House File 393 - Introduced

HOUSE FILE 393
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO HSB 25)

A BILL FOR

An Act relating to programs and activities under the purview of the department of public health, and including effective date provisions.

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

TLSB 1675HV (3) 87
pf/nh

DIVISION I

PROGRAM FLEXIBILITY AND EFFICIENCIES

Section 1. Section 125.59, subsection 1, paragraph b, Code 2017, is amended to read as follows:

b. If the transferred amount for this subsection exceeds grant requests funded to the ten thousand dollar maximum, the ~~Iowa~~ department of public health may use the remainder for activities and public information resources that align with best practices for substance-related disorder prevention or to increase grants pursuant to subsection 2.

Sec. 2. Section 135.11, subsection 31, Code 2017, is amended by striking the subsection.

Sec. 3. Section 135.150, subsection 2, Code 2017, is amended to read as follows:

2. The department shall report ~~semiannually~~ annually to the general assembly's standing committees on government oversight regarding the operation of the gambling treatment program. The report shall include but is not limited to information on the moneys expended and grants awarded for operation of the gambling treatment program.

DIVISION II

MEDICAL HOME AND PATIENT-CENTERED HEALTH ADVISORY COUNCIL

Sec. 4. Section 135.15, Code 2017, is amended by adding the following new subsection:

NEW SUBSECTION. 6. For the purposes of this section, "*dental home*" means a network of individualized care based on risk assessment, which includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.

Sec. 5. Section 135.159, Code 2017, is amended by striking the section and inserting in lieu thereof the following:

135.159 Patient-centered health advisory council.

1. The department shall establish a patient-centered health advisory council which shall include but is not limited to all of the following members, selected by their respective

organizations, and any other members the department determines necessary:

a. The director of human services, or the director's designee.

b. The commissioner of insurance, or the commissioner's designee.

c. A representative of the federation of Iowa insurers.

d. A representative of the Iowa dental association.

e. A representative of the Iowa nurses association.

f. A physician and an osteopathic physician licensed pursuant to chapter 148 who are family physicians and members of the Iowa academy of family physicians.

g. A health care consumer.

h. A representative of the Iowa collaborative safety net provider network established pursuant to section 135.153.

i. A representative of the Iowa developmental disabilities council.

j. A representative of the Iowa chapter of the American academy of pediatrics.

k. A representative of the child and family policy center.

l. A representative of the Iowa pharmacy association.

m. A representative of the Iowa chiropractic society.

n. A representative of the university of Iowa college of public health.

o. A certified palliative care physician.

2. The patient-centered health advisory council may utilize the assistance of other relevant public health and health care expertise when necessary to carry out the council's purposes and responsibilities.

3. A public member of the patient-centered health advisory council shall receive reimbursement for actual expenses incurred while serving in the member's official capacity only if the member is not eligible for reimbursement by the organization the member represents.

4. The purposes of the patient-centered health advisory

council shall include all of the following:

a. To serve as a resource on emerging health care transformation initiatives in Iowa.

b. To convene stakeholders in Iowa to streamline efforts that support state-level and community-level integration and focus on reducing fragmentation of the health care system.

c. To encourage partnerships and synergy between community health care partners in the state who are working on new system-level models to provide better health care at lower costs by focusing on shifting from volume-based to value-based health care.

d. To lead discussions on the transformation of the health care system to a patient-centered infrastructure that integrates and coordinates services and supports to address social determinants of health and to meet population health goals.

e. To provide a venue for education and information gathering for stakeholders and interested parties to learn about emerging health care initiatives across the state.

f. To develop recommendations for submission to the department related to health care transformation issues.

Sec. 6. Section 249N.2, subsections 15 and 19, Code 2017, are amended to read as follows:

15. *"Medical home"* means ~~medical home as defined in section 135.157.~~ a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access and integrate all medical and nonmedical health-related services across all elements of the health care system and the patient's community as needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the following characteristics:

a. A personal provider.

b. A provider-directed team-based medical practice.

c. Whole person orientation.

d. Coordination and integration of care.

e. Quality and safety.

f. Enhanced access to health care.

g. A payment system that appropriately recognizes the added value provided to patients who have a patient-centered medical home.

19. "*Primary medical provider*" means the personal provider ~~as defined in section 135.157~~ trained to provide first contact and continuous and comprehensive care to a member, chosen by a member or to whom a member is assigned under the Iowa health and wellness plan.

Sec. 7. Section 249N.2, Code 2017, is amended by adding the following new subsections:

NEW SUBSECTION. 17A. "*Personal provider*" means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health-related needs and, working with a team of health care professionals and providers of medical and nonmedical health-related services, provides for and coordinates appropriate care to address the health-related needs identified.

NEW SUBSECTION. 18A. "*Primary care provider*" includes but is not limited to any of the following licensed or certified health care professionals who provide primary care:

a. A physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist.

b. An advanced registered nurse practitioner.

c. A physician assistant.

d. A chiropractor.

Sec. 8. Section 249N.6, subsection 2, paragraph c, Code 2017, is amended to read as follows:

c. The department shall develop a mechanism for primary

medical providers, medical homes, and participating accountable care organizations to jointly facilitate member care coordination. The Iowa health and wellness plan shall provide for reimbursement of care coordination services provided under the plan ~~consistent with the reimbursement methodology developed pursuant to section 135.159~~.

Sec. 9. Section 249N.6, subsection 3, paragraph a, Code 2017, is amended to read as follows:

a. The department shall provide procedures for accountable care organizations that emerge through local markets to participate in the Iowa health and wellness plan provider network. Such accountable care organizations shall incorporate the medical home ~~as defined and specified in chapter 135, division XXII~~, as a foundation and shall emphasize whole-person orientation and coordination and integration of both clinical services and nonclinical community and social supports that address social determinants of health. A participating accountable care organization shall enter into a contract with the department to ensure the coordination and management of the health of attributed members, to produce quality health care outcomes, and to control overall cost.

Sec. 10. PALLIATIVE CARE REVIEW —— PATIENT-CENTERED HEALTH ADVISORY COUNCIL. The patient-centered health advisory council shall review the current level of public awareness regarding and the availability of palliative care services in the state and shall submit a report to the governor and the general assembly by December 31, 2017, including the council's findings and providing recommendations to increase public awareness and reduce barriers to access to palliative care services throughout the state.

Sec. 11. REPEAL. Sections 135.157 and 135.158, Code 2017, are repealed.

DIVISION III

WORKFORCE PROGRAMMING

Sec. 12. Section 84A.11, subsection 4, Code 2017, is amended

to read as follows:

4. The nursing workforce data clearinghouse shall be established and maintained in a manner consistent with the health care delivery infrastructure and health care workforce resources strategic plan developed pursuant to section ~~135.164~~ 135.163.

Sec. 13. Section 135.107, subsection 3, Code 2017, is amended to read as follows:

3. The center for rural health and primary care shall establish a primary care provider recruitment and retention endeavor, to be known as PRIMECARRE. The endeavor shall include a health care workforce and community support grant program~~,~~ and a primary care provider loan repayment program~~, and a primary care provider community scholarship program~~. The endeavor shall be developed and implemented in a manner to promote and accommodate local creativity in efforts to recruit and retain health care professionals to provide services in the locality. The focus of the endeavor shall be to promote and assist local efforts in developing health care provider recruitment and retention programs. The center for rural health and primary care may enter into an agreement with the college student aid commission for the administration of the center's grant and loan repayment programs.

a. ~~Community~~ Health care workforce and community support grant program.

(1) The center for rural health and primary care shall adopt rules establishing ~~an~~ flexible application ~~process~~ processes based upon the department's strategic plan to be used by the center to establish a grant assistance program as provided in this paragraph "*a*", and establishing the criteria to be used in evaluating the applications. Selection criteria shall include a method for prioritizing grant applications based on illustrated efforts to meet the health care provider needs of the locality and surrounding area. Such assistance may be in the form of a forgivable loan, grant, or other

nonfinancial assistance as deemed appropriate by the center. An application submitted ~~shall~~ may contain a commitment of ~~at least a dollar-for-dollar match of~~ matching funds for the grant assistance. Application may be made for assistance by a single community or group of communities or in response to programs recommended in the strategic plan to address health workforce shortages.

(2) Grants awarded under the program shall be ~~subject to the following limitations:~~

~~(a) Ten thousand dollars for a single community or region with a population of ten thousand or less. An award shall not be made under this program to a community with a population of more than ten thousand.~~

~~(b) An amount not to exceed one dollar per capita for a region in which the population exceeds ten thousand. For purposes of determining the amount of a grant for a region, the population of the region shall not include the population of any community with a population of more than ten thousand located in the region~~ awarded to rural, underserved areas or special populations as identified by the department's strategic plan or evidence-based documentation.

b. Primary care provider loan repayment program.

(1) A primary care provider loan repayment program is established to increase the number of health professionals practicing primary care in federally designated health professional shortage areas of the state. Under the program, loan repayment may be made to a recipient for educational expenses incurred while completing an accredited health education program directly related to obtaining credentials necessary to practice the recipient's health profession.

(2) The center for rural health and primary care shall adopt rules relating to the establishment and administration of the primary care provider loan repayment program. Rules adopted pursuant to this paragraph shall provide, at a minimum, for all of the following:

(a) Determination of eligibility requirements and qualifications of an applicant to receive loan repayment under the program, including but not limited to years of obligated service, clinical practice requirements, and residency requirements. One year of obligated service shall be provided by the applicant in exchange for each year of loan repayment, unless federal requirements otherwise require. Loan repayment under the program shall not be approved for a health provider whose license or certification is restricted by a medical regulatory authority of any jurisdiction of the United States, other nations, or territories.

(b) Identification of federally designated health professional shortage areas of the state and prioritization of such areas according to need.

(c) Determination of the amount and duration of the loan repayment an applicant may receive, giving consideration to the availability of funds under the program, and the applicant's outstanding educational loans and professional credentials.

(d) Determination of the conditions of loan repayment applicable to an applicant.

(e) Enforcement of the state's rights under a loan repayment program contract, including the commencement of any court action.

(f) Cancellation of a loan repayment program contract for reasonable cause unless federal requirements otherwise require.

(g) Participation in federal programs supporting repayment of loans of health care providers and acceptance of gifts, grants, and other aid or amounts from any person, association, foundation, trust, corporation, governmental agency, or other entity for the purposes of the program.

(h) Upon availability of state funds, determination of eligibility criteria and qualifications for participating communities and applicants not located in federally designated shortage areas.

(i) Other rules as necessary.

~~(3) The center for rural health and primary care may enter into an agreement under chapter 28E with the college student aid commission for the administration of this program.~~

~~*c. Primary care provider community scholarship program.*~~

~~(1) A primary care provider community scholarship program is established to recruit and to provide scholarships to train primary health care practitioners in federally designated health professional shortage areas of the state. Under the program, scholarships may be awarded to a recipient for educational expenses incurred while completing an accredited health education program directly related to obtaining the credentials necessary to practice the recipient's health profession.~~

~~(2) The department shall adopt rules relating to the establishment and administration of the primary care provider community scholarship program. Rules adopted pursuant to this paragraph shall provide, at a minimum, for all of the following:~~

~~(a) Determination of eligibility requirements and qualifications of an applicant to receive scholarships under the program, including but not limited to years of obligated service, clinical practice requirements, and residency requirements. One year of obligated service shall be provided by the applicant in exchange for each year of scholarship receipt, unless federal requirements otherwise require.~~

~~(b) Identification of federally designated health professional shortage areas of the state and prioritization of such areas according to need.~~

~~(c) Determination of the amount of the scholarship an applicant may receive.~~

~~(d) Determination of the conditions of scholarship to be awarded to an applicant.~~

~~(e) Enforcement of the state's rights under a scholarship contract, including the commencement of any court action.~~

~~(f) Cancellation of a scholarship contract for reasonable~~

~~cause.~~

~~(g) Participation in federal programs supporting scholarships for health care providers and acceptance of gifts, grants, and other aid or amounts from any person, association, foundation, trust, corporation, governmental agency, or other entity for the purposes of the program.~~

~~(h) Upon availability of state funds, determination of eligibility criteria and qualifications for participating communities and applicants not located in federally designated shortage areas.~~

~~(i) Other rules as necessary.~~

~~(3) The center for rural health and primary care may enter into an agreement under chapter 28E with the college student aid commission for the administration of this program.~~

Sec. 14. Section 135.107, subsection 4, paragraphs a, b, and c, Code 2017, are amended to read as follows:

a. Eligibility under any of the programs established under the primary care provider recruitment and retention endeavor shall be based upon a community health services assessment completed under subsection 2, paragraph *"a"*. ~~A community or region, as applicable, shall submit a letter of intent to conduct a community health services assessment and to apply for assistance under this subsection. The letter shall be in a form and contain information as determined by the center. A letter of intent shall be submitted to the center by January 1 preceding the fiscal year for which an application for assistance is to be made.~~ Participation in a community health services assessment process shall be documented by the community or region.

b. Assistance under this subsection shall not be granted until such time as the community or region making application has completed ~~the~~ a community health services assessment and adopted a long-term community health services assessment and developmental plan. In addition to any other requirements, ~~a developmental~~ an applicant's plan shall include, to the extent

possible, a clear commitment to informing high school students of the health care opportunities which may be available to such students.

c. The center for rural health and primary care shall seek additional assistance and resources from other state departments and agencies, federal agencies and grant programs, private organizations, and any other person, as appropriate. The center is authorized and directed to accept on behalf of the state any grant or contribution, federal or otherwise, made to assist in meeting the cost of carrying out the purpose of this subsection. All federal grants to and the federal receipts of the center are appropriated for the purpose set forth in such federal grants or receipts. Funds appropriated by the general assembly to the center for implementation of this subsection shall first be used for securing any available federal funds requiring a state match, with remaining funds being used for the health care workforce and community support grant program.

Sec. 15. Section 135.107, subsection 5, paragraph a, Code 2017, is amended to read as follows:

a. There is established an advisory committee to the center for rural health and primary care consisting of one representative, approved by the respective agency, of each of the following agencies: the department of agriculture and land stewardship, the ~~Iowa~~ department of public health, the department of inspections and appeals, ~~the~~ a national or regional institute for rural health policy, ~~the rural health resource center,~~ the institute of agricultural medicine and occupational health, and the Iowa state association of counties. The governor shall appoint two representatives of consumer groups active in rural health issues and a representative of each of two farm organizations active within the state, a representative of an agricultural business in the state, a representative of a critical needs hospital, a practicing rural family physician, a practicing rural

physician assistant, a practicing rural advanced registered nurse practitioner, and a rural health practitioner who is not a physician, physician assistant, or advanced registered nurse practitioner, as members of the advisory committee. The advisory committee shall also include as members two state representatives, one appointed by the speaker of the house of representatives and one by the minority leader of the house, and two state senators, one appointed by the majority leader of the senate and one by the minority leader of the senate.

Sec. 16. Section 135.163, Code 2017, is amended to read as follows:

135.163 Health ~~and long-term~~ care access.

The department shall coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, diverse, and sustainable health care workforce in this state. The health care delivery infrastructure and the health care workforce shall address the broad spectrum of health care needs of Iowans throughout their lifespan ~~including long-term care needs~~. The department shall, at a minimum, do all of the following:

1. Develop a strategic plan for health care delivery infrastructure and health care workforce resources in this state.

2. Provide for the continuous collection of data to provide a basis for health care strategic planning and health care policymaking.

3. Make recommendations regarding the health care delivery infrastructure and the health care workforce that assist in monitoring current needs, predicting future trends, and informing policymaking.

Sec. 17. Section 135.175, subsection 1, paragraph b, Code 2017, is amended to read as follows:

b. A health care workforce shortage fund is created in the state treasury as a separate fund under the control of the department, in cooperation with the entities identified

in this section as having control over the accounts within the fund. The fund and the accounts within the fund shall be controlled and managed in a manner consistent with the principles specified and the strategic plan developed pursuant to ~~sections~~ section 135.163 ~~and 135.164~~.

Sec. 18. Section 135.175, subsections 6 and 7, Code 2017, are amended to read as follows:

6. *a.* Moneys in the fund and the accounts in the fund shall only be appropriated in a manner consistent with the principles specified and the strategic plan developed pursuant to ~~sections~~ section 135.163 ~~and 135.164~~ to support the medical residency training state matching grants program, the fulfilling Iowa's need for dentists matching grant program, and to provide funding for state health care workforce shortage programs as provided in this section.

b. State programs that may receive funding from the fund and the accounts in the fund, if specifically designated for the purpose of drawing down federal funding, are the primary care recruitment and retention endeavor (PRIMECARRE), the Iowa affiliate of the national rural recruitment and retention network, the oral and health delivery systems bureau of the department, the primary care office and shortage designation program, and the state office of rural health, ~~and the Iowa health workforce center,~~ administered through the oral and health delivery systems 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;~~ any entity identified by the federal government entity through which federal funding for a specified health care workforce shortage initiative is received; and a program developed in accordance with the strategic plan developed by the department of public health in accordance with ~~sections~~ section 135.163 ~~and 135.164~~.

c. ~~State appropriations to the fund shall be allocated in equal amounts to each of the accounts within the fund, unless otherwise specified in the appropriation or allocation.~~ Any federal funding received for the purposes of addressing state health care workforce shortages shall be deposited in the health care workforce shortage national initiatives account, unless otherwise specified by the source of the funds, and shall be used as required by the source of the funds. If use of the federal funding is not designated, the funds shall be used in accordance with the strategic plan developed by the department of public health in accordance with ~~sections~~ section 135.163 ~~and 135.164~~, or to address workforce shortages as otherwise designated by the department of public health. Other sources of funding shall be deposited in the fund or account and used as specified by the source of the funding.

7. 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 appropriation, allocation, or source of the funds.

Sec. 19. REPEAL. Sections 135.164 and 135.180, Code 2017, are repealed.

DIVISION IV

UNFUNDED OR OUTDATED PROGRAM PROVISIONS

Sec. 20. Section 135.11, subsection 25, Code 2017, is amended by striking the subsection.

Sec. 21. Section 135.141, subsection 2, paragraph c, Code 2017, is amended by striking the paragraph.

Sec. 22. Section 135.141, subsection 2, paragraph e, Code 2017, is amended to read as follows:

e. For the purpose of ~~paragraphs "c" and~~ paragraph "d", an employee or agent of the department may enter into and examine any premises containing potentially dangerous agents with the consent of the owner or person in charge of the premises or, if the owner or person in charge of the premises

refuses admittance, with an administrative search warrant obtained under section 808.14. Based on findings of the risk assessment and examination of the premises, the director may order reasonable safeguards or take any other action reasonably necessary to protect the public health pursuant to rules adopted to administer this subsection.

Sec. 23. Section 901B.1, subsection 4, paragraph a, Code 2017, is amended to read as follows:

a. The district department of correctional services shall place an individual committed to it under section 907.3 to the sanction and level of supervision which is appropriate to the individual based upon a current risk assessment evaluation. Placements may be to levels two and three of the corrections continuum. ~~The district department may, with the approval of the Iowa department of public health and the department of corrections, place an individual in a level three substance abuse treatment facility established pursuant to section 135.130, to assist the individual in complying with a condition of probation.~~ The district department may, with the approval of the department of corrections, place an individual in a level four violator facility established pursuant to section 904.207 only as a penalty for a violation of a condition imposed under this section.

Sec. 24. REPEAL. Sections 135.26, 135.29, 135.130, and 135.152, Code 2017, are repealed.

DIVISION V

MISCELLANEOUS PROVISIONS

Sec. 25. Section 135A.2, subsection 6, Code 2017, is amended to read as follows:

6. "*Local board of health*" means ~~a county or district board of health~~ the same as defined in section 137.102.

Sec. 26. REPEAL. Section 135.132, Code 2017, is repealed.

DIVISION VI

IOWA HEALTH INFORMATION NETWORK

Sec. 27. Section 136.3, subsection 13, Code 2017, is amended

by striking the subsection.

Sec. 28. EFFECTIVE DATE. This division of this Act takes effect upon the assumption of the administration and governance, including but not limited to the assumption of the assets and liabilities, of the Iowa health information network by the designated entity as defined in 2015 Iowa Acts, ch.73, section 2. The department of public health shall notify the Code editor of the date of such assumption by the designated entity.

DIVISION VII

ORGANIZED DELIVERY SYSTEMS

Sec. 29. Section 135H.3, subsection 2, Code 2017, is amended to read as follows:

2. If a child is diagnosed with a biologically based mental illness as defined in section 514C.22 and meets the medical assistance program criteria for admission to a psychiatric medical institution for children, the child shall be deemed to meet the acuity criteria for medically necessary inpatient benefits under a group policy, contract, or plan providing for third-party payment or prepayment of health, medical, and surgical coverage benefits issued by a carrier, as defined in section 513B.2, ~~or by an organized delivery system authorized under 1993 Iowa Acts, ch. 158,~~ that is subject to section 514C.22. Such medically necessary benefits shall not be excluded or denied as care that is substantially custodial in nature under section 514C.22, subsection 8, paragraph "*b*".

Sec. 30. Section 505.32, subsection 2, paragraph h, Code 2017, is amended by striking the paragraph.

Sec. 31. Section 505.32, subsection 4, paragraph b, subparagraphs (1) and (2), Code 2017, are amended to read as follows:

(1) The commissioner may establish methodologies to provide uniform and consistent side-by-side comparisons of the health care coverage options that are offered by carriers~~, organized delivery systems,~~ and public programs in this state including

but not limited to benefits covered and not covered, the amount of coverage for each service, including copays and deductibles, administrative costs, and any prior authorization requirements for coverage.

(2) The commissioner may require each carrier~~, organized delivery system,~~ and public program in this state to describe each health care coverage option offered by that carrier~~,~~ ~~organized delivery system,~~ or public program in a manner so that the various options can be compared as provided in subparagraph (1).

Sec. 32. Section 507B.4, subsection 1, Code 2017, is amended to read as follows:

1. For purposes of subsection 3, paragraph *"p"*, *"insurer"* means an entity providing a plan of health insurance, health care benefits, or health care services, or an entity subject to the jurisdiction of the commissioner performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, ~~an organized delivery system authorized under 1993 Iowa Acts, ch. 158, and licensed by the department of public health,~~ a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. However, *"insurer"* does not include an entity that sells disability income or long-term care insurance.

Sec. 33. Section 507B.4A, subsection 2, paragraph a, Code 2017, is amended to read as follows:

a. An insurer providing accident and sickness insurance under chapter 509, 514, or 514A; a health maintenance organization; ~~an organized delivery system authorized under 1993 Iowa Acts, ch. 158, and licensed by the department of public health;~~ or another entity providing health insurance or health benefits subject to state insurance regulation shall either accept and pay or deny a clean claim.

Sec. 34. Section 509.3A, subsection 11, Code 2017, is

amended by striking the subsection.

Sec. 35. Section 509.19, subsection 2, paragraph d, Code 2017, is amended by striking the paragraph.

Sec. 36. Section 509A.6, Code 2017, is amended to read as follows:

509A.6 Contract with insurance carrier~~,~~ or health maintenance organization~~, or organized delivery system~~.

The governing body may contract with a nonprofit corporation operating under the provisions of this chapter or chapter 514 or with any insurance company having a certificate of authority to transact an insurance business in this state with respect of a group insurance plan, which may include life, accident, health, hospitalization and disability insurance during period of active service of such employees, with the right of any employee to continue such life insurance in force after termination of active service at such employee's sole expense; may contract with a nonprofit corporation operating under and governed by the provisions of this chapter or chapter 514 with respect of any hospital or medical service plan; and may contract with a health maintenance organization ~~or an organized delivery system~~ authorized to operate in this state with respect to health maintenance organization ~~or organized delivery system~~ activities.

Sec. 37. Section 513B.2, subsection 8, paragraph k, Code 2017, is amended by striking the paragraph.

Sec. 38. Section 513B.5, Code 2017, is amended to read as follows:

513B.5 Provisions on renewability of coverage.

1. Health insurance coverage subject to this chapter is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except for one or more of the following reasons:

a. The health insurance coverage sponsor fails to pay, or to make timely payment of, premiums or contributions pursuant to the terms of the health insurance coverage.

b. The health insurance coverage sponsor performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's ~~or organized delivery system's~~ minimum participation requirements.

d. Noncompliance with the carrier's ~~or organized delivery system's~~ employer contribution requirements.

e. A decision by the carrier ~~or organized delivery system~~ to discontinue offering a particular type of health insurance coverage in the state's small employer market. Health insurance coverage may be discontinued by the carrier ~~or organized delivery system~~ in that market only if the carrier ~~or organized delivery system~~ does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner ~~or director of public health~~. Notice to the commissioner ~~or director~~, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provides notice of its decision not to renew such plan to all affected small employers, participants, and beneficiaries no less than ninety days prior to the nonrenewal of the plan.

(3) Offers to each plan sponsor of the discontinued coverage, the option to purchase any other coverage currently offered by the carrier ~~or organized delivery system~~ to other employers in this state.

(4) Acts uniformly, in opting to discontinue the coverage and in offering the option under subparagraph (3), without regard to the claims experience of the sponsors under the discontinued coverage or to a health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

f. A decision by the carrier ~~or organized delivery system~~ to discontinue offering and to cease to renew all of its health insurance coverage delivered or issued for delivery to small employers in this state. A carrier ~~or organized delivery system~~ making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such coverage to the commissioner ~~or director of public health~~. Notice to the commissioner ~~or director~~, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected small employers, participants, and beneficiaries.

(2) Provide notice of its decision not to renew such coverage to all affected small employers, participants, and beneficiaries no less than one hundred eighty days prior to the nonrenewal of the coverage.

(3) Discontinue all health insurance coverage issued or delivered for issuance to small employers in this state and cease renewal of such coverage.

g. The membership of an employer in an association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage under this paragraph occurs uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner ~~or director of public health~~ finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's ~~or organized delivery system's~~ ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier ~~or organized delivery system~~ may modify the health insurance coverage for a product offered under group health insurance coverage in the small group market, for coverage that is available in such market other than only through one or more bona fide associations, if such modification is consistent with the laws

of this state, and is effective on a uniform basis among group health insurance coverage with that product.

2. A carrier ~~or organized delivery system~~ that elects not to renew health insurance coverage under subsection 1, paragraph *"f"*, shall not write any new business in the small employer market in this state for a period of five years after the date of notice to the commissioner ~~or director of public health~~.

3. This section, with respect to a carrier ~~or organized delivery system~~ doing business in one established geographic service area of the state, applies only to such carrier's ~~or organized delivery system's~~ operations in that service area.

Sec. 39. Section 513B.6, unnumbered paragraph 1, Code 2017, is amended to read as follows:

A small employer carrier ~~or organized delivery system~~ shall make reasonable disclosure in solicitation and sales materials provided to small employers of all of the following:

Sec. 40. Section 513B.6, subsection 2, Code 2017, is amended to read as follows:

2. The provisions concerning the small employer carrier's ~~or organized delivery system's~~ right to change premium rates and factors, including case characteristics, which affect changes in premium rates.

Sec. 41. Section 513B.7, Code 2017, is amended to read as follows:

513B.7 Maintenance of records.

1. A small employer carrier ~~or organized delivery system~~ shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

2. A small employer carrier ~~or organized delivery system~~ shall file each March 1 with the commissioner ~~or the director of public health~~ an actuarial certification that the small

employer carrier ~~or organized delivery system~~ is in compliance with this section and that the rating methods of the small employer carrier ~~or organized delivery system~~ are actuarially sound. A copy of the certification shall be retained by the small employer carrier ~~or organized delivery system~~ at its principal place of business.

3. A small employer carrier ~~or organized delivery system~~ shall make the information and documentation described in subsection 1 available to the commissioner ~~or the director of public health~~ upon request. The information is not a public record or otherwise subject to disclosure under chapter 22, and is considered proprietary and trade secret information and is not subject to disclosure by the commissioner ~~or the director of public health~~ to persons outside of the division ~~or department~~ except as agreed to by the small employer carrier ~~or organized delivery system~~ or as ordered by a court of competent jurisdiction.

Sec. 42. Section 513B.9A, subsection 1, unnumbered paragraph 1, Code 2017, is amended to read as follows:

A carrier ~~or organized delivery system~~ offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

Sec. 43. Section 513B.9A, subsection 4, paragraph a, Code 2017, is amended to read as follows:

a. A carrier ~~or organized delivery system~~ offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage.

Sec. 44. Section 513B.9A, subsection 4, paragraph b, subparagraph (2), Code 2017, is amended to read as follows:

(2) Prevent a carrier ~~or organized delivery system~~ offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Sec. 45. Section 513B.10, Code 2017, is amended to read as follows:

513B.10 Availability of coverage.

1. *a.* A carrier ~~or an organized delivery system~~ that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter.

b. A carrier ~~or organized delivery system~~ that offers health insurance coverage in the small group market through a network plan may do either of the following:

(1) Limit employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan.

(2) Deny such coverage to such employers within the service area of such plan if the carrier ~~or organized delivery system~~ has demonstrated to the applicable state authority both of the following:

(a) The carrier ~~or organized delivery system~~ will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees.

(b) The carrier ~~or organized delivery system~~ is applying this subparagraph uniformly to all employers without regard to

the claims experience of those employers and their employees and their dependents, or any health status-related factor relating to such employees or dependents.

c. A carrier ~~or organized delivery system~~, upon denying health insurance coverage in any service area pursuant to paragraph "*b*", subparagraph (2), shall not offer coverage in the small group market within such service area for a period of one hundred eighty days after the date such coverage is denied.

d. A carrier ~~or organized delivery system~~ may deny health insurance coverage in the small group market if the issuer has demonstrated to the commissioner ~~or director of public health~~ both of the following:

(1) The carrier ~~or organized delivery system~~ does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier ~~or organized delivery system~~ is applying the provisions of this paragraph uniformly to all employers in the small group market in this state consistent with state law and without regard to the claims experience of those employers and the employees and dependents of such employers, or any health status-related factor relating to such employees and their dependents.

e. A carrier ~~or organized delivery system~~, upon denying health insurance coverage pursuant to paragraph "*d*", shall not offer coverage in connection with health insurance coverages in the small group market in this state for a period of one hundred eighty days after the date such coverage is denied or until the carrier ~~or organized delivery system~~ has demonstrated to the commissioner ~~or director of public health~~ that the carrier ~~or organized delivery system~~ has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner ~~or director~~ may provide for the application of this paragraph on a service area-specific basis.

f. Paragraph "*a*" shall not be construed to preclude a carrier ~~or organized delivery system~~ from establishing

employer contribution rules or group participation rules for the offering of health insurance coverage in the small group market.

2. A carrier ~~or organized delivery system~~, subject to subsection 1, shall issue health insurance coverage to an eligible small employer that applies for the coverage and agrees to make the required premium payments and satisfy the other reasonable provisions of the health insurance coverage not inconsistent with this chapter. A carrier ~~or organized delivery system~~ is not required to issue health insurance coverage to a self-employed individual who is covered by, or is eligible for coverage under, health insurance coverage offered by an employer.

3. Health insurance coverage for small employers shall satisfy all of the following:

a. A carrier ~~or organized delivery system~~ offering group health insurance coverage, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.

(2) The exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

b. A carrier ~~or organized delivery system~~ offering group health insurance coverage shall not impose any preexisting

condition exclusion as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. A carrier ~~or organized delivery system~~ shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this section, *"affiliation period"* means a period of time not to exceed sixty days for new entrants and not to exceed ninety days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors. This paragraph does not preclude application of a waiting period applicable to all new enrollees under the health insurance coverage, provided that any ~~carrier or organized delivery system-imposed~~

carrier-imposed waiting period is no longer than sixty days and is used in lieu of a preexisting condition exclusion.

d. Health insurance coverage may exclude coverage for late enrollees for preexisting conditions for a period not to exceed eighteen months.

e. (1) Requirements used by a carrier ~~or organized delivery system~~ in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier ~~or organized delivery system~~.

(2) In applying minimum participation requirements with respect to a small employer, a carrier ~~or organized delivery system~~ shall not consider employees or dependents who have other creditable coverage in determining whether the applicable percentage of participation is met.

(3) A carrier ~~or organized delivery system~~ shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

f. (1) If a carrier ~~or organized delivery system~~ offers coverage to a small employer, the carrier ~~or organized delivery system~~ shall offer coverage to all eligible employees of the small employer and the employees' dependents. A carrier ~~or organized delivery system~~ shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(2) Except as provided under paragraphs *"a"* and *"d"*, a carrier ~~or organized delivery system~~ shall not modify health insurance coverage with respect to a small employer or any eligible employee or dependent through riders, endorsements, or other means, to restrict or exclude coverage or benefits for certain diseases, medical conditions, or services otherwise covered by the health insurance coverage.

g. A carrier ~~or organized delivery system~~ offering coverage

through a network plan shall not be required to offer coverage or accept applications pursuant to subsection 1 with respect to a small employer where any of the following ~~apply~~ applies:

(1) The small employer does not have eligible individuals who live, work, or reside in the service area for the network plan.

(2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier ~~or organized delivery system~~, if required, has demonstrated to the commissioner ~~or the director of public health~~ that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying the requirements of this lettered paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and the employees' dependents, or any health status-related factor relating to such employees and dependents.

(3) A carrier ~~or organized delivery system~~, upon denying health insurance coverage in a service area pursuant to subparagraph (2), shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the coverage is denied.

4. A carrier ~~or organized delivery system~~ shall not be required to offer coverage to small employers pursuant to subsection 1 for any period of time where the commissioner ~~or director of public health~~ determines that the acceptance of the offers by small employers in accordance with subsection 1 would place the carrier ~~or organized delivery system~~ in a financially impaired condition.

5. A carrier ~~or organized delivery system~~ shall not be required to provide coverage to small employers pursuant to subsection 1 if the carrier ~~or organized delivery system~~ elects not to offer new coverage to small employers in this state. However, a carrier ~~or organized delivery system~~ that elects not

to offer new coverage to small employers under this subsection shall be allowed to maintain its existing policies in the state, subject to the requirements of section 513B.5.

6. A carrier ~~or organized delivery system~~ that elects not to offer new coverage to small employers pursuant to subsection 5 shall provide notice to the commissioner ~~or director of public health~~ and is prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the commissioner ~~or director~~.

Sec. 46. Section 513C.3, subsection 5, Code 2017, is amended to read as follows:

5. *"Carrier"* means any entity that provides individual health benefit plans in this state. For purposes of this chapter, carrier includes an insurance company, a group hospital or medical service corporation, a fraternal benefit society, a health maintenance organization, and any other entity providing an individual plan of health insurance or health benefits subject to state insurance regulation. ~~*"Carrier"* does not include an organized delivery system.~~

Sec. 47. Section 513C.3, subsection 7, Code 2017, is amended by striking the subsection.

Sec. 48. Section 513C.3, subsection 9, Code 2017, is amended to read as follows:

9. *"Established service area"* means a geographic area, as approved by the commissioner and based upon the carrier's certificate of authority to transact business in this state, within which the carrier is authorized to provide coverage ~~or a geographic area, as approved by the director and based upon the organized delivery system's license to transact business in this state, within which the organized delivery system is authorized to provide coverage~~.

Sec. 49. Section 513C.3, subsection 12, Code 2017, is amended by striking the subsection.

Sec. 50. Section 513C.3, subsection 15, paragraph a, subparagraph (3), Code 2017, is amended by striking the

subparagraph.

Sec. 51. Section 513C.3, subsection 18, Code 2017, is amended to read as follows:

18. *"Restricted network provision"* means a provision of an individual health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier ~~or the organized delivery system~~ to provide health care services to covered individuals.

Sec. 52. Section 513C.5, subsection 1, unnumbered paragraph 1, Code 2017, is amended to read as follows:

Premium rates for any block of individual health benefit plan business issued on or after January 1, 1996, or the date rules are adopted by the commissioner of insurance ~~and the director of public health~~ and become effective, whichever date is later, by a carrier subject to this chapter shall be limited to the composite effect of allocating costs among the following:

Sec. 53. Section 513C.6, Code 2017, is amended to read as follows:

513C.6 Provisions on renewability of coverage.

1. An individual health benefit plan subject to this chapter is renewable with respect to an eligible individual or dependents, at the option of the individual, except for one or more of the following reasons:

a. The individual fails to pay, or to make timely payment of, premiums or contributions pursuant to the terms of the individual health benefit plan.

b. The individual performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the individual health benefit plan.

c. A decision by the individual carrier ~~or organized delivery system~~ to discontinue offering a particular type of individual health benefit plan in the state's individual insurance market. An individual health benefit plan may be

discontinued by the carrier ~~or organized delivery system~~ in that market with the approval of the commissioner ~~or the director~~ and only if the carrier ~~or organized delivery system~~ does all of the following:

(1) Provides advance notice of its decision to discontinue such plan to the commissioner ~~or director~~. Notice to the commissioner ~~or director~~, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected individuals.

(2) Provides notice of its decision not to renew such plan to all affected individuals no less than ninety days prior to the nonrenewal date of any discontinued individual health benefit plans.

(3) Offers to each individual of the discontinued plan the option to purchase any other health plan currently offered by the carrier ~~or organized delivery system~~ to individuals in this state.

(4) Acts uniformly in opting to discontinue the plan and in offering the option under subparagraph (3), without regard to the claims experience of any affected eligible individual or beneficiary under the discontinued plan or to a health status-related factor relating to any covered individuals or beneficiaries who may become eligible for the coverage.

d. A decision by the carrier ~~or organized delivery system~~ to discontinue offering and to cease to renew all of its individual health benefit plans delivered or issued for delivery to individuals in this state. A carrier ~~or organized delivery system~~ making such decision shall do all of the following:

(1) Provide advance notice of its decision to discontinue such plan to the commissioner ~~or director~~. Notice to the commissioner ~~or director~~, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph (2) to affected individuals.

(2) Provide notice of its decision not to renew such plan

to all individuals and to the commissioner ~~or director~~ in each state in which an individual under the discontinued plan is known to reside, no less than one hundred eighty days prior to the nonrenewal of the plan.

e. The commissioner ~~or director~~ finds that the continuation of the coverage is not in the best interests of the individuals, or would impair the carrier's ~~or organized delivery system's~~ ability to meet its contractual obligations.

2. At the time of coverage renewal, a carrier ~~or organized delivery system~~ may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

3. An individual carrier ~~or organized delivery system~~ that elects not to renew an individual health benefit plan under subsection 1, paragraph *"d"*, shall not write any new business in the individual market in this state for a period of five years after the date of notice to the commissioner ~~or director~~.

4. This section, with respect to a carrier ~~or organized delivery system~~ doing business in one established geographic service area of the state, applies only to such carrier's ~~or organized delivery system's~~ operations in that service area.

5. A carrier ~~or organized delivery system~~ offering coverage through a network plan is not required to renew or continue in force coverage or to accept applications from an individual who no longer resides or lives in, or is no longer employed in, the service area of such carrier ~~or organized delivery system~~, or no longer resides or lives in, or is no longer employed in, a service area for which the carrier is authorized to do business, but only if coverage is not offered or terminated uniformly without regard to health status-related factors of a covered individual.

6. A carrier ~~or organized delivery system~~ offering coverage through a bona fide association is not required to renew or

continue in force coverage or to accept applications from an individual through an association if the membership of the individual in the association on which the basis of coverage is provided ceases, but only if the coverage is not offered or terminated under this paragraph uniformly without regard to health status-related factors of a covered individual.

7. An individual who has coverage as a dependent under a basic or standard health benefit plan may, when that individual is no longer a dependent under such coverage, elect to continue coverage under the basic or standard health benefit plan if the individual so elects immediately upon termination of the coverage under which the individual was covered as a dependent.

Sec. 54. Section 513C.7, subsection 1, Code 2017, is amended to read as follows:

1. *a.* ~~(1)~~ A carrier shall file with the commissioner, in a form and manner prescribed by the commissioner, the basic or standard health benefit plan. A basic or standard health benefit plan filed pursuant to this paragraph may be used by a carrier beginning thirty days after it is filed unless the commissioner disapproves of its use.

~~(2)~~ *b.* The commissioner may at any time, after providing notice and an opportunity for a hearing to the carrier, disapprove the continued use by a carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

~~*b.* (1) An organized delivery system shall file with the director, in a form and manner prescribed by the director, the basic or standard health benefit plan to be used by the organized delivery system. A basic or standard health benefit plan filed pursuant to this paragraph may be used by the organized delivery system beginning thirty days after it is filed unless the director disapproves of its use.~~

~~(2) The director may at any time, after providing notice and an opportunity for a hearing to the organized delivery system, disapprove the continued use by an organized delivery system of~~

~~a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this chapter~~.

Sec. 55. Section 513C.7, subsection 3, Code 2017, is amended to read as follows:

3. A carrier ~~or an organized delivery system~~ shall not modify a basic or standard health benefit plan with respect to an individual or dependent through riders, endorsements, or other means to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

Sec. 56. Section 513C.9, subsections 1, 2, 3, 6, and 8, Code 2017, are amended to read as follows:

1. A carrier~~, an organized delivery system,~~ or an agent shall not do either of the following:

a. Encourage or direct individuals to refrain from filing an application for coverage with the carrier ~~or the organized delivery system~~ because of the health status, claims experience, industry, occupation, or geographic location of the individuals.

b. Encourage or direct individuals to seek coverage from another carrier ~~or another organized delivery system~~ because of the health status, claims experience, industry, occupation, or geographic location of the individuals.

2. Subsection 1, paragraph *"a"*, shall not apply with respect to information provided by a carrier ~~or an organized delivery system~~ or an agent to an individual regarding the established geographic service area of the carrier ~~or the organized delivery system,~~ or the restricted network provision of the carrier ~~or the organized delivery system~~.

3. A carrier ~~or an organized delivery system~~ shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for, or results in, the compensation paid to an agent for a sale of a basic or standard health benefit plan to vary because of the health status or permitted rating characteristics of the individual or the

individual's dependents.

6. Denial by a carrier ~~or an organized delivery system~~ of an application for coverage from an individual shall be in writing and shall state the reason or reasons for the denial.

8. If a carrier ~~or an organized delivery system~~ enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of individual health benefit plans in this state, the third-party administrator is subject to this section as if it were a carrier ~~or an organized delivery system~~.

Sec. 57. Section 513C.10, subsection 1, paragraph a, Code 2017, is amended to read as follows:

a. All persons that provide health benefit plans in this state including insurers providing accident and sickness insurance under chapter 509, 514, or 514A, whether on an individual or group basis; fraternal benefit societies providing hospital, medical, or nursing benefits under chapter 512B; and health maintenance organizations, ~~organized delivery systems,~~ other entities providing health insurance or health benefits subject to state insurance regulation, and all other insurers as designated by the board of directors of the Iowa comprehensive health insurance association with the approval of the commissioner shall be members of the association.

Sec. 58. Section 513C.10, subsection 2, paragraph a, Code 2017, is amended to read as follows:

a. Rates for basic and standard coverages as provided in this chapter shall be determined by each carrier ~~or organized delivery system~~ as the product of a basic and standard factor and the lowest rate available for issuance by that carrier ~~or organized delivery system~~ adjusted for rating characteristics and benefits. Basic and standard factors shall be established annually by the Iowa comprehensive health insurance association board with the approval of the commissioner. Multiple basic and standard factors for a distinct grouping of basic and

standard policies may be established. A basic and standard factor is limited to a minimum value defined as the ratio of the average of the lowest rate available for issuance and the maximum rate allowable by law divided by the lowest rate available for issuance. A basic and standard factor is limited to a maximum value defined as the ratio of the maximum rate allowable by law divided by the lowest rate available for issuance. The maximum rate allowable by law and the lowest rate available for issuance is determined based on the rate restrictions under this chapter. For policies written after January 1, 2002, rates for the basic and standard coverages as provided in this chapter shall be calculated using the basic and standard factors and shall be no lower than the maximum rate allowable by law. However, to maintain assessable loss assessments at or below one percent of total health insurance premiums or payments as determined in accordance with subsection 6, the Iowa comprehensive health insurance association board with the approval of the commissioner may increase the value for any basic and standard factor greater than the maximum value.

Sec. 59. Section 513C.10, subsections 3, 4, 7, 8, 9, and 10, Code 2017, are amended to read as follows:

3. Following the close of each calendar year, the association, in conjunction with the commissioner, shall require each carrier ~~or organized delivery system~~ to report the amount of earned premiums and the associated paid losses for all basic and standard plans issued by the carrier ~~or organized delivery system~~. The reporting of these amounts must be certified by an officer of the carrier ~~or organized delivery system~~.

4. The board shall develop procedures and assessment mechanisms and make assessments and distributions as required to equalize the individual carrier ~~and organized delivery system~~ gains or losses so that each carrier ~~or organized delivery system~~ receives the same ratio of paid claims to

ninety percent of earned premiums as the aggregate of all basic and standard plans insured by all carriers ~~and organized delivery systems~~ in the state.

7. The board shall develop procedures for distributing the assessable loss assessments to each carrier ~~and organized delivery system~~ in proportion to the carrier's ~~and organized delivery system's~~ respective share of premium for basic and standard plans to the statewide total premium for all basic and standard plans.

8. The board shall ensure that procedures for collecting and distributing assessments are as efficient as possible for carriers ~~and organized delivery systems~~. The board may establish procedures which combine, or offset, the assessment from, and the distribution due to, a carrier ~~or organized delivery system~~.

9. A carrier ~~or an organized delivery system~~ may petition the association board to seek remedy from writing a significantly disproportionate share of basic and standard policies in relation to total premiums written in this state for health benefit plans. Upon a finding that a carrier ~~or organized delivery system~~ has written a disproportionate share, the board may agree to compensate the carrier ~~or organized delivery system~~ either by paying to the carrier ~~or organized delivery system~~ an additional fee not to exceed two percent of earned premiums from basic and standard policies for that carrier ~~or organized delivery system~~ or by petitioning the commissioner ~~or director, as appropriate,~~ for remedy.

10. *~~a.~~* The commissioner, upon a finding that the acceptance of the offer of basic and standard coverage by individuals pursuant to this chapter would place the carrier in a financially impaired condition, shall not require the carrier to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.

~~*b. The director, upon a finding that the acceptance of the offer of basic and standard coverage by individuals pursuant*~~

~~to this chapter would place the organized delivery system in a financially impaired condition, shall not require the organized delivery system to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.~~

Sec. 60. Section 514A.3B, subsection 3, paragraph k, Code 2017, is amended by striking the paragraph.

Sec. 61. Section 514B.25A, Code 2017, is amended to read as follows:

514B.25A Insolvency protection — assessment.

1. Upon a health maintenance organization ~~or organized delivery system~~ authorized to do business in this state ~~and licensed by the director of public health~~ being declared insolvent by the district court, the commissioner may levy an assessment on each health maintenance organization ~~or organized delivery system~~ doing business in this state ~~and licensed by the director of public health, as applicable~~, to pay claims for uncovered expenditures for enrollees. The commissioner shall not assess an amount in any one calendar year which is more than two percent of the aggregate premium written by each health maintenance organization ~~or organized delivery system~~.

2. The commissioner may use funds obtained through an assessment under subsection 1 to pay claims for uncovered expenditures for enrollees of an insolvent health maintenance organization ~~or organized delivery system~~ and administrative costs. The commissioner, by rule, may prescribe the time, manner, and form for filing claims under this section. The commissioner may require claims to be allowed by an ancillary receiver or the domestic receiver or liquidator.

3. *a.* A receiver or liquidator of an insolvent health maintenance organization ~~or organized delivery system~~ shall allow a claim in the proceeding in an amount equal to uncovered expenditures and administrative costs paid under this section.

b. A person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the

commissioner to the extent of the benefits received. The commissioner may require an assignment of such rights by a payee, enrollee, or beneficiary, to the commissioner as a condition precedent to the receipt of such benefits. The commissioner is subrogated to these rights against the assets of the insolvent health maintenance organization ~~or organized delivery system~~ that are held by a receiver or liquidator of a foreign jurisdiction.

c. The assigned subrogation rights of the commissioner and allowed claims under this subsection have the same priority against the assets of the insolvent health maintenance organization ~~or organized delivery system~~ as those claims of persons entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

4. If funds assessed under subsection 1 are unused following the completion of the liquidation of an insolvent health maintenance organization ~~or organized delivery system~~, the commissioner shall distribute the remaining amounts, if such amounts are not de minimis, to the health maintenance organizations ~~or organized delivery systems~~ that were assessed.

5. The aggregate coverage of uncovered expenditures under this section shall not exceed three hundred thousand dollars with respect to one individual. Continuation of coverage shall cease after the lesser of one year after the health maintenance organization ~~or organized delivery system~~ is terminated by insolvency or the remaining term of the contract. The commissioner may provide continuation of coverage on a reasonable basis, including, but not limited to, continuation of the health maintenance organization ~~or organized delivery system~~ contract or substitution of indemnity coverage in a form as determined by the commissioner.

6. The commissioner may waive an assessment of a health maintenance organization ~~or organized delivery system~~ if such organization ~~or system~~ is impaired financially or would be impaired financially as a result of such assessment. A health

maintenance organization ~~or organized delivery system~~ that fails to pay an assessment within thirty days after notice of the assessment is subject to a civil forfeiture of not more than one thousand dollars for each day the failure continues, and suspension or revocation of its certificate of authority. An action taken by the commissioner to enforce an assessment under this section may be appealed by the health maintenance organization ~~or organized delivery system~~ pursuant to chapter 17A.

Sec. 62. Section 514C.10, subsection 2, paragraph e, Code 2017, is amended by striking the paragraph.

Sec. 63. Section 514C.11, Code 2017, is amended to read as follows:

514C.11 Services provided by licensed physician assistants and licensed advanced registered nurse practitioners.

1. Notwithstanding section 514C.6, a policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary medical or surgical care and treatment provided by a physician assistant licensed pursuant to chapter 148C, or provided by an advanced registered nurse practitioner licensed pursuant to chapter 152 and performed within the scope of the license of the licensed physician assistant or the licensed advanced registered nurse practitioner if the policy or contract would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery under chapter 148. The policy or contract shall provide that policyholders and subscribers under the policy or contract may reject the coverage for services which may be provided by a licensed physician assistant or licensed advanced registered nurse practitioner if the coverage is rejected for all providers of similar services. A policy or contract subject to this section shall not impose a practice or supervision restriction which is inconsistent with or more restrictive than

the restriction already imposed by law.

2. This section applies to services provided under a policy or contract delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1996, and to an existing policy or contract, on the policy's or contract's anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is later. This section does not apply to policyholders or subscribers eligible for coverage under Tit. XVIII of the federal Social Security Act or any similar coverage under a state or federal government plan.

3. For the purposes of this section, third-party payment or prepayment includes an individual or group policy of accident or health insurance or individual or group hospital or health care service contract issued pursuant to chapter 509, 514, or 514A, an individual or group health maintenance organization contract issued and regulated under chapter 514B, ~~an organized delivery system contract regulated under rules adopted by the director of public health,~~ or a preferred provider organization contract regulated pursuant to chapter 514F.

4. Nothing in this section shall be interpreted to require an individual or group health maintenance organization~~, an organized delivery system,~~ or a preferred provider organization or arrangement to provide payment or prepayment for services provided by a licensed physician assistant or licensed advanced registered nurse practitioner unless the physician assistant's supervising physician, the physician-physician assistant team, the advanced registered nurse practitioner, or the advanced registered nurse practitioner's collaborating physician has entered into a contract or other agreement to provide services with the individual or group health maintenance organization~~, the organized delivery system,~~ or the preferred provider organization or arrangement.

Sec. 64. Section 514C.13, subsection 1, paragraph h, Code 2017, is amended by striking the paragraph.

Sec. 65. Section 514C.13, subsection 2, Code 2017, is amended to read as follows:

2. A carrier ~~or organized delivery system~~ which offers to a small employer a limited provider network plan to provide health care services or benefits to the small employer's employees shall also offer to the small employer a point of service option to the limited provider network plan.

Sec. 66. Section 514C.13, subsection 3, unnumbered paragraph 1, Code 2017, is amended to read as follows:

A carrier ~~or organized delivery system~~ which offers to a large employer a limited provider network plan to provide health care services or benefits to the large employer's employees shall also offer to the large employer one or more of the following:

Sec. 67. Section 514C.14, subsections 1 and 3, Code 2017, are amended to read as follows:

1. Except as provided under subsection 2 or 3, a carrier, as defined in section 513B.2, ~~an organized delivery system authorized under 1993 Iowa Acts, ch. 158,~~ or a plan established pursuant to chapter 509A for public employees, which terminates its contract with a participating health care provider, shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the child birth and delivery. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

3. A carrier~~, organized delivery system,~~ or a plan established under chapter 509A, which terminates the contract of a participating health care provider for cause shall not be liable to pay for health care services provided by the health care provider to a covered person following the date of termination.

Sec. 68. Section 514C.15, Code 2017, is amended to read as

follows:

514C.15 Treatment options.

A carrier, as defined in section 513B.2,~~; an organized delivery system authorized under 1993 Iowa Acts, ch. 158, and licensed by the director of public health;~~ or a plan established pursuant to chapter 509A for public employees, shall not prohibit a participating provider from, or penalize a participating provider for, doing either of the following:

1. Discussing treatment options with a covered individual, notwithstanding the carrier's, ~~organized delivery system's,~~ or plan's position on such treatment option.

2. Advocating on behalf of a covered individual within a review or grievance process established by the carrier~~,~~ ~~organized delivery system,~~ or chapter 509A plan, or established by a person contracting with the carrier~~, organized delivery system,~~ or chapter 509A plan.

Sec. 69. Section 514C.16, subsection 1, Code 2017, is amended to read as follows:

1. A carrier, as defined in section 513B.2,~~; an organized delivery system authorized under 1993 Iowa Acts, ch. 158, and licensed by the director of public health;~~ or a plan established pursuant to chapter 509A for public employees, which provides coverage for emergency services, is responsible for charges for emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. Coverage for emergency services is subject to the terms and conditions of the health benefit plan or contract.

Sec. 70. Section 514C.17, subsections 1 and 3, Code 2017, are amended to read as follows:

1. Except as provided under subsection 2 or 3, if a carrier, as defined in section 513B.2, ~~an organized delivery system authorized under 1993 Iowa Acts, ch. 158,~~ or a plan established pursuant to chapter 509A for public employees, terminates its contract with a participating health care provider, a covered

individual who is undergoing a specified course of treatment for a terminal illness or a related condition, with the recommendation of the covered individual's treating physician licensed under chapter 148 may continue to receive coverage for treatment received from the covered individual's physician for the terminal illness or a related condition, for a period of up to ninety days. Payment for covered benefits and benefit levels shall be according to the terms and conditions of the contract.

3. Notwithstanding subsections 1 and 2, a carrier~~,~~ ~~organized delivery system,~~ or a plan established under chapter 509A which terminates the contract of a participating health care provider for cause shall not be required to cover health care services provided by the health care provider to a covered person following the date of termination.

Sec. 71. Section 514C.18, subsection 2, paragraph a, subparagraph (6), Code 2017, is amended by striking the subparagraph.

Sec. 72. Section 514C.19, subsection 7, paragraph a, subparagraph (6), Code 2017, is amended by striking the subparagraph.

Sec. 73. Section 514C.20, subsection 3, paragraph f, Code 2017, is amended by striking the paragraph.

Sec. 74. Section 514C.21, subsection 2, paragraph d, Code 2017, is amended by striking the paragraph.

Sec. 75. Section 514C.22, subsection 1, unnumbered paragraph 1, Code 2017, is amended to read as follows:

Notwithstanding the uniformity of treatment requirements of section 514C.6, a group policy, contract, or plan providing for third-party payment or prepayment of health, medical, and surgical coverage benefits issued by a carrier, as defined in section 513B.2, ~~or by an organized delivery system authorized under 1993 Iowa Acts, ch. 158,~~ shall provide coverage benefits for treatment of a biologically based mental illness if either of the following is satisfied:

Sec. 76. Section 514C.22, subsection 6, Code 2017, is amended to read as follows:

6. A carrier~~, organized delivery system,~~ or plan established pursuant to chapter 509A may manage the benefits provided through common methods including, but not limited to, providing payment of benefits or providing care and treatment under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system for the use of least restrictive and least costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

Sec. 77. Section 514C.25, subsection 2, paragraph a, subparagraph (5), Code 2017, is amended by striking the subparagraph.

Sec. 78. Section 514C.26, subsection 5, paragraph a, subparagraph (6), Code 2017, is amended by striking the subparagraph.

Sec. 79. Section 514C.27, subsection 1, unnumbered paragraph 1, Code 2017, is amended to read as follows:

Notwithstanding the uniformity of treatment requirements of section 514C.6, a group policy or contract providing for third-party payment or prepayment of health or medical expenses issued by a carrier, as defined in section 513B.2, ~~or by an organized delivery system authorized under 1993 Iowa Acts, ch. 158,~~ shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse if either of the following is satisfied:

Sec. 80. Section 514C.27, subsection 6, Code 2017, is amended to read as follows:

6. A carrier~~, organized delivery system,~~ or plan established pursuant to chapter 509A may manage the benefits provided through common methods including but not limited to providing payment of benefits or providing care and treatment

under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system for the use of least restrictive and least costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

Sec. 81. Section 514C.29, subsection 2, paragraph e, Code 2017, is amended by striking the paragraph.

Sec. 82. Section 514C.30, subsection 2, paragraph e, Code 2017, is amended by striking the paragraph.

Sec. 83. Section 514E.1, subsection 6, paragraph k, Code 2017, is amended by striking the paragraph.

Sec. 84. Section 514E.1, subsection 17, Code 2017, is amended by striking the subsection.

Sec. 85. Section 514E.2, subsection 1, paragraph a, Code 2017, is amended to read as follows:

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 association's board of directors and approved by the commissioner shall be members of the association.

Sec. 86. Section 514E.2, subsection 2, paragraph a, subparagraph (3), Code 2017, is amended to read as follows:

(3) Two members selected by the members of the association, one of whom shall be a representative from a corporation operating pursuant to chapter 514 on July 1, 1989, or any successor in interest, and one of whom shall be a representative of ~~an organized delivery system or~~ an insurer providing coverage pursuant to chapter 509 or 514A.

Sec. 87. Section 514E.7, subsection 1, paragraph a, subparagraphs (1) and (2), Code 2017, are amended to read as follows:

(1) A notice of rejection or refusal to issue substantially

similar insurance for health reasons by one carrier ~~or organized delivery system~~.

(2) A refusal by a carrier ~~or organized delivery system~~ to issue insurance except at a rate exceeding the plan rate.

Sec. 88. Section 514E.7, subsection 1, paragraph b, Code 2017, is amended to read as follows:

b. A rejection or refusal by a carrier ~~or organized delivery system~~ offering only stoploss, excess of loss, or reinsurance coverage with respect to an applicant under paragraph "*a*", subparagraphs (1) and (2), is not sufficient evidence for purposes of this subsection.

Sec. 89. Section 514E.9, Code 2017, is amended to read as follows:

514E.9 Rules.

Pursuant to chapter 17A, the commissioner ~~and the director of public health~~ shall adopt rules to provide for disclosure by carriers ~~and organized delivery systems~~ of the availability of insurance coverage from the association, and to otherwise implement this chapter.

Sec. 90. Section 514E.11, Code 2017, is amended to read as follows:

514E.11 Notice of association policy.

Every carrier, including a health maintenance organization subject to chapter 514B ~~and an organized delivery system~~, authorized to provide health care insurance or coverage for health care services in Iowa, shall provide a notice of the availability of coverage by the association to any person who receives a rejection of coverage for health insurance or health care services, or a rate for health insurance or coverage for health care services that will exceed the rate of an association policy, and that person is eligible to apply for health insurance provided by the association. Application for the health insurance shall be on forms prescribed by the association's board of directors and made available to the carriers ~~and organized delivery systems~~ and other entities

providing health care insurance or coverage for health care services regulated by the commissioner.

Sec. 91. Section 514F.5, Code 2017, is amended to read as follows:

514F.5 Experimental treatment review.

1. A carrier, as defined in section 513B.2, ~~an organized delivery system authorized under 1993 Iowa Acts, ch. 158,~~ or a plan established pursuant to chapter 509A for public employees, that limits coverage for experimental medical treatment, drugs, or devices, shall develop and implement a procedure to evaluate experimental medical treatments and shall submit a description of the procedure to the division of insurance. The procedure shall be in writing and must describe the process used to determine whether the carrier~~, organized delivery system,~~ or chapter 509A plan will provide coverage for new medical technologies and new uses of existing technologies. The procedure, at a minimum, shall require a review of information from appropriate government regulatory agencies and published scientific literature concerning new medical technologies, new uses of existing technologies, and the use of external experts in making decisions. A carrier~~, organized delivery system,~~ or chapter 509A plan shall include appropriately licensed or qualified professionals in the evaluation process. The procedure shall provide a process for a person covered under a plan or contract to request a review of a denial of coverage because the proposed treatment is experimental. A review of a particular treatment need not be reviewed more than once a year.

2. A carrier~~, organized delivery system,~~ or chapter 509A plan that limits coverage for experimental treatment, drugs, or devices shall clearly disclose such limitations in a contract, policy, or certificate of coverage.

Sec. 92. Section 514I.2, subsection 10, Code 2017, is amended to read as follows:

10. *"Participating insurer"* means any entity licensed by the

division of insurance of the department of commerce to provide health insurance in Iowa ~~or an organized delivery system licensed by the director of public health~~ that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

Sec. 93. Section 514J.102, subsection 24, Code 2017, is amended to read as follows:

24. *"Health carrier"* means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. ~~*"Health carrier"* includes, for purposes of this chapter, an organized delivery system.~~

Sec. 94. Section 514J.102, subsection 29, Code 2017, is amended by striking the subsection.

Sec. 95. Section 514K.1, subsection 1, unnumbered paragraph 1, Code 2017, is amended to read as follows:

A health maintenance organization~~, an organized delivery system,~~ or an insurer using a preferred provider arrangement shall provide to each of its enrollees at the time of enrollment, and shall make available to each prospective enrollee upon request, written information as required by rules adopted by the commissioner ~~and the director of public health~~. The information required by rule shall include, but not be limited to, all of the following:

Sec. 96. Section 514K.1, subsection 2, Code 2017, is amended to read as follows:

2. The commissioner ~~and the director~~ shall annually publish a consumer guide providing a comparison by plan on performance measures, network composition, and other key information to enable consumers to better understand plan differences.

Sec. 97. Section 514L.1, subsection 3, Code 2017, is amended to read as follows:

3. *"Provider of third-party payment or prepayment of prescription drug expenses"* or *"provider"* means a provider of an individual or group policy of accident or health insurance or an individual or group hospital or health care service contract issued pursuant to chapter 509, 514, or 514A, a provider of a plan established pursuant to chapter 509A for public employees, a provider of an individual or group health maintenance organization contract issued and regulated under chapter 514B, ~~a provider of an organized delivery system contract regulated under rules adopted by the director of public health,~~ a provider of a preferred provider contract issued pursuant to chapter 514F, a provider of a self-insured multiple employer welfare arrangement, and any other entity providing health insurance or health benefits which provide for payment or prepayment of prescription drug expenses coverage subject to state insurance regulation.

Sec. 98. Section 514L.2, subsection 1, paragraph a, unnumbered paragraph 1, Code 2017, is amended to read as follows:

A provider of third-party payment or prepayment of prescription drug expenses, including the provider's agents or contractors and pharmacy benefits managers, that issues a card or other technology for claims processing and an administrator of the payor, excluding administrators of self-funded employer sponsored health benefit plans qualified under the federal Employee Retirement Income Security Act of 1974, shall issue to its insureds a card or other technology containing uniform prescription drug information. The commissioner of insurance shall adopt rules for the uniform prescription drug information card or technology applicable to those entities subject to regulation by the commissioner of insurance. ~~The director of public health shall adopt rules for the uniform prescription drug information card or technology applicable to organized~~

~~delivery systems.~~ The rules shall require at least both of the following regarding the card or technology:

Sec. 99. Section 521F.2, subsection 7, Code 2017, is amended to read as follows:

7. *"Health organization"* means a health maintenance organization, limited service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under chapter 514~~,~~ or 514B, ~~or 1993 Iowa Acts, ch. 158,~~ or any other entity engaged in the business of insurance, risk transfer, or risk retention, that is subject to the jurisdiction of the commissioner of insurance ~~or the director of public health~~. *"Health organization"* does not include an insurance company licensed to transact the business of insurance under chapter 508, 515, or 520, and which is otherwise subject to chapter 521E.

Sec. 100. 1993 Iowa Acts, chapter 158, section 4, is amended to read as follows:

SEC. 4. EMERGENCY RULES. Pursuant to sections 1~~,~~ and 2~~, and 3~~ of this Act, the commissioner of insurance ~~or the director of public health~~ shall adopt administrative rules under section 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph "b", to implement the provisions of this Act and the rules shall become effective immediately upon filing, unless a later effective date is specified in the rules. Any rules adopted in accordance with the provisions of this section shall also be published as notice of intended action as provided in section 17A.4.

Sec. 101. REPEAL. Section 135.120, Code 2017, is repealed.

Sec. 102. REPEAL. 1993 Iowa Acts, chapter 158, section 3, is repealed.

Sec. 103. CODE EDITOR'S DIRECTIVE. The Code editor shall correct and eliminate any references to the term "organized delivery system" or other forms of the term anywhere else in the Iowa Code or Iowa Code Supplement, in any bills awaiting

codification, in this Act, and in any bills enacted by the Eighty-seventh General Assembly, 2017 Regular Session, or any extraordinary session.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to programs and activities under the purview of the department of public health (DPH).

Division I of the bill relates to program funding flexibility and reporting.

The bill provides that if the amount of estimated moneys to be received from certain liquor fees and retail beer permit fees that is transferred to DPH annually for grants to counties operating a substance abuse program exceeds grant requests, in addition to using the remainder for grants to entities to operate a substance abuse prevention program, DPH may also use the remainder for activities and public information resources that align with best practices for substance-related disorder prevention.

The bill eliminates the requirement under Code section 135.11, subsection 31, that DPH report to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, the legislative services agency, the legislative caucus staffs, and the department of management within 60 calendar days of applying for or renewing a federal grant which requires a state match or maintenance of effort and has a value of over $100,000, including a listing of the federal funding source and the potential need for the commitment of state funding in the present or future.

The bill amends Code section 135.150 to require DPH to report annually rather than semiannually to the general assembly's standing committees on government oversight regarding the operation of the gambling treatment program including information on the moneys expended and grants awarded for operation of the program.

Division II of the bill relates to medical home and the patient-centered health advisory council.

The bill amends provisions relating to medical homes. Code sections 135.157 and 135.158, providing definitions and describing the purposes and characteristics of medical homes, are repealed by the bill. Code section 135.159 provides parameters for the development and implementation of a medical home system in the state, as well as the establishment of the patient-centered health advisory council. The bill amends Code section 135.159 to provide for the continuation of the patient-centered health advisory council and to revise the purposes of the council.

The bill also makes conforming changes throughout the Code, including those relative to the definitions of "dental home", "medical home", "personal provider", "primary care provider", and "primary medical provider", due to elimination of certain definitions and concepts based upon the repeal of Code sections 135.157 and 135.158.

Division III of the bill includes provisions relating to workforce programming.

The bill amends Code section 135.107 relating to the center for rural health and primary care. Of the programs that constitute the primary care provider recruitment and retention endeavor or PRIMECARRE, the bill eliminates the primary care provider community scholarship program, but retains the primary care loan repayment program and the community grant program that is renamed the health care workforce and community support grant program. The bill amends the application and matching funds requirements for a grant under the health care workforce and community support grant program and specifies that the target areas for awarding of such grants are rural, underserved areas or special populations identified by the department's strategic plan or evidence-based documentation.

The bill provides that the primary care provider loan repayment program may cancel a loan repayment program contract

for reasonable cause unless federal requirements otherwise require and provides that the center for rural health and primary care may enter into an agreement with the college student aid commission for administration of the center's grant and loan repayment programs.

The bill eliminates the requirement that a community or region applying for assistance under any of the programs established under PRIMECARRE submit a letter of intent to conduct a community health services assessment and instead requires that the community or region shall document participation in the community health services assessment. In addition to any other requirements, an applicant's plan is also to include, to the extent possible, a clear commitment to informing high school students of the health care opportunities which may be available to such students.

The bill removes the representation by the obsolete rural health resource center on the advisory committee to the center for rural health and primary care and corrects the reference to a national or regional institute for rural health policy.

The bill eliminates the reference to "long-term care" in Code section 135.163 which directs DPH to coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, diverse, and sustainable health care workforce in this state. Under this section, DPH is required, at a minimum, to develop a strategic plan for health care delivery infrastructure and health care workforce resources in this state; provide for the continuous collection of data to provide a basis for health care strategic planning and health care policymaking; and make recommendations regarding the health care delivery infrastructure and the health care workforce that assist in monitoring current needs, predicting future trends, and informing policymaking.

The bill amends Code section 135.175 relating to the health care workforce support initiative, the workforce shortage fund,

and the accounts within the fund. The bill provides that state programs that may receive moneys from the fund or the accounts in the fund, if specifically designated for drawing down federal funding, include PRIMECARRE, the Iowa affiliate of the national rural recruitment and retention network, the oral and health delivery systems bureau of the department, the primary care office and shortage designation program, and the state office of rural health, but eliminates inclusion of the Iowa health workforce center, the area health education centers programs at Des Moines university osteopathic medical center and the university of Iowa, and the Iowa collaborative safety net provider network as potential recipients. The bill also eliminates the requirement that state appropriations to the fund shall be allocated in equal amounts to each of the accounts within the fund, unless otherwise specified in the appropriation or allocation, and eliminates the restriction that moneys in each of the accounts in the fund used for administrative purposes are not to exceed $100,000 in each account, but retains the limitation that no more than 5 percent of the moneys in any of the accounts within the fund shall be used for administrative purposes unless otherwise provided in the appropriation, allocation, or source of the funds.

The bill repeals Code section 135.164 which relates to the health care delivery infrastructure and health care workforce resources strategic plan to be developed by DPH including the specific elements of the strategic plan and the requirements for developing the strategic plan.

The bill repeals Code section 135.180, the mental health professional shortage area program, which provides stipends to support psychiatrist positions with an emphasis on securing and retaining medical directors at community mental health centers designated under Code chapter 230A and hospital psychiatric units that are located in mental health professional shortage areas.

Division IV of the bill relates to unfunded or outdated

program provisions.

The bill eliminates the provision under Code section 135.11 requiring DPH to establish and administer a substance abuse treatment facility for persons on probation, repeals Code section 135.130, and strikes the conforming provision in Code section 901B.1. The substance abuse treatment facility for persons on probation was authorized in 2001 but was never established.

The bill strikes the directive in Code section 135.141 for the division of acute disease prevention and emergency response of DPH to conduct and maintain a statewide risk assessment of any present or potential danger to the public health from biological agents.

The bill repeals Code section 135.26 establishing the automated external defibrillator (AED) grant program to provide matching fund grants to local boards of health, community organizations, or cities to implement AED programs.

The bill repeals Code section 135.29, relating to local substitute medical decision-making boards, which authorized each county to establish and fund a local substituted medical decision-making board to act as a substitute decision maker for patients incapable of making their own medical care decisions if no other substitute decision maker is available to act.

The bill repeals Code section 135.120, relating to the taxation of organized delivery systems (ODSs). 1993 Iowa Acts, chapter 158, section 3, directs DPH to adopt rules and a licensing procedure for the establishment of ODSs. The bill only eliminates the provision for taxation of ODSs, not all other provisions relating to ODSs.

The bill repeals Code section 135.152, the statewide obstetrical and newborn indigent patient care program. The program acts as a payer of last resort for eligible individuals but has not been utilized since 2009 due to other options for coverage including through the Medicaid program and the Affordable Care Act for otherwise eligible individuals.

Division V includes miscellaneous provisions.

The bill amends the definition of "local board of health" in Code section 135A.2 under the public health modernization Act to be consistent with the definition under Code chapter 137, relating to local boards of health.

The bill repeals Code section 135.132, the interagency pharmaceuticals bulk purchasing council. The provision was enacted in 2003, but the council was never established.

Division VI relates to the Iowa health information network. Legislation was enacted in 2015 Iowa Acts, chapter 73, to provide for the future assumption of the Iowa health information network by a designated entity. The bill includes a conforming change that would take effect upon future assumption of the Iowa health information network by a designated entity.

Division VII relates to organized delivery systems that are regulated by DPH. Organized delivery systems were created pursuant to 1993 Iowa Acts, chapter 158. Rules adopted under the provision define an organized delivery system as "an organization with defined governance that is responsible for delivering or arranging to deliver the full range of health care services covered under a standard benefit plan and is accountable to the public for the cost, quality and access of its services and for the effect of its services on their health." (641 IAC 201.2) An organization operating as an organized delivery system is required to assume risk and be subject to solvency standards. The bill eliminates all references to organized delivery systems in the Code and repeals the provision in the Acts authorizing the establishment of organized delivery systems. The most recent application for licensure was received by DPH in 1998. Since being authorized in 1993, only two entities applied for licensure as organized delivery systems and both of these entities have since ceased operations.