

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

PREAMBLE

This chapter defines and structures the Iowa Health and Wellness Plan, effective January 1, 2014, and administered by the department pursuant to 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187. Implementation of the Iowa Health and Wellness Plan is subject to approval by the Secretary of the United States Department of Health and Human Services of any waivers of the requirements of Title XIX of the Social Security Act to provide for federal funding of the plan. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.1(249A,85GA,SF446) Definitions.

“*Caretaker relative*” means a relative listed in 441—subrule 75.55(1).

“*Countable income*” means “modified adjusted gross income” (MAGI) or “household income,” as applicable, determined pursuant to 42 U.S.C. § 1396a(e)(14).

“*Department*” means the Iowa department of human services.

“*Enrollment period*” means the 12-month period for which Iowa Health and Wellness plan eligibility is established.

“*Essential health benefits*” means the essential health benefits defined at 42 U.S.C. § 18022.

“*Federal poverty level*” means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

“*Health insurance marketplace*” or “*exchange*” means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“*Iowa Health and Wellness Plan*” means the medical assistance program set forth in this chapter.

“*Iowa wellness plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Marketplace choice plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level.

“*Medical home*” means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient’s family; utilizes the partnership to access and integrate all medical and nonmedical health-related services across all elements of the health care system and the patient’s community as needed by the patient and the patient’s family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the following characteristics:

1. A personal provider.
2. A provider-directed team-based medical practice.
3. Whole person orientation.
4. Coordination and integration of care.
5. Quality and safety.
6. Enhanced access to health care.
7. A payment system that appropriately recognizes the added value provided to patients who have a patient-centered medical home.

“*Medically exempt individual*” means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR § 440.315 as amended on July 15, 2013.

“*Member*” means an individual who is receiving assistance under the Iowa Health and Wellness Plan described in this chapter.

“*Minimum essential coverage*” means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

“*Modified adjusted gross income*” means the financial-eligibility methodology prescribed in 42 U.S.C. § 1396a(e)(14).

“*Personal provider*” means the patient’s first point of contact in the health care system with a primary care provider who identifies the patient’s health-related needs and, working with a team of health care professionals and providers of medical and nonmedical health-related services, provides for and coordinates appropriate care to address the health-related needs identified.

“*Primary care provider*” includes but is not limited to any of the following licensed or certified health care professionals who provide primary care:

1. A physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist.
2. An advanced registered nurse practitioner.
3. A physician assistant.
4. A chiropractor.

“*Primary medical provider*” means a personal provider trained to provide first contact and continuous and comprehensive care to a member, chosen by a member or to whom a member is assigned under the Iowa health and wellness plan as the member’s primary medical provider.

“*Qualified employer-sponsored coverage*” shall be defined pursuant to 42 U.S.C. § 1396e-1(b).

“*Qualified health plan*” shall be defined pursuant to Section 1301 of the Patient Protection and Affordable Care Act, Public Law 111-152.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3548C, IAB 1/3/18, effective 2/7/18]

441—74.2(249A,85GA,SF446) Eligibility factors. Except as more specifically provided in this chapter, Iowa Health and Wellness Plan eligibility shall be determined according to the requirements of 441—Chapter 75.

74.2(1) Persons covered. Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under the Iowa Health and Wellness Plan shall be available to persons 19 through 64 years of age who:

- a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;
- b. Have countable income at or below 133 percent of the federal poverty level for their household size; and
- c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and
- d. Are not pregnant.

74.2(2) Parents or caretakers of dependent children. All children under the age of 21 living with a parent or other caretaker relative who will be claimed as a dependent by the parent or caretaker relative for state or federal income tax purposes must be enrolled in Medicaid, in the Children’s Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent’s or other caretaker relative’s eligibility for Iowa Health and Wellness Plan benefits.

74.2(3) Citizenship. To be eligible for Iowa Health and Wellness Plan benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.3(249A,85GA,SF446) Application. Medicaid application policies and procedures described in 441—Chapter 76 shall apply to applications for the Iowa Health and Wellness Plan.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.4(249A,85GA,SF446) Financial eligibility.

74.4(1) Countable income. Individuals are financially eligible for the Iowa Health and Wellness Plan if their countable income is no more than 133 percent of the federal poverty level, as of the date of a decision on initial or ongoing eligibility.

74.4(2) Household size. For financial eligibility purposes, household size shall be determined according to the modified adjusted gross income (MAGI) methodology.
[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.5(249A,85GA,SF446) Enrollment period.

74.5(1) Effective dates of eligibility. Iowa Health and Wellness Plan eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period shall continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,85GA,SF446).

74.5(2) Reinstatement. Enrollment for the Iowa Health and Wellness Plan may be reinstated without a new application in accordance with 441—subrule 76.12(2).

74.5(3) Presumptive eligibility. The enrollment period of 12 consecutive months shall not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with rules 441—76.7(249A) and 441—76.13(249A).

74.5(4) Retroactive enrollment. Medical assistance shall be available to a pregnant woman or an infant (under one year of age) for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—subrule 76.13(3).
[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—74.6(249A,85GA,SF446) Reporting changes.

74.6(1) Reporting requirements. As a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member turns 65.
- d. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
- e. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
- f. The member's countable income increases in a manner that must be reported according to the requirements of rule 441—76.15(249A).
- g. The member is confirmed pregnant.

74.6(2) Untimely report. When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible shall be considered an overpayment and be subject to recovery from the member in accordance with rule 441—75.28(249A) and 441—Chapter 11. Program expenditures may include, but are not limited to, premiums and capitation payments.

74.6(3) Effective date of change. After enrollment, changes reported during the month that affect the member's eligibility shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 16.3(1); or
 - b. The enrollment period has expired and the member is not eligible for a new enrollment period.
- [ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—74.7(249A,85GA,SF446) Reenrollment. A new eligibility determination is required for consecutive 12-month enrollment periods. The reenrollment process will follow the requirements in 441—subrule 76.14(2).

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.8(249A,85GA,SF446) Terminating enrollment. Iowa Health and Wellness Plan enrollment shall end when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the federal poverty level.
10. The member reports that she is pregnant.
11. The Iowa Health and Wellness Plan is discontinued according to the requirements in rule 441—74.14(249A,85GA,SF446).
12. The member does not pay monthly contributions as required by subrule 74.11(2).

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.9(249A,85GA,SF446) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with rule 441—75.28(249A).

74.9(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with rule 441—75.28(249A).

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.10(249A,85GA,SF446) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. A provider requesting a hearing on behalf of a member must have the prior express written consent of the member or the member's lawfully appointed guardian. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the provider submits a document providing the member's consent to the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily, and intelligently consents to the provider's bringing the state fair hearing on the member's behalf.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,85GA,SF446).

74.10(3) Coverage decisions and actions by participating marketplace choice plans must first be appealed through the plan's internal appeal process and through the external review process pursuant to Iowa Administrative Code 191—Chapter 76. After a member has exhausted the member's rights under the external review process, the member may appeal a decision or action pursuant to 441—Chapter 7. Appeal requests made pursuant to 441—Chapter 7 shall result in a change from benefits and service delivery under subrule 74.12(2) to benefits and service delivery under subrule 74.12(1). Benefits and service delivery under subrule 74.12(1) shall remain in effect for the remainder of the member's eligibility period.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.11(249A,85GA,SF446) Financial participation.

74.11(1) Copayment. Payment for nonemergency use of a hospital emergency department shall be subject to an \$8 copayment by the member, which shall be subtracted from the Iowa Health and Wellness Plan payment otherwise due to the provider. This copayment will be waived during calendar year 2014.

74.11(2) Monthly contributions. Members enrolled in the Iowa Health and Wellness Plan with household income at or above 50 percent of the federal poverty level are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to rule 441—75.70(249A), as a percentage of the federal poverty level (FPL) for the household. Monthly contribution amounts are as follows:

- (1) For a member with household income between 50 and 100 percent of the FPL, \$5;
- (2) For a member with household income above 100 percent of the FPL, \$10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

- (1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.
- (2) The member is determined to be a medically exempt individual pursuant to subrule 74.12(3).
- (3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.
- (4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.

d. Billing and payment. Form 470-5285, Iowa Health and Wellness Plan Billing Statement, shall be used for billing and collection.

(1) Method of payment. Members shall submit contribution payments to the following address: Iowa Medicaid Enterprise, Iowa Health and Wellness Plan Monthly Contributions, P.O. Box 14485, Des Moines, Iowa 50306-3485.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution for each month is due on the last calendar day of the month that the monthly contribution is to cover.

2. If the last calendar day falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department shall apply monthly contributions payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An Iowa wellness plan member who fails to pay the assessed monthly contributions and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with

rule 441—75.28(249A). A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) A marketplace choice plan member who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall have the member's eligibility terminated. In addition, the unpaid monthly contribution shall be subject to recovery in accordance with rule 441—75.28(249A) as an unpaid premium.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions must reenroll for Medicaid benefits pursuant to 441—Chapter 76.

f. Refund of monthly contributions.

(1) Monthly contributions paid for any period shall be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2) "c" or when a member's Iowa Health and Wellness Plan coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in the Iowa Health and Wellness Plan; or

2. The member dies.

(2) The amount of any refund shall be offset by any outstanding monthly contributions owed.

(3) The refund shall be paid within two calendar months.

74.11(3) Aggregate annual limits on copayments and monthly contributions. The total aggregate annual amount of copayments and monthly contributions for an individual shall not exceed 5 percent of the household's countable annual income determined pursuant to rule 441—75.70(249A).

74.11(4) Healthy behaviors. An Iowa Health and Wellness Plan member who completes a wellness examination and health risk assessment during any enrollment year shall have monthly contributions waived in the subsequent enrollment year.

a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

b. A health risk assessment must be one of the following:

(1) An "Assess My Health" assessment offered through the department;

(2) An assessment offered by a managed care plan through which the member is receiving Iowa Health and Wellness Plan benefits; or

(3) An assessment offered by a qualified health plan through which the member is receiving Iowa Health and Wellness Plan benefits.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—74.12(249A,85GA,SF446) Benefits and service delivery. Covered benefits and the service delivery method shall be determined by the member's countable income and health status.

74.12(1) Iowa wellness plan services. Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level shall be enrolled in the Iowa wellness plan unless the member is determined by the department to be a medically exempt individual. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for Iowa wellness plan services.

a. Covered Iowa wellness plan services are essential health benefits, all other benefits required pursuant to 42 U.S.C. § 1396u-7(b)(1)(B), including prescription drugs, and dental services consistent with 441—Chapter 78.

b. Members enrolled in the Iowa wellness plan shall be subject to enrollment in managed care, other than PACE programs, pursuant to 441—Chapter 88.

c. Dental services shall be provided through a contract with one or more commercial dental plans. The department may restrict member access to those entities with which the department contracts. The

dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) Marketplace choice plan services. At the department's discretion, Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level may be enrolled in a marketplace choice plan unless the member is determined by the department to be a medically exempt individual. At the department's discretion, marketplace choice coverage may be provided through designated qualified health plans available on the health insurance marketplace. Covered services not provided by the marketplace choice plan will be provided by the medical assistance program.

a. Upon enrollment, a member shall choose a qualified health plan from those designated by the department to provide coverage to marketplace choice plan members.

b. When the member does not select a qualified health plan pursuant to notice of the need to do so, the department will select a plan, enroll the member, and notify the member of the assigned plan.

c. The department shall pay premiums to designated qualified health plans participating on the health insurance marketplace to buy coverage for eligible marketplace choice plan members. The department shall begin payment of the member's premiums for the first month of enrollment in the qualified health plan. The qualified health plan shall provide the member with an insurance card identifying the member as an enrollee of the plan. The department shall provide the member with a medical assistance eligibility card for covered medical services not provided by the qualified health plan.

d. Covered services are all benefits, including essential health benefits, provided by the designated qualified health plan on the health insurance marketplace, including prescription drugs. Services not covered by the qualified health plan, but covered pursuant to the marketplace choice 1115 waiver or the marketplace choice state plan will be covered by the Medicaid program.

e. Dental services shall be provided through a contract with one or more commercial dental plans with covered services consistent with 441—Chapter 78. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(3) Medically exempt individuals. An Iowa Health and Wellness Plan member who has been determined by the department to be a medically exempt individual shall be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A member may attest to being a medically exempt individual by submitting a completed Form 470-5194.

b. A provider with a current National Provider Identifier number, an employee of the department of human services, a designee of the department of corrections, a qualified health plan, or a mental health and disability services region established pursuant to Iowa Code sections 331.388 to 331.399 may refer a member for a medically exempt individual determination by submitting a completed Form 470-5196, Medically Exempt Attestation and Referral Form.

c. Upon receipt of Form 470-5194 or 470-5196, the Iowa Medicaid enterprise shall determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR § 440.315 as amended on July 15, 2013.

74.12(4) Qualified employer-sponsored coverage. An individual who has access to cost-effective employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—74.13(249A,85GA,SF446) Claims and reimbursement methodologies.

74.13(1) Claims for services not provided by a qualified health plan. Claims for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's

qualified health plan shall be submitted to the Iowa Medicaid enterprise as required by 441—Chapter 80 or to the member’s Medicaid managed care organization.

74.13(2) *Payment for services not provided by a qualified health plan.* Payment for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member’s qualified health plan shall be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member’s Medicaid managed care organization and the provider.

74.13(3) *Payment for services provided by the marketplace choice plan.* Payment for services provided under the marketplace choice plan shall be made in accordance with the rates filed with the Iowa insurance division.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—74.14(249A,85GA,SF446) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for the Iowa Health and Wellness Plan is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services shall be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.15(249A,85GA,ch138) Enrollment for IowaCare members. Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

These rules are intended to implement 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187, and Iowa Code chapter 249A.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]

[Filed Emergency ARC 1214C, IAB 12/11/13, effective 11/13/13]

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