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COMMERCE, REGULATION & LABOR

HOUSE FILE 2445

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Passed House, Date _____ Passed Senate, Date _____

Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____

Approved _____

A BILL FOR

An Act relating to the establishment of a healthy Iowa for all program.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

HF 2445

TLSB 6312HH 80

pf/gg/14

S.F. _____ H.F. 2445

Section 1. NEW SECTION. 514M.1 SHORT TITLE.

This chapter shall be known and may be cited as the "Healthy Iowa for All" program.

Sec. 2. NEW SECTION. 514M.2 LEGISLATIVE INTENT.

It is the intent of the general assembly to establish the healthy Iowa for all program to provide access to comprehensive, quality, affordable health care coverage to eligible small employers, including the self-employed, their employees and their dependents, state employees and their dependents, local government employees and their dependents, and individuals, on a voluntary basis. It is also the intent of the general assembly that the healthy Iowa for all program monitor and improve the quality of health care in the state.

Sec. 3. NEW SECTION. 514M.3 DEFINITIONS.

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

1. "Board" means the HIFA program board created in section 514M.6.

2. "Department" means the Iowa department of public health.

3. "Dependent" means a spouse, an unmarried child under nineteen years of age, a child who is a student under twenty-three years of age and is financially dependent upon a plan enrollee, or a person of any age who is the child of a plan enrollee and is disabled and dependent upon that plan enrollee. "Dependent" may include a domestic partner.

4. "Director" means the director of public health.

5. "Eligible employer" means a business that employs at least two but not more than fifty eligible employees, the majority of whom are employed in the state, including a municipality or political subdivision that has fifty or fewer employees.

6. "Eligible individual" means any of the following:

a. A self-employed individual who works and resides in the state, and is organized as a sole proprietorship or in any

other legally recognized manner in which a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income.

b. An unemployed individual who resides in this state.

c. An individual employed by an employer that does not offer health insurance.

d. Uninsured individuals without access to employer coverage.

7. "Eligible local government employee" means a local government employee.

8. "Eligible state employee" means a state employee, including a state employee covered under a collective bargaining agreement.

9. "Employer" means the owner or responsible agent of a business authorized to sign contracts on behalf of the business.

10. "Federal poverty guidelines" means the federal poverty guidelines issued by the United States department of health and human services in the federal register.

11. "Health insurance carrier" means any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible individuals and dependents under this chapter.

12. "HIFA health insurance" means the health insurance product established by the HIFA program that is offered by a private health insurance carrier.

13. "HIFA health insurance program" or "insurance program" means the program through which HIFA health insurance is provided.

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

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

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

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

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

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

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

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

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

Sec. 4. NEW SECTION. 514M.4 HIFA PROGRAM ESTABLISHED.

1. The department shall establish the HIFA program to provide access to health care coverage to eligible employers, including the self-employed, their employees and dependents, eligible state employees and their dependents, eligible local

government employees and their dependents, and eligible individuals.

2. The department may do any of the following:

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

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

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

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

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

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

g. Accept appropriations, gifts, grants, loans, or other aid from public or private entities.

h. Contract with organizations with expertise in health care data, including a nonprofit health data processing entity in this state, to assist the Iowa quality forum established in section 514M.13 in the performance of its responsibilities.

i. Provide staff support and other assistance to the Iowa quality forum established in section 514M.13.

j. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried

out by one or more organizations organized, created, or operated under the laws of this state.

3. The department shall do all of the following:

a. Establish administrative and accounting procedures as recommended by the state auditor for the operation of the program.

b. Collect the savings offset payments as provided in section 514M.11.

c. Determine the comprehensive services and benefits to be included in HIFA health insurance and make recommendations to the board regarding the services and benefits.

d. Develop and implement an outreach program to publicize the existence of the HIFA program and the HIFA health insurance program and the eligibility requirements and the enrollment procedures for the HIFA health insurance program and to maintain public awareness of the HIFA program and the HIFA health insurance program.

e. Arrange for the provision of HIFA health insurance benefit coverage to eligible individuals, eligible employees, eligible state employees, and eligible local government employees through contracts with one or more qualified health insurance carriers.

f. Develop a high-risk pool for plan enrollees in HIFA health insurance in accordance with the provisions of section 514M.15.

4. Financial and performance audits or examinations of HIFA health insurance shall be conducted by the insurance division of the department of commerce, annually. A copy of any audit shall be provided to the commissioner of insurance, the governor, and the general assembly.

5. Beginning September 1, 2006, and annually thereafter, the department shall submit a report to the governor and the general assembly on the impact of the HIFA health insurance program on the small group, individual, state employee, and local government employee health insurance markets in this

state and any reduction in the number of uninsured individuals in the state. The department shall also report on membership in the HIFA health insurance program, the administrative expenses of the HIFA health insurance program, the extent of coverage, the effect on premiums, the number of covered lives, the number of HIFA health insurance policies issued or renewed, and HIFA health insurance premiums earned and claims incurred by health insurance carriers offering HIFA health insurance.

6. The department shall coordinate the activities of the HIFA program with health care programs offered through federal, state, and local governments.

Sec. 5. NEW SECTION. 514M.5 HIFA PROGRAM BOARD.

1. A HIFA program board for the HIFA program is established. The board shall meet not less than four times annually or at the call of the chairperson for the purposes of establishing policy and adopting rules for the program. The board shall consist of the following members:

a. Five public voting members who have knowledge or experience in one or more of the following areas, appointed by the governor and subject to confirmation by the senate:

(1) Health care purchasing.

(2) Health insurance.

(3) Health policy and law.

(4) State management and budgeting.

(5) Health care financing.

b. The director of public health, the director of human services, and the commissioner of insurance serving as ex officio, nonvoting members of the board.

c. Two members of the senate and two members of the house of representatives, serving as ex officio, nonvoting members. The legislative members of the board shall be appointed by the majority leader of the senate, after consultation with the president of the senate, and by the minority leader of the senate, and by the speaker of the house, after consultation

with the majority leader, and by the minority leader of the house of representatives. Legislative members shall receive compensation pursuant to section 2.12.

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

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

4. The board shall do all of the following:

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

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

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

d. In consultation with the Iowa quality forum advisory council, select a nationally recognized functional health assessment form for an initial assessment of all eligible employees, eligible individuals, eligible state employees, and

eligible local government employees participating in the HIFA health insurance program, establish a baseline for comparison purposes, and develop appropriate indicators to measure the health status of those participating in the program.

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

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

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

h. Provide for periodic assessment of the effectiveness of the outreach program.

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

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

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

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

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

Sec. 6. NEW SECTION. 514M.6 HIFA HEALTH INSURANCE PROGRAM.

1. a. The HIFA health insurance program shall provide for health benefits coverage through health insurance carriers that apply to the board and meet the qualifications described

in this section and any additional qualifications established by rule of the board.

b. If a sufficient number of health insurance carriers do not apply to offer and deliver health insurance under the insurance program, the board may propose the establishment of a nonprofit health care plan or may propose the expansion of an existing public plan. If the board proposes the establishment of a nonprofit health care plan or the expansion of an existing public plan, the board shall submit a proposal, including but not limited to a funding mechanism, to capitalize a nonprofit health care plan and any recommended legislation to the general assembly. The program shall not provide access to health insurance by establishing a nonprofit health care plan or through an existing public plan without specific legislative approval.

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

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

a. The HIFA health insurance program shall issue requests for proposals to select health insurance carriers.

b. The insurance program may include quality improvement, patient care management, and cost-containment provisions in the contracts with participating health insurance carriers or may arrange for the provision of such services through contracts with other entities.

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

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

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

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

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

Sec. 7. NEW SECTION. 514M.7 ELIGIBILITY REQUIREMENTS.

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

a. Eligible individuals and their dependents.

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

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

d. Eligible local government employees and their dependents.

2. In order to participate, an eligible employer, the

state, or the local government shall pay at least sixty percent of the individual employee's premium costs or the combined premium costs of the individual employee and dependents of the employee.

3. The HIFA health insurance program shall collect payments from participating employers and plan enrollees to cover the costs of all of the following:

a. Insurance coverage for enrolled employees and their dependents in contribution amounts determined by the board.

b. Quality assurance, patient care management, and cost-containment programs.

c. Administrative services.

d. Other health promotion costs.

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

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

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

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

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

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

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

b. The HIFA health insurance program shall collect payments from eligible individuals participating in the HIFA health insurance program to cover the costs of all of the following:

(1) Insurance coverage for eligible individuals and their dependents in contribution amounts determined by the board.

(2) Quality assurance, patient care management, and cost-containment programs.

(3) Administrative services.

(4) Other health promotion costs.

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

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

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

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

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

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

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

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

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

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

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

1. The HIFA health insurance program shall establish sliding-scale subsidies for the purchase of HIFA health insurance by an individual or employee whose income is at or below three hundred percent of the federal poverty guidelines and who is not eligible for any other state or federally funded program. The HIFA health insurance program may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage by an employee of an employer with more than fifty employees, whose income is under three hundred percent of the federal poverty guidelines and who is not eligible for any other state or federally funded program.

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

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

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

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

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

2. Ensure all of the following:

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

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

c. That premiums are set utilizing a modified community rating.

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

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

2. For the purpose of providing funds necessary to provide subsidies pursuant to section 514M.9, and to support the Iowa quality forum pursuant to section 514M.13, the board shall establish a savings offset amount to be paid by health

insurance carriers, employee benefit excess insurance carriers, and third-party administrators, not including carriers and third-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability, income, long-term care, Medicare supplemental, or other limited benefit health insurance, annually at a rate that may not exceed savings resulting from decreasing rates of growth in bad debt and charity care costs. Payment of the savings offset shall begin January 1, 2006. The savings offset amount as determined by the board is the determining factor for inclusion of savings offset payments in premiums through rate-setting review by the insurance division of the department of commerce. Savings offset payments must be made quarterly and are due not less than thirty days after written notice to the health insurance carriers, employee benefit excess insurance carriers, and third-party administrators.

3. Each health insurance carrier, employee benefit excess insurance carrier, and third-party administrator shall pay a savings offset in an amount not to exceed four percent of annual health insurance premiums and employee benefit excess insurance premiums on policies issued pursuant to the laws of this state that insure residents of this state. The savings offset payment shall not exceed savings resulting from decreasing rates of growth in bad debt and charity care costs. The savings offset payment applies to premiums paid on or after July 1, 2005. Savings offset payments shall reflect aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this state, as a result of the operation of the HIFA health insurance program as determined by the board. A health insurance carrier or employee benefit excess insurance carrier shall not be required to pay a savings offset payment on policies or contracts insuring federal employees.

4. The board shall make reasonable efforts to ensure that

premium revenue, or claims plus any administrative expenses and fees with respect to third-party administrators, is counted only once with respect to any savings offset payment. For that purpose, the board shall require each health insurance carrier to include in its premium revenue gross of reinsurance ceded. The board shall allow a health insurance carrier to exclude from its gross premium revenue reinsurance premiums that have been counted by the primary insurer for the purpose of determining its savings offset payment under this subsection. The board shall allow each employee benefit excess insurance carrier to exclude from its gross premium revenue the amount of claims that have been counted by a third-party administrator for the purpose of determining its savings offset payment under this subsection. The board may verify each health insurance carrier's, employee benefit excess insurance carrier's, and third-party administrator's savings offset payment based on annual statements and other reports determined to be necessary by the board.

5. The commissioner of insurance may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any health insurance carrier or the license of any third-party administrator to operate in this state that fails to pay a savings offset payment. In addition, the commissioner may assess civil penalties against any health insurance carrier, employee benefit excess insurance carrier, or third-party administrator that fails to pay a savings offset payment or may take any other enforcement action authorized to collect any unpaid savings offset payments.

6. On an annual basis no later than April 30 of each year, the board shall prospectively determine the savings offset to be applied during each twelve-month period. Annual offset payments shall be reconciled to determine whether unused payments may be returned to health insurance carriers, employee benefit excess insurance carriers, and third-party

administrators according to a formula developed by the board. Savings offset payments shall be used solely to fund the subsidies authorized by section 514M.9 and to support the Iowa quality forum established in section 514M.13 and may not exceed savings from reductions in growth of bad debt and charity care.

7. In accordance with the requirements of this subsection, every health insurance carrier and health care provider shall demonstrate that best efforts have been made to ensure that a carrier has recovered savings offset payments made pursuant to this section through negotiated reimbursement rates that reflect health care providers' reductions or stabilization in the cost of bad debt and charity care as a result of the operation of HIFA health insurance.

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

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

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

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

(1) The total enrollment in the HIFA health insurance program, including the number of enrollees previously underinsured or uninsured, the number of enrollees previously insured, the number of individual enrollees, the number of enrollees enrolled through small employers, the number of enrollees enrolled through the state of Iowa, and the number

of enrollees enrolled through local governments.

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

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

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

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

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

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

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

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

annually thereafter.

c. Health insurance carriers and health care providers shall report annually, beginning July 1, 2006, and each July 1 thereafter, information regarding the experience of the prior twelve-month period on the efforts undertaken by the carrier and provider to recover savings offset payments, as reflected in reimbursement rates, through a reduction or stabilization in bad debt and charity care costs as a result of the operation of the HIFA health insurance program. The board shall determine the appropriate format for the report and utilize existing data on file with state agencies or other organizations to minimize duplication. The report shall be submitted to the board. Using the information submitted by carriers and providers, the board shall submit a summary of that information by October 1, 2006, and annually thereafter to the commissioner of insurance, the governor, and the general assembly.

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

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

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

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

3. The fund 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 fund shall not be considered revenue of the state, but rather shall be funds of the HIFA program. The moneys deposited in the fund 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 fund shall be credited to the fund.

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

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

Sec. 13. NEW SECTION. 514M.13 IOWA QUALITY FORUM.

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

2. The forum shall do all of the following:

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

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

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

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

e. Work collaboratively with health care providers, health

insurance carriers, and others to report in useable formats, comparative health care quality information to consumers, purchasers, providers, insurers, and policymakers. The forum shall produce annual quality reports.

f. Conduct education campaigns to help health care consumers make informed decisions and engage in healthy lifestyles.

g. Adopt plans to provide medication therapy management by pharmacy providers targeted to individuals who have multiple chronic conditions, use multiple prescriptions, and are likely to incur high drug expenses in order to ensure appropriate use of prescription drugs to improve therapeutic outcomes and reduce adverse drug reactions.

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

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

j. Submit an annual report to the governor and the general assembly and make the report available to the public.

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

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

a. One member who is a physician.

b. One member who is a health care economist.

c. One member who is a pharmacist.

d. One member who represents hospitals.

e. One member who is a representative of the university of

Iowa college of public health.

f. One member who is a representative of a private employer with not more than fifty employees.

g. One member who is a representative of a private employer with more than one thousand employees.

h. One member who is a representative of organized labor.

i. One member who is a representative of a consumer health advocacy group.

j. The director of public health, or the director's designee.

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

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

a. Shall serve five-year staggered terms as designated by the governor.

b. Shall be subject to chapter 69 with regard to the filling of vacancies, membership terms, payment of compensation and expenses, and removal.

c. Are entitled to receive reimbursement of actual expenses incurred in the discharge of their duties and are also eligible to receive compensation as provided in section 7E.6.

d. Shall not serve more than two consecutive terms.

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

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

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

a. Convene a group of health care providers to provide input and advice to the council.

b. Provide expertise in health care quality to assist the board.

c. Advise and support the forum by doing all of the following:

(1) Establishing and monitoring, with the HIFA program, an annual work plan for the forum.

(2) Providing guidance in the adoption of quality and performance measures.

(3) Serving as a liaison between the provider group established in paragraph "a" and the forum.

(4) Conducting public hearings and meetings.

(5) Reviewing consumer education materials developed by the forum.

d. Assist the board in selecting the nationally recognized functional health assessment.

e. Make recommendations regarding quality assurance and quality improvement priorities for inclusion in the state health plan described in section 514M.16.

f. Serve as a liaison between the forum and other organizations working in the field of health care quality.

Sec. 15. NEW SECTION. 514M.15 HIFA HIGH-RISK POOL.

1. A plan enrollee shall be included in the HIFA high-risk pool if the total cost of health care services for the enrollee exceeds fifty thousand dollars in any twelve-month period.

2. The HIFA program shall develop appropriate patient care management protocols, develop procedures for implementing those protocols, and determine the manner in which patient care management shall be provided to plan enrollees in the HIFA high-risk pool. Patient care management shall be provided by appropriate individual health care professionals under the HIFA program. The HIFA program shall include patient care management in its contract with participating health insurance carriers for HIFA high-risk pool enrollees pursuant to this section, contract separately with another entity for patient care management services, or provide patient care management services directly through the HIFA

program.

3. The HIFA program shall submit a report to the governor and the general assembly, no later than January 1, 2006, outlining the patient care management protocols, procedures, and delivery mechanisms used to provide patient care management services to HIFA high-risk pool enrollees and the assessment tool used to measure individual patient care management activities. The report shall also include the number of plan enrollees in the high-risk pool, the types of diagnoses managed within the high-risk pool, the claims experience within the high-risk pool, and the number and type of claims exceeding fifty thousand dollars for enrollees in the high-risk pool and for all enrollees in the HIFA health insurance program.

4. On or before October 1, 2008, the HIFA program shall evaluate the impact of HIFA health insurance on average health insurance premium rates in this state and on the rate of uninsured individuals in this state and compare the trends in those rates to the trends in the average premium rates and average rates of uninsured individuals for the states that have established a statewide high-risk pool as of July 1, 2004. The board shall submit the evaluation of the impact of HIFA health insurance in this state in comparison to states with high-risk pools to the governor and the general assembly by January 1, 2009. If the trend in average premium rates in this state and rate of uninsured individuals exceeds the trend for the average among the states with high-risk pools, the board shall submit legislation on January 1, 2009, that proposes to establish a statewide high-risk pool in this state consistent with the characteristics of high-risk pools operating in other states.

Sec. 16. NEW SECTION. 514M.16 STATE HEALTH PLANNING.

1. The governor or the governor's designee shall do all of the following:

a. Develop and issue a biennial state health plan. The

first plan shall be issued by May 2005.

b. Make an annual report to the public assessing the progress toward meeting goals of the plan and provide any updates, as necessary, to the plan.

c. Issue an annual statewide health expenditure budget report that shall serve as the basis for establishing priorities within the plan.

2. a. The state health plan issued pursuant to subsection 1 shall establish a comprehensive, coordinated approach to the development of health care facilities and resources in the state based on statewide cost, quality, and access goals and strategies to ensure access to affordable health care, maintain a rational system of health care, and promote the development of the health care workforce.

b. In developing the plan, the governor shall, at a minimum, seek input from the Iowa quality forum, the Iowa quality forum advisory council, and other appropriate agencies and organizations.

3. The plan shall do all of the following:

a. Assess health care cost, quality, and access in the state.

b. Develop benchmarks to measure cost, quality, and access goals and report on progress toward meeting those goals.

c. Establish and set annual priorities among health care cost, quality, and access goals.

d. Outline strategies to do all of the following:

(1) Promote health systems change.

(2) Address the factors influencing health care cost increases.

(3) Address the major threats to public health and safety in the state, including, but not limited to, lung disease, diabetes, cancer, and heart disease.

e. Provide recommendations to help purchasers and providers make decisions that improve public health and build an affordable, high-quality health care system.

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

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

Sec. 18. IMPLEMENTATION COSTS. The Iowa department of public health shall work with the commissioner of insurance to seek funding through the federal government, a private foundation, or other appropriate source to defray the initial costs to implement the provisions of this Act, including but not limited to the initial subsidy provisions.

EXPLANATION

This bill establishes a healthy Iowa for all (HIFA) program which includes the HIFA health insurance program, the HIFA program fund, the Iowa quality forum, the HIFA high-risk pool, and state health planning.

The bill establishes the HIFA program within the Iowa department of public health to provide access to health care coverage to eligible employers, including the self-employed, their employees and dependents, state employees and their dependents, local government employees and their dependents, and individuals and their dependents.

The HIFA board consists of five voting members appointed by the governor, subject to confirmation by the senate, and ex officio members including the director of public health, the director of human services, the commissioner of insurance, two members of the senate, and two members of the house of representatives.

The bill provides the duties of the department and the board.

The HIFA health insurance program is to provide health benefits coverage through health insurance carriers that apply to the board and meet the qualifications specified. The bill provides that if a sufficient number of health insurance carriers do not apply to offer and deliver health insurance, the board may propose the establishment of a nonprofit health care plan or may propose the expansion of an existing public

plan. The health insurance program is to select health insurance carriers through a request for proposals process.

The bill provides eligibility provisions and requirements of employers and individuals participating in the program, including contribution levels and employee participation.

The bill provides subsidies on a sliding scale for individual and employee enrollees whose income is at or below 300 percent of the federal poverty guidelines.

The bill provides for the financing of the HIFA program through the collection of savings offset payments made by insurance carriers, employee benefit excess insurance carriers, and third-party administrators based on savings in charity care, bad debt, and savings due to cost controls resulting from the HIFA health insurance program. The bill provides a process for identifying the savings and the amount of the offset payments.

The bill establishes a HIFA program fund. The bill also establishes an Iowa quality forum to collect and review health care quality data, to educate consumers regarding health care and healthy lifestyles, and to make recommendations to the governor regarding the state health plan. An Iowa quality forum advisory council is established to advise the forum.

The bill provides for the establishment of a high-risk pool for enrollees whose total annual health costs exceed $50,000. The bill provides for state health planning through the development and issuance of a biennial state health plan.

The bill directs the Iowa department of public health to work with the commissioner of insurance in seeking federal, foundation, or other funding to defray the bill's initial implementation costs.