



[HF 685](#) – Medicaid, Liens, and Third-Party Recovery (LSB1182HZ.1)
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Fiscal Note Version – Final Action

Description

[House File 685](#) relates to the Medicaid program, including third-party lien recovery, taxation of managed care organization (MCO) premiums, and nursing facility licensing and financing.

Division I — Medicaid Program Third-Party Recovery

Description and Background

Division I relates to the duties of third parties, defined in the Division, and includes insurance companies. Division I does the following:

- Provides that third-party obligations specified in the Division are a condition of doing business in Iowa.
- Requires that a third party that is an insurance carrier enter into a health insurance data match program with the Department of Health and Human Services (HHS) to compare beneficiaries between State and third-party systems.
- Prohibits a third party from denying any claim submitted by a Medicaid payor, including an MCO, to a third party solely due to procedural reasons.
- Allows the HHS to adopt administrative rules to administer Division I.
- Specifies that it is the intent of the General Assembly that Medicaid payors be the payor of last resort for medical services.
- Allows a Medicaid payor to assign its rights under the Division to another Medicaid payor, a provider, or a contractor.
- Requires a Medicaid recipient or the recipient's agent to inform the Medicaid payor of any third-party benefits the recipient is eligible to receive.
- Specifies that a Medicaid payor is automatically eligible to collect a debt and has an automatic lien upon the collateral for the full amount of medical assistance provided by the Medicaid payor for medical services furnished as a result of any covered illness or injury for which a third party is or may be liable.
- Allows a Medicaid payor to institute, intervene in, or join in any legal or administrative proceeding to recover damages in an action derivative of the rights of the recipient, and requires that the Medicaid payor provide written notice to the recipient no later than 30 days after filing a derivative action against a third party.
- Makes the entire amount of a settlement between a recipient and a third party subject to a Medicaid payor's claim for reimbursement of the amount of medical assistance provided. The Division establishes a rebuttable presumption that in a tort action against a third party, all Medicaid payors collectively receive two-thirds of the remaining amount recovered or the total amount of medical assistance provided by the Medicaid payors, whichever is less, after attorney and filing fees. The Division allows the recipient to contest the calculation in court. If there are competing claims of Medicaid payors, each payor is entitled to the respective pro rata share of the available recovered amount.

- Allows a Medicaid payor to make settlements with third parties.

Iowa Code section [249A.37](#), which is stricken in Division I, currently relates to health care information sharing by health insurers. The section allows the State to request information regarding a patient from health insurers, requires that health insurers accept the State's right of recovery from the insurers for Medicaid expenses, mandates a response from health insurers based on a State request regarding a claim, and requires a health insurer to agree not to deny claims based on a procedural reason.

Medicaid third-party liability refers to the legal obligation of third parties, such as health insurers, to pay part or all of the expenditures for medical assistance provided under a Medicaid state plan. Under federal law, third parties are the primary payor of medical expenses when coverage also includes Medicaid. State Medicaid programs may contract with MCOs to provide health care to beneficiaries, and based on Section [1902\(a\)](#) of the federal Social Security Act, may delegate responsibility and authority to the MCOs to perform third-party discovery and recovery activities. The Medicaid program may authorize the MCO to use a contractor to complete these activities. According to [42 U.S.C. §1396a\(a\)\(25\)\(I\)](#), when third-party liability responsibilities are delegated to an MCO, third parties are required to treat the MCO as if it were the State, including providing access to third-party eligibility and claims data to identify individuals with third-party coverage, adhering to the assignment of rights from the State to the MCO of a beneficiary's right to payment by health insurers for health care services, and refraining from denying payment of claims submitted by the MCO for procedural reasons. In FY 2022, Iowa MCOs recovered \$227.7 million in third-party liability from other insurers.

In 2022, the U.S. Supreme Court ruled in [Gallardo v. Marstiller](#) that state Medicaid programs are permitted to seek reimbursement from settlement payments allocated for future medical care. This ruling validated a state's right to collect tort recoveries from Medicaid beneficiaries, and allows Iowa and a Medicaid payor to expand its ability to recoup health care costs from third parties, including settlements and judgments.

Assumptions/Fiscal Impact

According to the HHS, the fiscal impact of Division I due to third-party liability recoveries is expected to be minimal and cannot be estimated due to lack of data. Future recoveries may affect capitation rate-setting for Medicaid MCOs.

Division II — Medicaid Managed Care Organization Taxation of Premiums

Description and Background

Division II establishes a new 2.5% tax on MCO premiums received and taxable, set to begin on January 1, 2024. The tax will be paid on or before March 1 of the year following the calendar year when the tax is due. The MCOs are expected to prepay the tax, with one-half of the MCO's liability for the preceding calendar year due on or before June 1 and the other half of the prepayment due on or before August 15. Any excess prepayment may be credited to the following year or refunded, as specified in the Division. A Medicaid MCO Premiums Fund is created in the Division, and all MCO premium tax revenue will be deposited into the Fund and appropriated to the HHS to use for the Medicaid program. Moneys in the Fund do not revert and are permitted to carry forward. Any interest earned is credited to the Fund.

Currently, there are a number of sources of State revenue used as matching funds to access federal resources in the Medicaid program, outside of the annual State Medicaid appropriation, which was \$1.510 billion in 2022 Iowa Acts, [House File 2578](#) (FY 2023 Health and Human Services Appropriations Act). Iowa Code section [249A.21](#) specifies an assessment (not to exceed 6.0% for actual paid claims) for intermediate care facilities for persons with an

intellectual disability (ICF/ID), which is paid by facilities to the HHS to use for federal matching funds for Medicaid services. The ICF/ID also has a 1.5% penalty on the amount owed to the HHS. Other assessments in statute for Medicaid include the Nursing Facility Quality Assurance Assessment Program (Iowa Code chapter [249L](#)) and the Hospital Health Care Access Assessment Program (Iowa Code chapter [249M](#)).

Assumptions/Fiscal Impact

- According to the HHS, the 2.5% premium tax received from State-funded MCO premiums is to be reimbursed to MCOs through the capitation rate-setting process.
- MCOs pay the entire premium tax for calendar year (CY) 2024 on March 1, 2025 (FY 2025), while the 50.0% prepayments for CY 2025 are made on June 1, 2025 (FY 2025) and August 15, 2025 (FY 2026).
- Prepayment of CY 2026 taxes begins on June 1, 2026 (FY 2026).
- Federal reimbursement using State MCO premium tax revenue is based on blended Federal Medical Assistance Percentage (FMAP) rates of 70.0% federal funds and 30.0% State funds.
- According to the HHS, in FY 2025 the MCO premium tax will create \$66.8 million from State-funded premiums and \$155.8 million from federally funded premiums.
- According to the HHS, in FY 2026 and beyond, the MCO premium tax will create \$44.5 million from State-funded premiums and \$103.9 million from federally funded premiums.
- Decisions on how to allocate the State net revenue from the MCO premium tax have not been made by the HHS and the General Assembly and are not identified in the Bill.

Figure 1 summarizes the revenue impact from Division II of the Bill. Revenues are to be deposited into the Medicaid MCO Premiums Fund created in Division II.

Figure 1 — HF 685 (Division II) — MCO Premium Tax Revenue (In Millions)

Fiscal Year	MCO Premium Tax	MCO Reimbursement from State	State Net Revenue
FY 2024	\$ 0.0	\$ 0.0	\$ 0.0
FY 2025	222.6	-66.8	155.8
FY 2026	148.4	-44.5	103.9

Division III — Nursing Facility Licensing and Financing

Description and Background

Division III relates to the imposition of a temporary moratorium for new construction or an increase in bed capacity of nursing facilities. Division III does the following:

- Starting July 1, 2023, allows the Department of Inspections, Appeals, and Licensing (DIAL), in consultation with the HHS, to impose a temporary moratorium on the submission of applications for new construction of nursing facilities or a permanent change that increases bed capacity for existing nursing facilities for an initial period of 12 months. The DIAL may extend the moratorium in 6-month increments but for no longer than 36 months.
- Allows the DIAL, in consultation with the HHS, to waive the moratorium if there is a need for specialized-needs beds or if the average occupancy of all licensed nursing facility beds located within the county and contiguous counties of the location of the proposed increase in nursing facility bed capacity exceeded 85.0% during the three most recent calendar quarters as published by the Centers for Medicare and Medicaid Services (CMS).

- Requires the DIAL to publish any request for a waiver of the moratorium and any explanation approving or denying the waiver request.
- Requires applicants to the DIAL for a nursing facility license to provide information related to the following:
 - The organizational and ownership structures of the applicant.
 - Any related party transactions and associated reimbursement structures.
 - The financial suitability of the applicant to operate a nursing facility.
 - Whether the applicant has voluntarily surrendered a license while under investigation in another licensing jurisdiction.
 - Whether another licensing jurisdiction has taken disciplinary action against the applicant relating to the applicant's operation of a nursing facility.
 - Whether there are complaints, allegations, or investigations against the applicant in another licensing jurisdiction.
 - Supporting documentation regarding the resolution of any disciplinary action against the applicant in another jurisdiction.
 - Whether a nursing facility owned or operated by the applicant has been subject to a court-appointed receiver or temporary manager.
- Allows the DIAL to request additional or supplemental information with the application, including verification of cash or liquid reserves to maintain nursing facility operations for at least two months.
- Allows the DIAL to require an applicant for a nursing facility to establish an escrow account containing funds sufficient to support full-service operation of the facility for at least a two-month period, which is required to be terminated no later than five years from the date of initial commencement of operation of a nursing facility.
- Requires the HHS to develop a publicly available dashboard by January 1, 2024, detailing the number of nursing facility beds available in the State, the overall quality rating of the available nursing facility beds as specified by the CMS, any increase or decrease in the number of available nursing facility beds in each county, and an explanation of the causes of any increase or decrease in available nursing facility beds.
- Prohibits hospitals participating in the Hospital Directed Payment Program from passing on a directed payment increase to non-Medicaid payors, with a penalty of being reimbursed at the base rate provided under Medicaid for one year from the date the violation is discovered.
- Prohibits a nursing facility from passing the quality assurance assessment on to non-Medicaid payors, including as a rate increase or service charge.
- Requires the HHS to convene a workgroup to review the existing nursing facility bed need formula, with a report of recommendations of the workgroup regarding improvement to the formula submitted to the Governor and the General Assembly by December 2, 2024.

Iowa Code chapter 249L outlines the quality assurance assessment, which was created in 2009 Iowa Acts, chapter [160](#) (Nursing Facilities — Quality Assurance Assessments and Provider Reimbursements Act), and is imposed on nursing facilities to be used for federal reimbursement of Medicaid-eligible services. In FY 2022, \$49.5 million was collected from the assessment to use for Medicaid.

2023 Iowa Acts, [Senate File 514](#) (State Government Alignment Act), transfers the responsibility for licensing of nursing facilities from the Iowa Department of Public Health to the DIAL effective July 1, 2023.

Assumptions/Fiscal Impact

Division III of the Bill is expected to have no fiscal impact. It was reported by the HHS that the section of the Bill requiring the HHS to create a dashboard detailing nursing facility bed data can be performed utilizing existing department personnel and contracts.

Sources

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Iowa Judicial Branch
Legislative Services Agency analysis

/s/ Jennifer Acton

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The fiscal note for this Bill was prepared pursuant to [Joint Rule 17](#) and the Iowa Code. Data used in developing this fiscal note is available from the Fiscal Services Division of the Legislative Services Agency upon request.

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