House Amendment to
Senate File 296

S-3210

Amend Senate File 296, as amended, passed, and reprinted by the Senate, as follows:

1. By striking everything after the enacting clause and inserting:

<DIVISION I
HEALTHY IOWA PLAN

Section 1. NEW SECTION. **249N.1 Title.**

This chapter shall be known and may be cited as the *"Healthy Iowa Plan"*.

Sec. 2. NEW SECTION. **249N.2 Definitions.**

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

1. *"Accountable care organization"* means a risk-bearing, integrated health care organization characterized by a payment and care delivery model that ties provider reimbursement to quality metrics and reductions in the total cost of care for an attributed population of patients.

2. *"Affordable Care Act"* or *"federal Act"* means the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148 as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

3. *"Clean claim"* means a claim submitted by a healthy Iowa plan provider that may be adjudicated as paid or denied.

4. *"Covered benefits"* means reimbursable health care services as specified in section 249N.6.

5. *"Department"* means the department of human services.

6. *"Director"* means the director of human services.

7. *"Essential health benefits"* means essential health benefits as defined in section 1302 of the Affordable Care Act, that include at least the general categories and the items and services covered within the categories of ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

8. *"Federal approval"* means approval by the centers for Medicare and Medicaid services of the United States department of health and human services.

9. *"Federal poverty level"* means the most recently revised poverty income guidelines published by the United States department of health and human services.

10. *"Full benefits recipient"* means an adult who is

eligible for full medical assistance benefits pursuant to chapter 249A under any category of eligibility.

11. *"Healthy Iowa plan"* or *"plan"* means the healthy Iowa plan established under this chapter.

12. *"Healthy Iowa plan provider"* means any provider enrolled in the medical assistance program or any participating accountable care organization.

13. *"Healthy Iowa plan provider network"* means the health care delivery network approved by the department for healthy Iowa plan members.

14. *"Medical assistance program"* or *"Medicaid"* means the program paying all or part of the costs of care and services provided to an individual pursuant to chapter 249A and Tit. XIX of the federal Social Security Act.

15. *"Medicare"* means the federal Medicare program established pursuant to Tit. XVIII of the federal Social Security Act.

16. *"Member"* means an individual who meets the eligibility requirements of section 249N.5 and is enrolled in the healthy Iowa plan.

17. *"My health rewards account"* means an account established by the department pursuant to section 249N.9 on behalf of a member to contain contributions from the member, financial incentives earned by the member, and other payments made by the plan, to be used by the member for payment of required contributions, cost-sharing, and health improvements.

18. *"Participating accountable care organization"* means an accountable care organization approved by the department to participate in the healthy Iowa plan provider network.

19. *"Preventive care services"* means care that is provided to an individual to promote health, prevent disease, or diagnose disease.

20. *"Primary medical provider"* means the primary care provider chosen by a member or to whom a member is assigned to provide and manage the member's primary care and to provide referrals, as necessary and required by the healthy Iowa plan, to other healthy Iowa plan providers.

21. *"Value-based reimbursement"* means a payment methodology that links provider reimbursement to improved performance by health care providers by holding health care providers accountable for both the cost and quality of care provided.

Sec. 3. NEW SECTION. **249N.3 Purpose — establishment of healthy Iowa plan.**

1. The purpose of this chapter is to establish and administer a healthy Iowa plan to promote increased access to health care, quality health care outcomes,

and the use of personal responsibility mechanisms that encourage individuals with incomes at or below one hundred percent of the federal poverty level to be cost-conscious consumers of health care and to exhibit healthy behaviors.

2. The healthy Iowa plan is established within the medical assistance program and shall be administered by the department. Except as otherwise specified in this chapter, the rules applicable to the medical assistance program pursuant to chapter 249A shall be applicable to the healthy Iowa plan.

3. The department may contract with a third-party administrator to provide eligibility determination support, and to administer enrollment, member outreach, my health rewards account services, and other components of the healthy Iowa plan.

Sec. 4. NEW SECTION. **249N.4 Federal financial participation — limitations of program.**

1. This chapter shall be implemented only to the extent that federal matching funds are available for nonfederal expenditures under this chapter. Except as otherwise provided in section 249N.11, the department shall not expend funds under this chapter, including but not limited to expenditures for reimbursement of providers and program administration, if appropriated nonfederal funds are not matched by federal financial participation.

2. Enrollment in the healthy Iowa plan may be limited, closed, or reduced and the scope and duration of services provided under the healthy Iowa plan may be limited, reduced, or terminated if the department determines that federal financial participation or appropriated nonfederal funds will not be available to pay for existing or additional enrollment costs.

3. The provisions of this chapter shall not be construed, are not intended as, and shall not imply a grant of entitlement to services for individuals who are eligible for covered benefits under this chapter or for utilization of services that do not exist or are not otherwise available under this chapter. Any state obligation to provide covered benefits pursuant to this chapter is limited to the extent of the funds appropriated or distributed for the purposes of this chapter.

4. The provisions of this chapter shall not be construed and are not intended to affect the provision of services to medical assistance program recipients existing on January 1, 2014.

Sec. 5. NEW SECTION. **249N.5 Healthy Iowa plan — eligibility.**

1. Except as otherwise provided in this chapter, an individual nineteen through sixty-four years of age shall be eligible for covered benefits specified in this chapter when provided through the healthy Iowa plan provider network as described in this chapter, if the individual meets all of the following conditions:

a. The individual meets the citizenship or alienage requirements of the medical assistance program, is a resident of Iowa, and provides a social security number upon application for the plan.

b. The individual has household income at or below one hundred percent of the federal poverty level. Household income shall be determined using the modified adjusted gross income methodology pursuant to section 2002 of the Affordable Care Act.

c. The individual fulfills all other conditions of participation in the healthy Iowa plan, including member financial participation pursuant to section 249N.8.

2. The following individuals are not eligible for the healthy Iowa plan:

a. An individual eligible as a full benefits recipient under the medical assistance program.

b. An individual who is entitled to or enrolled for Medicare benefits under part A, or is enrolled for Medicare benefits under part B, of Tit. XVIII of the federal Social Security Act.

c. An individual who is pregnant and otherwise eligible for the medical assistance program pursuant to section 249A.3.

d. An individual who has access to affordable employer-sponsored health care coverage, as defined by rule of the department to align with rules adopted by the federal internal revenue service under the federal Affordable Care Act.

3. *a.* Each applicant for the healthy Iowa plan shall provide to the department all insurance information required by the health insurance premium payment program in accordance with rules adopted by the department.

b. The department may elect to pay the cost of premiums for applicants with access to employer-sponsored health care coverage if the department determines such payment to be cost-effective.

c. Eligibility for the healthy Iowa plan is a qualifying event under the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

d. If premium payment is provided under this

subsection for employer-sponsored health care coverage, the healthy Iowa plan shall supplement such coverage as necessary to provide the covered benefits specified under section 249N.6.

4. The department shall implement the healthy Iowa plan in a manner that ensures that the healthy Iowa plan is the payor of last resort.

5. A member is eligible for coverage effective the first day of the month following the month of application for enrollment.

6. Following initial enrollment, a member is eligible for covered benefits for twelve months, subject to program termination and other limitations otherwise specified in this chapter. The department shall review the member's eligibility on at least an annual basis.

Sec. 6. NEW SECTION. **249N.6 Healthy Iowa plan — covered benefits.**

Members shall receive coverage for benefits pursuant to 42 U.S.C. § 1396u-7(b)(1)(B), adjusted as necessary to provide the essential health benefits required pursuant to section 1302 of the federal Act, and including habilitation services consistent with the state medical assistance program section 1915I waiver.

Sec. 7. NEW SECTION. **249N.7 Healthy Iowa plan provider network.**

1. The department shall develop a regionalized healthy Iowa plan provider network statewide.

2. The healthy Iowa plan provider network shall include all providers enrolled in the medical assistance program and participating accountable care organizations. Reimbursement under this chapter shall only be made to such healthy Iowa plan providers for covered benefits.

3. *a.* Upon enrollment, a member shall choose a primary medical provider within the healthy Iowa plan provider network.

b. If the member does not choose a primary medical provider, the department shall assign the member to a primary medical provider in accordance with the mandatory enrollment provisions specified in rules adopted by the department pursuant to chapter 249A and in accordance with quality data available to the department.

c. The department shall develop a mechanism for primary medical providers and participating accountable care organizations within a region to jointly facilitate member care coordination.

4. *a.* The healthy Iowa plan provider network shall include at least one participating accountable care

organization per region with which the department shall contract to ensure the coordination and management of the health of the members within the region, to produce improved health care quality, and to control overall cost. The department shall contract with the acute care teaching hospital located in a county with a population over three hundred fifty thousand to act as a participating accountable care organization within the region specified by the department.

b. The department shall establish the qualifications, contracting processes, and contract terms for a participating accountable care organization. The department shall also establish a methodology for attribution of a specified member population to the participating accountable care organization.

c. A participating accountable care organization contract shall establish accountability based on quality performance and total cost of care metrics for the attributed population. The metrics shall include but are not limited to risk sharing, including both shared savings and shared costs, between the state and the participating accountable care organization.

d. The department shall ensure that payments made to participating accountable care organizations do not exceed available funds in the healthy Iowa account created in section 249N.11.

e. The participating accountable care organization shall provide access by members to primary medical providers within thirty miles or thirty minutes of a member's residence, unless such access is technically infeasible.

5. To the extent possible, members shall have a choice of providers within the healthy Iowa plan provider network, subject to the results of attribution under this section and subject to all of the following:

a. Member choice may be limited by the participating accountable care organization, with prior approval of the department, if the member's health condition would benefit from limiting the member's choice of a healthy Iowa plan provider to ensure coordination of services, or due to overutilization of covered benefits. The participating accountable care organization shall provide thirty days' notice to the member prior to limitation of such choice.

b. The department may require that access to services not provided through the participating accountable care organization be subject to prior authorization by the participating accountable care organization, if such prior authorization is projected

to improve health care delivery in the region.

6. *a.* A healthy Iowa plan provider shall submit clean claims within twenty days of the date of provision of a covered benefit to a member.

b. A healthy Iowa plan provider shall be reimbursed for covered benefits under the healthy Iowa plan utilizing the same reimbursement methodology as that applicable to individuals eligible for medical assistance under section 249A.3, subsection 1.

c. Notwithstanding paragraph "*b*", a participating accountable care organization under contract with the department shall be reimbursed utilizing a value-based reimbursement methodology.

7. *a.* Healthy Iowa plan providers shall exchange member health information as provided by rule to facilitate coordination and management of care, improved health outcomes, and reduction in costs.

b. The department shall provide the health care claims data of attributed members to a member's participating accountable care organization on a timeframe established by rule of the department.

Sec. 8. NEW SECTION. **249N.8 Member financial participation.**

1. Membership in the healthy Iowa plan shall require payment of a monthly contribution and cost-sharing amounts, annually, that align with the cost-sharing limitations requirements for American health benefit exchanges under the Affordable Care Act. Copayments under the healthy Iowa plan shall be applicable only to nonemergency use of a hospital emergency department. Contribution and cost-sharing amounts, including an annual deductible, shall be established by rule of the department.

2. *a.* Even though a member is eligible for coverage effective the first day of the month following the month of application for enrollment, claims for covered benefits shall not be paid until the initial monthly contribution payment is made by the member. If the initial monthly contribution payment is made within sixty days of the eligibility date, claims for covered benefits are payable from the effective date of eligibility.

b. Timely payment of monthly contributions, within sixty days of the date the payment is due, is a condition of membership. A member who does not make such timely payment is subject to disenrollment from the plan, following notice from the department. Following such disenrollment, an individual is not eligible for reapplication for membership in the plan for twelve months from the date of disenrollment.

c. A member may request a hardship exemption if a hardship would accrue from imposing payment of the monthly contribution. Information regarding the contribution obligation and the hardship exemption, including the process by which a prospective member may apply for the hardship exemption, shall be provided to a prospective member at the time of application for enrollment.

3. Any required member contributions or cost-sharing that are unpaid are a debt owed the state.

Sec. 9. NEW SECTION. **249N.9 My health rewards accounts.**

1. The department shall establish a my health rewards account for each healthy Iowa plan member.

2. The plan shall deposit all of the following in a member's health rewards account:

a. All member contributions collected under section 249N.8.

b. Financial incentive payments paid by the plan, annually, for the member's completion of a health risk assessment, completion of an annual physical, receipt of preventive services specified by the plan, or the entering into by a member of a health responsibility and self-sufficiency agreement, as specified by rule of the department.

c. A payment paid by the plan upon initial enrollment and annually thereafter, of an amount that is the difference between the sum of the required contributions made by the member plus the financial incentive amounts paid by the plan, and the total annual deductible for the member as established by rule.

3. The moneys in a member's account shall only be distributed from the account and used to improve the health of the member as specified by rule based on best practices. Such uses may include but are not limited to payment for smoking cessation services or nutrition counseling, or payment of required contributions or cost-sharing amounts, exclusive of copayments for nonemergency use of a hospital emergency department. A member's deductible amount under the plan shall be debited against the member's account annually.

4. If a member demonstrates an established pattern of failure to pay required contribution or cost-sharing amounts, or a pattern of inappropriate use of emergency department or covered benefits, the member may be subject to forfeiture of the funds in the account, following notice from the department.

5. Any funds remaining in a member's my health rewards account annually at the end of a twelve-month

enrollment period are subject to the following:

a. If the member renews enrollment, the funds shall remain in the account to be used to defray the costs of the member's contributions and cost-sharing requirements in the subsequent enrollment period. However, if the member did not complete the preventive care services specified by the plan during the prior enrollment period, any portion of the remaining amount paid by the plan shall not be used to defray the costs of the member's contributions or cost-sharing requirements in the subsequent enrollment period.

b. If an individual is no longer eligible for the plan, does not reenroll in the plan, or is terminated from the plan for nonpayment of required contributions or cost-sharing amounts, the plan shall refund a prorated amount of the member's contributions as determined by rule of the department, less any outstanding contributions or cost-sharing owed by the member, to the individual within sixty days of such occurrence. Any portion of the remaining amount in the account paid by the plan shall revert to the healthy Iowa account.

Sec. 10. NEW SECTION. **249N.10 Funding — county and county hospital contributions — certified public expenditures.**

1. Notwithstanding any provision to the contrary relating to the taxes levied by a county pursuant to section 331.424A for which the collection is performed after January 1, 2014, the county treasurer of each county shall distribute thirty-seven and eighty-four hundredths percent of the maximum amount authorized to be levied and collected pursuant to section 331.424A, to the treasurer of state for deposit in the healthy Iowa account created in section 249N.11. One-half of the total amount specified under this subsection shall be distributed by each county treasurer to the treasurer of state by October 15, and one-half of the total amount shall be distributed to the treasurer of state by April 15, annually.

2. Notwithstanding any provision to the contrary, for the collection of taxes levied under section 347.7, for which the collection is performed after January 1, 2014, the county treasurer of a county with a population over three hundred fifty thousand in which a publicly owned acute care teaching hospital is located shall distribute the proceeds collected pursuant to section 347.7, in a total amount of forty-two million dollars annually, which would otherwise be distributed to the county hospital, to the treasurer of state for deposit in the healthy Iowa account created in section

249N.11 as follows:

a. The first nineteen million dollars in collections pursuant to section 347.7, between July 1 and December 31 annually, shall be distributed to the treasurer of state for deposit in the healthy Iowa account and collections during this time period in excess of nineteen million dollars shall be distributed to the acute care teaching hospital identified in this subsection. In addition, of the collections during this time period in excess of nineteen million dollars received by the acute care teaching hospital, two million dollars shall be distributed by the acute care teaching hospital to the treasurer of state for deposit in the healthy Iowa account in the month of January following the July 1 through December 31 period.

b. The first nineteen million dollars in collections pursuant to section 347.7, between January 1 and June 30 annually, shall be distributed to the treasurer of state for deposit in the healthy Iowa account and collections during this time period in excess of nineteen million dollars shall be distributed to the acute care teaching hospital identified in this subsection. In addition, of the collections during this time period in excess of nineteen million dollars received by the acute care teaching hospital, two million dollars shall be distributed by the acute care teaching hospital to the treasurer of state for deposit in the healthy Iowa account in the month of July following the January 1 through June 30 period.

3. In addition to the funding specified in this section, the university of Iowa hospitals and clinics shall certify public expenditures in an amount equal to provide the nonfederal share of total expenditures not to exceed thirty million dollars annually.

4. The distribution of county hospital funds to the treasurer of state required under this section shall not be the basis for an increase in the amount levied and a county hospital shall not thereby increase the amount levied pursuant to section 347.7.

Sec. 11. NEW SECTION. **249N.11 Healthy Iowa account.**

1. A healthy Iowa account is created in the state treasury under the authority of the department. Moneys appropriated from the general fund of the state to the account, proceeds distributed from county treasurers as specified in section 249N.10, and moneys from any other source credited to the account shall be deposited in the account. Moneys deposited in or credited to the account are appropriated to the department of human services to be used for the purposes of the healthy

Iowa plan including administration of the plan and to provide nonfederal matching funds for the healthy Iowa plan, as specified in this chapter. An amount shall be appropriated from the account to the county with a population over three hundred fifty thousand in which a publicly owned acute care teaching hospital is located, annually, to offset any difference between the amount of proceeds required to be distributed by the county treasurer to the account and the actual amount received by the hospital in reimbursements through the healthy Iowa plan in the preceding fiscal year.

2. The account shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys in the account shall not be considered revenue of the state, but rather shall be funds of the account. The moneys in the account are not subject to section 8.33 and shall not be transferred, used, obligated, appropriated, or otherwise encumbered, except to provide for the purposes of this chapter. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the account shall be credited to the account.

3. The department shall adopt rules pursuant to chapter 17A to administer the account.

Sec. 12. NEW SECTION. **249N.12 Adoption of rules — sole-source administration — reports.**

1. The department shall adopt rules pursuant to chapter 17A as necessary to administer this chapter. The department may adopt emergency rules under section 17A.4, subsection 3, and section 17A.5, subsection 2, paragraph *"b"*, as necessary for the administration of this chapter and the rules shall become effective immediately upon filing or on a later effective date specified in the rules, unless the effective date is delayed by the administrative rules review committee. Any rules adopted in accordance with this section shall not take effect before the rules are reviewed by the administrative rules review committee. The delay authority provided to the administrative rules review committee under section 17A.4, subsection 7, and section 17A.8, subsection 9, shall be applicable to a delay imposed under this section, notwithstanding a provision in those sections making them inapplicable to section 17A.5, subsection 2, paragraph *"b"*. Any rules adopted in accordance with the provisions of this section shall also be published as notice of intended action as provided in section 17A.4.

2. Notwithstanding section 8.47 or any other provision of law to the contrary, the department may

utilize a sole-source approach to administer this chapter.

3. The department shall submit all of the following to the governor and the generally assembly:

a. Biennially, a report of the results of a review, by county and region, of mental health services previously funded through taxes levied by counties pursuant to section 331.424A, that are funded during the reporting period under the healthy Iowa plan.

b. Annually, a report of the results of a review of the outcomes and effectiveness of mental health services provided under the healthy Iowa plan.

c. Annually, an analysis of whether the amount distributed by each county to the treasurer of state pursuant to section 249N.10, subsection 1, is commensurate with the cost of mental health services being provided under the healthy Iowa plan.

Sec. 13. Section 249J.26, subsection 2, Code 2013, is amended to read as follows:

2. This chapter is repealed ~~October~~ December 31, 2013.

Sec. 14. HEALTHY IOWA ACCOUNT —— APPROPRIATION FROM GENERAL FUND —— FY 2013-2014. There is appropriated from the general fund of the state to the department of human services for the fiscal year beginning July 1, 2013, and ending June 30, 2014, the following amount or so much thereof as is necessary for the purposes designated:

For deposit in the healthy Iowa account created in section 249N.11, as enacted in this division of this Act, to be used for the purposes of the account:

..... $ 23,000,000

Sec. 15. MEDICAL ASSISTANCE APPROPRIATION —— TRANSFER TO THE HEALTHY IOWA ACCOUNT —— FY 2013-2014. Of the funds appropriated to the department of human services from the general fund of the state for the fiscal year beginning July 1, 2013, and ending June 30, 2014, for the medical assistance program, $35,500,000 is transferred to the healthy Iowa account created in section 249N.11, as enacted in this division of this Act, for the purposes of the account.

Sec. 16. DIRECTIVE TO DEPARTMENT OF HUMAN SERVICES. Upon enactment of this division of this Act, the department of human services shall request federal approval of a medical assistance section 1115 demonstration waiver to implement this division of this Act effective January 1, 2014.

Sec. 17. EFFECTIVE UPON ENACTMENT AND CONTINGENT IMPLEMENTATION.

1. This division of this Act, being deemed of

immediate importance, takes effect upon enactment. However, the department of human services shall implement this division of this Act effective January 1, 2014, contingent and only upon receipt of federal approval of the waiver request submitted under this division of this Act.

2. Notwithstanding subsection 1, if any portion of the waiver is denied or if federal approval or financial participation relative to any portion of the waiver is denied, the department shall only implement this division of this Act in accordance with both of the following:

a. To the extent that federal approval is received and federal financial participation is available.

b. To the extent federal approval is not required and federal participation is not applicable.

3. The distributions of taxes levied pursuant to section 331.424A and distributed by each county treasurer to the treasurer of state pursuant to section 249N.10 and the distribution of taxes levied pursuant to section 347.7 and distributed by the county treasurer of a county with a population over three hundred fifty thousand in which a publicly owned acute care teaching hospital is located to the treasurer of state pursuant to section 249N.10, shall not be distributed until the department of human services has received federal approval of the waiver request submitted under this division of this Act.

DIVISION II

MEDICAL MALPRACTICE ACTIONS

Sec. 18. Section 147.139, Code 2013, is amended to read as follows:

147.139 Expert witness testimony —— standards.

1. If the standard of care given by a physician and surgeon or an osteopathic physician and surgeon licensed pursuant to chapter 148, or a dentist licensed pursuant to chapter 153, is at issue, the court shall only allow a person to qualify as an expert witness and to testify on the issue of the appropriate standard of care ~~if the person's medical or dental qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case.~~, breach of the standard of care, or proximate cause of any damages or injury as a result of said breach if all of the following qualifications of the person are established:

a. The person is licensed to practice medicine, osteopathic medicine, or dentistry and in the five years preceding the allegedly negligent act, was engaged in the active practice of medicine, osteopathic

medicine, or dentistry, or was a qualified instructor at an accredited university of medicine and surgery, osteopathic medicine and surgery, or dentistry.

b. The person practices or provides university instruction in the same or substantially similar specialty as the defendant.

c. If the defendant is board-certified in a specialty, the person is also certified in that specialty by a board recognized by the American board of medical specialties or the American osteopathic association and is licensed and in good standing in each state of licensure, and has not had the person's license revoked or suspended in the past five years.

2. A person who is not licensed in this state who testifies pursuant to this section as an expert against a defendant, whether in contract or tort arising out of the provision of or failure to provide care, shall be deemed to hold a temporary license to practice in this state for the purpose of providing such testimony and shall be subject to the authority of the applicable licensing board in this state including but not limited to section 147.55.

Sec. 19. NEW SECTION. **147.140 Malpractice review panels.**

1. For the purpose of this section, "*health care provider*" means a physician and surgeon, osteopathic physician and surgeon, dentist, podiatric physician, optometrist, pharmacist, chiropractor, physician assistant, advanced registered nurse practitioner, or nurse licensed pursuant to this chapter, a facility certified as an ambulatory surgical center under the federal Medicare program, a hospital licensed pursuant to chapter 135B, or a health care facility licensed pursuant to chapter 135C.

2. *a.* Immediately after the filing of any action for personal injury or wrongful death against any health care provider based upon the alleged negligence of the licensee in the practice of that profession or occupation, or upon the alleged negligence of a facility certified as an ambulatory surgical center under the federal Medicare program, hospital, or health care facility in patient care and the answer thereto by all named defendants, the chief judge of the judicial district within which the action is filed shall select a person pursuant to subsection 4 to serve as chairperson of a malpractice review panel to review the validity of the action.

b. Upon the selection of the chairperson, all legal proceedings in the malpractice action shall be stayed until thirty days after the malpractice review panel

issues its findings under subsection 13.

3. *a.* The chairperson selected pursuant to subsection 2 shall serve as a nonvoting member of the malpractice review panel.

b. The chairperson shall select the members of the malpractice review panel pursuant to subsection 6.

4. *a.* All of the following persons shall be eligible to serve on a review panel:

(1) Retired judges, and senior judges and retired senior judges as defined in section 602.9202.

(2) Health care providers and attorneys recommended by their respective professions to serve on malpractice review panels pursuant to this section. As a condition of licensure as a health care provider or as an attorney in this state, a health care provider or attorney selected to serve on a malpractice review panel shall be required to serve if so selected.

(3) Residents of this state who are neither attorneys nor health care providers.

b. For purposes of selecting members of a malpractice review panel, the clerk of the supreme court shall maintain a list of persons identified in paragraph "*a*", subparagraphs (1) and (2). Persons identified in paragraph "*a*", subparagraph (3), shall be selected from a current jury pool.

5. *a.* The chairperson of the malpractice review panel shall be compensated. If the chairperson is receiving compensation for the chairperson's service on the review panel pursuant to section 602.1612, the chairperson shall not receive additional compensation for serving on the review panel.

b. A resident of this state who is neither an attorney nor a health care provider who is selected as a member of a review panel shall receive fifty dollars per day for participating in hearings and deliberations relating to service on the review panel.

c. All members of a review panel shall be reimbursed for travel expenses.

6. *a.* Within ten days of receipt of the notification of selection as chairperson of the malpractice review panel, the chairperson shall select the following persons to serve as members of the malpractice review panel for the particular malpractice action as follows:

(1) An attorney licensed to practice law in this state.

(2) A health care provider licensed in this state.

(3) A resident of this state who is neither an attorney nor a health care provider.

b. A person who is not referred to in paragraph "*a*"

may be selected to serve on the review panel if agreed to by all parties to the malpractice action.

7. *a.* Within thirty days of convening the malpractice review panel, a party to the proceedings shall produce to all other parties all medical and health care provider records within the possession or control of the party pertaining to the plaintiff regardless of whether the party believes such records are relevant to the proceedings.

b. The chairperson may permit reasonable discovery, and if so allowed, shall determine a timetable for any additional discovery prior to the hearing before the malpractice review panel. Depositions of persons other than the parties and experts designated by the parties shall not be taken except for good cause shown by the party requesting the deposition.

c. The chairperson shall have the power to issue subpoenas for both discovery and compulsion of testimony in the same manner and method as the district court.

d. The chairperson shall also determine a date by which the plaintiff must submit a certificate-of-merit affidavit as provided in subsection 8 for each defendant the plaintiff intends to call as a witness to testify with respect to the issues of the applicable standard of care, breach of the applicable standard of care, or causation.

8. *a.* A plaintiff shall submit a separate certificate-of-merit affidavit for each defendant named in the malpractice action. The affidavit submitted for each defendant must be signed by an expert. The affidavit must certify under the oath of the expert all of the following:

(1) The expert's statement of familiarity with the applicable standard of care.

(2) The expert's statement that the standard of care was breached by the health care provider named as the defendant.

(3) The expert's statement of the actions that the health care provider failed to take or should have taken to comply with the standard of care.

(4) The expert's statement of the manner by which the breach of the standard of care was the cause of the injury alleged in the petition.

b. A single expert need not certify all of the elements in paragraph "*a*" in regard to one particular defendant, however, each of the elements must be certified by an expert in regard to each defendant.

c. If a plaintiff fails to submit a certificate-of-merit affidavit within the time

period determined by the chairperson, the chairperson shall file a motion with the district court to dismiss the plaintiff's malpractice action with regard to the defendant for which the certificate-of-merit affidavit was not submitted. The district court shall then dismiss with prejudice the plaintiff's malpractice action against the defendant.

9. *a.* Within six months from the date all members of the malpractice review panel were appointed, unless the time period has been extended by the chairperson for good cause shown by a requesting party, the chairperson of the review panel shall hold a hearing of the full review panel to review the plaintiff's claims and the defendant's defenses. In no event shall any extension cause the hearing to occur more than one year after all review panel members were appointed.

b. Except as otherwise provided in this subsection, one combined hearing or hearings shall be held for all claims under this section arising out of the same malpractice action. If the malpractice action includes more than one defendant, the parties may, upon agreement of all parties, require that separate hearings be held for each defendant or group of defendants. The chairperson may, for good cause shown, order separate hearings.

10. At the hearing before the malpractice review panel, all parties who are natural persons shall be personally present and all entity parties shall have a representative present with responsibility for the subject matter that is the subject of the malpractice action. If a plaintiff fails to appear at the hearing, the chairperson shall file a motion with the district court to dismiss the plaintiff's action with prejudice, and the court shall grant the motion. If the defendant fails to appear at the hearing, the defendant shall be precluded from presenting any evidence or making any presentation before the malpractice review panel or at any subsequent trial. The absence of a party or an entity's representative may be excused by the chairperson for good cause shown.

11. At the hearing before the malpractice review panel, the plaintiff shall present the plaintiff's case to the review panel and each defendant shall present the defendant's case in response to the plaintiff's presentation. Wide latitude shall be afforded the parties in the conduct of the hearing including but not limited to the right of examination and cross-examination of witnesses by attorneys for the parties. Depositions allowed to be taken under subsection 7 shall be admissible regardless of whether

the person deposed is available at the hearing. The Iowa rules of civil procedure shall not apply at the hearing, and evidence may be admitted if such evidence is evidence upon which reasonable persons are accustomed to rely. The chairperson shall make all procedural rulings and such rulings shall be binding and final. The hearing shall be recorded either electronically or by a court reporter. The cost of recording the hearing shall be equally divided among the parties. The record of the proceedings and all documents presented as exhibits shall be confidential except in the following circumstances:

a. Any testimony or writings made under oath may be used in subsequent proceedings for purposes of impeachment.

b. The party who made a statement or presented evidence agrees to the submission, use, or disclosure of the statement or evidence.

c. The parties unanimously agree upon disclosure of any part of the record or proceedings.

12. Upon the conclusion of the hearing, the malpractice review panel may request from any party additional evidence, records, or other information to be submitted in writing or at a continuation of the hearing. A continued hearing shall be held as soon as possible. A continued hearing shall be attended by the same review panel members and parties who attended the initial hearing, unless otherwise agreed to by all parties.

13. The malpractice review panel shall issue its findings in writing within thirty days of submission of all presentations and evidence.

a. The review panel's findings shall contain answers to all of the following questions:

(1) Whether the acts or omissions complained of constitute a deviation from the applicable standard of care by the health care provider charged with such care.

(2) If the acts or omissions complained of are found to have constituted a deviation from the applicable standard of care, whether the acts or omissions complained of proximately caused the injury complained of.

(3) If negligence on the part of a health care provider is found, whether any negligence on the part of the plaintiff was equal to or greater than the negligence of the health care provider.

b. The review panel shall make any affirmative finding by a preponderance of the evidence.

c. With regard to each question, the review

panel's findings with regard to each question shall be determined by a majority of the panel members. The determination of the answer to any question by any individual review panel member shall be confidential and shall not be disclosed to any party or other member of the public. The findings shall reflect the number of review panel members making a determination of an answer in the affirmative and in making a determination of an answer in the negative. The findings, including the cumulative determinations in the affirmative and the negative for each answer, shall be signed by all review panel members, with each review panel member attesting that the written findings accurately reflect the determinations made.

d. The chairperson of the review panel shall serve the findings upon the parties within seven days of the date of the findings. The review panel's written findings shall be preserved until thirty days after final judgment or the action is finally resolved after which time such findings shall be destroyed. All medical and health care provider records shall be returned to the party providing them to the review panel.

e. The deliberations and discussion of the review panel shall be privileged and confidential and a review panel member shall not be asked or compelled to testify at a later proceeding concerning the deliberations, discussions, or findings expressed during the review panel's deliberations, except as such deliberation, discussion, or findings may be required to prove an allegation of intentional fraud. All review panel members and the chairperson shall be immune from liability as a result of participation in or serving as a review panel member, except for instances of intentional fraud by a panel member.

14. The effect of the malpractice review panel's findings shall be as follows:

a. If the review panel's findings are unanimous and unfavorable to the plaintiff in such a manner as would not permit recovery by the plaintiff if the answers were made at trial, all of the following shall apply:

(1) The review panel's findings are admissible in any subsequent court action for professional negligence against the health care provider accused of professional negligence by the claimant based upon the same set of facts which were considered reviewed by the review panel.

(2) If the malpractice action proceeds and results in a verdict and judgment for the defendant, the plaintiff shall be required to pay all expert witness

fees and court costs incurred by the defendant.

(3) If the malpractice action proceeds and results in a verdict and judgment for the plaintiff, any noneconomic damages awarded to the plaintiff shall not exceed two hundred fifty thousand dollars.

b. If the review panel's findings are unanimous and unfavorable to the defendant, in such a manner as would permit the plaintiff to recover if the defendant's answers were made at trial, all of the following shall apply:

(1) The review panel's findings are admissible in any subsequent court action for professional negligence against the health care provider accused of professional negligence by the claimant based upon the same set of facts which were considered reviewed by the review panel.

(2) The defendant shall promptly admit liability or enter into negotiations to pay the plaintiff's claim for damages.

(3) If liability is admitted, the claim may be resubmitted to the review panel upon agreement of the plaintiff and the defendant for a determination of damages. Any determination of damages by the review panel shall be admissible in any subsequent malpractice action.

(4) If liability is not admitted and the parties are not able to resolve the claim through settlement negotiations within thirty days after service of the review panel's findings, the plaintiff may proceed with the malpractice action. If the plaintiff obtains a verdict or judgment in excess of the plaintiff's last formal demand in the settlement negotiations following the review panel's findings, the defendant shall be required to pay all expert witness fees and court costs incurred by the plaintiff.

15. *a.* Upon the selection of all members of the malpractice review panel, each party shall pay to the clerk of the district court a filing fee of two hundred fifty dollars.

b. Any party may apply to the chairperson of the malpractice review panel for a waiver of the filing fee. The chairperson shall grant the waiver if the party is indigent.

c. Any party who is or was an employee of another party at the time of the claimed injury and was acting in the course and scope of employment with such other party shall not be required to pay a filing fee.

Sec. 20. NEW SECTION. **622.31A Evidence-based medical practice guidelines — affirmative defense.**

1. For purposes of this section:

a. *"Evidence-based medical practice guidelines"* means voluntary medical practice parameters or protocols established and released through a recognized physician consensus-building organization approved by the United States department of health and human services, through the American medical association's physician consortium for performance improvement or similar activity, or through a recognized national medical specialty society.

b. *"Health care provider"* means a physician and surgeon, osteopathic physician and surgeon, physician assistant, or advanced registered nurse practitioner.

2. In any action for personal injury or wrongful death against any health care provider based upon the alleged negligence of the health care provider in patient care, the health care provider may assert, as an affirmative defense, that the health care provider complied with evidence-based medical practice guidelines in the diagnosis and treatment of a patient.

3. A judge may admit evidence-based medical practice guidelines into evidence if introduced only by a health care provider or by the health care provider's employer and if the health care provider or the health care provider's employer establishes foundational evidence in support of the evidence-based medical practice guidelines as well as evidence that the health care provider complied with the guidelines. Evidence of departure from an evidence-based medical practice guideline is admissible only on the issue of whether the health care provider is entitled to assert an affirmative defense.

4. This section shall not apply to any of the following:

a. A mistaken determination by the health care provider that the evidence-based medical practice guideline applied to a particular patient where such mistake is caused by the health care provider's negligence or intentional misconduct.

b. The health care provider's failure to properly follow the evidence-based medical practice guideline where such failure is caused by the health care provider's negligence or intentional misconduct. There shall be no presumption of negligence if a health care provider does not adhere to an evidence-based medical practice guideline.>

2. Title page, by striking lines 1 through 5 and inserting <An Act relating to health care by establishing the healthy Iowa plan, affecting medical malpractice actions, making appropriations, providing remedies, and including effective date provisions.>