, subscription, advance, service, product
59 16 sample, subsidy, economic benefit, or anything of value
59 17 provided, unless consideration of equal or greater value is
59 18 received, and includes anything of value provided to a health
59 19 care practitioner for less than market value.
59 20 5. "Health care practitioner" means a health care
59 21 professional who is licensed to prescribe prescription drugs,
59 22 or a partnership or corporation consisting of such health care
59 23 professionals, or an officer, employee, agent, or contractor
59 24 of such a health care professional acting in the course of
59 25 employment, agency, or contract related to or supportive of
59 26 the provision of health care by the health care professional.
59 27 6. "Manufacturer" means a person engaged in the
59 28 manufacturing, preparing, propagating, compounding,
59 29 processing, packaging, repackaging, distributing, or labeling
59 30 of prescription drugs, biologics, or medical devices.
59 31 7. "Marketing" means any of the following activities
59 32 undertaken or materials or products made available to
59 33 practitioners or to the general public related to the transfer
59 34 of prescription drugs, biologics, or medical devices from the
59 35 producer or seller to the consumer or buyer:
60 1 a. Advertising, publicizing, promoting, or selling a
60 2 prescription drug, biologic, or medical device through any
60 3 media or method including electronically or through the
60 4 internet.
60 5 b. Activities undertaken for the purpose of influencing
60 6 the market share of a prescription drug, biologic, or medical
60 7 device or the prescribing patterns of a prescriber, including
60 8 a detailing visit or a personal appearance.
60 9 c. Activities undertaken to evaluate or improve the
60 10 effectiveness of a sales force.
60 11 d. A brochure, media advertisement or announcement,

60 12 poster, or free sample of a prescription drug, biologic, or
60 13 medical device.
60 14 8. "Medical device" means device as defined in section
60 15 155A.3.
60 16 9. "Prescription drug" means prescription drug as defined
60 17 in section 155A.3.
60 18 10. "Significant educational, scientific, or policy=making
60 19 conference or seminar" means an educational, scientific, or
60 20 policy=making conference or seminar that meets both of the
60 21 following requirements:
60 22 a. Is accredited by the accreditation council for
60 23 continuing medical education or a comparable organization.
60 24 b. Offers continuing medical education credit, features
60 25 multiple presenters on scientific research, or is authorized
60 26 by the sponsoring association to recommend or make policy.
60 27 11. "State health care program" means a program for which
60 28 the state purchases prescription drugs, biologics, or medical
60 29 devices, including but not limited to the medical assistance
60 30 program, or a state employee, corrections, or retirement
60 31 system program.
60 32 12. "Wholesaler" means wholesaler as defined in section
60 33 155A.3.
60 34 Sec. 47. NEW SECTION. 155C.3 GIFTS TO HEALTH CARE
60 35 PRACTITIONERS PROHIBITED.
61 1 1. A manufacturer or wholesaler, or a manufacturer's or
61 2 wholesaler's agent, who participates in a state health care
61 3 program shall not offer or give any gift to a health care
61 4 practitioner.
61 5 2. Notwithstanding subsection 1, the following gifts are
61 6 not prohibited but shall be disclosed pursuant to sections
61 7 155C.4 and 155C.5:
61 8 a. Payment to the sponsor of a significant educational,
61 9 scientific, or policy=making conference or seminar if the
61 10 payment is not made directly to a health care practitioner;
61 11 the payment is used solely for bona fide educational purposes;
61 12 and all conference or seminar activities are objective, free
61 13 from industry influence, and do not promote specific products.
61 14 b. Reasonable honoraria and payment of the reasonable
61 15 expenses of a health care practitioner who serves on the
61 16 faculty at a significant educational, scientific, or
61 17 policy=making conference or seminar pursuant to an explicit
61 18 contract with specific deliverables which are restricted to
61 19 scientific issues, not marketing efforts, and the content of
61 20 any presentation, including slides and written materials, are
61 21 determined by the health care practitioners.
61 22 c. Compensation for the substantial professional or
61 23 consulting services of a health care practitioner in
61 24 connection with a bona fide clinical trial pursuant to an
61 25 explicit contract with specific deliverables which are
61 26 restricted to scientific issues, not marketing efforts.
61 27 Sec. 48. NEW SECTION. 155C.4 DISCLOSURE OF EXEMPTED
61 28 GIFTS.
61 29 1. a. Annually, on or before December 1, every
61 30 manufacturer or wholesaler of prescription drugs, biologics,
61 31 or medical devices that participates in a state health care
61 32 program shall disclose to the department, the value, nature,
61 33 purpose, and recipient of any gift not prohibited in section
61 34 155C.3, which is provided by the manufacturer or wholesaler,
61 35 directly or through its agents, to any health care
62 1 practitioner or any other person in this state authorized to
62 2 prescribe, dispense, or purchase prescription drugs,
62 3 biologics, or medical devices in this state.
62 4 b. For each expenditure, the manufacturer or wholesaler
62 5 shall also identify the recipient and the recipient's address,
62 6 credentials, institutional affiliation, and state board or
62 7 drug enforcement agency numbers.
62 8 2. Each manufacturer or wholesaler subject to the
62 9 provisions of this section shall also disclose to the
62 10 department the name and address of the individual responsible
62 11 for the manufacturer's or wholesaler's compliance with this
62 12 section, or if this information has been previously reported,
62 13 any changes in the name or address of the individual
62 14 responsible for the manufacturer's or wholesaler's compliance
62 15 with this section.
62 16 3. The report shall be accompanied by payment of a fee, to
62 17 be established by rule of the department, to defray
62 18 administrative costs.
62 19 4. The department shall make all disclosed data publicly
62 20 available and easily searchable on its internet site.
62 21 Sec. 49. NEW SECTION. 155C.5 ADVERTISING AND MARKETING
62 22 EXPENDITURE REPORTING.

62 23   1. Annually, on or before December 1, every manufacturer
62 24 or wholesaler of prescription drugs, biologics, or medical
62 25 devices that participates in a state health care program shall
62 26 submit to the department a report on advertising and marketing
62 27 expenditures.
62 28   2. The report shall be in the form and manner required by
62 29 the department and accompanied by payment of a fee, as
62 30 established by rule of the department.
62 31   3. The annual report required by this section shall
62 32 include all of the following information as it pertains to
62 33 marketing activities conducted within this state in a form
62 34 that provides the value, nature, purpose, and recipients of
62 35 the expense of marketing activities:
63 1   a. Information on gifts reported under section 155C.4.
63 2   b. All other expenses, whether direct or indirect,
63 3 associated with advertising, marketing, and promotion of
63 4 prescription drugs, biologics, and medical devices including
63 5 but not limited to all of the following:
63 6   (1) Expenses associated with radio, television, magazines,
63 7 newspapers, direct mail, and telephone communications as they
63 8 pertain to residents of this state, including a reasonable
63 9 estimate of the value of expenses associated with advertising
63 10 purchased for a regional or national market that includes
63 11 advertising within this state.
63 12   (2) Any other expenses relating to the indirect promotion
63 13 of prescription drugs, biologics, and medical devices in this
63 14 state including but not limited to support of independent or
63 15 continuing medical education programs, including payments to
63 16 medical education companies; design, printing, and production
63 17 costs of patient education materials and disease management
63 18 materials distributed within this state; consulting fees and
63 19 expenses, participation in speakers' bureaus, and honoraria or
63 20 other payments for speaking at or attending meetings,
63 21 lectures, or conferences; writing articles or publications;
63 22 charitable grants, either directly or earmarked, even if
63 23 unrestricted; product samples if allowed; and market research
63 24 surveys or other activities undertaken in support of
63 25 developing advertising or marketing strategies.
63 26   (3) The aggregate cost of all employees or contractors of
63 27 the manufacturer, wholesaler, or labeler who directly or
63 28 indirectly engage in the advertising or promotional activities
63 29 listed in subparagraphs (1) and (2), including all forms of
63 30 payment to those employees or contractors. The costs reported
63 31 under this subparagraph shall reflect only that portion of
63 32 payment to employees or contractors that pertains to
63 33 activities within this state or to recipients of the
63 34 advertising or promotional activities who are residents of or
63 35 are employed in this state.
64 1   4. Each manufacturer or wholesaler subject to the
64 2 provisions of this section shall also disclose to the
64 3 department the name and address of the individual responsible
64 4 for the manufacturer's or wholesaler's compliance with this
64 5 section, or if this information has been previously reported,
64 6 any changes to the name or address of the individual
64 7 responsible for the manufacturer's or wholesaler's compliance
64 8 with the provisions of this section.
64 9   Sec. 50. NEW SECTION. 155C.6 DEPARTMENTAL REPORTS.
64 10   The department shall provide an annual report to the
64 11 governor and the general assembly on or before January 15,
64 12 containing an analysis of the data submitted to the department
64 13 under section 155C.4 and 155C.5. The report shall include all
64 14 of the following:
64 15   1. Information on gifts required to be disclosed under
64 16 section 155C.4, which shall be presented in aggregate form and
64 17 by selected types of health care practitioners or individual
64 18 health care practitioners, as prioritized each year by the
64 19 department and analyzed to determine whether prescribing
64 20 patterns by these health care practitioners reimbursed by the
64 21 state health care programs may reflect manufacturer's or
64 22 wholesaler's influence.
64 23   2. Information on all marketing activities, whether direct
64 24 or indirect, including the scope of prescription drug,
64 25 biologics, and medical device marketing activities and
64 26 expenses and their effect on the cost, utilization, and
64 27 delivery of health care services and any recommendations with
64 28 regard to marketing activities of prescription drug,
64 29 biologics, and medical device manufacturers or wholesalers.
64 30   3. Information on violations and enforcement actions
64 31 brought pursuant to this chapter.
64 32   Sec. 51. NEW SECTION. 155C.7 PUBLIC RECORDS.
64 33   1. The information required to be submitted pursuant to

64 34 sections 155C.4 and 155C.5, and the data and reports compiled
64 35 by the department pursuant to section 155C.6, are public
65 1 records.
65 2 2. Notwithstanding any other provision of law to the
65 3 contrary, the identity of health care practitioners and other
65 4 recipients of gifts, payments, and materials required to be
65 5 reported in this section do not constitute confidential
65 6 information or trade secrets.
65 7 Sec. 52. NEW SECTION. 155C.8 ENFORCEMENT == RULES.
65 8 1. The department may bring an action for injunctive
65 9 relief, costs, and attorneys fees, and to impose a civil
65 10 penalty of no more than ten thousand dollars per violation on
65 11 a manufacturer or wholesaler that fails to comply with any
65 12 provision of this chapter.
65 13 2. The department shall adopt rules as necessary to
65 14 administer this chapter.
65 15 DATA MINING
65 16 Sec. 53. NEW SECTION. 155D.1 PURPOSES.
65 17 The purposes of this chapter are the following:
65 18 1. To safeguard the confidentiality of prescribing
65 19 information, protect the integrity of the doctor=patient
65 20 relationship, maintain the integrity and public trust in the
65 21 medical profession, combat vexatious and harassing sales
65 22 practices, restrain undue influence exerted by pharmaceutical
65 23 industry marketing representatives over prescribing decisions,
65 24 and further the state interest in improving the quality and
65 25 lowering the cost of health care.
65 26 2. To ensure the confidentiality of data held by a state
65 27 agency which could be used directly or indirectly to identify
65 28 a patient or a health care professional licensed to prescribe
65 29 drugs, biologics, or medical devices.
65 30 3. To ensure compliance with federal Medicaid law and
65 31 regulations prohibiting the disclosure and use of Medicaid
65 32 data except to administer the Medicaid program, and to ensure
65 33 that data held by the department of human services or its
65 34 agents that could directly or indirectly identify patients or
65 35 health care professionals licensed to prescribe products be
66 1 kept confidential.
66 2 4. To regulate the monitoring of prescribing practices
66 3 solely for commercial marketing purposes by entities selling
66 4 prescribed products, and not to regulate monitoring for other
66 5 uses, such as quality control, research unrelated to
66 6 marketing, or use by governments or other entities not in the
66 7 business of selling health care products.
66 8 Sec. 54. NEW SECTION. 155D.2 DEFINITIONS.
66 9 As used in this chapter, unless the context otherwise
66 10 requires:
66 11 1. "Biologic" means a biological product as defined in 42
66 12 U.S.C. } 262.
66 13 2. "Bona fide clinical trial" means a research project
66 14 that prospectively assigns human subjects to intervention and
66 15 comparison groups to study the cause and effect relationship
66 16 between a medical intervention and a health outcome.
66 17 3. "Individual identifying information" means information
66 18 which directly or indirectly identifies a prescriber or a
66 19 patient, and the information is derived from or relates to a
66 20 prescription for any prescribed product.
66 21 4. "Marketing" means an activity by a company or an agent
66 22 of the company making or selling prescribed products intended
66 23 to influence prescribing or purchasing choices of the
66 24 company's prescribed products, including but not limited to
66 25 any of the following:
66 26 a. Advertising, publicizing, promoting, or sharing
66 27 information about a prescribed product.
66 28 b. Identifying individuals to receive a message promoting
66 29 use of a particular prescribed product, including but not
66 30 limited to an advertisement, brochure, or contact by a sales
66 31 representative.
66 32 c. Planning the substance of a sales representative visit
66 33 or communication or the substance of an advertisement or other
66 34 promotional message or document.
66 35 d. Evaluating or compensating sales representatives.
67 1 e. Identifying individuals to receive any form of gift,
67 2 product sample, consultancy, or any other item, service,
67 3 compensation, or employment of value.
67 4 f. Advertising or promoting prescribed products directly
67 5 to patients.
67 6 5. "Medicaid program" means the medical assistance program
67 7 administered as specified under chapter 249A.
67 8 6. "Pharmacy" means pharmacy as defined in section 155A.3.
67 9 7. "Prescription drug" means prescription drug as defined

67 10 in section 155A.3.
67 11   8. "Prescribed product" means a biologic, prescription
67 12 drug, or a medical device.
67 13   9. "Prescriber" means a health care practitioner who is
67 14 licensed to prescribe prescription drugs, biologics, or
67 15 medical devices in this state.
67 16   10. "Regulated record" means information or documentation
67 17 from a prescription written by a prescriber doing business in
67 18 this state or a prescription dispensed in this state.
67 19   11. "State health care program" means a program for which
67 20 the state purchases prescribed products, including but not
67 21 limited to a state employee, corrections, or retirement system
67 22 program, but does not include the medical assistance program.
67 23   Sec. 55. NEW SECTION. 155D.3 PRIVACY PROVISIONS.
67 24   1. a. A person, including a state health care program,
67 25 shall not knowingly disclose or use regulated records that
67 26 include individual identifying information for the marketing
67 27 of a prescribed product.
67 28   b. The department of human services shall ensure that the
67 29 department, its employees, and agents, comply with the
67 30 limitations on redisclosure or use of medical assistance
67 31 program prescription information as provided for under state
67 32 and federal law and applicable federal regulations, and shall
67 33 have policies and procedures to ensure compliance with such
67 34 state and federal laws and federal regulations.
67 35   2. a. Regulated records containing individual identifying
68 1 information may be disclosed, sold, transferred, exchanged, or
68 2 used only for nonmarketing purposes including but not limited
68 3 to:
68 4   (1) Activities related to filling a valid prescription,
68 5 including but not limited to the dispensing of a prescribed
68 6 product to a patient or to the patient's authorized
68 7 representative; the transmission of regulated record
68 8 information between an authorized prescriber and a pharmacy;
68 9 the transfer of regulated record information between
68 10 pharmacies; the transfer of regulated records that may occur
68 11 if pharmacy ownership is changed or transferred and pharmacy
68 12 reimbursement.
68 13   (2) Law enforcement purposes as otherwise authorized or
68 14 required by statute or court order.
68 15   (3) Research including but not limited to bona fide
68 16 clinical trials, postmarketing surveillance research, product
68 17 safety studies, population=based public health research, and
68 18 research regarding the effects of health care practitioner
68 19 prescribing practices, and statistical reports if individual
68 20 identifing information is not published, redisclosed, or used
68 21 to identify or contact individuals.
68 22   (4) Product safety evaluations, product recalls and
68 23 specific risk management plans, as identified or requested by
68 24 the federal food and drug administration, or its successor
68 25 agency.
68 26   (5) Pharmacy reimbursement, formulary compliance, case
68 27 management related to the diagnosis, treatment, or management
68 28 of illness for a specific patient, including but not limited
68 29 to care management educational communications provided to a
68 30 patient about the patient's health condition, adherence to a
68 31 prescribed course of therapy, or other information about the
68 32 product being dispensed, treatment options, or clinical
68 33 trials.
68 34   (6) Utilization review by the state, by a health care
68 35 provider, or by the patient's insurance provider for health
69 1 care services, including but not limited to determining
69 2 compliance with the terms of coverage or medical necessity.
69 3   (7) The collection and analysis of product utilization
69 4 data for health care quality improvement purposes, including
69 5 but not limited to development of evidence=based treatment
69 6 guidelines or health care performance effectiveness and
69 7 efficiency measures, promoting compliance with evidence=based
69 8 treatment guidelines or health care performance measures, and
69 9 providing prescribers with information that details their
69 10 practices relative to their peers to encourage prescribing
69 11 consistent with evidence=based practice.
69 12   (8) The collection and dissemination of product
69 13 utilization data to promote transparency in evaluating
69 14 performance related to the health care quality improvement
69 15 measures.
69 16   (9) The transfer of product utilization data to and
69 17 through secure electronic health record or personal health
69 18 record systems.
69 19   (10) Use by any government agency or government agency
69 20 sponsored program in carrying out its functions, or by any

69 21 private person acting on behalf of a federal, state, or local
69 22 agency in carrying out its functions.
69 23   (11) Use in connection with any civil, criminal,
69 24 administrative, or arbitral proceeding in any federal, state,
69 25 or local court or agency or before any self=regulatory body,
69 26 including but not limited to the service of process,
69 27 investigation in anticipation of litigation, and the execution
69 28 or enforcement of judgments and orders, or pursuant to an
69 29 order of a federal, state, or local court.
69 30   b. An authorized recipient of regulated records containing
69 31 individual identifying information may resell, reuse, or
69 32 redisclose the information only as permitted under paragraph
69 33 "a".
69 34   c. An authorized recipient that resells, reuses, or
69 35 rediscloses individual identifying information covered by this
70 1 chapter shall maintain for a period of five years, records
70 2 identifying each person or entity that receives the
70 3 information and the permitted purpose for which the
70 4 information will be used. The authorized recipient shall make
70 5 such records available to any person upon request.
70 6   3. This section shall not be interpreted to prohibit
70 7 conduct involving the collection, use, transfer, or sale of
70 8 regulated records for marketing purposes if all of the
70 9 following conditions apply:
70 10   a. The data is aggregated.
70 11   b. The data does not contain individually identifying
70 12 information.
70 13   c. There is no reasonable basis to believe that the data
70 14 can be used to obtain individually identifying information.
70 15   4. This section shall not prevent any person from
70 16 disclosing individual identifying information to the
70 17 identified individual if the information does not include
70 18 protected information pertaining to any other person.
70 19   Sec. 56. NEW SECTION. 155D.4 CIVIL PENALTY ==
70 20 ENFORCEMENT == RULEMAKING.
70 21   1. Any person who knowingly fails to comply with the
70 22 requirements of this chapter or rules adopted pursuant to this
70 23 chapter by using or disclosing regulated records in a manner
70 24 not authorized by this chapter or rules adopted pursuant to
70 25 this chapter is subject to a civil penalty of not more than
70 26 fifty thousand dollars per violation. Each disclosure of a
70 27 regulated record constitutes a separate violation.
70 28   2. The attorney general shall enforce payment of penalties
70 29 assessed under this section.
70 30   3. The board of pharmacy shall adopt rules to administer
70 31 this chapter including the assessment of penalties under this
70 32 section.
70 33   Sec. 57. NEW SECTION. 155D.5 CONSUMER FRAUD.
70 34   A violation of this chapter is an unfair or deceptive act
70 35 in trade or commerce and an unfair method of competition under
71 1 the consumer fraud Act, section 714.16.
71 2   PHARMACY BENEFITS MANAGEMENT
71 3   Sec. 58. NEW SECTION. 510B.8 DISCLOSURE OF REVENUES
71 4 RECEIVED FROM PHARMACEUTICAL MANUFACTURER OR LABELER UNDER
71 5 CONTRACT == CONTENT FEES.
71 6   1. A covered entity may request that any pharmacy benefits
71 7 manager with which it has a contract for pharmacy benefits
71 8 management disclose to the covered entity each pharmaceutical
71 9 manufacturer or labeler with whom the pharmacy benefits
71 10 manager has a contract. The pharmacy benefits manager shall
71 11 disclose all of the following in writing:
71 12   a. The aggregate amount and, for a list of drugs to be
71 13 specified in the contract, the specific amount of all rebates
71 14 and other retrospective utilization discounts received by the
71 15 pharmacy benefits manager from the pharmaceutical manufacturer
71 16 or labeler that is earned in connection with the dispensing of
71 17 prescription drugs to covered individuals under health care
71 18 coverage provisions by the covered entity or for which the
71 19 covered entity is the designated administrator.
71 20   b. The nature, type, and amount of all other revenue
71 21 received by the pharmacy benefits manager directly or
71 22 indirectly from each pharmaceutical manufacturer or labeler
71 23 for any other products or services provided by the pharmacy
71 24 benefits manager with respect to programs that the covered
71 25 entity contracts with the pharmacy benefits manager to provide
71 26 to its covered individuals.
71 27   c. Any prescription drug utilization information requested
71 28 by the covered entity relating to covered individuals.
71 29   2. A pharmacy benefits manager shall provide the
71 30 information requested by the covered entity for such
71 31 disclosure within thirty days of receipt of a request. If

71 32 requested, the information shall be provided at least once
71 33 each year. The contract entered into between the pharmacy
71 34 benefits manager and the covered entity shall specify any fees
71 35 to be charged for drug utilization information requested by
72 1 the covered entity.
72 2 DIVISION VIII
72 3 HEALTH CARE TRANSPARENCY
72 4 Sec. 59. HEALTH CARE DATA == COLLECTION FROM HOSPITALS.
72 5 The department of public health shall adopt rules pursuant to
72 6 1996 Iowa Acts, chapter 1212, section 5, subsection 1,
72 7 paragraph "a", subparagraph (4), to direct hospitals to submit
72 8 data to the Iowa healthcare collaborative as defined in
72 9 section 135.40, which shall serve as the intermediary for the
72 10 department in collecting inpatient, outpatient, and ambulatory
72 11 information from hospitals.
72 12 Sec. 60. HEALTH CARE DATA == PLAN FOR COLLECTION FROM
72 13 HEALTH CARE PROVIDERS. The Iowa healthcare collaborative, as
72 14 defined in section 135.40, shall develop a plan for the
72 15 collection, analysis, and publishing of clinical data from
72 16 physicians and health care providers other than hospitals.
72 17 The plan shall address the feasibility of a physician
72 18 all=payer database to allow collection of claims data from all
72 19 private and public payors of physicians.
72 20 Sec. 61. COORDINATION OF HEALTH CARE EFFORTS. The Iowa
72 21 healthcare collaborative, as defined in section 135.40, shall
72 22 provide support to the electronic health information advisory
72 23 council established pursuant to section 135.156, the medical
72 24 home system advisory council established pursuant to section
72 25 135.159, the prevention and chronic care management initiative
72 26 advisory council established pursuant to section 135.161, the
72 27 clinicians advisory panel established pursuant to section
72 28 135.162, and the medical assistance quality improvement
72 29 council established pursuant to section 249A.36, as follows:
72 30 1. To provide direction in promoting and coordinating
72 31 quality, safety, and value improvement collaborative efforts
72 32 among the health care providers involved in the various
72 33 initiatives described in this section.
72 34 2. To provide support to the health care providers
72 35 involved in the various initiatives described in this section
73 1 to develop their understanding of the requirements established
73 2 by the initiatives and to enable the effective execution of
73 3 the strategies developed by each initiative.
73 4 EXPLANATION
73 5 DIVISION I. IOWA HEALTH CARE COVERAGE PARTNERSHIP PROGRAM.
73 6 Division I of this bill establishes the Iowa health care
73 7 coverage partnership program in the department of
73 8 administrative services (DAS). The program allows employees,
73 9 public officials, and retired employees of a nonstate public
73 10 employer, and employees of a nonprofit employer, or small
73 11 employer to be considered state employees for the purpose of
73 12 enrolling in a state health or medical group insurance plan
73 13 provided to state employees by DAS and requires such
73 14 participating employees and public officials to be pooled with
73 15 state employees in the state plan. In order to be eligible to
73 16 participate in the partnership program, an employer must apply
73 17 for the coverage and all employees and public officials of
73 18 such an employer must agree to enroll in a state health or
73 19 medical insurance plan. Employees and public officials of
73 20 such employers receive health coverage under the same
73 21 conditions as state employees and shall not be denied coverage
73 22 on the basis of risk, cost, preexisting conditions, or other
73 23 factors not applicable to state employees.
73 24 Premium payments for coverage received through the program
73 25 must be the same as for state employees, including any
73 26 premiums paid by state employees, except that premium rates
73 27 for coverage for employees of small businesses may reflect
73 28 characteristics applicable to small group insurance pursuant
73 29 to Code section 513B.4. An employer must participate in the
73 30 partnership program for at least three years.
73 31 DAS is required to collaborate with the Iowa choice
73 32 insurance exchange to develop and procure coverage to be
73 33 offered through the partnership program that meets minimum
73 34 standards of quality and affordability and to implement and
73 35 administer the program. DAS is not required to offer coverage
74 1 through the partnership program from every vendor providing
74 2 coverage under the state plan, and may procure coverage from
74 3 different vendors and offer different insurance plans than
74 4 those available to state employees.
74 5 Each employer who participates in the Iowa health care
74 6 coverage partnership program must pay monthly premium amounts
74 7 for coverage to DAS, plus administrative fees calculated on a

74 8 per=month basis per employee or official. An employer may
74 9 require each covered employee or official to contribute a
74 10 portion of the cost of such coverage under the state plan,
74 11 subject to any collective bargaining obligations. The
74 12 payments are to be deposited in the health insurance
74 13 administration fund created in Code section 8A.454 for state
74 14 employee premium payments, but separately accounted for and
74 15 expended for coverage being provided pursuant to the
74 16 partnership program.
74 17 If monthly premium payments are not made, DAS may charge
74 18 interest on the unpaid balance. If a nonstate public employer
74 19 fails to make premium payments, DAS may direct the treasurer
74 20 of state to withhold grants, allocations, or appropriations
74 21 payable to the nonstate public employer, until the premium
74 22 payments are made. If a nonprofit employer or small employer
74 23 fails to make premium payments, DAS may terminate
74 24 participation of that employer's employees in the state plan
74 25 and request the attorney general to recover the unpaid premium
74 26 and interest costs.
74 27 For purposes of the program, a "nonstate public employer"
74 28 is a political subdivision of the state, including but not
74 29 limited to counties, cities, community colleges, and
74 30 quasi=public agencies but not school districts. A "nonprofit
74 31 employer" is a corporation organized or recognized as a
74 32 nonprofit corporation under state or federal law. A "small
74 33 employer" is an entity with 1 to 50 full=time employees, the
74 34 majority of whom are employed in the state.
74 35 DIVISION II. IOWA CHOICE INSURANCE EXCHANGE. Division II
75 1 of the bill contains new Code chapter 514M. The purpose of
75 2 the chapter is to ensure that all children and all other
75 3 Iowans in the state have affordable, quality health care
75 4 coverage, and to decrease health care costs and health care
75 5 coverage costs.
75 6 The bill creates the Iowa choice insurance exchange as a
75 7 nonprofit corporation under the aegis of the insurance
75 8 division of the department of commerce. All health and
75 9 accident insurance carriers, all organized delivery systems
75 10 licensed by the department of public health to provide health
75 11 insurance or health care services in Iowa, and all other
75 12 insurers designated by the exchange are members of the
75 13 exchange.
75 14 The exchange is required to exercise its powers through a
75 15 board of directors. The board of directors consists of 10
75 16 voting members representative of specified constituencies
75 17 appointed by the governor and subject to confirmation by the
75 18 senate, and eight nonvoting members including four members of
75 19 the general assembly. The voting members of the board are
75 20 required to appoint an executive director of the exchange and
75 21 the governor is required to appoint a secretary of the board,
75 22 with both appointments subject to confirmation by the senate.
75 23 The exchange is required to submit a plan of operation to
75 24 the commissioner of insurance. At the end of each year the
75 25 exchange is required to determine its net premiums and
75 26 payments received, the expenses of administration, and
75 27 incurred losses and to recover any losses by assessing all
75 28 members of the exchange as specified in the bill.
75 29 The exchange is charged with developing a comprehensive
75 30 health care coverage plan to accomplish the purposes of the
75 31 new Code chapter including access to public or private health
75 32 care coverage for all Iowans, especially children, which may
75 33 be subsidized or unsubsidized, depending on family income.
75 34 The exchange is also required to design and implement a
75 35 health care coverage program called Iowa choice, which offers
76 1 private health care coverage that meets certain minimum
76 2 standards of quality and affordability with options to
76 3 purchase at least three levels of benefits, and to design and
76 4 administer a subsidy program for payment of premiums for
76 5 health care coverage for low=income people that complements
76 6 Medicaid and includes cost=sharing by the insured using a
76 7 sliding scale based on income utilizing the federal poverty
76 8 level guidelines.
76 9 The Iowa choice insurance exchange pool is created in the
76 10 state treasury as a separate fund under the control of the
76 11 exchange to be credited with all moneys collected from
76 12 premiums paid for health care plans offered by the exchange,
76 13 and any other funds that are appropriated or transferred to
76 14 the pool. These funds are appropriated to the exchange to
76 15 accomplish the purposes set forth in new Code chapter 514M.
76 16 The board of the exchange is also required to design and
76 17 implement a program to protect the health of all Iowans, that
76 18 includes a timetable and procedures for implementation, to

76 19 ensure that all children and adults in the state have health
76 20 care coverage, to assign and enroll children without such
76 21 coverage to appropriate coverage, and to collaborate with
76 22 members of the exchange to institute health insurance reforms.
76 23   COORDINATING AMENDMENTS. Coordinating amendments are made
76 24 in Code chapter 514E by removing duties and powers from the
76 25 Iowa comprehensive health insurance association which are now
76 26 assigned to the Iowa choice insurance exchange and repealing a
76 27 provision creating the Iowa choice health care coverage
76 28 advisory council.
76 29   DIVISION III. HEALTH CARE COVERAGE OF ADULT CHILDREN.
76 30 Code section 422.7 is amended to provide that if the health
76 31 benefits coverage or insurance of an Iowa taxpayer includes
76 32 coverage of a nonqualified tax dependent as determined by the
76 33 federal internal revenue service, the amount of the value of
76 34 that coverage is not subject to state income tax. This
76 35 amendment applies retroactively to January 1, 2009.
77 1   Code section 509.3(8), relating to group health insurance,
77 2 Code section 509A.13B, relating to group health insurance for
77 3 public employees, and Code section 514A.3B(2), relating to
77 4 individual policies of health insurance, are amended to
77 5 require that adult children who are unmarried, residents of
77 6 this state and up to 25 years of age, or who are full=time
77 7 students, be allowed to reenroll in previously existing
77 8 dependent coverage of their parents. Currently, those
77 9 provisions only allow continuation of such existing coverage.
77 10   DIVISION IV. MEDICAL ASSISTANCE AND HAWK=I PROVISIONS.
77 11 Division IV of this bill includes provisions relating to the
77 12 medical assistance (Medicaid) and hawk=i programs.
77 13   The division directs the department of human services (DHS)
77 14 to provide state=only funded medical assistance or hawk=i
77 15 coverage, as appropriate, to individuals under 19 years of age
77 16 who meet income eligibility requirements under the respective
77 17 program. The division also directs DHS to take such actions
77 18 as may be necessary to ensure the receipt of federal financial
77 19 participation under the Medicaid program or state children's
77 20 health insurance program and any other federal funding sources
77 21 that may become available in the future to provide coverage to
77 22 these populations.
77 23   The division amends the income tax provision for reporting
77 24 of a dependent child's health care coverage status to require,
77 25 beginning with the tax returns for tax year 2009, that a
77 26 person who files an individual or joint income tax return
77 27 indicate the presence or absence of health care coverage for
77 28 each dependent child for whom an exemption is claimed. If the
77 29 taxpayer indicates that a dependent child does not have health
77 30 care coverage and the income of the taxpayer's tax return does
77 31 not exceed the highest level of income eligibility standard
77 32 for the Medicaid or hawk=i program, the department of revenue
77 33 is required to send a notice to the taxpayer that the
77 34 dependent child may be eligible for these programs and to
77 35 provide information to the taxpayer about how to enroll the
78 1 dependent child in the appropriate program. The taxpayer is
78 2 then required to submit an application for the appropriate
78 3 program within 90 days of receiving the enrollment
78 4 information. The department of revenue, in cooperation with
78 5 DHS, is directed to adopt rules including rules regarding the
78 6 enforcement of the required provision of information and
78 7 required application for an appropriate program. Information
78 8 to be reported by the department of revenue includes whether a
78 9 taxpayer who claims a dependent indicates coverage or lack of
78 10 coverage for the dependent, and the number of those indicating
78 11 the absence of coverage who comply or do not comply with the
78 12 requirement for application for an appropriate program, and
78 13 any enforcement action taken.
78 14   The division provides for coverage under the Medicaid
78 15 program of a pregnant woman with a family income of up to 300
78 16 percent of the federal poverty level, beginning July 1, 2009.
78 17   The division includes provisions to improve access to and
78 18 retention in the Medicaid and hawk=i programs. The division
78 19 provides for presumptive eligibility for children under the
78 20 Medicaid and hawk=i programs beginning July 1, 2009, and for
78 21 one pay stub verification as verification of income for these
78 22 programs when it is indicative of future income. The division
78 23 also requires the Medicaid program to allow for an averaging
78 24 of three years of income for self=employed families to
78 25 establish eligibility, to extend the period for annual renewal
78 26 by members, and to implement passive renewal.
78 27   DIVISION V. VOLUNTEER HEALTH CARE PROVIDERS. Division V
78 28 of this bill expands the volunteer health care provider
78 29 program to include health care provider offices. The division

78 30 provides that a health care provider office providing free
78 31 care under the program is considered a state agency for the
78 32 sole purpose of the program and for Code chapter 669 (State
78 33 Tort Claims Act) and is to be afforded protection under Code
78 34 chapter 669 for all claims arising from the provision of free
78 35 care by a health care provider registered with the program and
79 1 complying with the requirements of the program. Additionally,
79 2 a health care provider providing free care under the program
79 3 at a health care provider office is considered an employee of
79 4 the state under Code chapter 669 and is afforded protection as
79 5 an employee of the state if the health care provider is
79 6 registered with the department of public health and provides
79 7 care at the health care provider office. The division defines
79 8 "health care provider office" as the private office or clinic
79 9 of an individual health care provider or group of health care
79 10 providers but does not include a field dental clinic, a free
79 11 clinic, or a hospital.
79 12 DIVISION VI. HEALTH CARE WORKFORCE SUPPORT INITIATIVE.
79 13 Division VI of this bill establishes a health care workforce
79 14 support initiative, including a health care workforce shortage
79 15 fund.
79 16 The division creates a health care workforce shortage fund
79 17 in the state treasury as a separate fund under the control of
79 18 the college student aid commission (commission). Moneys
79 19 appropriated from the general fund of the state to the fund,
79 20 moneys received from the federal government for the purposes
79 21 of addressing the health care workforce shortage,
79 22 contributions, grants and other funds from communities and
79 23 health care employers, and moneys from any other public or
79 24 private source credited to the fund are to be deposited in the
79 25 fund. Moneys deposited in or credited to the fund are
79 26 appropriated to provide grants to support a medical residency
79 27 training grants program, a health care professional loan
79 28 repayment program, and a nurse educator forgivable loan and
79 29 nursing faculty fellowship program as established in the
79 30 division. The division provides that in any annual
79 31 appropriation from the fund, the total amount appropriated for
79 32 the medical residency training grants program shall not exceed
79 33 $11 million, the amount appropriated for the health care
79 34 professional forgivable loan program shall not exceed $3
79 35 million, and the amount appropriated for the nursing educator
80 1 forgivable loan program and nursing faculty fellowship program
80 2 shall not exceed $1 million.
80 3 The division creates a health care workforce shortage
80 4 advisory council. The membership of the advisory council
80 5 consists of a representative of the departments of public
80 6 health, human services, and education, the office of the
80 7 attorney general, the university of Iowa college of medicine,
80 8 the university of Iowa hospitals and clinics, Iowa health
80 9 systems, Mercy medical center, Des Moines university ==
80 10 osteopathic medical center (DMU), the Iowa hospital
80 11 association, the Iowa medical society, and the Iowa nurses
80 12 association. The advisory council is directed to provide
80 13 oversight of the programs established under the division and
80 14 to provide recommendations to the commission regarding
80 15 administration of the programs including prioritization in the
80 16 awarding of grants, loans, and fellowships based upon data
80 17 demonstrating the specific health care provider needs in the
80 18 state. Additionally, the advisory council is directed to
80 19 provide recommendations to the commission regarding
80 20 coordination of the programs established with other health
80 21 care provider=related financial assistance programs available
80 22 in the state.
80 23 The division directs the commission to establish a medical
80 24 residency training grants program to provide grants to
80 25 sponsors of accredited graduate medical education residency
80 26 programs in the state to establish, expand, or support medical
80 27 residency training programs. The grant funds may be used to
80 28 support medical residency programs through the establishment
80 29 of new or alternative campus accredited medical residency
80 30 training programs, new residency positions within existing
80 31 accredited medical residency or fellowship training programs,
80 32 or the funding of not more than 25 total residency positions
80 33 which are in excess of the federal Medicare residency cap.
80 34 The commission is to adopt rules relating to eligibility
80 35 requirements, an application process, criteria for preference
81 1 in the awarding of grants, criteria for determining the amount
81 2 of a grant, and use of the funds awarded.
81 3 The division directs the commission to establish a health
81 4 care professional forgivable loan program to assist health
81 5 care professionals in repaying outstanding education loans.

81 6 The commission is to administer the program with the
81 7 assistance of DMU, and DMU is to receive a fee for
81 8 administration of the program. The commission, with the
81 9 assistance of DMU and based on recommendations from the
81 10 advisory council, is directed to adopt rules pursuant to Code
81 11 chapter 17A relating to the establishment and administration
81 12 of the program, including rules addressing eligibility and
81 13 qualification requirements for health care professionals,
81 14 medically underserved communities, and health care employers
81 15 participating in the program, the process for awarding loans,
81 16 public awareness and dissemination of applications, the amount
81 17 of the loan repayment and the specifics of obligated service
81 18 for a loan recipient, determination of the conditions of loan
81 19 repayment applicable to an applicant, enforcement of the
81 20 state's rights under a loan repayment agreement, waiver,
81 21 suspension, or cancellation of a loan repayment agreement in
81 22 appropriate situations, and a process for monitoring
81 23 compliance with eligibility requirements, obligated service
81 24 provisions, and use of funds by program recipients. The
81 25 division also provides that a recipient in the loan repayment
81 26 program is responsible for reporting on federal income tax
81 27 forms any amount received through the program, to the extent
81 28 required by federal law. However, a recipient in compliance
81 29 with the requirements of the loan repayment program is not
81 30 subject to state income taxation for loan repayments received
81 31 through the program.
81 32 The division also directs the commission to establish two
81 33 programs under a nursing workforce shortage initiative. The
81 34 nurse educator forgivable loan program is established to
81 35 provide loan forgiveness for qualifying loans for nurse
82 1 educators. A "qualifying loan" is a government or commercial
82 2 loan for actual costs paid for tuition, reasonable education
82 3 expenses, and reasonable living expenses related to the
82 4 graduate or undergraduate education of a nurse. The program
82 5 provides for payment of up to $20,000 for a qualifying loan,
82 6 if the nurse educator remains teaching in a qualifying
82 7 position for a period of not less than four consecutive
82 8 academic years. The nurse educator and the commission are
82 9 required to enter into an agreement specifying the obligations
82 10 of the nurse educator and the commission. If the nurse
82 11 educator leaves the teaching position prior to teaching for
82 12 four consecutive academic years, the nurse educator is liable
82 13 to repay the amount of the qualifying loan paid or forgiven
82 14 through the program plus interest. However, if the nurse
82 15 educator leaves the teaching position involuntarily, the nurse
82 16 educator is not liable to repay the amount paid or forgiven,
82 17 but is responsible for paying the amount remaining due on a
82 18 qualifying loan. The division directs the commission in
82 19 consultation with the advisory council to adopt rules for the
82 20 program including specifying what constitutes a qualifying
82 21 teaching position. The commission is also required to
82 22 establish a nursing faculty fellowship program to provide
82 23 funds to nursing schools in the state for fellowships for
82 24 individuals employed in qualifying positions on the nursing
82 25 faculty. The program is designed to assist nursing schools in
82 26 filling vacancies in qualifying positions throughout the
82 27 state. The commission, in consultation with the advisory
82 28 council and in cooperation with nursing schools throughout the
82 29 state, is to develop a distribution formula which provides
82 30 that no more than 30 percent of the available funds are
82 31 awarded to a single nursing school. Additionally, the program
82 32 limits funding for a qualifying position in a nursing school
82 33 to no more than $10,000 per year for up to three years. The
82 34 commission, in consultation with the advisory council, is
82 35 required to adopt rules for administration of the program
83 1 including determining what constitutes a qualifying position
83 2 at a nursing school. In determining eligibility for a
83 3 fellowship, the commission is to consider the length of time a
83 4 qualifying position has gone unfilled at a nursing school,
83 5 documented recruiting efforts by a nursing school, the
83 6 geographic location of a nursing school, the type of nursing
83 7 program offered at the nursing school, and the need for the
83 8 specific nursing program in the state.
83 9 The division requires the commission to submit an annual
83 10 report to the governor and the general assembly regarding the
83 11 status of the health care workforce support initiative,
83 12 including the balance remaining in and appropriations from the
83 13 workforce shortage fund.
83 14 The division repeals sections relating to the osteopathic
83 15 physician recruitment program, which is replaced with the
83 16 health care professional loan repayment program established in

83 17 the division.
83 18 The division also directs the Code editor to create a new
83 19 division in Code chapter 261 (college student aid commission),
83 20 the health care workforce support initiative.
83 21 DIVISION VII. PHARMACEUTICAL=RELATED PROVISIONS. Division
83 22 VII of this bill includes various pharmaceutical=related
83 23 provisions.
83 24 The division includes provisions relating to medication
83 25 therapy management. The division provides for the
83 26 establishment of a medication therapy management advisory
83 27 committee, appointed by the director of public health and
83 28 comprised of three licensed pharmacists selected by the Iowa
83 29 pharmacy association, two licensed physicians, one consumer
83 30 representative, and one health insurer. The duties of the
83 31 advisory committee are to advise the director of public health
83 32 and the commissioner of insurance in the development and
83 33 administration of the medication therapy management benefit
83 34 coverage, including adoption of rules pursuant to Code chapter
83 35 17A, and to annually evaluate and submit a compilation of
84 1 findings on the effect of medication therapy management on
84 2 quality of care, patient outcomes, and health coverage costs.
84 3 The advisory committee shall compile its findings on an annual
84 4 basis and submit its findings and recommendations to the
84 5 governor and the general assembly. The director of public
84 6 health may contract with an academic institution or other
84 7 appropriate entity that has expertise in evaluating health
84 8 care outcomes for the purpose of completing the evaluation.
84 9 The division also requires that a person who provides an
84 10 individual or group policy of accident or health insurance or
84 11 individual or group hospital or health care service contract
84 12 issued pursuant to Code chapter 509 (group insurance), Code
84 13 chapter 509A (group insurance for public employees), Code
84 14 chapter 514 (nonprofit health service corporations), or Code
84 15 chapter 514A (accident or health insurance), or an individual
84 16 or group health maintenance organization contract issued and
84 17 regulated under Code chapter 514B, which is delivered,
84 18 amended, or renewed on or after July 1, 2009, and which
84 19 provides pharmaceutical benefits, provide coverage benefits
84 20 for medication therapy management in accordance with rules
84 21 adopted by the commissioner of insurance. The division
84 22 specifies the parameters for adoption of rules for the
84 23 coverage benefit.
84 24 The division directs the department of public health to
84 25 establish and administer an evidence=based prescription drug
84 26 education program designed to provide health care
84 27 professionals who are licensed to prescribe or dispense
84 28 prescription drugs with information and education regarding
84 29 the therapeutic and cost=effective utilization of prescription
84 30 drugs. The division specifies the entities with which the
84 31 department is to collaborate in establishing and administering
84 32 the program including physicians, pharmacists, private
84 33 insurers, hospitals, pharmacy benefits managers, the medical
84 34 assistance drug utilization review commission, medical and
84 35 pharmacy schools, and other entities providing evidence=based
85 1 education to health care professionals that are licensed to
85 2 prescribe or dispense prescription drugs. The division
85 3 authorizes the department to contract with entities to provide
85 4 technical and clinical support to the program, to establish
85 5 and collect fees from private payors for participation in the
85 6 program, and to seek funding from nongovernmental health
85 7 foundations or other nonprofit charitable foundations to
85 8 establish and administer the program.
85 9 The division prohibits gifts to health care practitioners
85 10 from manufacturers and wholesalers of prescription drugs,
85 11 biologics, and medical devices, who participate in state
85 12 health programs, with limited exceptions. The division also
85 13 requires the disclosure of information about advertising and
85 14 marketing spending, and gifts excluded from the ban, and
85 15 requires the compilation of annual reports analyzing this data
85 16 by the department of administrative services.
85 17 The division includes provisions relating to the
85 18 safeguarding of the confidentiality of prescribing information
85 19 (data mining). The division establishes purposes of the new
85 20 Code chapter (155D), including that it is the chapter's
85 21 purpose to regulate the monitoring of prescribing practices
85 22 solely for commercial marketing purposes by entities selling
85 23 prescribed products, and not to regulate monitoring for other
85 24 uses, such as quality control, research unrelated to
85 25 marketing, or use by governments or other entities not in the
85 26 business of selling health care products.
85 27 The division provides privacy protections including that a

85 28 person, including a state health care program, shall not
85 29 knowingly disclose or use regulated records that include
85 30 individual identifying information to market a prescribed
85 31 product. The division also directs the department of human
85 32 services as the Medicaid agency to ensure that the department,
85 33 its employees, and agents, comply with the limitations on
85 34 redisclosure or use of medical assistance program prescription
85 35 information as provided for under state and federal law and
86 1 applicable federal regulations.
86 2 The division provides that regulated records containing
86 3 individual identifying information may be disclosed, sold,
86 4 transferred, exchanged, or used only for nonmarketing purposes
86 5 and specifies some of these nonmarketing purposes.
86 6 The division provides that it is not to be interpreted to
86 7 prohibit conduct involving the collection, use, transfer, or
86 8 sale of regulated records for marketing purposes if the data
86 9 is aggregated, the data does not contain individually
86 10 identifying information, and there is no reasonable basis to
86 11 believe that the data can be used to obtain individually
86 12 identifying information. The division does not prevent any
86 13 person from disclosing individual identifying information to
86 14 the identified individual if the information does not include
86 15 protected information pertaining to any other person.
86 16 The division provides that a person who knowingly fails to
86 17 comply with the requirements of the division or rules adopted
86 18 pursuant to the division by using or disclosing regulated
86 19 records in a manner not authorized by the division or rules
86 20 adopted under the division is subject to a civil penalty of
86 21 not more than $50,000 per violation. The division directs the
86 22 attorney general to enforce payment of penalties assessed
86 23 under the division and directs the board of pharmacy to adopt
86 24 rules to administer the division including the assessing of
86 25 penalties.
86 26 A violation of the new Code chapter may be enforced through
86 27 Iowa's consumer fraud Act.
86 28 The division includes provisions relating to pharmacy
86 29 benefits management. The division adds to the current
86 30 regulation of pharmacy benefits managers in Code chapter 510B
86 31 by including provisions relating to disclosure of revenues
86 32 received from pharmaceutical manufacturers or labelers by
86 33 pharmacy benefit managers.
86 34 DIVISION VIII. HEALTH CARE TRANSPARENCY. Division VIII of
86 35 this bill relates to health care transparency efforts. The
87 1 division directs the department of public health to adopt
87 2 rules to direct hospitals to submit data to the Iowa
87 3 healthcare collaborative, which is to serve as the
87 4 department's intermediary in collecting inpatient, outpatient,
87 5 and ambulatory information from hospitals. Currently, the
87 6 rules provide for collection of this information by the Iowa
87 7 hospital association, which submits the data to the department
87 8 for publication.
87 9 The division also directs the Iowa healthcare collaborative
87 10 to develop a plan for the collection, analysis, and publishing
87 11 of clinical data from physicians and health care providers
87 12 other than hospitals. The plan is to address the feasibility
87 13 of a physician all=payer database to allow for the collection
87 14 of claims data from all public and private payors of
87 15 physicians.
87 16 The division also directs the Iowa healthcare collaborative
87 17 to provide support to a number of councils tasked with health
87 18 care reform efforts pursuant to 2008 Iowa Acts, chapter 1188.
87 19 The councils include the electronic health information
87 20 advisory council, the medical home system advisory council,
87 21 the prevention and chronic care management initiative advisory
87 22 council, the clinicians advisory panel, and the medical
87 23 assistance quality improvement council. The division directs
87 24 the collaborative to provide support by providing direction in
87 25 promoting and coordinating quality, safety, and value
87 26 improvement collaborative efforts among the health care
87 27 providers involved in the various initiatives and by providing
87 28 support to the health care providers involved in the various
87 29 initiatives to develop their understanding of the requirements
87 30 established by the initiatives and to enable the effective
87 31 execution of the strategies developed by each initiative.