Senate File 389 - Introduced

SENATE FILE _____
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SF 48)

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to health care, health care providers, and health care coverage, providing penalties, and providing retroactive and other effective dates.
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
TLSB 1747SV 83
pf/rj/14

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DIVISION I
IOWA CHOICE INSURANCE EXCHANGE

Section 1. NEW SECTION. 514M.1 SHORT TITLE.
This chapter shall be known and may be cited as the "Iowa Choice Insurance Exchange Act".

Sec. 2. NEW SECTION. 514M.2 PURPOSE.
It is the purpose of this chapter to:
1. Ensure that all children in the state have affordable, quality health care coverage with the following priorities:
a. Provide funding to cover all children who are eligible for Medicaid and hawk=i by December 31, 2010.
b. As funding becomes available, provide subsidized coverage which meets certain standards of quality and affordability to the remaining uninsured children less than nineteen years of age under a sliding scale based on family income.
c. Require all parents of children less than nineteen years of age to indicate on their Iowa tax returns whether their children have health care coverage.
d. Require that all parents of children less than nineteen years of age with a family income that is less than three hundred percent of the federal poverty level must provide proof of qualified health care coverage for their children which meets certain standards of quality and affordability.
e. Move towards a future requirement that all parents of children must provide proof of qualified health care coverage for their children which meets certain standards of quality and affordability.
2. Ensure that all Iowans have qualified health care coverage which meets certain standards of quality and affordability with the following priorities:
a. Continue to expand options for individuals who are dually eligible for Medicare and Medicaid, typically the chronically disabled, by utilizing evidence=based medical treatments.
b. Ensure that all health and long=term care workers have qualified health care coverage which meets certain standards of quality and affordability.
c. Maximize eligibility of low=income adults nineteen years of age and older for public health care coverage.
d. As funding becomes available, provide subsidized coverage which meets certain standards of quality and affordability to the remaining low=income adults.
e. Move towards a future requirement that all Iowans must provide proof of qualified health care coverage which meets certain standards of quality and affordability.
3. Decrease health care costs and health care coverage costs by:
a. Instituting insurance reforms that assure the

availability of private insurance coverage for all Iowans by addressing issues involving guaranteed availability and issue of insurance to applicants; preexisting condition exclusions; portability; and allowable or required pooling and rating classifications.

b. Requiring every child who has public health care coverage or is insured by a plan created by the Iowa health care coverage exchange to have a medical home as defined in section 135.157.

c. Establishing a statewide telehealth system.

d. Implementing cost containment strategies such as disease management programs, advance medical directives or end of life planning initiatives, transparency in health care cost and quality information, and an expanded certificate of need process.

4. Develop a program to offer health care coverage under the state health or medical group insurance plan to nonstate public employees, including employees of counties, cities, schools, and community colleges, and employees of nonprofit employers and small employers and to pool such employees with the state plan.

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

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

1. "Board" means the board of directors of the Iowa choice insurance exchange.

2. "Carrier" means an insurer providing accident and sickness insurance under chapter 509, 514, or 514A and includes a health maintenance organization established under chapter 514B if payments received by the health maintenance organization are considered premiums pursuant to section 514B.31 and are taxed under chapter 432. "Carrier" also includes a corporation which becomes a mutual insurer pursuant to section 514.23 and any other person as defined in section 4.1, subsection 20, who is or may become liable for the tax imposed by chapter 432.

3. "Commissioner" means the commissioner of insurance.

4. "Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or part B Medicare pursuant to Title XVIII of the federal Social Security Act.

d. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.

e. 10 U.S.C. ch. 55.

f. A health or medical care program provided through the Indian health service or a tribal organization.

g. A state health benefits risk pool.

h. A health plan offered under 5 U.S.C. ch. 89.

i. A public health plan as defined under federal regulations.

j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. } 2504(e).

k. An organized delivery system licensed by the director of public health.

l. The hawk=i program authorized by chapter 514I.

5. "Director" means the director of revenue.

6. "Exchange" means the Iowa choice insurance exchange.

7. "Executive director" means the executive director of the Iowa choice insurance exchange.

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

9. a. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

b. For purposes of this subsection, "medical care" means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in subparagraph (1).

(3) Insurance covering medical care referred to in subparagraph (1) or (2).

c. For purposes of this subsection, the following apply:

(1) A plan, fund, or program established or maintained by a partnership which, but for this subsection, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care for present or former partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.

(2) With respect to a group health plan, the term "employer" includes a partnership with respect to a partner.

(3) With respect to a group health plan, the term "participant" includes the following:

(a) With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.

(b) With respect to a group health plan maintained by a self=employed individual under which one or more of the self=employed individual's employees are participants, the self=employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual's dependents may be eligible to receive benefits under the plan.

10. "Health care services" means services, the coverage of which is authorized under chapter 509, 514, 514A, or 514B as limited by benefit plans established by the exchange's board of directors, with the approval of the commissioner and includes services for the purposes of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

11. "Health insurance" means accident and sickness insurance authorized by chapter 509, 514, or 514A.

12. a. "Health insurance coverage" means health insurance coverage offered to individuals, including group conversion coverage.

b. "Health insurance coverage" does not include any of the following:

(1) Coverage for accident=only or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical=payment insurance.

(6) Credit=only insurance.

(7) Coverage for on=site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

(1) Limited=scope dental or vision benefits.

(2) Benefits for long=term care, nursing home care, home health care, or community=based care.

(3) Any other similar limited benefits as provided by rule of the commissioner.

d. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

e. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55 and similar supplemental coverage provided to coverage under group health insurance coverage.

13. "Insured" means an individual who is provided qualified health care coverage under a policy, which policy may include dependents and other covered persons.

14. "Medical assistance program" means the federal=state assistance program established under Title XIX of the federal Social Security Act and chapter 249A.

15. "Medicare" means the federal government health insurance program established under Title XVIII of the federal Social Security Act.

16. "Organized delivery system" means an organized

delivery system as licensed by the director of public health.

17. "Policy" means a contract, policy, or plan of health insurance.

18. "Policy year" means a consecutive twelve=month period during which a policy provides or obligates the carrier to provide health insurance.

19. "Qualified health care coverage" means creditable coverage which meets minimum standards of quality and affordability as determined by the board by rule.

20. "Resident" means a person who is a resident of this state for state income tax purposes.

Sec. 4. NEW SECTION. 514M.4 IOWA CHOICE INSURANCE EXCHANGE CREATED == BOARD OF DIRECTORS.

1. The Iowa choice insurance exchange is created as a nonprofit corporation under the purview of the insurance division of the department of commerce.

a. All carriers and all organized delivery systems licensed by the director of public health providing health insurance or health care services in Iowa, whether on an individual or group basis, and all other insurers designated by the exchange's board of directors and approved by the commissioner shall be members of the exchange.

b. The exchange shall operate under a plan of operation established and approved under section 514M.5 and shall exercise its powers through a board of directors established under this section.

2. The board of directors of the exchange shall consist of the following members:

a. Persons who are voting members of the board appointed by the governor and subject to confirmation by the senate:

(1) A practicing physician licensed to practice medicine and surgery or osteopathic medicine and surgery.

(2) A practicing nurse licensed as a registered nurse or a licensed practical nurse or vocational nurse.

(3) A representative of the federation of Iowa insurers.

(4) A health economist who resides in Iowa.

(5) A health benefit manager.

(6) A consumer who is a representative of a children's advocacy organization.

(7) A consumer who is a representative of the state's adult uninsured population.

(8) A consumer who is a member of a racial or ethnic minority group.

(9) A representative of organized labor.

(10) A representative of an organization of small businesses.

(11) A representative of the alliance of nonprofit agencies.

b. Persons who are ex officio, nonvoting members of the board:

(1) The commissioner of insurance, or a designee.

(2) The director of human services, or a designee.

(3) The director of public health, or a designee.

(4) The director of the department of administrative services, or a designee.

(5) Four members of the general assembly, one appointed by the speaker of the house of representatives, one appointed by the minority leader of the house of representatives, one appointed by the majority leader of the senate, and one appointed by the minority leader of the senate.

c. Each member of the board appointed by the governor shall be a resident of this state and the composition of voting members of the board shall be in compliance with sections 69.16, 69.16A, and 69.16C.

d. The voting members of the board shall be appointed for terms of six years beginning and ending as provided in section 69.19. A member of the board is eligible for reappointment. The governor shall fill a vacancy for the remainder of the unexpired term. A member of the board may be removed by the governor for misfeasance, malfeasance, or willful neglect of duty or other cause after notice and a public hearing unless the notice and hearing are waived by the member in writing.

e. The voting members of the board shall annually elect one of the members as chairperson and one as vice chairperson.

f. A majority of the voting members of the board constitutes a quorum. The affirmative vote of a majority of the voting members is necessary for any action taken by the board. The majority shall not include a member who has a conflict of interest and a statement by a member of a conflict of interest is conclusive for this purpose. A vacancy in the voting membership of the board does not impair the right of a

quorum to exercise the rights and perform the duties of the board. An action taken by the board under this chapter may be authorized by resolution at a regular or special meeting and each resolution shall take effect immediately and need not be published or posted. Meetings of the board shall be held at the call of the chairperson or at the request of a majority of the voting members.

g. Members of the board may be reimbursed from the moneys of the exchange for expenses incurred by them as members, but shall not be otherwise compensated by the exchange for their services.

h. The voting members of the board shall give bond as required for public officers in chapter 64.

i. The members of the board are subject to and are officials within the meaning of chapter 68B.

j. All employees of the exchange are exempt from chapter 8A, subchapter IV, and chapter 97B.

3. The voting members of the board shall appoint an executive director to supervise the administrative affairs and general management and operations of the exchange. The executive director of the board shall keep a record of the proceedings of the board and shall be custodian of all books, documents, and papers filed with the board, the minute book or journal of the board, and the official seal of the board. The executive director may cause copies to be made of minutes and other records and documents of the board and may give certificates under the official seal of the board that the copies are true copies, and persons dealing with the board may rely upon the certificates.

4. The exchange shall be considered a governmental body for the purposes of chapter 21 and a government body for the purposes of chapter 22.

Sec. 5. NEW SECTION. 514M.5 PLAN OF OPERATION == ASSESSMENTS.

1. The exchange shall submit to the commissioner a plan of operation for the exchange and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the exchange. The plan of operation shall include provisions for the development of a comprehensive health care coverage plan as provided in section 514M.6. The plan of operation becomes effective upon approval in writing by the commissioner prior to the date on which the coverage under this chapter must be made available. After notice and hearing, the commissioner shall approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the exchange, and provides for the sharing of exchange losses, if any, on an equitable and proportionate basis among the member carriers. If the exchange fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or if at any later time the exchange fails to submit suitable amendments to the plan, the commissioner shall adopt, pursuant to chapter 17A, rules necessary to administer this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the exchange and approved by the commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

a. The handling and accounting of assets and moneys of the exchange.

b. The amount and method of reimbursing members of the board.

c. Regular times and places for meetings of the board.

d. Records to be kept of all financial transactions, and the annual fiscal reporting to the commissioner.

e. The periodic advertising of the general availability of health insurance coverage from the exchange.

f. Additional provisions necessary or proper for the execution of the powers and duties of the exchange.

2. The plan of operation may provide that the powers and duties of the exchange may be delegated to a person who will perform functions similar to those of the exchange. A delegation under this section takes effect only upon the approval of both the board and the commissioner. The commissioner shall not approve a delegation unless the protections afforded to the insureds are substantially equivalent to or greater than those provided under this chapter.

3. The exchange has the general powers and authority enumerated by this section and executed in accordance with the plan of operation approved by the commissioner under

subsection 1. The exchange has the general powers and authority granted under the laws of this state to carriers licensed to issue health insurance coverage. In addition, the exchange may do any of the following:

a. Enter into contracts as necessary or proper to carry out this chapter.

b. Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

c. Take legal action necessary to avoid the payment of improper claims against the exchange or the coverage provided by or through the exchange.

d. Establish or utilize a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

e. Establish appropriate rates, scales of rates, rate classifications, and rating adjustments, which rates shall not be unreasonable in relation to the health care coverage provided and the reasonable operations expenses of the exchange.

f. Pool risks among members.

g. Issue exchange policies on an indemnity or provision of service basis providing the health care coverage required by this chapter.

h. Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

i. Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the exchange.

j. Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the exchange, policy and other contract design, and any other functions within the authority of the exchange.

k. Hire independent consultants as necessary.

l. Develop a method of advising applicants of the availability of other health care coverages outside the exchange.

m. Include in its policies a provision providing for subrogation rights by the exchange in a case in which the exchange pays expenses on behalf of an individual who is injured or suffers a disease under circumstances creating a liability upon another person to pay damages to the extent of the expenses paid by the exchange but only to the extent the damages exceed the policy deductible and coinsurance amounts paid by the insured. The exchange may waive its subrogation rights if it determines that the exercise of the rights would be impractical, uneconomical, or would work a hardship on the insured.

n. Establish lines of credit, and establish one or more cash and investment accounts to receive payments for services rendered, appropriations from the state, and all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the federal Employee Retirement Income Security Act of 1974.

o. Design and approve the use of its trademarks, brand names, seals, logos, and similar instruments by participating carriers, employers, or organizations.

p. Enter into agreements with the department of revenue, the department of human services, the division of insurance, and any other state agencies the exchange deems necessary to administer its duties under this chapter.

q. Seek and receive any grant funding from the federal government, departments or agencies of the state, and private foundations.

4. Following the close of each calendar year, the exchange shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the exchange for the year. The exchange shall certify the amount of any net loss for the preceding calendar year to the commissioner and director of revenue. Any loss shall be assessed by the exchange to all members of the exchange in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year or on any other equitable basis as provided in the plan of operation. In sharing losses, the exchange may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the

ability of the member to fulfill its contractual obligations. The exchange may also provide for an initial or interim assessment against members of the exchange if necessary to assure the financial capability of the exchange to meet the incurred or estimated claims expenses or operating expenses of the exchange until the next calendar year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums.

a. For purposes of this subsection, "total health insurance premiums" and "payments for subscriber contracts" include, without limitation, premiums or other amounts paid to or received by a member for individual and group health plan coverage provided under any chapter of the Code or Acts, and "paid losses" includes, without limitation, claims paid by a member operating on a self=funded basis for individual and group health plan coverage provided under any chapter of the Code or Acts.

b. For purposes of calculating and conducting the assessment under this subsection, the exchange shall have the express authority to require members to report on an annual basis each member's total health insurance premiums and payments for subscriber contracts and paid losses. A member is liable for its share of the assessment calculated in accordance with this section regardless of whether it participates in the individual insurance market.

5. The exchange shall conduct annual audits to assure the general accuracy of the financial data submitted to the exchange, and the exchange shall have an annual audit of its operations, made by an independent certified public accountant.

6. The exchange is subject to examination by the commissioner. Not later than April 30 of each year, the board shall submit to the commissioner a financial report for the preceding calendar year in a form approved by the commissioner.

7. The exchange is subject to oversight by the legislative fiscal committee of the legislative council. Not later than April 30 of each year, the board shall submit to the governor, the speaker of the house of representatives, the majority leader of the senate, and the legislative fiscal committee a financial report, including enrollment information, for the preceding year in a form approved by the committee.

8. All policy forms issued by the exchange must be filed with and approved by the commissioner before their use.

9. The exchange is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

10. The exchange shall develop and implement a plan and corresponding timeline detailing action steps toward implementing this chapter, by rules adopted pursuant to chapter 17A as provided in section 514M.7.

Sec. 6. NEW SECTION. 514M.6 IOWA CHOICE INSURANCE EXCHANGE COVERAGE.

1. The exchange, in collaboration with the Iowa Medicaid enterprise and the hawk=i board, shall develop a comprehensive health care coverage plan to provide health care coverage to all children without such coverage, that utilizes and modifies existing public programs including the medical assistance program and hawk=i program and maximizes the ability of the state to obtain federal funding and reimbursement for such programs. The plan shall also provide access to private unsubsidized, affordable, qualified health care coverage to children who are not otherwise eligible for health care coverage through public programs.

2. The comprehensive plan developed by the exchange shall also consider and recommend options to provide access to private unsubsidized, affordable, qualified health care coverage to all Iowa children less than nineteen years of age with a family income that is more than three hundred percent of the federal poverty level and to adults and families with a family income that is up to four hundred percent of the federal poverty level who are not otherwise eligible for health care coverage through public programs.

3. The comprehensive plan developed by the exchange shall also consider and recommend options to offer a program to provide coverage under the state health or medical group insurance plan to nonstate public employees, including employees of counties, cities, schools, and community colleges, and employees of nonprofit employers and small employers and to pool such employees with the state plan. The program developed shall allow employees and officials of such

employers who apply for coverage to be covered under the state plan under the same conditions that state employees are covered under the state plan and not be denied coverage on the basis of risk, cost, preexisting conditions, or other factors not applicable to state employees. The plan may include options for the coverage of such employees and officials under the state plan that include but are not limited to the following:

a. Criteria for participation in and withdrawal from the program.

b. Minimum participation intervals.

c. Collaboration with the department of administrative services to develop coverage options for coverage from vendors other than those providing coverage to state employees and under plans different from those available to state employees, that meet minimum standards of quality and affordability.

d. Application and enrollment procedures.

e. Premium rates and procedures for the payment of premiums by participants.

4. The exchange shall have broad authority to accomplish the purposes of this chapter, including but not limited to:

a. Establishing, by rule, what constitutes qualified health care coverage within parameters set by statute which may include consideration of the following factors:

(1) Setting parameters for what is affordable by creating an affordability schedule that is conservative to prevent harm to people who are struggling financially and that utilizes a progressive scale of subsidization by the state that decreases as incomes increase and requires people with very low incomes to pay only small amounts for health care coverage with no financial penalties.

(2) Setting the maximum limit for affordability of coverage at approximately six and one=half percent of an individual's or family's income, including consideration of assets held.

b. Establishing what constitutes qualified health care coverage which meets certain standards of quality and affordability. For purposes of defining qualified health care coverage, the board may consider requirements for coverage and benefits that include but are not limited to:

(1) No underwriting requirements and no preexisting condition exclusions.

(2) Portability.

(3) Coverage of physical, behavioral, and dental health services, vision services, and prescription drugs.

(4) Copayments and deductibles that do not exceed specified amounts, with no copayments or deductibles for wellness, prevention, disease, and chronic care management services.

(5) No reimbursement of providers for an otherwise covered service if the service is required solely on account of the provider's avoidable medical error.

(6) A requirement that all insureds have a medical home.

(7) Coverage of wellness, prevention, disease management, and chronic care management services including, without limitation, physical and psycho=social screenings for children which satisfy the Medicaid early periodic screening, diagnosis, and treatment standards.

(8) Coverage of emergency mental health services when provided by a state=certified emergency mental health services provider.

(9) Incentives for participating health care providers that:

(a) Utilize electronic prescriptions.

(b) Utilize electronic medical records.

(c) Provide rate schedules of all services provided to the board.

c. Establishing threshold requirements for a future mandate to provide health care coverage that must be met by parents of children less than nineteen years of age with family incomes greater than three hundred percent of the federal poverty level.

d. Collaborating with carriers to do the following, including but not limited to:

(1) Assuring the availability of private health insurance coverage to all Iowans by designing solutions to issues related to guaranteed issuance of insurance, preexisting condition exclusions, portability, and allowable pooling and rating classifications.

(2) Formulating principles that ensure fair and appropriate practices related to issues involving individual

health insurance policies such as recision and preexisting condition clauses, and that provide for a binding third party review process to resolve disputes related to such issues.

(3) Designing affordable, portable health insurance plans that meet the needs of low=income populations.

5. The exchange shall design and implement a health care coverage program called Iowa choice which offers private qualified health care coverage through the exchange with options to purchase at least three levels of benefits including a gold plan which offers a comprehensive benefits package, a silver plan which offers a medium benefits package, and a bronze plan which offers a basic benefits package. The Iowa choice care plans shall be available for purchase by individuals and families. The purchase of Iowa choice health care coverage may be publicly subsidized for low=income individuals and families who do not meet eligibility guidelines for any other public program. Iowa choice health care coverage shall also provide affordable, unsubsidized qualified health care coverage options for purchase by any person who wishes to purchase them, including individuals, families, and employees of small businesses.

6. The exchange shall design and administer a subsidy program for payment of premiums for health care coverage for low=income people that complements, not supplants, Medicaid and includes cost=sharing by the insured using a sliding scale based on income utilizing the federal poverty level guidelines. The subsidy program may include subsidizing an employee's purchase of health insurance offered by that person's employer. The subsidy program may be implemented incrementally as funding becomes available and may include rolling implementation of the program to specified subgroups of low=income children, adults, and families with incomes up to four hundred percent of the federal poverty level.

7. The exchange shall provide for the coordination of a children's health care network in the state that acts as a resource for consumers to transition seamlessly among public and private health care coverage options, including but not limited to medical assistance, hawk=i, and Iowa choice care programs.

8. The exchange shall conduct a study of the cost to the state of providing public health care coverage to undocumented children including information concerning how many undocumented children live in the state, where the undocumented children live, and a comparison of the social and economic impacts of providing or not providing public health care coverage to such children.

9. The exchange shall conduct a study of pharmacy benefits managers in the state to review all of the following:

a. Transparency and disclosure arrangements between pharmacy benefits managers and covered entities.

b. Confidentiality protections for information disclosed to covered entities and remedies for unauthorized disclosure.

c. The ability of covered entities to audit pharmacy benefits managers.

d. Appropriate remedies for covered entities to enforce a provision of or for a violation of a provision of chapter 510B, as amended in this Act.

10. The exchange shall implement initiatives such as uniform insurance applications, uniform billing and coding procedures in Iowa choice plans, and other standardized administrative procedures that make the purchase of insurance easier and lower administrative costs. The board may determine what constitutes an equitable administrative formula for carriers.

11. The exchange shall encourage initiatives that allow portability of insurance plans offered by the exchange.

12. The exchange may set and control premiums by establishing what constitutes reasonable rates to ensure affordability of coverage.

13. The exchange shall study the ramifications of requiring each employer with more than ten employees in the state to adopt and maintain a cafeteria plan that satisfies section 125 of the federal Internal Revenue Code of 1986, and the rules adopted by the exchange.

14. The exchange shall establish procedures for the selection and approval of qualified health care coverage plans to be offered through the exchange.

15. The exchange shall establish procedures for the enrollment of eligible individuals and groups.

16. The exchange shall establish procedures for appeals of eligibility decisions for the Iowa choice insurance exchange.

17. The exchange shall operate a health insurance service center that collects and distributes information to consumers about all health insurance policies, contracts, and plans available in the state and provides information to eligible Iowans about the exchange.

18. The exchange shall establish and manage a system of collecting all premium payments made by, or on behalf of, individuals obtaining health insurance through the exchange, including any premium payments made by enrollees, employers, unions, or other organizations.

19. The exchange shall establish and manage a system of remitting premium assistance payments to the carriers.

20. The exchange shall establish a plan for publicizing the existence of the exchange and the exchange's requirements and enrollment procedures.

21. The exchange shall develop criteria for determining that certain health insurance plans shall no longer be made available through the exchange, and develop a plan to decertify and remove exchange approval from certain health benefit plans.

22. The exchange shall develop criteria for health insurance plans eligible for premium assistance payments through the Iowa choice insurance exchange.

23. The exchange shall establish criteria for determining each applicant's eligibility to purchase health insurance offered by the exchange, including eligibility for premium assistance payments.

24. The exchange shall establish criteria for insurance producers licensed under chapter 522B to sell private health care coverage offered through the exchange, including the amount of commission which may be earned for sales of such coverage.

25. The exchange may contract with professional service firms as deemed necessary to carry out the requirements of this section, and fix their compensation.

26. The exchange may contract with companies which provide third=party administrative and billing services for health insurance products.

27. The exchange shall design a premium schedule to be published by the exchange by December 1 of each year, which, accounting for maximum pricing in all rating factors with an exception for age, includes the lowest premium on the market for which an individual would be eligible for qualified health care coverage as determined by the board. The schedule shall publish premiums allowing variance for age and rate basis type.

Sec. 7. NEW SECTION. 514M.7 RULES.

The commissioner and the board shall adopt rules pursuant to chapter 17A, to implement the provisions of this chapter.

Sec. 8. NEW SECTION. 514M.8 IOWA CHOICE INSURANCE EXCHANGE FUND ESTABLISHED.

1. The Iowa choice insurance exchange fund is created in the state treasury as a separate fund under the control of the exchange. There shall be credited to the fund all moneys collected from premiums paid for health care plans offered by the exchange, and any other funds that are appropriated or transferred to the fund. All moneys deposited or paid into the fund shall only be appropriated to the exchange to be used for the purposes set forth in this chapter.

2. Notwithstanding section 8.33, any balance in the fund on June 30 of each fiscal year shall not revert to the general fund of the state, but shall be available for purposes of this chapter in subsequent fiscal years.

Sec. 9. NEW SECTION. 514M.9 COLLECTIVE ACTION == IMMUNITY.

Neither the participation by carriers or members in the exchange, the establishment of rates, forms, or procedures for coverage issued by the exchange, nor any joint or collective action required by this chapter shall be the basis of any legal civil action, or criminal liability against the exchange or members of it either jointly or separately.

Sec. 10. NEW SECTION. 514M.10 UNIVERSAL HEALTH CARE COVERAGE == TRANSITION == IMPLEMENTATION.

1. To protect the health of all Iowans, the board shall design and implement a program, including a timetable and procedures for implementation, to ensure that all children in the state have qualified health care coverage by maximizing the use of state and private financial support as follows:

a. All children who are eligible for Medicaid and hawk=i shall have coverage by December 31, 2010. Parents of such children shall provide proof that each child has qualified

health care coverage at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns or during school registration.

b. As funding becomes available, the state shall provide a subsidy to assist with the purchase of qualified health care coverage for the remaining uninsured children up to nineteen years of age with a family income of up to four hundred percent of the federal poverty level, using a sliding scale based on family income. Parents of such children who are eligible for subsidies shall provide proof that each child has qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns or during school registration.

c. All parents of children less than nineteen years of age shall be required to provide proof that each child has qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement shall include a reporting requirement on Iowa income tax returns or during school registration.

2. To protect the health of all Iowans, the board shall design and implement a program, including a timetable and procedures for implementation after all children have qualified health care coverage, to ensure that all adults in the state have qualified health care coverage as follows:

a. The state shall continue to expand options for individuals who are dually eligible for Medicare and Medicaid by utilizing evidence=based care.

b. As funding becomes available, the state shall provide a subsidy to assist uninsured health and long=term care workers with the purchase of qualified health care coverage. "Health and long=term care workers" shall be defined by the board by rules adopted under chapter 17A. A health or long=term care worker who is eligible for the subsidy shall provide proof of qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns.

c. As funding becomes available, the state shall provide a subsidy to assist with the purchase of qualified health care coverage by the remaining uninsured adults with a family income of up to four hundred percent of the federal poverty level, using a sliding scale based on income. A person who is eligible for the subsidy shall provide proof of qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns.

d. All adults shall be required to provide proof of qualified health care coverage, at a time and in a manner as specified by the board by rule. Implementation of this requirement may include a reporting requirement on Iowa income tax returns.

3. An adult or parent of a child who is required to provide proof of qualified health care coverage of the adult or child and does not do so shall automatically be assigned and enrolled in the appropriate health care coverage program at a cost and in a time and manner determined by the board by rule.

4. The board shall collaborate with the department of human services, the insurance division of the department of commerce, and with members of the exchange to institute health insurance reforms that may become effective once universal health coverage of all Iowans has been achieved. Such reforms may include:

a. Carriers will enroll any applicant rated up to two hundred percent of standard at a maximum premium rate of one hundred fifty percent of the standard rate.

b. Any applicant rated over two hundred percent of standard will be enrolled in a plan offered by the state, such as the Iowa comprehensive health insurance association pool or the Iowa choice insurance exchange pool or a combination thereof at one hundred fifty percent of standard premium rates with the state subsidizing any cost over that amount.

c. Carriers will offer open enrollment periods where any applicant may enroll with no preexisting condition exclusions.

d. Carriers will guarantee issuance of insurance with no preexisting condition exclusions if an applicant has no more than sixty=three days of lapse of coverage.

5. The Iowa choice insurance exchange program shall be implemented by the board by rule pursuant to chapter 17A in

accordance with parameters and schedules established by statute. The administrative rules review committee may provide oversight of the rules through the administrative rulemaking process.

COORDINATING AMENDMENTS

Sec. 11. Section 21.2, subsection 1, Code 2009, is amended by adding the following new paragraph:

NEW PARAGRAPH. i. A nonprofit corporation established pursuant to chapter 514M.

Sec. 12. Section 22.1, subsection 1, Code 2009, is amended to read as follows:

1. The term "government body" means this state, or any county, city, township, school corporation, political subdivision, tax=supported district, nonprofit corporation other than a fair conducting a fair event as provided in chapter 174, whose facilities or indebtedness are supported in whole or in part with property tax revenue and which is licensed to conduct pari=mutuel wagering pursuant to chapter 99D, nonprofit corporation established pursuant to chapter 514M, or other entity of this state, or any branch, department, board, bureau, commission, council, committee, official, or officer of any of the foregoing or any employee delegated the responsibility for implementing the requirements of this chapter.

Sec. 13. Section 514E.1, subsections 15 and 22, Code 2009, are amended by striking the subsections.

Sec. 14. Section 514E.2, subsection 3, unnumbered paragraph 1, Code 2009, is amended to read as follows:

The association shall submit to the commissioner a plan of operation for the association and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. ~~The plan of operation shall include provisions for the development of a comprehensive health care coverage plan as provided in section 514E.5. In developing the comprehensive plan the association shall give deference to the recommendations made by the advisory council as provided in section 514E.6, subsection 1. The association shall approve or disapprove but shall not modify recommendations made by the advisory council. Recommendations that are approved shall be included in the plan of operation submitted to the commissioner. Recommendations that are disapproved shall be submitted to the commissioner with reasons for the disapproval.~~ The plan of operation becomes effective upon approval in writing by the commissioner prior to the date on which the coverage under this chapter must be made available. After notice and hearing, the commissioner shall approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association, and provides for the sharing of association losses, if any, on an equitable and proportionate basis among the member carriers. If the association fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or if at any later time the association fails to submit suitable amendments to the plan, the commissioner shall adopt, pursuant to chapter 17A, rules necessary to implement this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

Sec. 15. Sections 514E.5 and 514E.6, Code 2009, are repealed.

DIVISION II

HEALTH CARE COVERAGE OF ADULT CHILDREN

Sec. 16. Section 422.7, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 29A. If the health benefits coverage or insurance of the taxpayer includes coverage of a nonqualified tax dependent as determined by the federal internal revenue service, subtract, to the extent included, the amount of the value of such coverage attributable to the nonqualified tax dependent.

Sec. 17. Section 509.3, subsection 8, Code 2009, is amended to read as follows:

8. A provision that the insurer will permit continuation of existing coverage or reenrollment in previously existing coverage for an unmarried child of an insured or enrollee who so elects, at least through the policy anniversary date on or after the date the child marries, ceases to be a resident of this state, or attains the age of twenty=five years old,

whichever occurs first, or so long as the unmarried child maintains full=time status as a student in an accredited institution of postsecondary education.

In addition to the provisions required in subsections 1 through 7, the commissioner shall require provisions through the adoption of rules implementing the federal Health Insurance Portability and Accountability Act, Pub. L. No. 104=191.

Sec. 18. Section 509A.13B, Code 2009, is amended to read as follows:

509A.13B ~~CONTINUATION OF DEPENDENT~~ COVERAGE OF CHILDREN == CONTINUATION OR REENROLLMENT.

If a governing body, a county board of supervisors, or a city council has procured accident or health care coverage for its employees under this chapter such coverage shall permit continuation of existing coverage or reenrollment in previously existing coverage for an unmarried child of an insured or enrollee who so elects, at least through the policy anniversary date on or after the date the child marries, ceases to be a resident of this state, or attains the age of twenty=five years old, whichever occurs first, or so long as the unmarried child maintains full=time status as a student in an accredited institution of postsecondary education.

Sec. 19. Section 514A.3B, subsection 2, Code 2009, is amended to read as follows:

2. An insurer issuing an individual policy or contract of accident and health insurance which provides coverage for children of the insured shall permit continuation of existing coverage or reenrollment in previously existing coverage for an unmarried child of an insured or enrollee who so elects, at least through the policy anniversary date on or after the date the child marries, ceases to be a resident of this state, or attains the age of twenty=five years old, whichever occurs first, or so long as the unmarried child maintains full=time status as a student in an accredited institution of postsecondary education.

Sec. 20. APPLICABILITY. The sections of this Act amending section 509.3, subsection 8, 509A.13B, and 514A.3B, subsection 2, apply to policies, contracts, or plans of accident and health insurance delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2009.

Sec. 21. RETROACTIVE APPLICABILITY DATE. The section of this Act enacting section 422.7, subsection 29A, applies retroactively to January 1, 2009, for tax years beginning on or after that date.

DIVISION III
MEDICAL ASSISTANCE AND HAWK=I PROVISIONS
COVERAGE FOR ALL INCOME=ELIGIBLE CHILDREN

Sec. 22. NEW SECTION. 249A.3A MEDICAL ASSISTANCE == ALL INCOME=ELIGIBLE CHILDREN.

The department shall provide medical assistance to individuals under nineteen years of age who meet the income eligibility requirements for the state medical assistance program and for whom federal financial participation is or becomes available for the cost of such assistance.

Sec. 23. NEW SECTION. 514I.8A HAWK=I == ALL INCOME=ELIGIBLE CHILDREN.

The department shall provide coverage to individuals under nineteen years of age who meet the income eligibility requirements for the hawk=i program and for whom federal financial participation is or becomes available for the cost of such coverage.

REQUIRED APPLICATION FOR DEPENDENT CHILD HEALTH CARE COVERAGE

Sec. 24. Section 422.12M, Code 2009, is amended to read as follows:

422.12M INCOME TAX FORM == INDICATION OF DEPENDENT CHILD HEALTH CARE COVERAGE.

1. The director shall draft the income tax form to ~~allow~~ require beginning with the tax returns for tax year ~~2008~~ 2010, a person who files an individual or joint income tax return with the department under section 422.13 to indicate the presence or absence of health care coverage for each dependent child for whom an exemption is claimed.

2. Beginning with the income tax return for tax year ~~2008~~ 2010, a person who files an individual or joint income tax return with the department under section 422.13, ~~may~~ shall report on the income tax return, in the form required, the presence or absence of health care coverage for each dependent child for whom an exemption is claimed.

a. If the taxpayer indicates on the income tax return that a dependent child does not have health care coverage, and the

income of the taxpayer's tax return does not exceed the highest level of income eligibility standard for the medical assistance program pursuant to chapter 249A or the hawk=i program pursuant to chapter 514I, the department shall send a notice to the taxpayer indicating that the dependent child may be eligible for the medical assistance program or the hawk=i program and providing information to the taxpayer about how to enroll the dependent child in the ~~programs~~ appropriate program. The taxpayer shall submit an application for the appropriate program within ninety days of receipt of the enrollment information.

~~b. Notwithstanding any other provision of law to the contrary, a taxpayer shall not be subject to a penalty for not providing the information required under this section.~~

~~c.~~ b. The department shall consult with the department of human services in developing the tax return form and the information to be provided to tax filers under this section.

3. The department, in cooperation with the department of human services, shall adopt rules pursuant to chapter 17A to administer this section, including rules defining "health care coverage" for the purpose of indicating its presence or absence on the tax form and enforcement provisions relating to the required indication of a dependent child's health care coverage status on the tax form and the required application for an appropriate program as specified in this section.

4. The department, in cooperation with the department of human services, shall report, annually, to the governor and the general assembly all of the following:

a. The number of Iowa families, by income level, claiming the state income tax exemption for dependent children.

b. The number of Iowa families, by income level, claiming the state income tax exemption for dependent children ~~who also~~ and whether they indicate the presence or absence of health care coverage for the dependent children.

c. The effect of the reporting requirements and provision of information ~~requirements~~ required under this section on the number and percentage of children in the state who are uninsured.

d. The number of those indicating the absence of coverage who comply or do not comply with the requirement for application for an appropriate program, and any enforcement action taken.

PREGNANT WOMEN INCOME ELIGIBILITY FOR MEDICAID

Sec. 25. Section 249A.3, subsection 1, paragraph l, Code 2009, is amended to read as follows:

l. (1) Is an infant whose income is not more than two hundred percent of the federal poverty level, as defined by the most recently revised income guidelines published by the United States department of health and human services.

(2) Additionally, effective July 1, 2009, medical assistance shall be provided to ~~an~~ a pregnant woman or infant whose family income is at or below three hundred percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services, if otherwise eligible.

Sec. 26. Section 514I.8, subsection 1, Code 2009, is amended to read as follows:

1. Effective July 1, 1998, and notwithstanding any medical assistance program eligibility criteria to the contrary, medical assistance shall be provided to, or on behalf of, an eligible child under the age of nineteen whose family income does not exceed one hundred thirty=three percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services. Additionally, effective July 1, 2000, and notwithstanding any medical assistance program eligibility criteria to the contrary, medical assistance shall be provided to, or on behalf of, an eligible infant whose family income does not exceed two hundred percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services. Effective July 1, 2009, and notwithstanding any medical assistance program eligibility criteria to the contrary, medical assistance shall be provided to, or on behalf of, a pregnant woman or an eligible child who is an infant and whose family income is at or below three hundred percent of the federal poverty level, as defined by the most recently revised poverty income guidelines published by the United States department of health and human services.

Sec. 27. Section 249A.4, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 16. Implement the premium assistance program options described under the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3, for the medical assistance program. The department may adopt rules as necessary to administer these options.

Sec. 28. Section 513C.3, subsections 14 and 15, Code 2009, are amended to read as follows:

14. "Qualifying event" means any of the following:

a. Loss of eligibility for medical assistance provided pursuant to chapter 249A, coverage provided pursuant to chapter 514I, or Medicare coverage provided pursuant to Title XVIII of the federal Social Security Act.

b. Loss or change of dependent status under qualifying previous coverage.

c. The attainment by an individual of the age of majority.

d. Loss of eligibility for the hawk=i program authorized in chapter 514I.

15. a. "Qualifying existing coverage" or "qualifying previous coverage" means benefits or coverage provided under any of the following:

~~a.~~ (1) Any group health insurance that provides benefits similar to or exceeding benefits provided under the standard health benefit plan, provided that such policy has been in effect for a period of at least one year.

~~b.~~ (2) An individual health insurance benefit plan, including coverage provided under a health maintenance organization contract, a hospital or medical service plan contract, or a fraternal benefit society contract, that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, provided that such policy has been in effect for a period of at least one year.

~~c.~~ (3) An organized delivery system that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, provided that the benefits provided by the organized delivery system have been in effect for a period of at least one year.

(4) Coverage provided under chapter 249A or 514I.

b. For purposes of this subsection, an association policy under chapter 514E is not considered "qualifying existing coverage" or "qualifying previous coverage".

Sec. 29. Section 514A.3B, subsection 1, Code 2009, is amended to read as follows:

1. An insurer which accepts an individual for coverage under an individual policy or contract of accident and health insurance shall waive any time period applicable to a preexisting condition exclusion or limitation period requirement of the policy or contract with respect to particular services in an individual health benefit plan for the period of time the individual was previously covered by qualifying previous coverage as defined in section 513C.3 that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty=three days prior to the effective date of the new policy or contract. Any days of ~~coverage provided to an individual pursuant to chapter 249A or 514I, or~~ Medicare coverage provided pursuant to Title XVIII of the federal Social Security Act, do not constitute qualifying previous coverage. Such days of ~~chapter 249A or 514I or~~ Medicare coverage shall be counted as part of the maximum sixty=three=day grace period and shall not constitute a basis for the waiver of any preexisting condition exclusion or limitation period. Any days of coverage provided to an individual pursuant to chapter 249A or 514I constitute qualifying previous coverage.

Sec. 30. Section 514E.5, subsections 1 and 7, Code 2009, are amended to read as follows:

1. The association, in consultation with the Iowa choice health care coverage advisory council, shall develop a comprehensive health care coverage plan to provide health care coverage to all children without such coverage, that utilizes and modifies existing public programs including the medical assistance program~~,~~ and hawk=i program, ~~and hawk=i expansion program,~~ and to provide access to private unsubsidized, affordable, qualified health care coverage to children who are not otherwise eligible for health care coverage through public programs.

7. The association shall submit the comprehensive plan

required by this section to the governor and the general assembly by December 15, 2008. The appropriations to cover children under the medical assistance~~,~~ and hawk=i~~, and hawk=i expansion~~ programs as provided in this Act and to provide related outreach for fiscal year 2009=2010 and fiscal year 2010=2011 are contingent upon enactment of a comprehensive plan during the 2009 regular session of the Eighty=third General Assembly that provides health care coverage for all children in the state. Enactment of a comprehensive plan shall include a determination of what the prospects are of federal action which may impact the comprehensive plan and the fiscal impact of the comprehensive plan on the state budget.

Sec. 31. Section 514I.1, subsection 4, Code 2009, is amended to read as follows:

4. It is the intent of the general assembly that the hawk=i program be an integral part of the continuum of health insurance coverage and that the program be developed and implemented in such a manner as to facilitate movement of families between health insurance providers and to facilitate the transition of families to private sector health insurance coverage. ~~It is the intent of the general assembly in developing such continuum of health insurance coverage and in facilitating such transition, that beginning July 1, 2009, the department implement the hawk=i expansion program.~~

Sec. 32. Section 514I.2, subsection 8, Code 2009, is amended by striking the subsection.

Sec. 33. Section 514I.3, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 6. Health care coverage provided under this chapter in accordance with Title XXI of the federal Social Security Act shall be recognized as prior creditable coverage as defined in the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104=191, and as qualifying previous coverage as defined in sections 514A.3B and 513C.3 for the purposes of portability to private individual or group health insurance coverage. If necessary to prove such prior creditable coverage or qualifying previous coverage, the department shall issue certificates of creditable coverage to the family of a participating eligible child moving from coverage under this chapter to private health care coverage.

Sec. 34. Section 514I.4, subsection 2, Code 2009, is amended to read as follows:

2. a. The director, with the approval of the board, may contract with participating insurers to provide dental=only services.

b. The director, with the approval of the board, may contract with participating insurers to provide the supplemental dental=only coverage to otherwise eligible children who have private health care coverage as specified in the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3.

Sec. 35. Section 514I.4, subsection 5, paragraphs a and b, Code 2009, are amended to read as follows:

a. Develop a joint program application form ~~not to exceed two pages in length, which is consistent with the rules of the board,~~ which is easy to understand, complete, and concise, ~~and which, to the greatest extent possible, coordinates with the~~ supplemental forms, and the same application and renewal verification process for both the hawk=i and medical assistance ~~program~~ programs.

b. (1) Establish the family cost sharing amounts for children of families with incomes of one hundred fifty percent or more but not exceeding two hundred percent of the federal poverty level, of not less than ten dollars per individual and twenty dollars per family, if not otherwise prohibited by federal law, with the approval of the board.

(2) Establish for children of families with incomes exceeding two hundred percent but not exceeding three hundred percent of the federal poverty level, family cost=sharing amounts, criteria for modification of the cost=sharing amounts, and graduated premiums, in accordance with federal law, with the approval of the board.

Sec. 36. Section 514I.5, subsection 7, paragraph l, Code 2009, is amended to read as follows:

l. Develop options and recommendations to allow children eligible for the hawk=i ~~or hawk=i expansion~~ program to participate in qualified employer=sponsored health plans through a premium assistance program. The options and recommendations shall ensure reasonable alignment between the benefits and costs of the hawk=i ~~and hawk=i expansion programs~~

program and the employer=sponsored health plans consistent with federal law. ~~The options and recommendations shall be completed by January 1, 2009, and submitted to the governor and the general assembly for consideration as part of the hawk=i and hawk=i expansion programs.~~ In addition, the board shall implement the premium assistance program options described under the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3, for the hawk=i program.

Sec. 37. Section 514I.5, subsection 8, paragraph e, Code 2009, is amended by adding the following new subparagraph:

NEW SUBPARAGRAPH. (15) Translation and interpreter services as specified pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3.

Sec. 38. Section 514I.5, subsection 8, paragraph g, Code 2009, is amended to read as follows:

g. Presumptive eligibility criteria for the program. Beginning July 1, 2009, presumptive eligibility shall be provided for eligible children.

Sec. 39. Section 514I.5, subsection 9, Code 2009, is amended to read as follows:

9. a. The hawk=i board may provide approval to the director to contract with participating insurers to provide dental=only services. In determining whether to provide such approval to the director, the board shall take into consideration the impact on the overall program of single source contracting for dental services.

b. The hawk=i board may provide approval to the director to contract with participating insurers to provide the supplemental dental=only coverage to otherwise eligible children who have private health care coverage as specified in the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3.

Sec. 40. Section 514I.6, subsections 2 and 3, Code 2009, are amended to read as follows:

2. Provide or reimburse accessible, quality medical or dental services.

3. Require that any plan provided by the participating insurer establishes and maintains a conflict management system that includes methods for both preventing and resolving disputes involving the health or dental care needs of eligible children, and a process for resolution of such disputes.

Sec. 41. Section 514I.6, subsection 4, paragraph a, Code 2009, is amended to read as follows:

a. A list of providers of medical or dental services under the plan.

Sec. 42. Section 514I.7, subsection 2, paragraph d, Code 2009, is amended to read as follows:

d. Monitor and assess the medical and dental care provided through or by participating insurers as well as complaints and grievances.

Sec. 43. Section 514I.8, subsection 2, paragraph c, Code 2009, is amended to read as follows:

c. Is a member of a family whose income does not exceed ~~two~~ three hundred percent of the federal poverty level, as defined in 42 U.S.C. } 9902(2), including any revision required by such section, and in accordance with the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3.

Sec. 44. Section 514I.10, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. Cost sharing for an eligible child whose family income exceeds two hundred percent but does not exceed three hundred percent of the federal poverty level may include copayments and graduated premium amounts which do not exceed the limitations of federal law.

Sec. 45. Section 514I.11, subsections 1 and 3, Code 2009, are amended to read as follows:

1. A hawk=i trust fund is created in the state treasury under the authority of the department of human services, in which all appropriations and other revenues of the program ~~and the hawk=i expansion program~~ such as grants, contributions, and participant payments shall be deposited and used for the purposes of the program ~~and the hawk=i expansion program~~. The moneys in the fund shall not be considered revenue of the state, but rather shall be funds of the program.

3. Moneys in the fund are appropriated to the department and shall be used to offset any program ~~and hawk=i expansion program~~ costs.

Sec. 46. MEDICAL ASSISTANCE PROGRAM == PROGRAMMATIC AND

PROCEDURAL PROVISIONS. The department of human services shall adopt rules pursuant to chapter 17A to provide for all of the following:

1. To allow for the submission of one pay stub per employer by an individual as verification of earned income for the medical assistance program when it is indicative of future income.

2. To allow for an averaging of three years of income for self=employed families to establish eligibility for the medical assistance program.

3. To extend the period for annual renewal by medical assistance members by mailing the renewal form to the member on the first day of the month prior to the month of renewal.

4. To provide for all of the following in accordance with the requirements for qualification for the performance bonus payments described under the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3:

a. Utilization of joint applications and supplemental forms, and the same application and renewal verification processes for the medical assistance and hawk=i programs.

b. Implementation of administrative or paperless verification at renewal for the medical assistance program.

c. Utilization of presumptive eligibility when determining a child's eligibility for the medical assistance program.

d. Utilization of the express lane option, including utilization of other public program databases to reach and enroll children in the medical assistance program.

5. To provide translation and interpretation services under the medical assistance program as specified pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3.

Sec. 47. HAWK=I PROGRAM == PROGRAMMATIC AND PROCEDURAL PROVISIONS. The hawk=i board, in consultation with the department of human services, shall adopt rules pursuant to chapter 17A to provide for all of the following:

1. To allow for the submission of one pay stub per employer by an individual as verification of earned income for the hawk=i program when it is indicative of future income.

2. To allow for an averaging of three years of income for self=employed families to establish eligibility for the hawk=i program.

3. To provide for all of the following in accordance with the requirements for qualification for the performance bonus payments described under the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3:

a. Utilization of joint applications and supplemental forms, and the same application and renewal verification processes for the hawk=i and medical assistance programs.

b. Implementation of administrative or paperless verification at renewal for the hawk=i program.

c. Utilization of presumptive eligibility when determining a child's eligibility for the hawk=i program.

d. Utilization of the express lane option, including utilization of other public program databases to reach and enroll children in the hawk=i program.

Sec. 48. DEMONSTRATION GRANTS == CHIPRA. The department of human services in cooperation with the department of public health and other appropriate agencies, shall apply for grants available under the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111=3, to promote outreach activities and quality child health outcomes under the medical assistance and hawk=i programs.

Sec. 49. Section 514I.12, Code 2009, is repealed.

Sec. 50. EFFECTIVE DATE. The section of this division of this Act amending section 422.12M, takes effect July 1, 2010.

DIVISION IV
VOLUNTEER HEALTH CARE PROVIDERS

Sec. 51. Section 135.24, Code 2009, is amended to read as follows:

135.24 VOLUNTEER HEALTH CARE PROVIDER PROGRAM ESTABLISHED == IMMUNITY FROM CIVIL LIABILITY.

1. The director shall establish within the department a program to provide to eligible hospitals, clinics, free clinics, field dental clinics, <u>health care provider offices,</u> or other health care facilities, health care referral programs, or charitable organizations, free medical, dental, chiropractic, pharmaceutical, nursing, optometric, psychological, social work, behavioral science, podiatric, physical therapy, occupational therapy, respiratory therapy,

and emergency medical care services given on a voluntary basis by health care providers. A participating health care provider shall register with the department and obtain from the department a list of eligible, participating hospitals, clinics, free clinics, field dental clinics, health care provider offices, or other health care facilities, health care referral programs, or charitable organizations.

2. The department, in consultation with the department of human services, shall adopt rules to implement the volunteer health care provider program which shall include the following:

a. Procedures for registration of health care providers deemed qualified by the board of medicine, the board of physician assistants, the dental board, the board of nursing, the board of chiropractic, the board of psychology, the board of social work, the board of behavioral science, the board of pharmacy, the board of optometry, the board of podiatry, the board of physical and occupational therapy, the board of respiratory care, and the Iowa department of public health, as applicable.

b. Procedures for registration of free clinics, ~~and~~ field dental clinics, and health care provider offices.

c. Criteria for and identification of hospitals, clinics, free clinics, field dental clinics, health care provider offices, or other health care facilities, health care referral programs, or charitable organizations, eligible to participate in the provision of free medical, dental, chiropractic, pharmaceutical, nursing, optometric, psychological, social work, behavioral science, podiatric, physical therapy, occupational therapy, respiratory therapy, or emergency medical care services through the volunteer health care provider program. A free clinic, a field dental clinic, a health care provider office, a health care facility, a health care referral program, a charitable organization, or a health care provider participating in the program shall not bill or charge a patient for any health care provider service provided under the volunteer health care provider program.

d. Identification of the services to be provided under the program. The services provided may include, but shall not be limited to, obstetrical and gynecological medical services, psychiatric services provided by a physician licensed under chapter 148, dental services provided under chapter 153, or other services provided under chapter 147A, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 154, 154B, 154C, 154D, 154F, or 155A.

3. A health care provider providing free care under this section shall be considered an employee of the state under chapter 669, shall be afforded protection as an employee of the state under section 669.21, and shall not be subject to payment of claims arising out of the free care provided under this section through the health care provider's own professional liability insurance coverage, provided that the health care provider has done all of the following:

a. Registered with the department pursuant to subsection 1.

b. Provided medical, dental, chiropractic, pharmaceutical, nursing, optometric, psychological, social work, behavioral science, podiatric, physical therapy, occupational therapy, respiratory therapy, or emergency medical care services through a hospital, clinic, free clinic, field dental clinic, health care provider office, or other health care facility, health care referral program, or charitable organization listed as eligible and participating by the department pursuant to subsection 1.

4. A free clinic providing free care under this section shall be considered a state agency solely for the purposes of this section and chapter 669 and shall be afforded protection under chapter 669 as a state agency for all claims arising from the provision of free care by a health care provider registered under subsection 3 who is providing services at the free clinic in accordance with this section or from the provision of free care by a health care provider who is covered by adequate medical malpractice insurance as determined by the department, if the free clinic has registered with the department pursuant to subsection 1.

5. A field dental clinic providing free care under this section shall be considered a state agency solely for the purposes of this section and chapter 669 and shall be afforded protection under chapter 669 as a state agency for all claims arising from the provision of free care by a health care provider registered under subsection 3 who is providing

services at the field dental clinic in accordance with this section or from the provision of free care by a health care provider who is covered by adequate medical malpractice insurance, as determined by the department, if the field dental clinic has registered with the department pursuant to subsection 1.

5A. A health care provider office providing free care under this section shall be considered a state agency solely for the purposes of this section and chapter 669 and shall be afforded protection under chapter 669 as a state agency for all claims arising from the provision of free care by a health care provider registered under subsection 3 who is providing services at the health care provider office in accordance with this section or from the provision of free care by a health care provider who is covered by adequate medical malpractice insurance, as determined by the department, if the health care provider office has registered with the department pursuant to subsection 1.

6. For the purposes of this section:

a. "Charitable organization" means a charitable organization within the meaning of section 501(c)(3) of the Internal Revenue Code.

b. "Field dental clinic" means a dental clinic temporarily or periodically erected at a location utilizing mobile dental equipment, instruments, or supplies, as necessary, to provide dental services.

c. "Free clinic" means a facility, other than a hospital or health care provider's office which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code and which has as its sole purpose the provision of health care services without charge to individuals who are otherwise unable to pay for the services.

d. "Health care provider" means a physician licensed under chapter 148, a chiropractor licensed under chapter 151, a physical therapist licensed pursuant to chapter 148A, an occupational therapist licensed pursuant to chapter 148B, a podiatrist licensed pursuant to chapter 149, a physician assistant licensed and practicing under a supervising physician pursuant to chapter 148C, a licensed practical nurse, a registered nurse, or an advanced registered nurse practitioner licensed pursuant to chapter 152 or 152E, a respiratory therapist licensed pursuant to chapter 152B, a dentist, dental hygienist, or dental assistant registered or licensed to practice under chapter 153, an optometrist licensed pursuant to chapter 154, a psychologist licensed pursuant to chapter 154B, a social worker licensed pursuant to chapter 154C, a mental health counselor or a marital and family therapist licensed pursuant to chapter 154D,* a pharmacist licensed pursuant to chapter 155A, or an emergency medical care provider certified pursuant to chapter 147A.

e. "Health care provider office" means the private office or clinic of an individual health care provider or group of health care providers but does not include a field dental clinic, a free clinic, or a hospital.

DIVISION V

HEALTH CARE WORKFORCE SUPPORT INITIATIVE

Sec. 52. Section 135.11, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 32. Administer the portion of the workforce shortage initiative established in section 261.128 relating to the medical residency training state matching grants program.

Sec. 53. Section 135.153, subsection 2, Code 2009, is amended to read as follows:

2. a. The network shall form a governing group which includes two individuals each representing community health centers, rural health clinics, free clinics, maternal and child health centers, the expansion population provider network as described in chapter 249J, local boards of health that provide direct services, the state board of health, Iowa family planning network agencies, child health specialty clinics, and other safety net providers.

b. The governing group shall administer the portion of the workforce shortage initiative established in section 261.128 relating to the safety net provider recruitment and retention initiatives program.

Sec. 54. Section 261.2, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 10. Administer the portions of the health care workforce support initiative established in section 261.128 relating to the health care professional incentive

payment program and the nursing workforce shortage initiative.

Sec. 55. Section 261.23, subsection 1, Code 2009, is amended to read as follows:

1. A registered nurse and nurse educator loan forgiveness program is established to be administered by the commission. The program shall consist of loan forgiveness for eligible federally guaranteed loans for registered nurses and nurse educators who practice or teach in this state. For purposes of this section, unless the context otherwise requires, "nurse educator" means a registered nurse who holds a master's degree or doctorate degree and is employed as a faculty member who teaches nursing as provided in 655 IAC 2.6(152) at a community college, an accredited private institution, or an institution of higher education governed by the state board of regents.

Sec. 56. Section 261.23, subsection 2, paragraph c, Code 2009, is amended to read as follows:

c. Complete and return, on a form approved by the commission, an affidavit of practice verifying that the applicant is a registered nurse practicing in this state or a nurse educator teaching at a community college, an accredited private institution, or an institution of higher learning governed by the state board of regents.

Sec. 57. NEW SECTION. 261.128 HEALTH CARE WORKFORCE SUPPORT INITIATIVE == WORKFORCE SHORTAGE FUND.

1. HEALTH CARE WORKFORCE SHORTAGE FUND == ACCOUNTS.

a. A health care workforce shortage fund is created in the state treasury as a separate fund under the control of the commission, the department of public health, the governing group of the Iowa collaborative safety net provider network as described in section 135.153, or the state entity identified for receipt of the federal funds by the federal government entity through which the federal funding is available for a specified health care workforce shortage initiative, as specified in this subsection. The fund and the accounts within the fund shall consist of moneys appropriated from the general fund of the state for the healthcare workforce support initiative; moneys received from the federal government for the purposes of addressing the health care workforce shortage; contributions, grants, and other moneys from communities and health care employers; and moneys from any other public or private source available. The commission, the department of public health, the governing group of the Iowa collaborative safety net provider network as described in section 135.153, or the state entity identified for receipt of the federal funds by the federal government entity through which the federal funding is available for a specified health care workforce shortage initiative may receive contributions, grants, and in=kind contributions to support the purposes of the fund and the accounts within the fund.

b. The fund and the accounts within 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 and the accounts within the fund shall not be considered revenue of the state, but rather shall be moneys of the fund or the accounts. The moneys in the fund and the accounts within 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 section. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the fund shall be credited to the fund and the accounts within the fund.

c. The fund shall consist of the following accounts:

(1) The medical residency training account. The medical residency training account shall be under the control of the department of public health and the moneys in the account shall be used for the purposes of the medical residency training state matching grants program as specified in this section. Moneys in the account shall consist of moneys received by the fund or the account and specifically dedicated to the medical residency training account and for the purposes of such account.

(2) The health care professional and nurse workforce shortage initiative account. The health care professional and nurse workforce shortage initiative account shall be under the control of the commission and the moneys in the account shall be used for the purposes of the health care professional incentive payment program and the nurse workforce shortage initiative as specified in this section. Moneys in the account shall consist of moneys received by the fund or the account and specifically dedicated to the health care professional and nurse workforce shortage initiative account

and for the purposes of the account.

(3) The safety net provider network workforce shortage account. The safety net provider network workforce shortage account shall be under the control of the governing group of the Iowa collaborative safety net provider network and the moneys in the account shall be used for the purposes of the safety net provider recruitment and retention initiatives program as specified in this section. Moneys in the account shall consist of moneys received by the fund or the account and specifically dedicated to the safety net provider network workforce shortage account and for the purposes of the account.

(4) The health care workforce shortage national initiatives account. The health care workforce shortage national initiatives account shall be under the control of the state entity identified for receipt of the federal funds by the federal government entity through which the federal funding is available for a specified health care workforce shortage initiative. Moneys in the account shall consist of moneys received by the fund or the account and specifically dedicated to the health care workforce shortage national initiatives account and for a specified health care workforce shortage initiative.

d. (1) Moneys in the fund and the accounts in the fund shall only be appropriated to support the medical residency training state matching grants program, the health care professional incentive payment program, the nurse educator incentive payment and nursing faculty fellowship programs, the safety net recruitment and retention initiatives program, for national health care workforce shortage initiatives, and to provide funding for state health care workforce shortage programs as provided in this section.

(2) For the purposes of this section, in addition to the programs otherwise specified in this section to receive funding, state health care workforce shortage programs that may receive funding from the fund or the accounts within the fund in order to draw down the maximum amount of federal funding available are the primary care recruitment and retention endeavor (PRIMECARRE), the Iowa affiliate of the national rural recruitment and retention network, the primary care office shortage designation program, the state office of rural health, and the Iowa health workforce center, administered through the bureau of health care access of the department of public health; the area health education centers programs at Des Moines university == osteopathic medical center and the university of Iowa; the Iowa collaborative safety net provider network established pursuant to section 135.153; and any entity identified by the federal government entity through which federal funding for a specified health care workforce shortage initiative is received.

(3) State appropriations from the fund shall be made in equal amounts to each of the accounts within the fund. Any federal funding received for the purposes of addressing state health care workforce shortages shall, unless otherwise restricted by federal law or regulation, be allocated equally between the workforce represented by the Iowa safety net provider network and other eligible health care providers in the state.

e. No more than five percent of the moneys in any of the accounts within the fund, not to exceed one hundred thousand dollars in each account, shall be used for administrative purposes, unless otherwise provided by the source of the funds.

2. MEDICAL RESIDENCY TRAINING STATE MATCHING GRANTS PROGRAM.

a. The department of public health shall establish a medical residency training state matching grants program to provide matching state funding to sponsors of accredited graduate medical education residency programs in this state to establish, expand, or support medical residency training programs. For the purposes of this section, unless the context otherwise requires, "accredited" means a graduate medical education program approved by the accreditation council for graduate medical education. The grant funds may be used to support medical residency programs through any of the following:

(1) The establishment of new or alternative campus accredited medical residency training programs. For the purposes of this subparagraph, "new or alternative campus accredited medical residency training program" means a program that is accredited by a recognized entity approved for such

purpose by the accreditation council for graduate medical education with the exception that a new medical residency training program that, by reason of an insufficient period of operation is not eligible for accreditation on or before the date of submission of an application for a grant, may be deemed accredited if the accreditation council for graduate medical education finds, after consultation with the appropriate accreditation entity, that there is reasonable assurance that the program will meet the accreditation standards of the entity prior to the date of graduation of the initial class in the program.

(2) The provision of new residency positions within existing accredited medical residency or fellowship training programs.

(3) The funding of residency positions which are in excess of the federal residency cap. For the purposes of this subparagraph, "in excess of the federal residency cap" means a residency position for which no federal Medicare funding is available because the residency position is a position beyond the cap for residency positions established by the federal Balanced Budget Act of 1997, Pub. L. No. 105=33.

b. The department of public health shall adopt rules pursuant to chapter 17A to provide for all of the following:

(1) Eligibility requirements for and qualifications of a sponsor of an accredited graduate medical education residency program to receive a grant. The requirements and qualifications shall include but are not limited to all of the following:

(a) Only a sponsor that establishes a dedicated fund to support a residency program that meets the specifications of this subsection shall be eligible to receive a matching grant.

(b) A sponsor shall demonstrate through documented financial information as prescribed by rule of the department of public health, that funds have been reserved by the sponsor in the amount required to provide matching funds for each residency proposed in the request for state matching funds.

(c) A sponsor shall demonstrate through objective evidence as prescribed by rule of the department of public health, a need for such residency program in the state.

(2) The application process for the grant.

(3) Criteria for preference in awarding of the grants, including preference in the residency specialty.

(4) Determination of the amount of a grant. The total amount of a grant awarded to a sponsor shall be limited to no more than twenty=five percent of the amount that the sponsor has demonstrated through documented financial information has been reserved by the sponsor for each residency sponsored for the purpose of the residency program.

(5) The maximum award of grant funds to a particular individual sponsor per year. An individual sponsor shall not receive more than twenty=five percent of the state matching funds available each year to support the program.

(6) Use of the funds awarded. Funds may be used to pay the costs of establishing, expanding, or supporting an accredited graduate medical education program as specified in this section, including but not limited to the costs associated with residency stipends and physician faculty stipends.

3. HEALTH CARE PROFESSIONAL INCENTIVE PAYMENT PROGRAM.

a. The commission shall establish a health care professional incentive payment program to recruit and retain health care professionals in this state.

b. The commission shall administer the incentive payment program with the assistance of Des Moines university == osteopathic medical center. From funds appropriated from the health care professional and nurse workforce shortage initiative account of the health care workforce shortage fund for the purposes of the program, the commission shall pay a fee to Des Moines university == osteopathic medical center for the administration of the program.

c. The commission, with the assistance of Des Moines university == osteopathic medical center, shall adopt rules pursuant to chapter 17A, relating to the establishment and administration of the health care professional incentive payment program. The rules adopted shall address all of the following:

(1) Eligibility and qualification requirements for a health care professional, a community, and a health care employer to participate in the incentive payment program. Any community in the state and all health care specialties shall be considered for participation. However, health care

providers located in and communities that are designated as medically underserved areas or populations or that are designated as health professional shortage areas by the health resources and services administration of the United States department of health and human services shall have first priority in the awarding of incentive payments.

(a) To be eligible, a health care professional at a minimum must not have any unserved obligations to a federal, state, or local government or other entity that would prevent compliance with obligations under the loan; must have a current and unrestricted license to practice the professional's respective profession; and must be able to begin full=time clinical practice upon signing an agreement for an incentive payment.

(b) To be eligible, a community must provide a clinical setting for full=time practice of a health care professional and must provide a fifty thousand dollar matching contribution for a physician and a fifteen thousand dollar matching contribution for any other health care professional to receive an equal amount of state matching funds.

(c) To be eligible, a health care employer must provide a clinical setting for a full=time practice of a health care professional and must provide a fifty thousand dollar matching contribution for a physician and a fifteen thousand dollar matching contribution for any other health care professional to receive an equal amount of state matching funds.

(2) The process for awarding incentive payments. The commission shall receive recommendations from the department of public health regarding selection of incentive payment recipients. The process shall require each recipient to enter into an agreement with the commission that specifies the obligations of the recipient and the commission prior to receiving the incentive payment.

(3) Public awareness regarding the program including notification of potential health care professionals, communities, and health care employers about the program and dissemination of applications to appropriate entities.

(4) Measures regarding all of the following:

(a) The amount of the incentive payment and the specifics of obligated service for an incentive payment recipient. An incentive payment recipient shall agree to provide service in full=time clinical practice for a minimum of four years. If an incentive payment recipient is sponsored by a community or health care entity partner, the obligated service shall be provided in the sponsoring community or health care entity location. An incentive payment recipient sponsored by a health care employer shall agree to provide health care services as specified in an employment agreement with the sponsoring health care entity.

(b) Determination of the conditions of the incentive payment applicable to an incentive payment recipient. At the time of approval for participation in the program, an incentive payment recipient shall be required to submit proof of indebtedness incurred as the result of obtaining loans to pay for educational costs resulting in a degree in health sciences. For the purposes of this subparagraph division, "indebtedness" means debt incurred from obtaining a government or commercial loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate, undergraduate, or associate education of a health care professional.

(c) Enforcement of the state's rights under an incentive payment agreement, including the commencement of any court action. A recipient who fails to fulfill the requirements of the incentive payment agreement is subject to repayment of the incentive payment in an amount equal to the amount of the incentive payment. A recipient who fails to meet the requirements of the incentive payment agreement may also be subject to repayment of moneys advanced by a community or health care employer partner as provided in any agreement with the partner.

(d) A process for monitoring compliance with eligibility requirements, obligated service provisions, and use of funds by recipients to verify eligibility of recipients and to ensure that state, federal, and other matching funds are used in accordance with program requirements.

(e) The use of the funds received. Any portion of the incentive payment that is attributable to federal funds shall be used as required by the federal entity providing the funds. Any portion of the incentive payment that is attributable to state funds shall first be used toward payment of any

outstanding loan indebtedness of the recipient. The remaining portion of the incentive payment shall be used as specified in the incentive payment agreement.

d. A recipient is responsible for reporting on federal income tax forms any amount received through the program, to the extent required by federal law. Incentive payments received through the program by a recipient in compliance with the requirements of the incentive payment program are exempt from state income taxation.

5. NURSING WORKFORCE SHORTAGE INITIATIVE.

a. NURSE EDUCATOR INCENTIVE PAYMENT PROGRAM.

(1) The commission shall establish a nurse educator incentive payment program. For the purposes of this paragraph, "nurse educator" means a registered nurse who holds a master's degree or doctorate degree and is employed as a faculty member who teaches nursing in a nursing education program as provided in 655 IAC 2.6 at a community college, an accredited private institution, or an institution of higher education governed by the state board of regents.

(2) The program shall consist of incentive payments to recruit and retain nurse educators. The program shall provide for incentive payments of up to twenty thousand dollars for a nurse educator who remains teaching in a qualified teaching position for a period of not less than four consecutive academic years.

(3) The nurse educator and the commission shall enter into an agreement specifying the obligations of the nurse educator and the commission. If the nurse educator leaves the qualifying teaching position prior to teaching for four consecutive academic years, the nurse educator shall be liable to repay the incentive payment amount to the state, plus interest as specified by rule. However, if the nurse educator leaves the qualifying teaching position involuntarily, the nurse educator shall be liable to repay only a pro rata amount of the incentive payment based on incompleted years of service.

(4) The commission, in consultation with the advisory council, shall adopt rules pursuant to chapter 17A relating to the establishment and administration of the nurse educator incentive payment program. The rules shall include provisions specifying what constitutes a qualifying teaching position.

b. NURSING FACULTY FELLOWSHIP PROGRAM.

(1) The commission shall establish a nursing faculty fellowship program to provide funds to nursing schools in the state, including but not limited to nursing schools located at community colleges, for fellowships for individuals employed in qualifying positions on the nursing faculty. The program shall be designed to assist nursing schools in filling vacancies in qualifying positions throughout the state.

(2) The commission, in consultation with the department of public health and in cooperation with nursing schools throughout the state, shall develop a distribution formula which shall provide that no more than thirty percent of the available moneys are awarded to a single nursing school. Additionally, the program shall limit funding for a qualifying position in a nursing school to no more than ten thousand dollars per year for up to three years.

(3) The commission, in consultation with the department of public health, shall adopt rules pursuant to chapter 17A to administer the program. The rules shall include provisions specifying what constitutes a qualifying position at a nursing school.

(4) In determining eligibility for a fellowship, the commission shall consider all of the following:

(a) The length of time a qualifying position has gone unfilled at a nursing school.

(b) Documented recruiting efforts by a nursing school.

(c) The geographic location of a nursing school.

(d) The type of nursing program offered at the nursing school, including associate, bachelor's, master's, or doctoral degrees in nursing, and the need for the specific nursing program in the state.

6. SAFETY NET PROVIDER RECRUITMENT AND RETENTION INITIATIVES PROGRAM. The Iowa collaborative safety net provider network governing group as described in section 135.153, shall establish a safety net provider incentive payment program to administer recruitment and retention initiatives that may include but are not limited to loan repayment and loan forgiveness programs to address the health care workforce shortages of safety net providers. The department of public health, in cooperation with the Iowa

collaborative safety net provider network shall adopt rules pursuant to chapter 17A for the implementation and administration of such initiatives.

7. ANNUAL REPORT. The commission shall submit an annual report to the governor and the general assembly regarding the status of the health care workforce support initiative, including the balance remaining in and appropriations from the health care workforce shortage fund.

Sec. 58. HEALTH CARE WORKFORCE INITIATIVES == FEDERAL FUNDING. The department of public health shall work with the department of workforce development and health care stakeholders to apply for federal moneys allocated in the federal American Recovery and Reinvestment Act of 2009 for health care workforce initiatives that are available through a competitive grant process administered by the health resources and services administration of the United States department of health and human services or the United States department of health and human services. Any federal moneys received shall be deposited in the health care workforce shortage fund created in section 261.128 of this Act and shall be used for the purposes specified for the fund and for the purposes specified in the federal American Recovery and Reinvestment Act of 2009.

Sec. 59. Sections 261.19 and 261.19B, Code 2009, are repealed.

Sec. 60. CODE EDITOR DIRECTIVE. The Code editor shall create a new division in chapter 261 codifying section 261.128, as enacted in this Act, as the health care workforce support initiative.

DIVISION VI
PHARMACEUTICAL=RELATED INITIATIVES
MEDICATION THERAPY MANAGEMENT

Sec. 61. MEDICATION THERAPY MANAGEMENT == FINDINGS, DIRECTIVE, REPORT.

1. The general assembly finds all of the following:

a. The utilization and reimbursement of pharmaceutical case management services under the medical assistance program has resulted in the successful management of chronic disease states of medical assistance program recipients in a cost=effective manner.

b. The utilization of pharmaceutical case management or medication therapy management is consistent with the concept of a medical home, as defined in section 135.157.

c. The success and cost=effectiveness of medication therapy management in public programs such as the medical assistance and federal Medicare programs could also be realized through private health care coverage and should be a covered benefit under individual and group health insurance policies.

2. Based upon these findings, the general assembly directs all health insurance plans in the state subject to regulation by the commissioner of insurance to examine the feasibility and efficacy of including medication therapy management as a covered benefit under individual and group health insurance policies.

a. If the health insurance plan determines the inclusion of medication therapy management as a covered benefit to be feasible and efficacious, the general assembly encourages the plan to provide such coverage by January 1, 2010.

b. If the health insurance plan determines that inclusion of medication therapy management as a covered benefit is not feasible and efficacious, and does not provide coverage of the health insurance plan by January 1, 2010, the health care plan shall submit, to the chairpersons of the committees on human resources of the senate and house of representatives by January 1, 2010, a written report detailing the health insurance plan's examination and analysis of the issue and any reasons and supporting data for not including medication therapy management as a covered benefit.

3. For the purposes of this section, "medication therapy management" means pharmaceutical case management services as provided under the medical assistance program in accordance with 441 IAC 78.47.

EVIDENCE=BASED PRESCRIPTION DRUG EDUCATION PROGRAM

Sec. 62. NEW SECTION. 155B.1 DEFINITIONS.

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

1. "Board" means the board of pharmacy.

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

3. "Prescription drug" means prescription drug as defined in section 155A.3.

Sec. 63. NEW SECTION. 155B.2 EVIDENCE=BASED PRESCRIPTION DRUG EDUCATION PROGRAM.

1. The board shall establish and administer an evidence=based prescription drug education program designed to provide health care professionals who are licensed to prescribe or dispense prescription drugs with information and education regarding the therapeutic and cost=effective utilization of prescription drugs.

2. a. In establishing and administering the program, the board shall request input and collaboration from physicians, pharmacists, private insurers, hospitals, pharmacy benefits managers, the medical assistance drug utilization review commission, medical and pharmacy schools, and other entities providing evidence=based education to health care professionals that are licensed to prescribe or dispense prescription drugs. To the greatest extent possible, the information regarding the therapeutic and cost=effective utilization of prescription drugs shall be gender, race, ethnicity, and age specific.

b. The board may contract with an Iowa=based college of pharmacy to provide technical and clinical support to the board in establishing and administering the program.

3. The department may establish and collect fees from private payors for participation in the program. The department may seek funding from nongovernmental health foundations or other nonprofit charitable foundations to establish and administer the program.

GIFTS TO HEALTH CARE PRACTITIONERS

Sec. 64. NEW SECTION. 155C.1 PURPOSES.

The purposes of this chapter are to improve the public health and the quality of prescribing and medical decision making; promote consumer access to information relating to medical care and gifts; reduce the inappropriate influence of gifts and payments on provider medical decisions; limit annual increases in the cost of health care; and assist the state in its role as a purchaser of health care services and an administrator of health care programs by enabling the state to determine the effect of gifts on the cost, utilization, and delivery of health care services.

Sec. 65. NEW SECTION. 155C.2 DEFINITIONS.

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

1. "Biologic" means a biological product as defined in 42 U.S.C. } 262.

2. "Bona fide clinical trial" means any research project that prospectively assigns human subjects to intervention and comparison groups to study the cause and effect relationship between a medical intervention and a health outcome.

3. "Department" means the department of administrative services.

4. "Gift" means a payment, fee, food, entertainment, travel, honorarium, subscription, advance, service, subsidy, economic benefit, or anything of value provided, unless consideration of equal or greater value is received, and includes anything of value provided to a health care practitioner for less than market value. "Gift" does not include product samples or negotiated rebates or discounts.

5. "Health care practitioner" means a health care professional who is licensed to prescribe prescription drugs, or a partnership or corporation consisting of such health care professionals, or an officer, employee, agent, or contractor of such a health care professional acting in the course of employment, agency, or contract related to or supportive of the provision of health care by the health care professional.

6. "Manufacturer" means a person engaged in the manufacturing, preparing, propagating, compounding, processing, packaging, repackaging, distributing, or labeling of prescription drugs, biologics, or medical devices.

7. "Medical device" means device as defined in section 155A.3.

8. "Prescription drug" means prescription drug as defined in section 155A.3.

9. "Significant educational, scientific, or policy=making conference or seminar" means an educational, scientific, or policy=making conference or seminar that meets both of the following requirements:

a. Is accredited by the accreditation council for continuing medical education or a comparable organization.

b. Offers continuing medical education credit, features multiple presenters on scientific research, or is authorized by the sponsoring association to recommend or make policy.

10. "State health care program" means a program for which the state purchases prescription drugs, biologics, or medical devices, including but not limited to the medical assistance program, or a state employee, corrections, or retirement system program.

11. "Wholesaler" means wholesaler as defined in section 155A.3.

Sec. 66. NEW SECTION. 155C.3 GIFTS TO HEALTH CARE PRACTITIONERS PROHIBITED.

1. A manufacturer or wholesaler, or a manufacturer's or wholesaler's agent, who participates in a state health care program shall not offer or give any gift to a health care practitioner.

2. Notwithstanding subsection 1, the following gifts are not prohibited but shall be disclosed pursuant to section 155C.4:

a. Payment to the sponsor of a significant educational, scientific, or policy=making conference or seminar if the payment is not made directly to a health care practitioner; the payment is used solely for bona fide educational purposes; and all conference or seminar activities are objective, free from industry influence, and do not promote specific products.

b. Reasonable honoraria and payment of the reasonable expenses of a health care practitioner who serves on the faculty at a significant educational, scientific, or policy=making conference or seminar pursuant to an explicit contract with specific deliverables which are restricted to scientific issues, not marketing efforts, and the content of any presentation, including slides and written materials, are determined by the health care practitioners.

c. Compensation for the substantial professional or consulting services of a health care practitioner in connection with a bona fide clinical trial pursuant to an explicit contract with specific deliverables which are restricted to scientific issues, not marketing efforts.

Sec. 67. NEW SECTION. 155C.4 DISCLOSURE OF EXEMPTED GIFTS.

1. a. Annually, on or before December 1, every manufacturer or wholesaler of prescription drugs, biologics, or medical devices that participates in a state health care program shall disclose to the department, the value, nature, purpose, and recipient of any gift not prohibited in section 155C.3, which is provided by the manufacturer or wholesaler, directly or through its agents, to any health care practitioner or any other person in this state authorized to prescribe, dispense, or purchase prescription drugs, biologics, or medical devices in this state.

b. For each expenditure, the manufacturer or wholesaler shall also identify the recipient and the recipient's address, credentials, institutional affiliation, and state board or drug enforcement agency numbers.

2. Each manufacturer or wholesaler subject to the provisions of this section shall also disclose to the department the name and address of the individual responsible for the manufacturer's or wholesaler's compliance with this section, or if this information has been previously reported, any changes in the name or address of the individual responsible for the manufacturer's or wholesaler's compliance with this section.

3. The report shall be accompanied by payment of a fee, to be established by rule of the department, to defray administrative costs.

4. The department shall make all disclosed data publicly available and easily searchable on its internet site.

Sec. 68. NEW SECTION. 155C.5 DEPARTMENTAL REPORTS.

The department shall provide an annual report to the governor and the general assembly on or before January 15, containing an analysis of the data submitted to the department under section 155C.4. The report shall include all of the following:

1. Information on gifts required to be disclosed under section 155C.4, which shall be presented in aggregate form and by selected types of health care practitioners or individual health care practitioners, as prioritized each year by the department and analyzed to determine whether prescribing patterns by these health care practitioners reimbursed by the state health care programs may reflect manufacturer's or wholesaler's influence.

2. Information on violations and enforcement actions brought pursuant to this chapter.

Sec. 69. NEW SECTION. 155C.6 PUBLIC RECORDS.

1. The information required to be submitted pursuant to section 155C.4, and the data and reports compiled by the department pursuant to section 155C.5, are public records.

2. Notwithstanding any other provision of law to the contrary, the identity of health care practitioners and other recipients of gifts, payments, and materials required to be reported in this section do not constitute confidential information or trade secrets.

Sec. 70. NEW SECTION. 155C.7 ENFORCEMENT == RULES.

1. The department may bring an action for injunctive relief, costs, and attorneys fees, and to impose a civil penalty of no more than ten thousand dollars per violation on a manufacturer or wholesaler that fails to comply with any provision of this chapter.

2. The department shall adopt rules as necessary to administer this chapter.

Sec. 71. STUDY OF PROVISION OF PHARMACEUTICAL PRODUCT SAMPLES == REPORT.

1. The department of public health shall convene an advisory group of appropriate stakeholders to study the advantages and disadvantages of the provision of pharmaceutical product samples to the health care system and to consumers in this state.

2. The advisory group shall review and analyze all of the following:

a. The overall advantages and disadvantages of pharmaceutical product samples.

b. The effect of the provision of pharmaceutical product samples on the quality of health care received.

c. The influence of pharmaceutical product samples on medication practices, prescribing behaviors, and requests for changes in formularies.

d. The nature of the product and prescribing information accompanying the pharmaceutical product samples, including whether unbiased, evidence=based product and prescribing information is made available.

e. The effectiveness and appropriateness of treatment as influenced by the use of pharmaceutical product samples, including whether the choice by the health care provider of an available sample differs from what would have been the provider's preferred choice.

f. The value of having pharmaceutical product samples available based on the socioeconomic or insured status of patients, and the economic consequences to the patient who receives samples.

g. The increased short=term and long=term costs or savings to the health care system through the availability of pharmaceutical product samples, including the individual short=term and long=term, out=of=pocket increases in cost or savings to patients.

h. Regulatory, security, and safety issues related to the use of pharmaceutical product samples, including the potential for medication errors and interactions, the loss of pharmacist interaction with patients regarding the pharmaceutical product, and distribution practices.

i. The variation in use and advantages or disadvantages of pharmaceutical product samples, based upon the type of health care provider.

j. Alternatives to the current pharmaceutical product sample practice, such as the use of vouchers for free sample prescription drugs or the limitation of samples to only generic or preferred brand name samples.

k. The views of various types of health care providers regarding the use of pharmaceutical product samples.

3. The department shall submit a report of its findings and recommendations to the governor and the general assembly by December 15, 2009.

DATA MINING

Sec. 72. NEW SECTION. 155D.1 PURPOSES.

The purposes of this chapter are the following:

1. To safeguard the confidentiality of prescribing information, protect the integrity of the doctor=patient relationship, maintain the integrity and public trust in the medical profession, combat vexatious and harassing sales practices, restrain undue influence exerted by pharmaceutical industry marketing representatives over prescribing decisions, and further the state interest in improving the quality and lowering the cost of health care.

2. To ensure the confidentiality of data held by a state agency which could be used directly or indirectly to identify a patient or a health care professional licensed to prescribe

drugs, biologics, or medical devices.

3. To ensure compliance with federal Medicaid law and regulations prohibiting the disclosure and use of Medicaid data except to administer the Medicaid program, and to ensure that data held by the department of human services or its agents that could directly or indirectly identify patients or health care professionals licensed to prescribe products be kept confidential.

4. To regulate the monitoring of prescribing practices solely for commercial marketing purposes by entities selling prescribed products, and not to regulate monitoring for other uses, such as quality control, research unrelated to marketing, or use by governments or other entities not in the business of selling health care products.

Sec. 73. NEW SECTION. 155D.2 DEFINITIONS.

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

1. "Biologic" means a biological product as defined in 42 U.S.C. } 262.

2. "Bona fide clinical trial" means a research project that prospectively assigns human subjects to intervention and comparison groups to study the cause and effect relationship between a medical intervention and a health outcome.

3. "Individual identifying information" means information which directly or indirectly identifies a prescriber or a patient, and the information is derived from or relates to a prescription for any prescribed product.

4. "Marketing" means an activity by a company or an agent of the company making or selling prescribed products intended to influence prescribing or purchasing choices of the company's prescribed products, including but not limited to any of the following:

a. Advertising, publicizing, promoting, or sharing information about a prescribed product.

b. Identifying individuals to receive a message promoting use of a particular prescribed product, including but not limited to an advertisement, brochure, or contact by a sales representative.

c. Planning the substance of a sales representative visit or communication or the substance of an advertisement or other promotional message or document.

d. Evaluating or compensating sales representatives.

e. Identifying individuals to receive any form of gift, product sample, consultancy, or any other item, service, compensation, or employment of value.

f. Advertising or promoting prescribed products directly to patients.

5. "Medicaid program" means the medical assistance program administered as specified under chapter 249A.

6. "Pharmacy" means pharmacy as defined in section 155A.3.

7. "Prescription drug" means prescription drug as defined in section 155A.3.

8. "Prescribed product" means a biologic, prescription drug, or a medical device.

9. "Prescriber" means a health care practitioner who is licensed to prescribe prescription drugs, biologics, or medical devices in this state.

10. "Regulated record" means information or documentation from a prescription written by a prescriber doing business in this state or a prescription dispensed in this state.

11. "State health care program" means a program for which the state purchases prescribed products, including but not limited to a state employee, corrections, or retirement system program, but does not include the medical assistance program.

Sec. 74. NEW SECTION. 155D.3 PRIVACY PROVISIONS.

1. a. A person, including a state health care program, shall not knowingly disclose or use regulated records that include individual identifying information for the marketing of a prescribed product.

b. The department of human services shall ensure that the department, its employees, and agents, comply with the limitations on redisclosure or use of medical assistance program prescription information as provided for under state and federal law and applicable federal regulations, and shall have policies and procedures to ensure compliance with such state and federal laws and federal regulations.

2. a. Regulated records containing individual identifying information may be disclosed, sold, transferred, exchanged, or used only for nonmarketing purposes including but not limited to:

(1) Activities related to filling a valid prescription,

including but not limited to the dispensing of a prescribed product to a patient or to the patient's authorized representative; the transmission of regulated record information between an authorized prescriber and a pharmacy; the transfer of regulated record information between pharmacies; the transfer of regulated records that may occur if pharmacy ownership is changed or transferred and pharmacy reimbursement.

(2) Law enforcement purposes as otherwise authorized or required by statute or court order.

(3) Research including but not limited to bona fide clinical trials, postmarketing surveillance research, product safety studies, population=based public health research, and research regarding the effects of health care practitioner prescribing practices, and statistical reports if individual identifing information is not published, redisclosed, or used to identify or contact individuals.

(4) Product safety evaluations, product recalls and specific risk management plans, as identified or requested by the federal food and drug administration, or its successor agency.

(5) Pharmacy reimbursement, formulary compliance, case management related to the diagnosis, treatment, or management of illness for a specific patient, including but not limited to care management educational communications provided to a patient about the patient's health condition, adherence to a prescribed course of therapy, or other information about the product being dispensed, treatment options, or clinical trials.

(6) Utilization review by the state, by a health care provider, or by the patient's insurance provider for health care services, including but not limited to determining compliance with the terms of coverage or medical necessity.

(7) The collection and analysis of product utilization data for health care quality improvement purposes, including but not limited to development of evidence=based treatment guidelines or health care performance effectiveness and efficiency measures, promoting compliance with evidence=based treatment guidelines or health care performance measures, and providing prescribers with information that details their practices relative to their peers to encourage prescribing consistent with evidence=based practice.

(8) The collection and dissemination of product utilization data to promote transparency in evaluating performance related to the health care quality improvement measures.

(9) The transfer of product utilization data to and through secure electronic health record or personal health record systems.

(10) Use by any government agency or government agency sponsored program in carrying out its functions, or by any private person acting on behalf of a federal, state, or local agency in carrying out its functions.

(11) Use in connection with any civil, criminal, administrative, or arbitral proceeding in any federal, state, or local court or agency or before any self=regulatory body, including but not limited to the service of process, investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, or pursuant to an order of a federal, state, or local court.

b. An authorized recipient of regulated records containing individual identifying information may resell, reuse, or redisclose the information only as permitted under paragraph "a".

c. An authorized recipient that resells, reuses, or rediscloses individual identifying information covered by this chapter shall maintain for a period of five years, records identifying each person or entity that receives the information and the permitted purpose for which the information will be used. The authorized recipient shall make such records available to any person upon request.

3. This section shall not be interpreted to prohibit conduct involving the collection, use, transfer, or sale of regulated records for marketing purposes if all of the following conditions apply:

a. The data is aggregated.

b. The data does not contain individually identifying information.

c. There is no reasonable basis to believe that the data can be used to obtain individually identifying information.

4. This section shall not prevent any person from

disclosing individual identifying information to the identified individual if the information does not include protected information pertaining to any other person.

Sec. 75. NEW SECTION. 155D.4 CIVIL PENALTY == ENFORCEMENT == RULEMAKING.

1. Any person who knowingly fails to comply with the requirements of this chapter or rules adopted pursuant to this chapter by using or disclosing regulated records in a manner not authorized by this chapter or rules adopted pursuant to this chapter is subject to a civil penalty of not more than fifty thousand dollars per violation. Each disclosure of a regulated record constitutes a separate violation.

2. The attorney general shall enforce payment of penalties assessed under this section.

3. The board of pharmacy shall adopt rules to administer this chapter including the assessment of penalties under this section.

Sec. 76. NEW SECTION. 155D.5 CONSUMER FRAUD.

A violation of this chapter is an unfair or deceptive act in trade or commerce and an unfair method of competition under the consumer fraud Act, section 714.16.

DIVISION VII
HEALTH CARE TRANSPARENCY

Sec. 77. Section 135.11, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 32. Establish an office of health care reform to coordinate health care reform initiatives and activities related to the medical home system advisory council, the electronic health information advisory council and executive committee, the prevention and chronic care management advisory council, the direct care worker task force, the health and long=term care access technical advisory committee, the clinicians advisory panel, the long=term living initiatives of the department of elder affairs, medical assistance and hawk=i program expansions and initiatives, prevention and wellness initiatives including but not limited to those administered through the Iowa healthy communities initiative pursuant to section 135.27 and through the governor's council on physical fitness and nutrition, health care transparency activities, and other health care reform=related advisory bodies and activities to provide direction and promote collaborative efforts among health care providers involved in the initiatives and activities. The office shall also monitor state and federal health care reform initiatives to promote further coordination and collaboration of health care reform initiatives and activities.

Sec. 78. Section 135.156, subsection 3, paragraph c, subparagraph (2), Code 2009, is amended to read as follows:

(2) Consult with the Iowa communications network, private fiberoptic networks, and any other communications entity to seek collaboration, avoid duplication, and leverage opportunities in developing a network backbone. Any public or private network developed shall comply with the single patient identifier, standard continuity of care record, and other requirements developed by the executive committee. All portions of the public or private network backbone shall be structured in a manner which allows for seamless interoperability between such portions of the network.

Sec. 79. Section 135.165, Code 2009, is amended to read as follows:

135.165 HEALTH CARE TRANSPARENCY == REPORTING REQUIREMENTS == HOSPITALS AND NURSING FACILITIES.

1. Each hospital and nursing facility in this state that is recognized by the Internal Revenue Code as a nonprofit organization or entity shall submit to the department of public health and the legislative services agency, annually, a copy of the hospital's or nursing facility's internal revenue service form 990, including but not limited to schedule J or any successor schedule that provides compensation information for certain officers, directors, trustees, and key employees, information about the highest compensated employees, and information regarding revenues, expenses, excess or surplus revenues, and reserves within ninety days following the due date for filing the hospital's or nursing facility's return for the taxable year.

2. Each hospital and nursing facility in this state that is not recognized by the Internal Revenue Code as a nonprofit organization or entity shall submit to the department of public health and the legislative services agency, annually, in a format specified by rule of the department, the information required to be submitted by nonprofit hospitals

and nursing facilities pursuant to subsection 1.

Sec. 80. NEW SECTION. 135.166 HEALTH CARE DATA == COLLECTION FROM HOSPITALS.

1. The department of public health shall enter into a memorandum of understanding to utilize the Iowa hospital association to act as the department's intermediary in collecting, maintaining, and disseminating hospital inpatient, outpatient, and ambulatory information, as initially authorized in 1996 Iowa Acts, chapter 1212, section 5, subsection 1, paragraph "a", subparagraph (4) and 641 IAC 177.3.

2. The memorandum of understanding shall include but is not limited to provisions that address the duties of the department and the Iowa hospital association; the collection, reporting, use and disclosure, storage, confidentiality, publication, and ownership of the data; access by the department of any database of the data maintained by the Iowa hospital association; any fees for the collection, maintenance, or distribution of the data; and the bases for amendment or termination of the memorandum of understanding.

Sec. 81. HEALTH CARE QUALITY AND COST TRANSPARENCY == WORKGROUP.

1. a. A health care quality and cost transparency workgroup is created to develop recommendations for legislation and policies regarding health care quality and cost including measures to be utilized in providing transparency to consumers of health care and health care coverage.

b. Membership of the workgroup shall include but is not limited to representatives of the Iowa healthcare collaborative, the department of public health, the department of human services, the insurance division of the department of commerce, the Iowa hospital association, the Iowa medical society, the Iowa health buyers alliance, the AARP Iowa chapter, the university of Iowa public policy center, and other interested consumers, advocates, purchasers, providers, and legislators.

c. The department of public health shall provide staffing assistance to the workgroup.

2. The workgroup shall do all of the following:

a. Review the approaches of other states in addressing health care transparency information.

b. Develop and compile recommendations and strategies to lower health care costs and health care coverage costs for consumers and businesses.

c. Review and recommend health care quality and cost measures to be reported by health plans, hospitals, and physicians. Any measure recommended shall be evidence=based and clinically important, reasonably feasible to implement, and easily understood by the health care consumer.

d. Develop a plan for the collection, analysis, and publishing of clinical data from physicians and health care providers other than hospitals.

e. Develop a plan to collect and publish as a database, consumer health care quality and cost information designed to make available to consumers transparent health care cost information, quality information including but not limited to hospital infection rates, medication and surgical errors, and such other information necessary to empower consumers, including uninsured consumers, to make economically sound and medically appropriate health care decisions.

3. The workgroup shall submit a written report of the workgroup's findings, recommendations, and plans, to the general assembly on or before December 15, 2009.

EXPLANATION

This bill relates to health care, health care providers, and health care coverage, and provides penalties.

DIVISION I. IOWA CHOICE INSURANCE EXCHANGE. Division I of the bill contains new Code chapter 514M. The purpose of the chapter is to ensure that all children and all other Iowans in the state have affordable, quality health care coverage, and to decrease health care costs and health care coverage costs.

The bill creates the Iowa choice insurance exchange as a nonprofit corporation under the aegis of the insurance division of the department of commerce. All health and accident insurance carriers, all organized delivery systems licensed by the department of public health to provide health insurance or health care services in Iowa, and all other insurers designated by the exchange are members of the exchange.

The exchange is required to exercise its powers through a

board of directors. The board of directors consists of 11 voting members representative of specified constituencies appointed by the governor and subject to confirmation by the senate, and eight nonvoting members including four members of the general assembly. The voting members of the board are required to appoint an executive director of the exchange. The exchange is considered a governmental body for the purposes of the state open meetings law and a government body for the purposes of the state open records law.

The exchange is required to submit a plan of operation to the commissioner of insurance for approval. At the end of each year the exchange is required to determine its net premiums and payments received, the expenses of administration, and incurred losses and to recover any losses by assessing all members of the exchange as specified in the bill. The exchange is required to conduct annual audits and issue yearly financial reports to the commissioner of insurance, the governor, the speaker of the house of representatives, the majority leader of the senate, and the legislative fiscal committee.

The exchange is charged with developing a comprehensive health care coverage plan to accomplish the purposes of the new Code chapter including access to public or private health care coverage for all Iowans, especially children, which may be subsidized or unsubsidized, depending on family income.

The exchange is also required to design and implement a health care coverage program called Iowa choice, which offers private health care coverage that meets certain minimum standards of quality and affordability with options to purchase at least three levels of benefits, and to design and administer a subsidy program for payment of premiums for health care coverage for low=income people that complements Medicaid and includes cost=sharing by the insured using a sliding scale based on income utilizing the federal poverty level guidelines. Subsidies may be provided to children, adults, and families with incomes up to 400 percent of the federal poverty level guidelines. The comprehensive plan shall consider offering state health insurance coverage to nonstate public employees and employees of nonprofit employers and small employers. The exchange shall also study the cost to the state of providing public health care to undocumented children and study the use of pharmacy benefit managers in the state.

The Iowa choice insurance exchange fund is created in the state treasury as a separate fund under the control of the exchange to be credited with all moneys collected from premiums paid for health care plans offered by the exchange, and any other funds that are appropriated or transferred to the fund. These funds shall only be appropriated to the exchange to accomplish the purposes set forth in new Code chapter 514M.

The board of the exchange is also required to design and implement a program to protect the health of all Iowans, that includes a timetable and procedures for implementation, to ensure that all children and adults in the state have health care coverage, to assign and enroll children without such coverage to appropriate coverage, and to collaborate with the department of human services, the insurance division of the department of commerce, and with members of the exchange to institute health insurance reforms.

COORDINATING AMENDMENTS. Coordinating amendments are made in Code section 21.2(1) indicating that the exchange is subject to the state open meetings law and to Code section 22.1(1) making the exchange subject to the state open records law. Coordinating amendments are also made in Code chapter 514E by removing duties and powers from the Iowa comprehensive health insurance association which are assigned under the bill to the Iowa choice insurance exchange and repealing a provision creating the Iowa choice health care coverage advisory council.

DIVISION II. HEALTH CARE COVERAGE OF ADULT CHILDREN. Code section 422.7 is amended to provide that if the health benefits coverage or insurance of an Iowa taxpayer includes coverage of a nonqualified tax dependent as determined by the federal internal revenue service, the amount of the value of that coverage is not subject to state income tax. This amendment applies retroactively to January 1, 2009.

Code section 509.3(8), relating to group health insurance, Code section 509A.13B, relating to group health insurance for public employees, and Code section 514A.3B(2), relating to individual policies of health insurance, are amended to

require that adult children who are unmarried, residents of this state and up to 25 years of age, or who are full=time students, be allowed to reenroll in previously existing dependent coverage of their parents. Currently, those provisions only allow continuation of such existing coverage.

DIVISION III. MEDICAL ASSISTANCE AND HAWK=I PROVISIONS.

Division III of this bill includes provisions relating to the medical assistance (Medicaid) and hawk=i programs.

The division directs the department of human services (DHS) to provide state=only funded medical assistance or hawk=i coverage, as appropriate, to individuals under 19 years of age who meet income eligibility requirements under the respective program and for whom federal financial participation is or becomes available.

The division amends the income tax provision for reporting of a dependent child's health care coverage status to require, beginning with the tax returns for tax year 2010, that a person who files an individual or joint income tax return indicate the presence or absence of health care coverage for each dependent child for whom an exemption is claimed. If the taxpayer indicates that a dependent child does not have health care coverage and the income of the taxpayer's tax return does not exceed the highest level of income eligibility standard for the Medicaid or hawk=i program, the department of revenue is required to send a notice to the taxpayer that the dependent child may be eligible for these programs and to provide information to the taxpayer about how to enroll the dependent child in the appropriate program. The taxpayer is then required to submit an application for the appropriate program within 90 days of receiving the enrollment information. The department of revenue, in cooperation with DHS, is directed to adopt rules including rules regarding the enforcement of the required provision of information and required application for an appropriate program. Information to be reported by the department of revenue includes whether a taxpayer who claims a dependent indicates coverage or lack of coverage for the dependent, and the number of those indicating the absence of coverage who comply or do not comply with the requirement for application for an appropriate program, and any enforcement action taken. This provision takes effect July 1, 2010.

The division provides for coverage under the Medicaid program of a pregnant woman with a family income of up to 300 percent of the federal poverty level, beginning July 1, 2009.

The division includes provisions to improve access to and retention in the Medicaid and hawk=i programs. The division directs DHS to implement a number of provisions included in the federal Children's Health Insurance Program Reauthorization Act of 2009 under both the Medicaid and hawk=i programs including implementing the premium assistance options; including translation and interpreter services as a covered benefit; utilizing a joint application and supplemental forms, and the same application and renewal verification processes for the medical assistance and hawk=i programs; implementing administrative or paperless verification at renewal; utilizing presumptive eligibility; and utilizing the express lane option to reach and enroll children in the programs. The bill also directs DHS to allow for the submission of one pay stub per employer by an individual as verification of earned income when it is indicative of future income and to allow for the averaging of three years of income for self=employed families to establish eligibility under the Medicaid and hawk=i programs, and directs DHS to extend the period for annual renewal by medical assistance members by mailing the renewal form to the member on the first day of the month prior to the month of renewal. The division also allows the hawk=i program to provide the supplemental dental=only coverage to children who have private coverage but would otherwise be eligible for the hawk=i program, which is a provision allowed under the federal Children's Health Insurance Program Reauthorization Act of 2009.

The division also eliminates the hawk=i expansion program, which was to extend coverage to children up to 300 percent of the federal poverty level through state=only funding, and folds the hawk=i expansion population into the existing hawk=i program which population is eligible for federal matching funds pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The division makes other conforming changes relative to eliminating the separate hawk=i expansion program. The division provides that Medicaid and

hawk=i coverage are creditable coverage, a qualifying event, and qualifying existing coverage for the purposes of portability to private and individual or group health insurance coverage. The division also directs DHS and the department of public health in cooperation with other appropriate agencies to apply for federal grants to promote outreach activities and quality child health outcomes under the Medicaid and hawk=i programs as provided under the federal Children's Health Insurance Program Reauthorization Act of 2009.

DIVISION IV. VOLUNTEER HEALTH CARE PROVIDERS. Division IV of the bill expands the volunteer health care provider program to include health care provider offices. The division provides that a health care provider office providing free care under the program is considered a state agency for the sole purpose of the program and for Code chapter 669 (State Tort Claims Act) and is to be afforded protection under Code chapter 669 for all claims arising from the provision of free care by a health care provider registered with the program and complying with the requirements of the program. Additionally, a health care provider providing free care under the program at a health care provider office is considered an employee of the state under Code chapter 669 and is afforded protection as an employee of the state if the health care provider is registered with the department of public health and provides care at the health care provider office. The division defines "health care provider office" as the private office or clinic of an individual health care provider or group of health care providers but does not include a field dental clinic, a free clinic, or a hospital.

DIVISION V. HEALTH CARE WORKFORCE SUPPORT INITIATIVE. Division V of the bill establishes a health care workforce support initiative, including a health care workforce shortage fund.

The division creates a health care workforce shortage fund and creates accounts within the fund under the control of the college student aid commission, the department of public health, the governing group of the Iowa health care collaborative safety net provider network, or the state entity identified for receipt of federal funds by the federal government for a specified health care workforce shortage initiative. The fund and the accounts in the fund consist of moneys appropriated from the general fund of the state; moneys received from the federal government; contributions, grants, and other moneys from communities and health care employers; and moneys from any other public or private source. The entities with control of the moneys are authorized to accept contributions, grants, and in=kind contributions, to support the purposes of the fund and the accounts. The fund consists of the medical residency training account under the control of the department of public health; the health care professional and nurse workforce shortage initiative account under the control of the college student aid commission; the safety net provider network workforce shortage account under the control of the governing group of the Iowa collaborative safety net provider network; and the health care workforce shortage national initiatives account under the control of the state entity identified by the federal government providing the funds. The bill specifies the purposes for which the moneys in the fund and the accounts can be used and identifies existing state programs or entities that may receive moneys in order to draw down the maximum amount of federal funding for health care workforce shortage programs and initiatives. The bill provides that state appropriations from the fund shall be made in equal amounts to the accounts and that any federal funding received, unless otherwise provided by the source of the funds, is to be allocated equally between the workforce represented by the Iowa collaborative safety net provider network and other eligible health care providers. The division limits administrative costs to 5 percent of the moneys in each account.

The division directs the department of public health to establish a medical residency training state matching grants program to provide grants to sponsors of accredited graduate medical education residency programs in the state to establish, expand, or support medical residency training programs. The grant funds may be used to support medical residency programs through the establishment of new or alternative campus accredited medical residency training programs, new residency positions within existing accredited medical residency or fellowship training programs, or

residency positions which are in excess of the federal Medicare residency cap. The department is to adopt rules relating to eligibility requirements, an application process, criteria for preference in the awarding of grants, criteria for determining the amount of a grant, and use of the funds awarded.

The division directs the college student aid commission to establish a health care professional incentive payment program to assist in the recruitment and retaining of health care professionals. The commission is to administer the program with the assistance of Des Moines university==osteopathic medical center (DMU), and DMU is to receive a fee for administration of the program. The commission, with the assistance of DMU, is directed to adopt rules pursuant to Code chapter 17A relating to the establishment and administration of the program, including rules addressing eligibility and qualification requirements for health care professionals, communities, and health care employers participating in the program, the process for awarding incentive payments, public awareness and dissemination of applications, the amount of the incentive payment and the specifics of obligated service for a recipient, determination of the conditions of incentive payment applicable to an applicant, enforcement of the state's rights under or incentive payment agreement, a process for monitoring compliance with eligibility requirements, obligated service provisions, and use of funds by the program and program recipients. The division also provides that a recipient is responsible for reporting on federal income tax forms any amount received through the program, to the extent required by federal law. However, a recipient in compliance with the requirements of the program is not subject to state income taxation for incentive payments received through the program.

The division includes community colleges in the existing nurse and nurse education loan forgiveness program and also directs the commission to establish two programs under a nursing workforce shortage initiative. The nurse educator incentive payment program is established to recruit and retain nurse educators. The program provides for an incentive payment of up to $20,000 for a nurse educator who remains teaching in a qualifying position for a period of not less than four consecutive academic years. The nurse educator and the commission are required to enter into an agreement specifying the obligations of the nurse educator and the commission. If the nurse educator leaves the teaching position prior to teaching for four consecutive academic years, the nurse educator is liable to repay the amount of the incentive payment paid through the program plus interest. However, if the nurse educator leaves the teaching position involuntarily, the nurse educator is liable to repay only the pro rata portion of the amount based on incompleted years of service. The division directs the commission to adopt rules for the program including specifying what constitutes a qualifying teaching position.

The commission is also required to establish a nursing faculty fellowship program to provide funds to nursing schools in the state for fellowships for individuals employed in qualifying positions on the nursing faculty. The program is designed to assist nursing schools in filling vacancies in qualifying positions throughout the state. The commission, in consultation with the department of public health and in cooperation with nursing schools throughout the state, is to develop a distribution formula which provides that no more than 30 percent of the available funds are awarded to a single nursing school. Additionally, the program limits funding for a qualifying position in a nursing school to no more than $10,000 per year for up to three years. The commission, in consultation with the department of public health, is required to adopt rules for administration of the program including determining what constitutes a qualifying position at a nursing school. In determining eligibility for a fellowship, the commission is to consider the length of time a qualifying position has gone unfilled at a nursing school, documented recruiting efforts by a nursing school, the geographic location of a nursing school, the type of nursing program offered at the nursing school, and the need for the specific nursing program in the state.

The division directs the Iowa collaborative safety net provider network governing group to establish a safety net provider incentive payment program to administer recruitment and retention initiatives that may include but are not limited

to loan repayment and loan forgiveness programs, and programs to address safety net provider shortages. The bill directs the department of public health in cooperation with the collaborative to adopt rules to implement and administer the initiatives.

The division requires the commission to submit an annual report to the governor and the general assembly regarding the status of the health care workforce support initiative, including the balance remaining in and appropriations from the workforce shortage fund.

The division repeals sections relating to the osteopathic physician recruitment program, which is replaced with the health care professional incentive payment program established in the division.

The division also directs the Code editor to create a new division in Code chapter 261 (college student aid commission), the health care workforce support initiative.

DIVISION VI. PHARMACEUTICAL=RELATED PROVISIONS. Division VI of the bill includes various pharmaceutical=related provisions.

The division includes provisions relating to medication therapy management. The division provides findings of the general assembly related to the utilization and reimbursement of pharmaceutical case management services under the Medicaid program to direct that all health insurance plans in the state examine the feasibility and efficacy of including medication therapy management as a covered benefit under individual and group health insurance policies. If an insurance plan determines that inclusion is feasible and efficacious, the general assembly encourages the plan to provide such coverage by January 1, 2010. If the plan determines the opposite, the plan is to submit to the chairpersons of the general assembly's committees on human resources a written report detailing the plan's examination and analysis of the issue and any reasons and supporting data for not including medication therapy management as a covered benefit. Under the division, "medication therapy management" means the same as pharmaceutical case management services under the Medicaid program.

The division directs the board of pharmacy to establish and administer an evidence=based prescription drug education program designed to provide health care professionals who are licensed to prescribe or dispense prescription drugs with information and education regarding the therapeutic and cost=effective utilization of prescription drugs. The division specifies the entities with which the board is to collaborate in establishing and administering the program including physicians, pharmacists, private insurers, hospitals, pharmacy benefits managers, the medical assistance drug utilization review commission, medical and pharmacy schools, and other entities providing evidence=based education to health care professionals that are licensed to prescribe or dispense prescription drugs. The division authorizes the board to contract with an Iowa=based college of pharmacy to provide technical and clinical support to the program, and provides that the department of public health may establish and collect fees from private payors for participation in the program, and seek funding from nongovernmental health foundations or other nonprofit charitable foundations to establish and administer the program.

The division prohibits gifts to health care practitioners from manufacturers and wholesalers of prescription drugs, biologics, and medical devices, who participate in state health programs, with limited exceptions. For the purposes of the division, "gifts" does not include product samples or negotiated rebates or discounts. The division also requires the disclosure of information about gifts excluded from the ban, and requires the compilation of annual reports analyzing this data by the department of administrative services. The division provides for injunctive relief and civil penalties for violations related to the gift prohibition. The division also provides for the convening of an advisory group by the department of public health to study the advantages and disadvantages of the provision of pharmaceutical product samples. The department is required to submit a report of its findings to the governor and the general assembly by December 15, 2009.

The division includes provisions relating to the safeguarding of the confidentiality of prescribing information (data mining). The division establishes purposes of the new Code chapter (155D), including that it is the chapter's

purpose to regulate the monitoring of prescribing practices solely for commercial marketing purposes by entities selling prescribed products, and not to regulate monitoring for other uses, such as quality control, research unrelated to marketing, or use by governments or other entities not in the business of selling health care products.

The division provides privacy protections including that a person, including a state health care program, shall not knowingly disclose or use regulated records that include individual identifying information to market a prescribed product. The division also directs DHS as the Medicaid agency to ensure that DHS, its employees, and agents, comply with the limitations on redisclosure or use of medical assistance program prescription information as provided for under state and federal law and applicable federal regulations.

The division provides that regulated records containing individual identifying information may be disclosed, sold, transferred, exchanged, or used only for nonmarketing purposes and specifies some of these nonmarketing purposes.

The division provides that it is not to be interpreted to prohibit conduct involving the collection, use, transfer, or sale of regulated records for marketing purposes if the data is aggregated, the data does not contain individually identifying information, and there is no reasonable basis to believe that the data can be used to obtain individually identifying information. The division does not prevent any person from disclosing individual identifying information to the identified individual if the information does not include protected information pertaining to any other person.

The division provides that a person who knowingly fails to comply with the requirements of the division or rules adopted pursuant to the division by using or disclosing regulated records in a manner not authorized by the division or rules adopted under the division is subject to a civil penalty of not more than $50,000 per violation. The division directs the attorney general to enforce payment of penalties assessed under the division and directs the board of pharmacy to adopt rules to administer the division including the assessing of penalties.

A violation of the new Code chapter may be enforced through Iowa's consumer fraud Act.

DIVISION VII. HEALTH CARE TRANSPARENCY. Division VII of the bill relates to health care transparency. The division directs the director of public health to establish an office of health care reform to coordinate health care reform initiatives and activities of various health care reform=related advisory bodies and activities in the state as well as to monitor state and federal health care reform initiatives and activities.

The division provides with regard to electronic health records that any public or private network developed shall comply with the requirements developed by the electronic health information executive committee, and that all portions of the public or private network backbone shall be structured in a manner which allows for seamless interoperability between the portions of the network.

The division requires each hospital and nursing facility in the state that is not a nonprofit entity, to annually submit to the department of public health and the legislative services agency information to be submitted by nonprofit hospitals or nursing facilities relating to the internal revenue services form 990.

The division directs the department of public health to enter into a memorandum of understanding to utilize the Iowa hospital association to act as the department's intermediary in collecting, maintaining, and disseminating hospital inpatient, outpatient, and ambulatory information.

The division creates a health care quality and cost transparency workgroup to develop recommendations for legislation and policies regarding health care quality and cost. The division specifies the membership of the workgroup and instructs the department of public health to provide staffing assistance to the workgroup. The division specifies the duties of the workgroup and directs the workgroup to submit a written report of its findings, recommendations, and plans to the general assembly on or before December 15, 2009.

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