

House Amendment 8243

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1 1 Amend House File 2470 as follows:
1 2 #1. Page 1, by inserting before line 1, the
1 3 following:
1 4 NEW SECTION. 514M.1 SHORT TITLE.
1 5 This chapter shall be known and may be cited as the
1 6 "Healthy Iowa for All" program.
1 7 Sec. 2. NEW SECTION. 514M.2 LEGISLATIVE INTENT.
1 8 It is the intent of the general assembly to
1 9 establish the healthy Iowa for all program to provide
1 10 access to comprehensive, quality, affordable health
1 11 care coverage to eligible small employers, including
1 12 the self-employed, their employees and their
1 13 dependents, state employees and their dependents,
1 14 local government employees and their dependents, and
1 15 individuals, on a voluntary basis. It is also the
1 16 intent of the general assembly that the healthy Iowa
1 17 for all program monitor and improve the quality of
1 18 health care in the state.
1 19 Sec. 3. NEW SECTION. 514M.3 DEFINITIONS.
1 20 As used in this chapter, unless the context
1 21 otherwise requires:
1 22 1. "Board" means the HIFA program board created in
1 23 section 514M.6.
1 24 2. "Department" means the Iowa department of
1 25 public health.
1 26 3. "Dependent" means a spouse, an unmarried child
1 27 under nineteen years of age, a child who is a student
1 28 under twenty-three years of age and is financially
1 29 dependent upon a plan enrollee, or a person of any age
1 30 who is the child of a plan enrollee and is disabled
1 31 and dependent upon that plan enrollee. "Dependent"
1 32 may include a domestic partner.
1 33 4. "Director" means the director of public health.
1 34 5. "Eligible employer" means a business that
1 35 employs at least two but not more than fifty eligible
1 36 employees, the majority of whom are employed in the
1 37 state, including a municipality or political
1 38 subdivision that has fifty or fewer employees.
1 39 6. "Eligible individual" means any of the
1 40 following:
1 41 a. A self-employed individual who works and
1 42 resides in the state, and is organized as a sole
1 43 proprietorship or in any other legally recognized
1 44 manner in which a self-employed individual may
1 45 organize, a substantial part of whose income derives
1 46 from a trade or business through which the individual
1 47 has attempted to earn taxable income.
1 48 b. An unemployed individual who resides in this
1 49 state.
1 50 c. An individual employed by an employer that does
2 1 not offer health insurance.
2 2 d. Uninsured individuals without access to
2 3 employer coverage.
2 4 7. "Eligible local government employee" means a
2 5 local government employee.
2 6 8. "Eligible state employee" means a state
2 7 employee, including a state employee covered under a
2 8 collective bargaining agreement.
2 9 9. "Employer" means the owner or responsible agent
2 10 of a business authorized to sign contracts on behalf
2 11 of the business.
2 12 10. "Federal poverty guidelines" means the federal
2 13 poverty guidelines issued by the United States
2 14 department of health and human services in the federal
2 15 register.
2 16 11. "Health insurance carrier" means any entity
2 17 licensed by the division of insurance of the
2 18 department of commerce to provide health insurance in
2 19 Iowa or an organized delivery system licensed by the
2 20 director of public health that has contracted with the
2 21 department to provide health insurance coverage to
2 22 eligible individuals and dependents under this
2 23 chapter.
2 24 12. "HIFA health insurance" means the health

2 25 insurance product established by the HIFA program that
2 26 is offered by a private health insurance carrier.

2 27 13. "HIFA health insurance program" or "insurance
2 28 program" means the program through which HIFA health
2 29 insurance is provided.

2 30 14. "HIFA program" or "program" means the healthy
2 31 Iowa for all program established in this chapter.

2 32 15. "Local government" means a city, county,
2 33 school district, and the institutions governed by the
2 34 board of regents.

2 35 16. "Modified community rating" means a method
2 36 used to develop a health insurance carrier's premiums
2 37 which spreads financial risk across a population by
2 38 limiting the utilization of health status and claims
2 39 experience as approved by the commissioner of
2 40 insurance.

2 41 17. "Participating employer" means an eligible
2 42 employer that contracts with and has employees
2 43 enrolled in the HIFA health insurance program.

2 44 18. "Plan enrollee" means an eligible individual
2 45 or eligible employee who enrolls in the HIFA health
2 46 insurance program.

2 47 19. "Provider" means any person, organization,
2 48 corporation, or association that provides health care
2 49 services and products and is authorized to provide
2 50 those services and products under state law.

3 1 20. "Reinsurance" means an agreement between
3 2 insurance companies under which one accepts all or
3 3 part of the risk or loss of the other.

3 4 21. "Third-party administrator" means any person
3 5 who, on behalf of any person who establishes a health
3 6 insurance plan covering residents of this state,
3 7 receives or collects charges, contributions, or
3 8 premiums for, or settles claims of residents in
3 9 connection with, any type of health benefit provided
3 10 in or as an alternative to insurance.

3 11 22. "Unemployed individual" means an individual
3 12 who does not work more than twenty hours per week for
3 13 any single employer.

3 14 Sec. 4. NEW SECTION. 514M.4 HIFA PROGRAM
3 15 ESTABLISHED.

3 16 1. The department shall establish the HIFA program
3 17 to provide access to health care coverage to eligible
3 18 employers, including the self-employed, their
3 19 employees and dependents, eligible state employees and
3 20 their dependents, eligible local government employees
3 21 and their dependents, and eligible individuals.

3 22 2. The department may do any of the following:

3 23 a. Have and exercise all powers necessary or
3 24 convenient to effect the purposes for which the
3 25 program is organized or to further the activities in
3 26 which the program may lawfully be engaged, including
3 27 the establishment of the insurance program.

3 28 b. Make and alter a plan of operation, not
3 29 inconsistent with this chapter or with state law, for
3 30 the administration and regulation of the activities of
3 31 the program.

3 32 c. Take any legal actions necessary or proper to
3 33 recover or collect savings offset payments due the
3 34 program or that are necessary for the proper
3 35 administration of the program.

3 36 d. Take any legal actions necessary to avoid the
3 37 payment of improper claims against the insurance
3 38 program or the coverage provided by or through the
3 39 insurance program to recover any amounts erroneously
3 40 or improperly paid by the insurance program, to
3 41 recover amounts paid by the insurance program as the
3 42 result of mistake of fact or law, and to recover other
3 43 amounts due the insurance program.

3 44 e. Enter into contracts with qualified third
3 45 parties, both private and public, for any service
3 46 necessary to carry out the purposes of this chapter.

3 47 f. Conduct studies and analyses related to the
3 48 provision of health care, health care costs, and
3 49 health care quality.

3 50 g. Accept appropriations, gifts, grants, loans, or
4 1 other aid from public or private entities.

4 2 h. Contract with organizations with expertise in
4 3 health care data, including a nonprofit health data
4 4 processing entity in this state, to assist the Iowa
4 5 quality forum established in section 514M.13 in the

4 6 performance of its responsibilities.
4 7 i. Provide staff support and other assistance to
4 8 the Iowa quality forum established in section 514M.13.
4 9 j. In accordance with the limitations and
4 10 restrictions of this chapter, cause any of its powers
4 11 or duties to be carried out by one or more
4 12 organizations organized, created, or operated under
4 13 the laws of this state.
4 14 3. The department shall do all of the following:
4 15 a. Establish administrative and accounting
4 16 procedures as recommended by the state auditor for the
4 17 operation of the program.
4 18 b. Collect the savings offset payments as provided
4 19 in section 514M.11.
4 20 c. Determine the comprehensive services and
4 21 benefits to be included in HIFA health insurance and
4 22 make recommendations to the board regarding the
4 23 services and benefits.
4 24 d. Develop and implement an outreach program to
4 25 publicize the existence of the HIFA program and the
4 26 HIFA health insurance program and the eligibility
4 27 requirements and the enrollment procedures for the
4 28 HIFA health insurance program and to maintain public
4 29 awareness of the HIFA program and the HIFA health
4 30 insurance program.
4 31 e. Arrange for the provision of HIFA health
4 32 insurance benefit coverage to eligible individuals,
4 33 eligible employees, eligible state employees, and
4 34 eligible local government employees through contracts
4 35 with one or more qualified health insurance carriers.
4 36 f. Develop a high-risk pool for plan enrollees in
4 37 HIFA health insurance in accordance with the
4 38 provisions of section 514M.15.
4 39 4. Financial and performance audits or
4 40 examinations of HIFA health insurance shall be
4 41 conducted by the insurance division of the department
4 42 of commerce, annually. A copy of any audit shall be
4 43 provided to the commissioner of insurance, the
4 44 governor, and the general assembly.
4 45 5. Beginning September 1, 2006, and annually
4 46 thereafter, the department shall submit a report to
4 47 the governor and the general assembly on the impact of
4 48 the HIFA health insurance program on the small group,
4 49 individual, state employee, and local government
4 50 employee health insurance markets in this state and
5 1 any reduction in the number of uninsured individuals
5 2 in the state. The department shall also report on
5 3 membership in the HIFA health insurance program, the
5 4 administrative expenses of the HIFA health insurance
5 5 program, the extent of coverage, the effect on
5 6 premiums, the number of covered lives, the number of
5 7 HIFA health insurance policies issued or renewed, and
5 8 HIFA health insurance premiums earned and claims
5 9 incurred by health insurance carriers offering HIFA
5 10 health insurance.
5 11 6. The department shall coordinate the activities
5 12 of the HIFA program with health care programs offered
5 13 through federal, state, and local governments.
5 14 Sec. 5. NEW SECTION. 514M.5 HIFA PROGRAM BOARD.
5 15 1. A HIFA program board for the HIFA program is
5 16 established. The board shall meet not less than four
5 17 times annually or at the call of the chairperson for
5 18 the purposes of establishing policy and adopting rules
5 19 for the program. The board shall consist of the
5 20 following members:
5 21 a. Five public voting members who have knowledge
5 22 or experience in one or more of the following areas,
5 23 appointed by the governor and subject to confirmation
5 24 by the senate:
5 25 (1) Health care purchasing.
5 26 (2) Health insurance.
5 27 (3) Health policy and law.
5 28 (4) State management and budgeting.
5 29 (5) Health care financing.
5 30 b. The director of public health, the director of
5 31 human services, and the commissioner of insurance
5 32 serving as ex officio, nonvoting members of the board.
5 33 c. Two members of the senate and two members of
5 34 the house of representatives, serving as ex officio,
5 35 nonvoting members. The legislative members of the
5 36 board shall be appointed by the majority leader of the

5 37 senate, after consultation with the president of the
5 38 senate, and by the minority leader of the senate, and
5 39 by the speaker of the house, after consultation with
5 40 the majority leader, and by the minority leader of the
5 41 house of representatives. Legislative members shall
5 42 receive compensation pursuant to section 2.12.

5 43 2. Members appointed by the governor shall serve
5 44 two-year staggered terms as designated by the
5 45 governor, and legislative members of the board shall
5 46 serve two-year terms. The filling of vacancies,
5 47 membership terms, payment of compensation and
5 48 expenses, and removal of the members who are
5 49 representatives of the public are governed by chapter
5 50 69. Members of the board are entitled to receive
6 1 reimbursement of actual expenses incurred in the
6 2 discharge of their duties. Public members of the
6 3 board are also eligible to receive per diem as
6 4 specified in section 7E.6 for each day spent in
6 5 performance of duties as members. The members shall
6 6 select a voting member as the chairperson on an annual
6 7 basis from among the membership of the board. Three
6 8 voting members of the board constitute a quorum. An
6 9 action taken by the board shall require the
6 10 affirmative vote of at least three members.

6 11 3. A member of the board or an employee of the
6 12 HIFA program or their dependent shall not receive any
6 13 direct personal benefit from the activities of the
6 14 program in assisting any private entity, except that
6 15 they may participate in HIFA health insurance on the
6 16 same terms as any other participant.

6 17 4. The board shall do all of the following:

6 18 a. Employ or contract for any personnel as may be
6 19 necessary to carry out the duties of the board.

6 20 b. Develop standards for selecting participating
6 21 health insurance carriers for the insurance program.

6 22 c. Establish penalties for breach of contract or
6 23 other violations of requirements or provisions under
6 24 the program.

6 25 d. In consultation with the Iowa quality forum
6 26 advisory council, select a nationally recognized
6 27 functional health assessment form for an initial
6 28 assessment of all eligible employees, eligible
6 29 individuals, eligible state employees, and eligible
6 30 local government employees participating in the HIFA
6 31 health insurance program, establish a baseline for
6 32 comparison purposes, and develop appropriate
6 33 indicators to measure the health status of those
6 34 participating in the program.

6 35 e. Specify the data to be maintained by the
6 36 department, including data to be collected for the
6 37 purposes of quality assurance reports.

6 38 f. Approve the benefits package design, review the
6 39 benefits package design on a periodic basis, and make
6 40 necessary changes in the benefit design to reflect the
6 41 results of the periodic reviews. The benefits package
6 42 shall provide comprehensive coverage and shall include
6 43 all benefits mandated by law.

6 44 g. Determine the contribution levels, deductibles,
6 45 and cost-sharing requirements of the HIFA health
6 46 insurance program.

6 47 h. Provide for periodic assessment of the
6 48 effectiveness of the outreach program.

6 49 i. Solicit input from the public regarding the
6 50 program and related issues and services.

7 1 j. Approve a high-risk pool for plan enrollees in
7 2 the HIFA health insurance program.

7 3 k. Adopt rules, in accordance with chapter 17A, as
7 4 necessary for the proper administration and
7 5 enforcement of this chapter.

7 6 5. State agencies shall provide technical
7 7 assistance and expertise to the board and the
7 8 department upon request. The attorney general shall
7 9 act as legal counsel to the board.

7 10 6. The board may appoint advisory committees to
7 11 assist the board and the department.

7 12 Sec. 6. NEW SECTION. 514M.6 HIFA HEALTH
7 13 INSURANCE PROGRAM.

7 14 1. a. The HIFA health insurance program shall
7 15 provide for health benefits coverage through health
7 16 insurance carriers that apply to the board and meet
7 17 the qualifications described in this section and any

7 18 additional qualifications established by rule of the
7 19 board.

7 20 b. If a sufficient number of health insurance
7 21 carriers do not apply to offer and deliver health
7 22 insurance under the insurance program, the board may
7 23 propose the establishment of a nonprofit health care
7 24 plan or may propose the expansion of an existing
7 25 public plan. If the board proposes the establishment
7 26 of a nonprofit health care plan or the expansion of an
7 27 existing public plan, the board shall submit a
7 28 proposal, including but not limited to a funding
7 29 mechanism, to capitalize a nonprofit health care plan
7 30 and any recommended legislation to the general
7 31 assembly. The program shall not provide access to
7 32 health insurance by establishing a nonprofit health
7 33 care plan or through an existing public plan without
7 34 specific legislative approval.

7 35 2. Nothing in this chapter shall be construed or
7 36 is intended as, or shall imply, a grant of entitlement
7 37 for services to persons who are eligible for
7 38 participation in the HIFA health insurance program
7 39 based upon eligibility consistent with the
7 40 requirements of this chapter. Any state obligation to
7 41 provide services pursuant to this chapter is limited
7 42 to the extent of the funds appropriated or provided
7 43 for implementation of this chapter.

7 44 3. The HIFA health insurance program may contract
7 45 with health insurance carriers licensed to sell health
7 46 insurance in the state or other private or public
7 47 third-party administrators to provide insurance under
7 48 the insurance program.

7 49 a. The HIFA health insurance program shall issue
7 50 requests for proposals to select health insurance
8 1 carriers.

8 2 b. The insurance program may include quality
8 3 improvement, patient care management, and cost=
8 4 containment provisions in the contracts with
8 5 participating health insurance carriers or may arrange
8 6 for the provision of such services through contracts
8 7 with other entities.

8 8 c. The insurance program shall require
8 9 participating health insurance carriers to offer a
8 10 benefit plan identical to the plan developed by the
8 11 board in the small group market.

8 12 d. The HIFA health insurance program may set
8 13 allowable rates for administration and underwriting
8 14 gains for the insurance program.

8 15 e. The HIFA health insurance program may
8 16 administer continuation benefits for eligible
8 17 individuals from employers with twenty or more
8 18 employees who have purchased health insurance coverage
8 19 through the program for the duration of their
8 20 eligibility periods for continuation of benefits
8 21 pursuant to Title X of the federal Consolidated
8 22 Omnibus Budget Reconciliation Act of 1986, Pub. L. No.
8 23 99=272, sections 10001 to 10003.

8 24 f. The HIFA health insurance program may
8 25 administer or contract to administer the United States
8 26 Internal Revenue Code of 1986, section 125, plans for
8 27 employers and employees participating in the program,
8 28 including medical expense reimbursement accounts and
8 29 dependent care reimbursement accounts.

8 30 g. The HIFA health insurance program shall
8 31 contract with eligible employers seeking assistance in
8 32 arranging for health benefits coverage for their
8 33 employees and the employees' dependents.

8 34 Sec. 7. NEW SECTION. 514M.7 ELIGIBILITY
8 35 REQUIREMENTS.

8 36 1. All of the following are eligible for
8 37 participation in the HIFA health insurance program:

8 38 a. Eligible individuals and their dependents.

8 39 b. The employees of an eligible employer and the
8 40 dependents of such employees.

8 41 c. Eligible state employees and their dependents,
8 42 in accordance with applicable collective bargaining
8 43 agreements.

8 44 d. Eligible local government employees and their
8 45 dependents.

8 46 2. In order to participate, an eligible employer,
8 47 the state, or the local government shall pay at least
8 48 sixty percent of the individual employee's premium

8 49 costs or the combined premium costs of the individual
8 50 employee and dependents of the employee.

9 1 3. The HIFA health insurance program shall collect
9 2 payments from participating employers and plan
9 3 enrollees to cover the costs of all of the following:
9 4 a. Insurance coverage for enrolled employees and
9 5 their dependents in contribution amounts determined by
9 6 the board.
9 7 b. Quality assurance, patient care management, and
9 8 cost=containment programs.
9 9 c. Administrative services.
9 10 d. Other health promotion costs.

9 11 4. The HIFA program board shall establish a
9 12 minimum required contribution level, to be paid by
9 13 participating employers toward the aggregate payment
9 14 in subsection 3. The minimum required contribution
9 15 level to be paid by participating employers shall be
9 16 prorated for employees that work less than the number
9 17 of hours of a full-time equivalent employee as
9 18 determined by the employer. The HIFA health insurance
9 19 program may establish a separate minimum contribution
9 20 level to be paid by employers toward coverage for
9 21 dependents of the employers' enrolled employees.

9 22 5. The HIFA health insurance program shall require
9 23 participating employers to certify that at least
9 24 seventy-five percent of their employees that work
9 25 thirty hours or more per week and who do not have
9 26 other creditable coverage are enrolled in the HIFA
9 27 health insurance program and that the employer group
9 28 otherwise meets the minimum participation
9 29 requirements.

9 30 6. The HIFA health insurance program shall reduce
9 31 the payment amounts for plan enrollees eligible for a
9 32 subsidy pursuant to section 514M.9 accordingly. The
9 33 employer shall pass along any subsidy received to the
9 34 enrollee up to the amount of payments made by the plan
9 35 enrollee.

9 36 7. The HIFA health insurance program may establish
9 37 other criteria for participation in the program.

9 38 8. The HIFA health insurance program may limit the
9 39 number of participating employers in the program.

9 40 9. The HIFA health insurance program may allow
9 41 eligible individuals and their dependents to purchase
9 42 insurance under the program in accordance with this
9 43 subsection.

9 44 a. The HIFA health insurance program may establish
9 45 contracts and other reporting forms and procedures
9 46 necessary for the efficient administration of
9 47 individual contracts.

9 48 b. The HIFA health insurance program shall collect
9 49 payments from eligible individuals participating in
9 50 the HIFA health insurance program to cover the costs
10 1 of all of the following:
10 2 (1) Insurance coverage for eligible individuals
10 3 and their dependents in contribution amounts
10 4 determined by the board.
10 5 (2) Quality assurance, patient care management,
10 6 and cost=containment programs.
10 7 (3) Administrative services.
10 8 (4) Other health promotion costs.

10 9 c. The HIFA health insurance program shall reduce
10 10 the payment amounts for individuals eligible for a
10 11 subsidy pursuant to section 514M.9 accordingly.

10 12 d. The HIFA health insurance program may require
10 13 that eligible individuals certify that all their
10 14 dependents are enrolled in the HIFA health insurance
10 15 program or are covered by another creditable plan.

10 16 e. The HIFA health insurance program may require
10 17 an eligible individual who is currently employed by an
10 18 eligible employer that does not offer health insurance
10 19 to certify that the current employer did not provide
10 20 access to an employer-sponsored benefits plan in the
10 21 twelve-month period immediately preceding the eligible
10 22 individual's application.

10 23 f. The HIFA health insurance program may limit the
10 24 number of individual plan enrollees.

10 25 g. The HIFA health insurance program may establish
10 26 other criteria for participation of individuals in the
10 27 insurance program.

10 28 Sec. 8. NEW SECTION. 514M.8 FACILITATION OF
10 29 ENROLLMENT IN HIFA HEALTH INSURANCE PROGRAM.

10 30 The department shall perform, at a minimum, all of
10 31 the following functions to facilitate enrollment in
10 32 the insurance program:

10 33 1. Publicize the availability of HIFA health
10 34 insurance to employers, self-employed individuals, and
10 35 others eligible to enroll in the program.

10 36 2. Screen all eligible individuals and employees
10 37 for eligibility for subsidies pursuant to section
10 38 514M.9.

10 39 3. Promote quality improvement, patient care
10 40 management, and cost-containment programs as part of
10 41 the insurance program.

10 42 Sec. 9. NEW SECTION. 514M.9 SUBSIDIES.

10 43 1. The HIFA health insurance program shall
10 44 establish sliding-scale subsidies for the purchase of
10 45 HIFA health insurance by an individual or employee
10 46 whose income is at or below three hundred percent of
10 47 the federal poverty guidelines and who is not eligible
10 48 for any other state or federally funded program. The
10 49 HIFA health insurance program may also establish
10 50 sliding-scale subsidies for the purchase of employer=
11 1 sponsored health coverage by an employee of an
11 2 employer with more than fifty employees, whose income
11 3 is under three hundred percent of the federal poverty
11 4 guidelines and who is not eligible for any other state
11 5 or federally funded program.

11 6 2. Subsidies shall be limited by the amount of
11 7 available funding.

11 8 3. The HIFA health insurance program may limit the
11 9 amount of the subsidy to individual plan enrollees to
11 10 forty percent of the payment.

11 11 Sec. 10. NEW SECTION. 514M.10 INSURANCE
11 12 CARRIERS.

11 13 To qualify as a health insurance carrier for HIFA
11 14 health insurance, a health insurance carrier shall do
11 15 all of the following:

11 16 1. Provide the comprehensive health services and
11 17 benefits as determined by the board, including a
11 18 standard benefit package that meets the requirements
11 19 for mandated coverage for specific health services,
11 20 specific diseases, and for certain providers of health
11 21 services under this title, and any supplemental
11 22 benefits as approved by the board.

11 23 2. Ensure all of the following:

11 24 a. That providers contracting with a health
11 25 insurance carrier contracted to provide coverage to
11 26 plan enrollees do not refuse to provide services to a
11 27 plan enrollee on the basis of health status, medical
11 28 condition, previous insurance status, race, color,
11 29 creed, age, national origin, citizenship status,
11 30 gender, sexual orientation, disability, or marital
11 31 status. This paragraph shall not be construed to
11 32 require a provider to furnish medical services that
11 33 are not within the scope of that provider's license.

11 34 b. That providers contracting with a health
11 35 insurance carrier contracted to provide coverage to
11 36 plan enrollees are reimbursed at the negotiated
11 37 reimbursement rates between the carrier and its
11 38 provider network.

11 39 c. That premiums are set utilizing a modified
11 40 community rating.

11 41 Sec. 11. NEW SECTION. 514M.11 SAVINGS OFFSET
11 42 PAYMENTS.

11 43 1. The board shall determine, annually, not later
11 44 than April 30, the aggregate measurable cost savings,
11 45 including any reduction or avoidance of bad debt and
11 46 charity care costs to health care providers in the
11 47 state as a result of the operation of the HIFA health
11 48 insurance program.

11 49 2. For the purpose of providing funds necessary to
11 50 provide subsidies pursuant to section 514M.9, and to
12 1 support the Iowa quality forum pursuant to section
12 2 514M.13, the board shall establish a savings offset
12 3 amount to be paid by health insurance carriers,
12 4 employee benefit excess insurance carriers, and third=
12 5 party administrators, not including carriers and
12 6 third-party administrators with respect to accidental
12 7 injury, specified disease, hospital indemnity, dental,
12 8 vision, disability, income, long-term care, Medicare
12 9 supplemental, or other limited benefit health
12 10 insurance, annually at a rate that may not exceed

12 11 savings resulting from decreasing rates of growth in
12 12 bad debt and charity care costs. Payment of the
12 13 savings offset shall begin January 1, 2006. The
12 14 savings offset amount as determined by the board is
12 15 the determining factor for inclusion of savings offset
12 16 payments in premiums through rate-setting review by
12 17 the insurance division of the department of commerce.
12 18 Savings offset payments must be made quarterly and are
12 19 due not less than thirty days after written notice to
12 20 the health insurance carriers, employee benefit excess
12 21 insurance carriers, and third-party administrators.
12 22 3. Each health insurance carrier, employee benefit
12 23 excess insurance carrier, and third-party
12 24 administrator shall pay a savings offset in an amount
12 25 not to exceed four percent of annual health insurance
12 26 premiums and employee benefit excess insurance
12 27 premiums on policies issued pursuant to the laws of
12 28 this state that insure residents of this state. The
12 29 savings offset payment shall not exceed savings
12 30 resulting from decreasing rates of growth in bad debt
12 31 and charity care costs. The savings offset payment
12 32 applies to premiums paid on or after July 1, 2005.
12 33 Savings offset payments shall reflect aggregate
12 34 measurable cost savings, including any reduction or
12 35 avoidance of bad debt and charity care costs to health
12 36 care providers in this state, as a result of the
12 37 operation of the HIFA health insurance program as
12 38 determined by the board. A health insurance carrier
12 39 or employee benefit excess insurance carrier shall not
12 40 be required to pay a savings offset payment on
12 41 policies or contracts insuring federal employees.
12 42 4. The board shall make reasonable efforts to
12 43 ensure that premium revenue, or claims plus any
12 44 administrative expenses and fees with respect to
12 45 third-party administrators, is counted only once with
12 46 respect to any savings offset payment. For that
12 47 purpose, the board shall require each health insurance
12 48 carrier to include in its premium revenue gross of
12 49 reinsurance ceded. The board shall allow a health
12 50 insurance carrier to exclude from its gross premium
13 1 revenue reinsurance premiums that have been counted by
13 2 the primary insurer for the purpose of determining its
13 3 savings offset payment under this subsection. The
13 4 board shall allow each employee benefit excess
13 5 insurance carrier to exclude from its gross premium
13 6 revenue the amount of claims that have been counted by
13 7 a third-party administrator for the purpose of
13 8 determining its savings offset payment under this
13 9 subsection. The board may verify each health
13 10 insurance carrier's, employee benefit excess insurance
13 11 carrier's, and third-party administrator's savings
13 12 offset payment based on annual statements and other
13 13 reports determined to be necessary by the board.
13 14 5. The commissioner of insurance may suspend or
13 15 revoke, after notice and hearing, the certificate of
13 16 authority to transact insurance in this state of any
13 17 health insurance carrier or the license of any third-
13 18 party administrator to operate in this state that
13 19 fails to pay a savings offset payment. In addition,
13 20 the commissioner may assess civil penalties against
13 21 any health insurance carrier, employee benefit excess
13 22 insurance carrier, or third-party administrator that
13 23 fails to pay a savings offset payment or may take any
13 24 other enforcement action authorized to collect any
13 25 unpaid savings offset payments.
13 26 6. On an annual basis no later than April 30 of
13 27 each year, the board shall prospectively determine the
13 28 savings offset to be applied during each twelve-month
13 29 period. Annual offset payments shall be reconciled to
13 30 determine whether unused payments may be returned to
13 31 health insurance carriers, employee benefit excess
13 32 insurance carriers, and third-party administrators
13 33 according to a formula developed by the board.
13 34 Savings offset payments shall be used solely to fund
13 35 the subsidies authorized by section 514M.9 and to
13 36 support the Iowa quality forum established in section
13 37 514M.13 and may not exceed savings from reductions in
13 38 growth of bad debt and charity care.
13 39 7. In accordance with the requirements of this
13 40 subsection, every health insurance carrier and health
13 41 care provider shall demonstrate that best efforts have

13 42 been made to ensure that a carrier has recovered
13 43 savings offset payments made pursuant to this section
13 44 through negotiated reimbursement rates that reflect
13 45 health care providers' reductions or stabilization in
13 46 the cost of bad debt and charity care as a result of
13 47 the operation of HIFA health insurance.

13 48 a. A health insurance carrier shall use best
13 49 efforts to ensure health insurance premiums reflect
13 50 any such recovery of savings offset payments as those
14 1 savings offset payments are reflected through incurred
14 2 claims experience.

14 3 b. During any negotiation with a health insurance
14 4 carrier relating to a health care provider's
14 5 reimbursement agreement with that carrier, a health
14 6 care provider shall provide data relating to any
14 7 reduction or avoidance of bad debt and charity care
14 8 costs to health care providers in this state as a
14 9 result of the operation of the HIFA health insurance
14 10 program.

14 11 8. The following reports are required in
14 12 accordance with this subsection:

14 13 a. On a quarterly basis, beginning with the first
14 14 quarter after the HIFA health insurance program begins
14 15 offering coverage, the board shall collect and report
14 16 on the following:

14 17 (1) The total enrollment in the HIFA health
14 18 insurance program, including the number of enrollees
14 19 previously underinsured or uninsured, the number of
14 20 enrollees previously insured, the number of individual
14 21 enrollees, the number of enrollees enrolled through
14 22 small employers, the number of enrollees enrolled
14 23 through the state of Iowa, and the number of enrollees
14 24 enrolled through local governments.

14 25 (2) The total number of enrollees covered in
14 26 health plans through large employers and self-insured
14 27 employers.

14 28 (3) The number of employers, both small employers
14 29 and large employers, who have ceased offering health
14 30 insurance or contributing to the cost of health
14 31 insurance for employees or who have begun offering
14 32 coverage on a self-insured basis.

14 33 (4) The number of employers, both small employers
14 34 and large employers, who have begun to offer health
14 35 insurance or contribute to the cost of health
14 36 insurance premiums for their employees.

14 37 (5) The number of new participating employers in
14 38 the HIFA health insurance program.

14 39 (6) The number of employers ceasing to offer
14 40 coverage through the HIFA health insurance program.

14 41 (7) The duration of employers' participation in
14 42 the HIFA health insurance program.

14 43 (8) A comparison of actual enrollees in the HIFA
14 44 health insurance program to the projected enrollees.

14 45 b. The board shall establish the total health care
14 46 spending in the state for the base year beginning July
14 47 1, 2003, and shall annually determine, in
14 48 collaboration with the commissioner of insurance,
14 49 appropriate actuarially supported trend factors that
14 50 reflect savings consistent with subsection 1 and
15 1 compare rates of spending growth to the base year of
15 2 2003. The board shall collect on an annual basis, in
15 3 consultation with the commissioner, information about
15 4 the total cost to the state's health care providers of
15 5 bad debt and charity care beginning with the base year
15 6 of 2003. This information may be compiled through
15 7 mechanisms including, but not limited to, standard
15 8 reporting or statistically accurate surveys of
15 9 providers and practitioners. The board shall utilize
15 10 existing data on file with state agencies or other
15 11 organizations to minimize duplication. The
15 12 comparisons to the base year shall be reported
15 13 beginning April 30, 2005, and annually thereafter.

15 14 c. Health insurance carriers and health care
15 15 providers shall report annually, beginning July 1,
15 16 2006, and each July 1 thereafter, information
15 17 regarding the experience of the prior twelve-month
15 18 period on the efforts undertaken by the carrier and
15 19 provider to recover savings offset payments, as
15 20 reflected in reimbursement rates, through a reduction
15 21 or stabilization in bad debt and charity care costs as
15 22 a result of the operation of the HIFA health insurance

15 23 program. The board shall determine the appropriate
15 24 format for the report and utilize existing data on
15 25 file with state agencies or other organizations to
15 26 minimize duplication. The report shall be submitted
15 27 to the board. Using the information submitted by
15 28 carriers and providers, the board shall submit a
15 29 summary of that information by October 1, 2006, and
15 30 annually thereafter to the commissioner of insurance,
15 31 the governor, and the general assembly.

15 32 9. The claims experience used to determine any
15 33 filed premiums or rating formula shall reasonably
15 34 reflect, in accordance with accepted actuarial
15 35 standards, known changes and offsets in payments by
15 36 the carrier to health care providers in this state,
15 37 including any reduction or avoidance of bad debt and
15 38 charity care costs to health care providers in this
15 39 state as a result of the operation of the HIFA health
15 40 insurance program.

15 41 Sec. 12. NEW SECTION. 514M.12 HIFA PROGRAM FUND.

15 42 1. A HIFA program fund is created in the state
15 43 treasury under the authority of the department for
15 44 deposit of any funds for initial operating expenses,
15 45 payments made by employers and individuals, any
15 46 savings offset payments made pursuant to section
15 47 514M.11, and any funds received from any public or
15 48 private source.

15 49 2. Moneys deposited in the fund shall be used only
15 50 for the purposes of the HIFA program as specified in
16 1 this chapter.

16 2 3. The fund shall be separate from the general
16 3 fund of the state and shall not be considered part of
16 4 the general fund of the state. The moneys in the fund
16 5 shall not be considered revenue of the state, but
16 6 rather shall be funds of the HIFA program. The moneys
16 7 deposited in the fund are not subject to section 8.33
16 8 and shall not be transferred, used, obligated,
16 9 appropriated, or otherwise encumbered, except to
16 10 provide for the purposes of this chapter.

16 11 Notwithstanding section 12C.7, subsection 2, interest
16 12 or earnings on moneys deposited in the fund shall be
16 13 credited to the fund.

16 14 4. The department shall adopt rules pursuant to
16 15 chapter 17A to administer the fund.

16 16 5. The treasurer of state shall provide a
16 17 quarterly report of fund activities and balances to
16 18 the board.

16 19 Sec. 13. NEW SECTION. 514M.13 IOWA QUALITY
16 20 FORUM.

16 21 1. The Iowa quality forum is established within
16 22 the HIFA program. The forum shall be governed by the
16 23 HIFA program board with advice from the Iowa quality
16 24 forum advisory council pursuant to section 514M.14.
16 25 The forum shall be funded, at least in part, through
16 26 the savings offset payments made pursuant to section
16 27 514M.11.

16 28 2. The forum shall do all of the following:

16 29 a. Collect and disseminate research regarding
16 30 health care quality, evidence-based medicine, and
16 31 patient safety to promote best practices.

16 32 b. Adopt a set of measures to evaluate and compare
16 33 health care quality and provider performance. The
16 34 measures must be adopted with guidance from the
16 35 advisory council pursuant to section 514M.14.

16 36 c. Coordinate the collection of health care
16 37 quality data in the state. The forum shall work with
16 38 entities that collect health care data to minimize
16 39 duplication and to minimize the burden on providers of
16 40 data.

16 41 d. Provide oversight for a retrospective drug
16 42 utilization review and quality assessment program.

16 43 e. Work collaboratively with health care
16 44 providers, health insurance carriers, and others to
16 45 report in useable formats, comparative health care
16 46 quality information to consumers, purchasers,
16 47 providers, insurers, and policymakers. The forum
16 48 shall produce annual quality reports.

16 49 f. Conduct education campaigns to help health care
16 50 consumers make informed decisions and engage in
17 1 healthy lifestyles.

17 2 g. Adopt plans to provide medication therapy
17 3 management by pharmacy providers targeted to

17 4 individuals who have multiple chronic conditions, use
17 5 multiple prescriptions, and are likely to incur high
17 6 drug expenses in order to ensure appropriate use of
17 7 prescription drugs to improve therapeutic outcomes and
17 8 reduce adverse drug reactions.

17 9 h. Encourage the adoption of electronic technology
17 10 and assist health care practitioners to implement
17 11 electronic systems for medical records and submission
17 12 of claims. The assistance may include, but is not
17 13 limited to, practitioner education, identification, or
17 14 establishment of low-interest financing options for
17 15 hardware and software and system implementation
17 16 support.

17 17 i. Make recommendations for inclusion in the state
17 18 health plan developed pursuant to section 514M.16.

17 19 j. Submit an annual report to the governor and the
17 20 general assembly and make the report available to the
17 21 public.

17 22 Sec. 14. NEW SECTION. 514M.14 IOWA QUALITY FORUM
17 23 ADVISORY COUNCIL.

17 24 1. An Iowa quality forum advisory council is
17 25 established to advise the forum. The council shall
17 26 consist of all of the following voting members,
17 27 appointed by the governor, subject to confirmation by
17 28 the senate:

17 29 a. One member who is a physician.
17 30 b. One member who is a health care economist.
17 31 c. One member who is a pharmacist.
17 32 d. One member who represents hospitals.
17 33 e. One member who is a representative of the
17 34 university of Iowa college of public health.
17 35 f. One member who is a representative of a private
17 36 employer with not more than fifty employees.
17 37 g. One member who is a representative of a private
17 38 employer with more than one thousand employees.
17 39 h. One member who is a representative of organized
17 40 labor.
17 41 i. One member who is a representative of a
17 42 consumer health advocacy group.
17 43 j. The director of public health, or the
17 44 director's designee.

17 45 2. The commissioner of insurance shall serve as an
17 46 ex officio nonvoting member of the advisory council.

17 47 3. All members of the advisory council with the
17 48 exception of the director of public health and the
17 49 commissioner of insurance are subject to the
17 50 following:

18 1 a. Shall serve five-year staggered terms as
18 2 designated by the governor.
18 3 b. Shall be subject to chapter 69 with regard to
18 4 the filling of vacancies, membership terms, payment of
18 5 compensation and expenses, and removal.
18 6 c. Are entitled to receive reimbursement of actual
18 7 expenses incurred in the discharge of their duties and
18 8 are also eligible to receive compensation as provided
18 9 in section 7E.6.
18 10 d. Shall not serve more than two consecutive
18 11 terms.

18 12 4. The advisory council shall annually choose one
18 13 of its voting members to serve as chairperson for a
18 14 one-year term.

18 15 5. The advisory council shall meet at least four
18 16 times annually and may meet at other times at the call
18 17 of the chairperson. Meetings of the council are
18 18 public proceedings.

18 19 6. The advisory council shall do all of the
18 20 following:

18 21 a. Convene a group of health care providers to
18 22 provide input and advice to the council.
18 23 b. Provide expertise in health care quality to
18 24 assist the board.
18 25 c. Advise and support the forum by doing all of
18 26 the following:

18 27 (1) Establishing and monitoring, with the HIFA
18 28 program, an annual work plan for the forum.
18 29 (2) Providing guidance in the adoption of quality
18 30 and performance measures.
18 31 (3) Serving as a liaison between the provider
18 32 group established in paragraph "a" and the forum.
18 33 (4) Conducting public hearings and meetings.
18 34 (5) Reviewing consumer education materials

18 35 developed by the forum.
18 36 d. Assist the board in selecting the nationally
18 37 recognized functional health assessment.
18 38 e. Make recommendations regarding quality
18 39 assurance and quality improvement priorities for
18 40 inclusion in the state health plan described in
18 41 section 514M.16.
18 42 f. Serve as a liaison between the forum and other
18 43 organizations working in the field of health care
18 44 quality.

18 45 Sec. 15. NEW SECTION. 514M.15 HIFA HIGH=RISK
18 46 POOL.
18 47 1. A plan enrollee shall be included in the HIFA
18 48 high=risk pool if the total cost of health care
18 49 services for the enrollee exceeds fifty thousand
18 50 dollars in any twelve=month period.
19 1 2. The HIFA program shall develop appropriate
19 2 patient care management protocols, develop procedures
19 3 for implementing those protocols, and determine the
19 4 manner in which patient care management shall be
19 5 provided to plan enrollees in the HIFA high=risk pool.
19 6 Patient care management shall be provided by
19 7 appropriate individual health care professionals under
19 8 the HIFA program. The HIFA program shall include
19 9 patient care management in its contract with
19 10 participating health insurance carriers for HIFA high=
19 11 risk pool enrollees pursuant to this section, contract
19 12 separately with another entity for patient care
19 13 management services, or provide patient care
19 14 management services directly through the HIFA program.
19 15 3. The HIFA program shall submit a report to the
19 16 governor and the general assembly, no later than
19 17 January 1, 2006, outlining the patient care management
19 18 protocols, procedures, and delivery mechanisms used to
19 19 provide patient care management services to HIFA high=
19 20 risk pool enrollees and the assessment tool used to
19 21 measure individual patient care management activities.
19 22 The report shall also include the number of plan
19 23 enrollees in the high=risk pool, the types of
19 24 diagnoses managed within the high=risk pool, the
19 25 claims experience within the high=risk pool, and the
19 26 number and type of claims exceeding fifty thousand
19 27 dollars for enrollees in the high=risk pool and for
19 28 all enrollees in the HIFA health insurance program.
19 29 4. On or before October 1, 2008, the HIFA program
19 30 shall evaluate the impact of HIFA health insurance on
19 31 average health insurance premium rates in this state
19 32 and on the rate of uninsured individuals in this state
19 33 and compare the trends in those rates to the trends in
19 34 the average premium rates and average rates of
19 35 uninsured individuals for the states that have
19 36 established a statewide high=risk pool as of July 1,
19 37 2004. The board shall submit the evaluation of the
19 38 impact of HIFA health insurance in this state in
19 39 comparison to states with high=risk pools to the
19 40 governor and the general assembly by January 1, 2009.
19 41 If the trend in average premium rates in this state
19 42 and rate of uninsured individuals exceeds the trend
19 43 for the average among the states with high=risk pools,
19 44 the board shall submit legislation on January 1, 2009,
19 45 that proposes to establish a statewide high=risk pool
19 46 in this state consistent with the characteristics of
19 47 high=risk pools operating in other states.

19 48 Sec. 16. NEW SECTION. 514M.16 STATE HEALTH
19 49 PLANNING.
19 50 1. The governor or the governor's designee shall
20 1 do all of the following:
20 2 a. Develop and issue a biennial state health plan.
20 3 The first plan shall be issued by May 2005.
20 4 b. Make an annual report to the public assessing
20 5 the progress toward meeting goals of the plan and
20 6 provide any updates, as necessary, to the plan.
20 7 c. Issue an annual statewide health expenditure
20 8 budget report that shall serve as the basis for
20 9 establishing priorities within the plan.
20 10 2. a. The state health plan issued pursuant to
20 11 subsection 1 shall establish a comprehensive,
20 12 coordinated approach to the development of health care
20 13 facilities and resources in the state based on
20 14 statewide cost, quality, and access goals and
20 15 strategies to ensure access to affordable health care,

20 16 maintain a rational system of health care, and promote
20 17 the development of the health care workforce.
20 18 b. In developing the plan, the governor shall, at
20 19 a minimum, seek input from the Iowa quality forum, the
20 20 Iowa quality forum advisory council, and other
20 21 appropriate agencies and organizations.
20 22 3. The plan shall do all of the following:
20 23 a. Assess health care cost, quality, and access in
20 24 the state.
20 25 b. Develop benchmarks to measure cost, quality,
20 26 and access goals and report on progress toward meeting
20 27 those goals.
20 28 c. Establish and set annual priorities among
20 29 health care cost, quality, and access goals.
20 30 d. Outline strategies to do all of the following:
20 31 (1) Promote health systems change.
20 32 (2) Address the factors influencing health care
20 33 cost increases.
20 34 (3) Address the major threats to public health and
20 35 safety in the state, including, but not limited to,
20 36 lung disease, diabetes, cancer, and heart disease.
20 37 e. Provide recommendations to help purchasers and
20 38 providers make decisions that improve public health
20 39 and build an affordable, high-quality health care
20 40 system.

20 41 Sec. 17. NEW SECTION. 514M.17 RULES.

20 42 The commissioner of insurance shall adopt rules,
20 43 pursuant to chapter 17A, as necessary to administer
20 44 this chapter.

20 45 Sec. 18. IMPLEMENTATION COSTS. The Iowa
20 46 department of public health shall work with the
20 47 commissioner of insurance to seek funding through the
20 48 federal government, a private foundation, or other
20 49 appropriate source to defray the initial costs to
20 50 implement the provisions of this Act relating to the
21 1 healthy Iowa for all program, including but not
21 2 limited to the initial subsidy provisions.>

21 3 #2. Title page, line 1, by inserting after the

1
21 4 word the following: 21 5 climate by providing for access to health care
21 6 coverage and providing for>.

21 7
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21 10 OSTERHAUS of Jackson

21 11 HF 2470.501 80

21 12 pf/pj