Senate File 567 - Introduced

SENATE FILE 567
BY COMMITTEE ON WAYS AND MEANS

(SUCCESSOR TO SF 462)
(SUCCESSOR TO SSB 1167)

A BILL FOR

An Act relating to health care services and financing including nursing facility licensing and financing and the Medicaid program including third-party recovery and taxation of Medicaid managed care organization premiums, and providing for licensee discipline.

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

TLSB 1182SZ (3) 90
pf/rh

DIVISION I

MEDICAID PROGRAM THIRD-PARTY RECOVERY

Section 1. Section 249A.37, Code 2023, is amended by striking the section and inserting in lieu thereof the following:

249A.37 Duties of third parties.

1. For the purposes of this section, *"Medicaid payor"*, *"recipient"*, *"third party"*, and *"third-party benefits"* mean the same as defined in section 249A.54.

2. The third-party obligations specified under this section are a condition of doing business in the state. A third party that fails to comply with these obligations shall not be eligible to do business in the state.

3. A third party that is a carrier, as defined in section 514C.13, shall enter into a health insurance data match program with the department for the sole purpose of comparing the names of the carrier's insureds with the names of recipients as required by section 505.25.

4. A third party shall do all of the following:

a. Cooperate with the Medicaid payor in identifying recipients for whom third-party benefits are available including but not limited to providing information to determine the period of potential third-party coverage, the nature of the coverage, and the name, address, and identifying number of the coverage. In cooperating with the Medicaid payor, the third party shall provide information upon the request of the Medicaid payor in a manner prescribed by the Medicaid payor or as agreed upon by the department and the third party.

b. (1) Accept the Medicaid payor's rights of recovery and assignment to the Medicaid payor as a subrogee, assignee, or lienholder under section 249A.54 for payments which the Medicaid payor has made under the Medicaid state plan or under a waiver of such state plan.

(2) In the case of a third party other than the original Medicare fee-for-service program under parts A and B of Tit.

XVIII of the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under Tit. XIX of the federal Social Security Act, accept authorization provided by the Medicaid payor that the health care item or service is covered under the Medicaid state plan or waiver of such state plan for such individual, as if such authorization were the prior authorization made by the third party for such item or service.

c. If, on or before three years from the date a health care item or service was provided, the Medicaid payor submits an inquiry regarding a claim for payment that was submitted to the third party, respond to that inquiry not later than sixty days after receiving the inquiry.

d. Respond to any Medicaid payor's request for payment of a claim described in paragraph "*c*" not later than ninety business days after receipt of written proof of the claim, either by paying the claim or issuing a written denial to the Medicaid payor.

e. Not deny any claim submitted by a Medicaid payor solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation at the point-of-sale that is the basis of the claim; or in the case of a third party other than the original Medicare fee-for-service program under parts A and B of Tit. XVIII of the federal Social Security Act, a Medicare advantage plan offered by a Medicare advantage organization under part C of Tit. XVIII of the federal Social Security Act, a reasonable cost reimbursement contract under 42 U.S.C. §1395mm, a health

care prepayment plan under 42 U.S.C. §1395l, or a prescription drug plan offered by a prescription drug plan sponsor under part D of Tit. XVIII of the federal Social Security Act, solely on the basis of a failure to obtain prior authorization for the health care item or service for which the claim is submitted if all of the following conditions are met:

(a) The claim is submitted to the third party by the Medicaid payor no later than three years after the date on which the health care item or service was furnished.

(b) Any action by the Medicaid payor to enforce its rights under section 249A.54 with respect to such claim is commenced not later than six years after the Medicaid payor submits the claim for payment.

5. Notwithstanding any provision of law to the contrary, the time limitations, requirements, and allowances specified in this section shall apply to third-party obligations under this section.

6. The department may adopt rules pursuant to chapter 17A as necessary to administer this section. Rules governing the exchange of information under this section shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and regulations promulgated in accordance with that Act and published in 45 C.F.R. pts. 160 — 164.

Sec. 2. Section 249A.54, Code 2023, is amended by striking the section and inserting in lieu thereof the following:

249A.54 Responsibility for payment on behalf of Medicaid-eligible persons —— liability of other parties.

1. It is the intent of the general assembly that a Medicaid payor be the payor of last resort for medical services furnished to recipients. All other sources of payment for medical services are primary relative to medical assistance provided by the Medicaid payor. If benefits of a third party

are discovered or become available after medical assistance has been provided by the Medicaid payor, it is the intent of the general assembly that the Medicaid payor be repaid in full and prior to any other person, program, or entity. The Medicaid payor shall be repaid in full from and to the extent of any third-party benefits, regardless of whether a recipient is made whole or other creditors are paid.

2. For the purposes of this section:

a. "Collateral" means all of the following:

(1) Any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's agent, related to any covered injury or illness, or medical services that necessitated that the Medicaid payor provide medical assistance to the recipient.

(2) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(3) Proceeds.

b. "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which the Medicaid payor is, or may be, obligated to provide, or has provided, medical assistance.

c. "Medicaid payor" means the department or any person, entity, or organization that is legally responsible by contract, statute, or agreement to pay claims for medical assistance including but not limited to managed care organizations and other entities that contract with the state to provide medical assistance under chapter 249A.

d. "Medical service" means medical or medically related institutional or noninstitutional care, or a medical or medically related institutional or noninstitutional good, item, or service covered by Medicaid.

e. "Payment" as it relates to third-party benefits, means

performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. *"To pay"* means to make payment.

f. "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds from the collateral and includes insurance payable because of loss or damage to the collateral or proceeds. *"Cash proceeds"* include money, checks, and deposit accounts and similar proceeds. All other proceeds are *"noncash proceeds"*.

g. "Recipient" means a person who has applied for medical assistance or who has received medical assistance.

h. "Recipient's agent" includes a recipient's legal guardian, legal representative, or any other person acting on behalf of the recipient.

i. "Third party" means an individual, entity, or program, excluding Medicaid, that is or may be liable to pay all or a part of the expenditures for medical assistance provided by a Medicaid payor to the recipient. A third party includes but is not limited to all of the following:

(1) A third-party administrator.

(2) A pharmacy benefits manager.

(3) A health insurer.

(4) A self-insured plan.

(5) A group health plan, as defined in section 607(1) of the federal Employee Retirement Income Security Act of 1974.

(6) A service benefit plan.

(7) A managed care organization.

(8) Liability insurance including self-insurance.

(9) No-fault insurance.

(10) Workers' compensation laws or plans.

(11) Other parties that by law, contract, or agreement are legally responsible for payment of a claim for medical services.

j. "Third-party benefits" mean any benefits that are or may

be available to a recipient from a third party and that provide or pay for medical services. "*Third-party benefits*" may be created by law, contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, recipient, or otherwise. "*Third-party benefits*" include but are not limited to all of the following:

(1) Benefits from collateral or proceeds.

(2) Health insurance benefits.

(3) Health maintenance organization benefits.

(4) Benefits from preferred provider arrangements and prepaid health clinics.

(5) Benefits from liability insurance, uninsured and underinsured motorist insurance, or personal injury protection coverage.

(6) Medical benefits under workers' compensation.

(7) Benefits from any obligation under law or equity to provide medical support.

3. Third-party benefits for medical services shall be primary to medical assistance provided by the Medicaid payor.

4. *a.* A Medicaid payor has all of the rights, privileges, and responsibilities identified under this section. Each Medicaid payor is a Medicaid payor to the extent of the medical assistance provided by that Medicaid payor. Therefore, Medicaid payors may exercise their Medicaid payor's rights under this section concurrently.

b. Notwithstanding the provisions of this subsection to the contrary, if the department determines that a Medicaid payor has not taken reasonable steps within a reasonable time to recover third-party benefits, the department may exercise all of the rights of the Medicaid payor under this section to the exclusion of the Medicaid payor. If the department determines the department will exercise such rights, the department shall give notice to third parties and to the Medicaid payor.

5. A Medicaid payor may assign the Medicaid payor's rights under this section, including but not limited to an assignment

to another Medicaid payor, a provider, or a contractor.

6. After the Medicaid payor has provided medical assistance under the Medicaid program, the Medicaid payor shall seek reimbursement for third-party benefits to the extent of the Medicaid payor's legal liability and for the full amount of the third-party benefits, but not in excess of the amount of medical assistance provided by the Medicaid payor.

7. On or before the thirtieth day following discovery by a recipient of potential third-party benefits, a recipient or the recipient's agent, as applicable, shall inform the Medicaid payor of any rights the recipient has to third-party benefits and of the name and address of any person that is or may be liable to provide third-party benefits.

8. When the Medicaid payor provides or becomes liable for medical assistance, the Medicaid payor has the following rights which shall be construed together to provide the greatest recovery of third-party benefits:

a. The Medicaid payor is automatically subrogated to any rights that a recipient or a recipient's agent or legally liable relative has to any third-party benefit for the full amount of medical assistance provided by the Medicaid payor. Recovery pursuant to these subrogation rights shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but shall provide full recovery to the Medicaid payor from any and all third-party benefits. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat, reduce, or prorate recovery by the Medicaid payor as to the Medicaid payor's subrogation rights granted under this paragraph.

b. By applying for, accepting, or accepting the benefit of medical assistance, a recipient or a recipient's agent or legally liable relative automatically assigns to the Medicaid payor any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

(1) The assignment granted under this paragraph is absolute and vests legal and equitable title to any such right in the Medicaid payor, but not in excess of the amount of medical assistance provided by the Medicaid payor.

(2) The Medicaid payor is a bona fide assignee for value in the assigned right, title, or interest and takes vested legal and equitable title free and clear of latent equities in a third party. Equities of a recipient or a recipient's agent, creditor, or health care provider shall not defeat or reduce recovery by the Medicaid payor as to the assignment granted under this paragraph.

c. The Medicaid payor is entitled to and has an automatic lien upon the collateral for the full amount of medical assistance provided by the Medicaid payor to or on behalf of the recipient for medical services furnished as a result of any covered injury or illness for which a third party is or may be liable.

(1) The lien attaches automatically when a recipient first receives medical services for which the Medicaid payor may be obligated to provide medical assistance.

(2) The filing of the notice of lien with the clerk of the district court in the county in which the recipient's eligibility is established pursuant to this section shall be notice of the lien to all persons. Notice is effective as of the date of filing of the notice of lien.

(3) If the Medicaid payor has actual knowledge that the recipient is represented by an attorney, the Medicaid payor shall provide the attorney with a copy of the notice of lien. However, this provision of a copy of the notice of lien to the recipient's attorney does not abrogate the attachment, perfection, and notice satisfaction requirements specified under subparagraphs (1) and (2).

(4) Only one claim of lien need be filed to provide notice and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by the

Medicaid payor for any specific covered injury or illness. The Medicaid payor may, in the Medicaid payor's discretion, file additional, amended, or substitute notices of lien at any time after the initial filing until the Medicaid payor has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

(5) A release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall not be effective as against a lien created under this paragraph, unless the Medicaid payor joins in the release or satisfaction or executes a release of the lien. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the Medicaid payor is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the Medicaid payor may recover from the person accepting the release or satisfaction or the person making the settlement the full amount of medical assistance provided by the Medicaid payor.

(6) The lack of a properly filed claim of lien shall not affect the Medicaid payor's assignment or subrogation rights provided in this subsection nor affect the existence of the lien, but shall only affect the effective date of notice.

(7) The lien created by this paragraph is a first lien and superior to the liens and charges of any provider of a recipient's medical services. If the lien is recorded, the lien shall exist for a period of seven years after the date of recording. If the lien is not recorded, the lien shall exist for a period of seven years after the date of attachment. If recorded, the lien may be extended for one additional period of seven years by rerecording the claim of lien within the

ninety-day period preceding the expiration of the lien.

9. Except as otherwise provided in this section, the Medicaid payor shall recover the full amount of all medical assistance provided by the Medicaid payor on behalf of the recipient to the full extent of third-party benefits. The Medicaid payor may collect recovered benefits directly from any of the following:

a. A third party.

b. The recipient.

c. The provider of a recipient's medical services if third-party benefits have been recovered by the provider. Notwithstanding any provision of this section to the contrary, a provider shall not be required to refund or pay to the Medicaid payor any amount in excess of the actual third-party benefits received by the provider from a third party for medical services provided to the recipient.

d. Any person who has received the third-party benefits.

10. *a.* A recipient and the recipient's agent shall cooperate in the Medicaid payor's recovery of the recipient's third-party benefits and in establishing paternity and support of a recipient child born out of wedlock. Such cooperation shall include but is not limited to all of the following:

(1) Appearing at an office designated by the Medicaid payor to provide relevant information or evidence.

(2) Appearing as a witness at a court proceeding or other legal or administrative proceeding.

(3) Providing information or attesting to lack of information under penalty of perjury.

(4) Paying to the Medicaid payor any third-party benefit received.

(5) Taking any additional steps to assist in establishing paternity or securing third-party benefits, or both.

b. Notwithstanding paragraph "*a*", the Medicaid payor has the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law.

c. The department may deny or terminate eligibility for any recipient who refuses to cooperate as required under this subsection unless the department has waived cooperation as provided under this subsection.

11. On or before the thirtieth day following the initiation of a formal or informal recovery, other than by filing a lawsuit, a recipient's attorney shall provide written notice of the activity or action to the Medicaid payor.

12. A recipient is deemed to have authorized the Medicaid payor to obtain and release medical information and other records with respect to the recipient's medical services for the sole purpose of obtaining reimbursement for medical assistance provided by the Medicaid payor.

13. *a.* To enforce the Medicaid payor's rights under this section, the Medicaid payor may, as a matter of right, institute, intervene in, or join in any legal or administrative proceeding in the Medicaid payor's own name, and in any or a combination of any, of the following capacities:

(1) Individually.

(2) As a subrogee of the recipient.

(3) As an assignee of the recipient.

(4) As a lienholder of the collateral.

b. An action by the Medicaid payor to recover damages in an action in tort under this subsection, which action is derivative of the rights of the recipient, shall not constitute a waiver of sovereign immunity.

c. A Medicaid payor, other than the department, shall obtain the written consent of the department before the Medicaid payor files a derivative legal action on behalf of a recipient.

d. When a Medicaid payor brings a derivative legal action on behalf of a recipient, the Medicaid payor shall provide written notice no later than thirty days after filing the action to the recipient, the recipient's agent, and, if the Medicaid payor has actual knowledge that the recipient is represented by an attorney, to the attorney of the recipient, as applicable.

e. If the recipient or a recipient's agent brings an action against a third party, on or before the thirtieth day following the filing of the action, the recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice to the Medicaid payor of the action, including the name of the court in which the action is brought, the case number of the action, and a copy of the pleadings. The recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice of intent to dismiss the action at least twenty-one days before the voluntary dismissal of an action against a third party. Notice to the Medicaid payor shall be sent as specified by rule.

14. On or before the thirtieth day before the recipient finalizes a judgment, award, settlement, or any other recovery where the Medicaid payor has the right to recovery, the recipient, the recipient's agent, or the attorney of the recipient or recipient's agent, as applicable, shall give the Medicaid payor notice of the judgment, award, settlement, or recovery. The judgment, award, settlement, or recovery shall not be finalized unless such notice is provided and the Medicaid payor has had a reasonable opportunity to recover under the Medicaid payor's rights to subrogation, assignment, and lien. If the Medicaid payor is not given notice, the recipient, the recipient's agent, and the recipient's or recipient's agent's attorney are jointly and severally liable to reimburse the Medicaid payor for the recovery received to the extent of medical assistance paid by the Medicaid payor. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

15. *a.* Except as otherwise provided in this section, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the Medicaid payor's claim for reimbursement of the amount of medical assistance provided and any lien pursuant to the claim.

b. Insurance and other third-party benefits shall not contain any term or provision which purports to limit or exclude payment or the provision of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance, and any such term or provision shall be void as against public policy.

16. In an action in tort against a third party in which the recipient is a party and which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

a. After deduction of reasonable attorney fees, reasonably necessary legal expenses, and filing fees, there is a rebuttable presumption that all Medicaid payors shall collectively receive two-thirds of the remaining amount recovered or the total amount of medical assistance provided by the Medicaid payors, whichever is less. A party may rebut this presumption in accordance with subsection 17.

b. The remaining recovered amount shall be paid to the recipient.

c. If the recovered amount available for the repayment of medical assistance is insufficient to satisfy the competing claims of the Medicaid payors, each Medicaid payor shall be entitled to the Medicaid payor's respective pro rata share of the recovered amount that is available.

17. *a.* A recipient or a recipient's agent who has notice or who has actual knowledge of the Medicaid payor's rights to third-party benefits under this section and who receives any third-party benefit or proceeds for a covered injury or illness shall on or before the sixtieth day after receipt of

the proceeds pay the Medicaid payor the full amount of the third-party benefits, but not more than the total medical assistance provided by the Medicaid payor, or shall place the full amount of the third-party benefits in an interest-bearing trust account for the benefit of the Medicaid payor pending a determination of the Medicaid payor's rights to the benefits under this subsection.

b. If federal law limits the Medicaid payor to reimbursement from the recovered damages for medical expenses, a recipient may contest the amount designated as recovered damages for medical expenses payable to the Medicaid payor pursuant to the formula specified in subsection 16. In order to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as medical expenses, including future medical expenses, is less than the amount calculated by the Medicaid payor pursuant to the formula specified in subsection 16. Alternatively, to successfully rebut the formula specified in subsection 16, the recipient shall prove, by clear and convincing evidence, that Medicaid provided a lesser amount of medical assistance than that asserted by the Medicaid payor. A settlement agreement that designates the amount of recovered damages for medical expenses is not clear and convincing evidence and is not sufficient to establish the recipient's burden of proof, unless the Medicaid payor is a party to the settlement agreement.

c. If the recipient or the recipient's agent filed a legal action to recover against the third party, the court in which such action was filed shall resolve any dispute concerning the amount owed to the Medicaid payor, and shall retain jurisdiction of the case to resolve the amount of the lien after the dismissal of the action.

d. If the recipient or the recipient's agent did not file a legal action, to resolve any dispute concerning the amount owed to the Medicaid payor, the recipient or the recipient's agent

shall file a petition for declaratory judgment as permitted under rule of civil procedure 1.1101 on or before the one hundred twenty-first day after the date of payment of funds to the Medicaid payor or the date of placing the full amount of the third-party benefits in a trust account. Venue for all declaratory actions under this subsection shall lie in Polk county.

e. If a Medicaid payor and the recipient or the recipient's agent disagree as to whether a medical claim is related to a covered injury or illness, the Medicaid payor and the recipient or the recipient's agent shall attempt to work cooperatively to resolve the disagreement before seeking resolution by the court.

f. Each party shall pay the party's own attorney fees and costs for any legal action conducted under this subsection.

18. Notwithstanding any other provision of law to the contrary, when medical assistance is provided for a minor, any statute of limitation or repose applicable to an action or claim of a legally responsible relative for the minor's medical expenses is extended in favor of the legally responsible relative so that the legally responsible relative shall have one year from and after the attainment of the minor's majority within which to file a complaint, make a claim, or commence an action.

19. In recovering any payments in accordance with this section, the Medicaid payor may make appropriate settlements.

20. If a recipient or a recipient's agent submits via notice a request that the Medicaid payor provide an itemization of medical assistance paid for any covered injury or illness, the Medicaid payor shall provide the itemization on or before the sixty-fifth day following the day on which the Medicaid payor received the request. Failure to provide the itemization within the specified time shall not bar a Medicaid payor's recovery, unless the itemization response is delinquent for more than one hundred twenty days without justifiable cause. A

Medicaid payor shall not be under any obligation to provide a final itemization until a reasonable period of time after the processing of payment in relation to the recipient's receipt of final medical services. A Medicaid payor shall not be under any obligation to respond to more than one itemization request in any one-hundred-twenty-day period. The notice required under this subsection means written notice sent via certified mail to the address listed on the department's internet site for a Medicaid payor's third-party liability contact. The notice requirement is only satisfied for the specific Medicaid payor upon receipt by the specific Medicaid payor's third-party liability contact of such written notice sent via certified mail.

21. The department may adopt rules to administer this section and applicable federal requirements.

DIVISION II

MEDICAID MANAGED CARE ORGANIZATION TAXATION OF PREMIUMS

Sec. 3. NEW SECTION. **249A.13 Medicaid managed care organization premiums fund.**

1. A Medicaid managed care organization premiums fund is created in the state treasury under the authority of the department of health and human services. Moneys collected by the director of the department of revenue as taxes on premiums pursuant to section 432.1A shall be deposited in the fund.

2. Moneys in the fund are appropriated to the department of health and human services for the purposes of the medical assistance program.

3. Notwithstanding section 8.33, moneys in the fund that remain unencumbered or unobligated at the close of a fiscal year shall not revert but shall remain available for expenditure for the purposes designated. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys in the fund shall be credited to the fund.

Sec. 4. NEW SECTION. **432.1A Health maintenance organization — medical assistance program — premium tax.**

1. Pursuant to section 514B.31, subsection 3, a health maintenance organization contracting with the department of health and human services to administer the medical assistance program under chapter 249A, shall pay as taxes to the director of the department of revenue for deposit in the Medicaid managed care organization premiums fund created in section 249A.13, an amount equal to two and one-half percent of the premiums received and taxable under subsection 514B.31, subsection 3.

2. Except as provided in subsection 3, the premium tax shall be paid on or before March 1 of the year following the calendar year for which the tax is due. The commissioner of insurance may suspend or revoke the license of a health maintenance organization subject to the premium tax in subsection 1 that fails to pay the premium tax on or before the due date.

3. *a.* Each health maintenance organization transacting business in this state that is subject to the tax in subsection 1 shall remit on or before June 1, on a prepayment basis, an amount equal to one-half of the health maintenance organization's premium tax liability for the preceding calendar year.

b. In addition to the prepayment amount in paragraph "*a*", each health maintenance organization subject to the tax in subsection 1 shall remit on or before August 15, on a prepayment basis, an additional one-half of the health maintenance organization's premium tax liability for the preceding calendar year.

c. The sums prepaid by a health maintenance organization under paragraphs "*a*" and "*b*" shall be allowed as credits against the health maintenance organization's premium tax liability for the calendar year during which the payments are made. If a prepayment made under this subsection exceeds the health maintenance organization's annual premium tax liability, the excess shall be allowed as a credit against the health maintenance organization's subsequent prepayment or tax

liabilities under this section. The commissioner of insurance shall authorize the department of revenue to make a cash refund to a health maintenance organization, in lieu of a credit against subsequent prepayment or tax liabilities under this section, if the health maintenance organization demonstrates the inability to recoup the funds paid via a credit. The commissioner of insurance shall adopt rules establishing a health maintenance organization's eligibility for a cash refund, and the process for the department of revenue to make a cash refund to an eligible health maintenance organization from the Medicaid managed care organization premiums fund created in section 249A.13. The commissioner of insurance may suspend or revoke the license of a health maintenance organization that fails to make a prepayment on or before the due date under this subsection.

d. Sections 432.10 and 432.14 are applicable to premium taxes due under this section.

Sec. 5. Section 514B.31, Code 2023, is amended by striking the section and inserting in lieu thereof the following:

514B.31 Taxation.

1. For the first five years of the existence of a health maintenance organization and the health maintenance organization's successors and assigns, the following shall not be considered premiums received and taxable under section 432.1:

a. Payments received by the health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this chapter.

b. Payments made by the health maintenance organization to providers for health care services, to insurers, or to corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under this chapter.

2. After the first five years of the existence of a

health maintenance organization and the health maintenance organization's successors and assigns, the following shall be considered premiums received and taxable under section 432.1:

a. Payments received by the health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this chapter.

b. Payments made by the health maintenance organization to providers for health care services, to insurers, or to corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under this chapter.

3. Notwithstanding subsections 1 and 2, beginning January 1, 2024, and for each subsequent calendar year, the following shall be considered premiums received and taxable under section 432.1A for a health maintenance organization contracting with the department of health and human services to administer the medical assistance program under chapter 249A:

a. Payments received by the health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this chapter.

b. Payments made by the health maintenance organization to providers for health care services, to insurers, or to corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under this chapter.

4. Payments made to a health maintenance organization by the United States secretary of health and human services under a contract issued under section 1833 or 1876 of the federal Social Security Act, or under section 4015 of the federal Omnibus Budget Reconciliation Act of 1987, shall not be considered premiums received and shall not be taxable under section 432.1 or 432.1A. Payments made to a health maintenance organization contracting with the department of health and

human services to administer the medical assistance program under chapter 249A shall not be taxable under section 432.1.

DIVISION III

NURSING FACILITY LICENSING AND FINANCING

Sec. 6. NEW SECTION. **135.63A Moratorium — new construction or permanent change in bed capacity — nursing facilities.**

1. Beginning July 1, 2023, the department, in consultation with the department of health and human services, may impose a temporary moratorium on submission of applications for new construction of a nursing facility or a permanent change in the bed capacity of a nursing facility that increases the bed capacity of the nursing facility for an initial period of twelve months. The department may extend the moratorium in six-month increments following the conclusion of the initial twelve-month period, but for no longer than a total of thirty-six months. The department shall document, in writing, the need for each extension of the moratorium.

2. The department, in consultation with the department of health and human services, may waive the moratorium as specified in this section if the department determines there is a need for specialized needs beds or if a waiver request has been made in the manner specified by the department.

Sec. 7. NEW SECTION. **135C.7A Nursing facility license application — required information — escrow account.**

1. In addition to the requirements of section 135C.7, an applicant for a nursing facility license shall provide all of the following information in the license application:

a. Information related to the applicant's financial suitability to operate a nursing facility as verified by the applicant.

b. Whether the applicant has voluntarily surrendered a license while under investigation in another licensing jurisdiction.

c. Whether another licensing jurisdiction has taken disciplinary action against the applicant relating to the

applicant's operation of a nursing facility or whether another nursing facility owned or operated by the applicant has been subject to operation by a court-appointed receiver or temporary manager.

d. Whether there are any complaints, allegations, or investigations against the applicant pending in another licensing jurisdiction.

2. The information or documents provided to the department under this section detailing the applicant's financial condition or the terms of the applicant's contractual business relationships shall be confidential and not considered a public record under chapter 22.

3. If an applicant does not have at least five years of experience operating a nursing facility in this state or pursuant to equivalent licensing or certification provisions in any other state, the applicant shall establish an escrow account containing an amount sufficient to support full service operation of the nursing facility for a two-month period. The Medicaid program shall be entitled to the funds held in escrow if the nursing facility is subject to operation under receivership pursuant to section 135C.30.

Sec. 8. Section 135C.10, Code 2023, is amended by adding the following new subsection:

NEW SUBSECTION. 9A. Failure of a nursing facility licensee or license applicant to establish financial suitability to operate a nursing facility including failure to establish an escrow account pursuant to section 135C.7A.

Sec. 9. Section 249L.3, Code 2023, is amended by adding the following new subsection:

NEW SUBSECTION. 6A. A nursing facility shall not knowingly pass the quality assurance assessment on to non-Medicaid payors, including as a rate increase or service charge. If a nursing facility violates this section, the department shall not reimburse the nursing facility the quality assurance assessment due the nursing facility under the medical

assistance program, but shall instead only reimburse the nursing facility at the nursing facility base reimbursement rate under the medical assistance program for one year from the date the violation is discovered.

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 health care services and financing including nursing facility licensing and financing and the Medicaid program including recovery by the department of health and human services (HHS or the department) from third parties and taxation of Medicaid managed care organization premiums.

DIVISION I —— MEDICAID PROGRAM THIRD-PARTY RECOVERY. The bill strikes and replaces current provisions in Code section 249A.37 (health care information sharing) and Code section 249A.54 (assignment —— lien).

Under the bill, new Code section 249A.37 (duties of third parties) relates to the duties of third parties, defined under the bill as "an individual, entity, or program, excluding Medicaid, that is or may be liable to pay all or a part of the expenditures for medical assistance provided by a Medicaid payor to the recipient". The listing of "third parties" includes but is not limited to a third-party administrator, a pharmacy benefits manager, a health insurer, a self-insured plan, a group health plan, a service benefit plan, a managed care organization, liability insurance including self-insurance, no-fault insurance, workers' compensation laws or plans, and other parties that by law, contract, or agreement are legally responsible for payment of a claim for a medical service. The bill also defines terms including "Medicaid payor", "recipient", "third party", and "third-party benefits".

The bill provides that the third-party obligations specified under the bill are a condition of doing business in the state, and a third party that fails to comply with these obligations shall not be eligible to do business in the state.

The bill requires that a third party that is a carrier shall enter into a health insurance data match program with HHS for the sole purpose of comparing the names of the carrier's insureds with the names of recipients as required by Code section 505.25 (information provided to medical assistance program, Hawki program, and child support services).

The bill specifies the duties of a third party under the Medicaid program including cooperating with the Medicaid payor in identifying recipients for whom third-party benefits are available; accepting the Medicaid payor's rights of recovery and assignment to the Medicaid payor for payments which the Medicaid payor has made; accepting authorization provided by the Medicaid payor that the health care item or service is covered as if such authorization were the prior authorization made by the third party for such health care item or service; responding to inquiries from Medicaid payors regarding claims for payment; and not denying claims submitted by a Medicaid payor solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to present proper documentation, or in the case of specified third-party payors solely on the basis of a failure to obtain prior authorization if certain conditions are met.

The department may adopt administrative rules to administer this Code section of the bill. Rules governing the exchange of information under the bill shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to the federal Health Insurance Portability and Accountability Act (HIPAA) and regulations promulgated in accordance with HIPAA.

Under new Code section 249A.54 (responsibility for payment on behalf of Medicaid-eligible persons —— liability of other parties) the bill includes specific provisions relating to the responsibility for payment on behalf of Medicaid recipients, which include both persons who have applied for and persons

who have received medical assistance, when other parties are liable.

The bill provides that it is the intent of the general assembly that Medicaid payors be the payor of last resort for medical services furnished to recipients. All other sources of payment for medical services are primary relative to medical assistance provided by the Medicaid payor. If benefits of a third party are discovered or become available after medical assistance has been provided by the Medicaid payor, it is the intent of the general assembly that the Medicaid payor be repaid in full and prior to any other person, program, or entity. The Medicaid payor shall be repaid in full from and to the extent of any third-party benefits, regardless of whether a recipient is made whole or other creditors paid.

The bill provides definitions for "collateral", "covered injury or illness", "Medicaid payor", "medical service", "payment", "proceeds", "recipient" which includes both an applicant for and recipient of medical assistance, "recipient's agent", "third party", and "third-party benefits".

The bill provides that third-party benefits for medical services shall be primary relative to medical assistance provided by the Medicaid payor. A Medicaid payor has all of the rights, privileges, and responsibilities identified under the bill, but if HHS determines that a Medicaid payor has not taken reasonable steps within a reasonable time to recover third-party benefits, HHS may exercise all of the rights of the Medicaid payor to the exclusion of the Medicaid payor following provision of notice to third parties and the Medicaid payor.

A Medicaid payor may assign the Medicaid payor's rights under the bill, including to another Medicaid payor, a provider, or a contractor. After the Medicaid payor has provided medical assistance, the Medicaid payor shall seek reimbursement for third-party benefits to the extent of the Medicaid payor's legal liability and for the full amount of the third-party benefits, but not in excess of the amount of

medical assistance provided by the Medicaid payor.

Within 30 days following discovery by a recipient of potential third-party benefits, a recipient or the recipient's agent, as applicable, shall inform the Medicaid payor of any rights the recipient has to third-party benefits and provide identifying information for any person that is or may be liable to provide third-party benefits.

The bill specifies the rights of a Medicaid payor when the Medicaid payor provides or becomes liable for medical assistance, including that the Medicaid payor is automatically subrogated to any rights that a recipient or a recipient's agent or legally liable relative has to any third-party benefit for the full amount of medical assistance provided by the Medicaid payor; that the Medicaid payor is automatically assigned any right, title, and interest a recipient or a recipient's agent or legally liable relative has to a third-party benefit by virtue of applying for, accepting, or accepting the benefit of medical assistance, excluding any Medicare benefit to the extent required to be excluded by federal law; and that the Medicaid payor is entitled to and has an automatic lien upon the collateral for the full amount of medical assistance provided by the Medicaid payor to or on behalf of the recipient for medical services furnished as a result of any covered injury or illness for which a third party is or may be liable.

Unless otherwise provided in the bill, the Medicaid payor shall recover the full amount of all medical assistance provided by the Medicaid payor on behalf of the recipient to the full extent of third-party benefits. A recipient and the recipient's agent shall cooperate in the Medicaid payor's recovery of the recipient's third-party benefits and in establishing paternity and support of a recipient child born out of wedlock. The Medicaid payor has the discretion to waive, in writing, the requirement of cooperation for good cause shown and as required by federal law. The department may

deny or terminate eligibility for any recipient who refuses to cooperate, unless HHS has waived cooperation.

Within 30 days of initiating formal or informal recovery, other than by filing a lawsuit, a recipient's attorney shall provide written notice of the activity or action to the Medicaid payor.

A recipient is deemed to have authorized the Medicaid payor to obtain and release medical information and other records with respect to the recipient's medical services for the sole purpose of obtaining reimbursement for medical assistance provided by the Medicaid payor.

To enforce the Medicaid payor's rights, the Medicaid payor may institute, intervene in, or join in any legal or administrative proceeding in the Medicaid payor's own name, and in a number or a combination of capacities listed in the bill. An action by the Medicaid payor to recover damages in an action in tort, which is derivative of the rights of the recipient, shall not constitute a waiver of sovereign immunity.

A Medicaid payor, other than HHS, shall obtain written consent from HHS before the Medicaid payor files a derivative legal action on behalf of a recipient, and when a Medicaid payor brings such a derivative action, the Medicaid payor shall provide written notice no later than 30 days after filing the action to the recipient, the recipient's agent, and, if the Medicaid payor has actual knowledge that the recipient is represented by an attorney, to the attorney of the recipient, as applicable.

If an action is filed by a recipient or a recipient's agent against a third party, the recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent, as applicable, shall provide written notice to the Medicaid payor of the action, including the name of the court in which the action is brought, the case number of the action, and a copy of the pleadings. The recipient, the recipient's agent, or the attorney of the recipient or the recipient's agent,

as applicable, shall also provide written notice of intent to dismiss the action prior to the voluntary dismissal of an action against a third party.

Before a recipient finalizes a judgment, award, settlement, or any other recovery where the Medicaid payor has the right to recovery, the recipient, the recipient's agent, or the attorney of the recipient or recipient's agent, as applicable, shall give the Medicaid payor notice, as specified, of the judgment, award, settlement, or recovery. The judgment, award, settlement, or recovery shall not be finalized unless the notice is provided and the Medicaid payor has a reasonable opportunity to recover under its rights to subrogation, assignment, and lien. If notice is not provided, the recipient, the recipient's agent, and the recipient's or recipient's agent's attorney are jointly and severally liable to reimburse the Medicaid payor for the recovery received to the extent of medical assistance paid by the Medicaid payor.

Unless otherwise provided, the entire amount of any settlement of the recipient's action or claim involving third-party benefits is subject to the Medicaid payor's claim for reimbursement of the amount of medical assistance provided and any lien pursuant to the claim.

The bill prohibits insurance and other third-party benefits from containing any term or provision which purports to limit or exclude payment or the provision of benefits for an individual if the individual is eligible for, or a recipient of, medical assistance, and any such term or provision shall be void as against public policy.

In an action in tort against a third party in which the recipient is a party, of the amount recovered in any resulting judgment, award, or settlement from a third party, after deduction of reasonable attorney fees, reasonably necessary legal expenses, and filing fees, there is a rebuttable presumption that all Medicaid payors shall collectively receive two-thirds of the remaining amount recovered or the total

amount of medical assistance provided by the Medicaid payors, whichever is less; and the remaining amount recovered shall be paid to the recipient. In calculating the Medicaid payor's recovered amount of medical assistance, the fee for services of an attorney retained by the recipient or the recipient's legal representative shall not exceed one-third of the judgment, award, or settlement amount. If the recovered amount is insufficient to satisfy the competing claims of the Medicaid payors, each Medicaid payor shall be entitled to the Medicaid payor's respective pro rata share of the recovered amount that is available.

A recipient or a recipient's agent who has notice or who has actual knowledge of the Medicaid payor's rights to third-party benefits who receives any third-party benefit or proceeds for a covered injury or illness, shall after receipt of the proceeds pay the Medicaid payor the full amount of the third-party benefits, but not more than the total medical assistance provided by the Medicaid payor, or shall place the full amount of the third-party benefits in an interest-bearing trust account for the benefit of the Medicaid payor pending a determination of the Medicaid payor's rights to the benefits.

If federal law limits the Medicaid payor to reimbursement from the recovered damages for medical expenses, a recipient may contest the amount designated as recovered damages for medical expenses payable to the Medicaid payor as specified in the formula under the bill. To successfully rebut the formula, the recipient shall prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as medical expenses, including future medical expenses, is less than the amount calculated by the Medicaid payor pursuant to the formula. Alternatively, to successfully rebut the formula, the recipient shall prove, by clear and convincing evidence, that Medicaid provided a lesser amount of medical assistance than that asserted by the Medicaid payor. A settlement agreement that designates the amount of recovered

damages for medical expenses is not clear and convincing evidence and is not sufficient to establish the recipient's burden of proof, unless the Medicaid payor is a party to the settlement agreement.

If the recipient or the recipient's agent filed a legal action to recover against the third party, the court in which such action was filed shall resolve any dispute concerning the amount owed to the Medicaid payor, and shall retain jurisdiction of the case to resolve the amount of the lien after the dismissal of the action. If the recipient or the recipient's agent did not file a legal action to resolve any dispute concerning the amount owed to the Medicaid payor, the recipient or the recipient's agent shall file a petition for declaratory judgment. Venue for all such declaratory actions shall lie in Polk county. Each party shall pay the party's own attorney fees and costs for any legal action conducted under this provision of the bill.

If a Medicaid payor and the recipient or the recipient's agent disagree as to whether a medical claim is related to a covered injury or illness, the Medicaid payor and the recipient or the recipient's agent shall attempt to work cooperatively to resolve the disagreement before seeking resolution by the court.

With regard to medical assistance provided to a minor, and notwithstanding any other provision of law to the contrary, any statute of limitations or repose applicable to an action or claim of a legally responsible relative for the minor's medical expenses is extended in favor of the legally responsible relative so that the legally responsible relative shall have one year from and after the attainment of the minor's majority within which to file a complaint, make a claim, or commence an action.

In recovering any payments under the bill, the Medicaid payor may make appropriate settlements.

The bill provides the process and limitations for a request

by a recipient or a recipient's agent that a Medicaid payor provide an itemization of medical assistance paid for any covered injury or illness via notice as specified under the bill.

The department may adopt administrative rules to administer this portion of the bill and applicable federal requirements.

DIVISION II —— MEDICAID MANAGED CARE ORGANIZATION TAXATION OF PREMIUMS. The bill relates to taxation of health maintenance organizations.

Under current Code section 514B.31 (taxation), for the first five years of the existence of a health maintenance organization (HMO) or its successor, payments received by the HMO for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled, and payments made by the HMO to a provider for health care services, to insurers, or to corporations authorized under Code chapter 514 (nonprofit health services corporations) for insurance, indemnity, or other service benefits, are not considered premiums received and not taxable under Code section 432.1 (tax on gross premiums —— exclusions). After five years, payments received by the HMO or its successor for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled, and payments made by the HMO to a provider for health care services, to insurers, or to corporations authorized under Code chapter 514 (nonprofit health services corporations) for insurance, indemnity, or other service benefits, are considered premiums received and taxable under Code section 432.1. Current Code section 514B.31 also provides that certain payments made by the United States secretary of health and human services are not considered premiums and therefore not taxable under Code section 432.1.

The bill amends Code section 514B.31 to exempt from consideration as premiums and therefore not taxable under either Code section 432.1 (tax on gross premiums —— exclusions) or new Code section 432.1A (health maintenance organization ——

medical assistance program —— premium tax) payments to health maintenance organizations from the United States secretary of health and human services under contracts issued under section 1833 or 1876 of the federal Social Security Act or section 4015 of the federal Omnibus Budget Reconciliation Act of 1987. However, the bill provides that payments made to a health maintenance organization contracting with HHS to administer the Medicaid program shall not be taxable only under Code section 432.1. The bill also amends Code section 514B.31 to provide that notwithstanding the provisions applicable to HMOs under Code section 514B.31 relating to a premium tax, beginning January 1, 2024, and for each subsequent calendar year, for an HMO contracting with HHS to administer the medical assistance program under Code chapter 249A, payments received by the HMO for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled, and payments made by the HMO to a provider for health care services, to insurers, or to corporations authorized under Code chapter 514 for insurance, indemnity, or other service benefits, are considered premiums received and taxable under new Code section 432.1A.

The bill establishes under new Code section 432.1A the parameters of the new tax on HMOs contracting with HHS to administer the medical assistance program under Code chapter 249A. Such HMOs shall pay as taxes to the director of the department of revenue for deposit in the Medicaid managed care organization premiums fund an amount equal to 2.5 percent of the premiums received and taxable. The premium tax shall be paid on or before March 1 of the year following the calendar year for which the tax is due. The commissioner of insurance may suspend or revoke the license of an HMO subject to the premium tax that fails to pay the premium tax on or before the due date. Code sections 432.10 (sufficiency of remitted tax —— notice) and 432.14 (statute of limitations) apply to the premium tax due.

An HMO subject to the new tax shall remit on or before June

1 1, on a prepayment basis, an amount equal to one-half of the
2 HMO's premium tax liability for the preceding calendar year;
3 and shall remit on or before August 15, on a prepayment basis,
4 an additional one-half of the HMO's premium tax liability
5 for the preceding calendar year. If a prepayment exceeds
6 the HMO's annual premium tax liability, the excess shall be
7 allowed as a credit against the HMO's subsequent prepayment
8 or tax liabilities. The HMO may receive a credit or a cash
9 refund in lieu of a credit against subsequent prepayment or
10 tax liabilities. The commissioner of insurance may suspend or
11 revoke the license of an HMO that fails to make a prepayment on
12 or before the due date.
13 The bill creates in new Code section 249A.13 a Medicaid
14 managed care organization premiums fund in the state treasury
15 under the authority of HHS. Moneys collected from the new
16 tax on premiums shall be deposited in the fund. Moneys in
17 the fund are appropriated to HHS for the purposes of the
18 medical assistance program. Moneys in the fund that remain
19 unencumbered or unobligated at the close of a fiscal year shall
20 not revert but shall remain available for expenditure for the
21 purposes designated. Interest or earnings on moneys in the
22 fund shall be credited to the fund.
23 DIVISION III —— NURSING FACILITY LICENSING AND FINANCING.
24 The bill creates a moratorium on new construction or permanent
25 change in bed capacity for nursing facilities. The bill
26 provides that beginning July 1, 2023, the department of
27 inspections, appeals, and licensing (DIAL), in consultation
28 with HHS, may impose a temporary moratorium on submission of
29 applications for new construction of a nursing facility or a
30 permanent change in the bed capacity of a nursing facility
31 that increases the bed capacity of the nursing facility for an
32 initial period of 12 months. The department of inspections,
33 appeals, and licensing may extend the moratorium in six-month
34 increments but for no longer than a total of 36 months, and
35 must document in writing the need for each extension of the

moratorium. The department of inspections, appeals, and licensing, in consultation with HHS, may waive the moratorium if DIAL determines there is a need for specialized needs beds or if a waiver request has been made in the manner specified by DIAL.

The bill also requires an applicant for a nursing facility license to provide information related to the applicant's financial suitability to operate a nursing facility as verified by the applicant; whether the applicant has voluntarily surrendered a license while under investigation in another licensing jurisdiction; whether another licensing jurisdiction has taken disciplinary action against the applicant relating to the applicant's operation of a nursing facility and whether another nursing facility owned or operated by the applicant has been subject to operation by a court-appointed receiver or temporary manager; and whether there are any complaints, allegations, or investigations against the applicant pending in another jurisdiction. The information and documents provided by the applicant detailing the applicant's financial condition or the terms of the applicant's contractual business relationships are confidential and not considered a public record under Code chapter 22. If an applicant does not have at least five years of experience operating a nursing facility in this state or under an equivalent licensing or certification provision in any other state, the applicant shall establish an escrow account with an amount sufficient to support full service operation of the nursing facility for a two-month period. The Medicaid program is entitled to the funds held in escrow if the nursing facility is subject to operation under a receivership. Failure of a nursing facility licensee or applicant to establish financial suitability to operate a nursing facility including failure to establish an escrow account is grounds for DIAL to deny, suspend, or revoke a nursing facility license.

The bill also provides with regard to the nursing facility

quality assurance assessment imposed under Code chapter 249L (nursing facility quality assurance assessment program) that a nursing facility shall not knowingly pass the quality assurance assessment on to non-Medicaid payors, including as a rate increase or service charge. If a nursing facility violates this provision, HHS shall not reimburse the nursing facility the quality assurance assessment due the nursing facility under the Medicaid program, but shall instead only reimburse the nursing facility the nursing facility base reimbursement rate under the Medicaid program for one year from the date the violation is discovered.