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COMMERCE, REGULATION & LABOR

HOUSE FILE 78
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Passed House, Date _____ Passed Senate, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

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

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

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HF 78

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

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

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

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

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

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

17 1. "Board" means the HIFA program board created in section
18 514M.6.

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

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

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

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

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

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

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

5 b. An unemployed individual who resides in this state.

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

8 d. Uninsured individuals without access to employer
9 coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 1. The HIFA program is established under the authority of
33 the department to provide access to health care coverage to
34 eligible employers, including the self-employed, their
35 employees and dependents, eligible state employees and their

1 dependents, eligible local government employees and their
2 dependents, and eligible individuals.

3 2. The department may do any of the following:

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

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

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

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

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

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

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

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

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

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

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

3 3. The department shall do all of the following:

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

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

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

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

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

23 f. Develop a high-risk pool for plan enrollees in HIFA
24 health insurance in accordance with the provisions of section
25 514M.15.

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

31 5. Beginning September 1, 2007, and annually thereafter,
32 the department shall submit a report to the governor and the
33 general assembly on the impact of the HIFA health insurance
34 program on the small group, individual, state employee, and
35 local government employee health insurance markets in this

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

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

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

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

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

- 22 (1) Health care purchasing.
- 23 (2) Health insurance.
- 24 (3) Health policy and law.
- 25 (4) State management and budgeting.
- 26 (5) Health care financing.

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

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

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

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

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

25 4. The board shall do all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 a. Eligible individuals and their dependents.

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

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

33 d. Eligible local government employees and their
34 dependents.

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

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

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

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

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

12 c. Administrative services.

13 d. Other health promotion costs.

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

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

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

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

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

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

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

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

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

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

19 (3) Administrative services.

20 (4) Other health promotion costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 2. Ensure all of the following:

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

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

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

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

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

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

1 insurance carriers, employee benefit excess insurance
2 carriers, and third-party administrators, not including
3 carriers and third-party administrators with respect to
4 accidental injury, specified disease, hospital indemnity,
5 dental, vision, disability, income, long-term care, Medicare
6 supplemental, or other limited benefit health insurance,
7 annually at a rate that may not exceed savings resulting from
8 decreasing rates of growth in bad debt and charity care costs.
9 Payment of the savings offset shall begin January 1, 2007.
10 The savings offset amount as determined by the board is the
11 determining factor for inclusion of savings offset payments in
12 premiums through rate-setting review by the insurance division
13 of the department of commerce. Savings offset payments must
14 be made quarterly and are due not less than thirty days after
15 written notice to the health insurance carriers, employee
16 benefit excess insurance carriers, and third-party
17 administrators.

18 3. Each health insurance carrier, employee benefit excess
19 insurance carrier, and third-party administrator shall pay a
20 savings offset in an amount not to exceed four percent of
21 annual health insurance premiums and employee benefit excess
22 insurance premiums on policies issued pursuant to the laws of
23 this state that insure residents of this state. The savings
24 offset payment shall not exceed savings resulting from
25 decreasing rates of growth in bad debt and charity care costs.
26 The savings offset payment applies to premiums paid on or
27 after July 1, 2006. Savings offset payments shall reflect
28 aggregate measurable cost savings, including any reduction or
29 avoidance of bad debt and charity care costs to health care
30 providers in this state, as a result of the operation of the
31 HIFA health insurance program as determined by the board. A
32 health insurance carrier or employee benefit excess insurance
33 carrier shall not be required to pay a savings offset payment
34 on policies or contracts insuring federal employees.

35 4. The board shall make reasonable efforts to ensure that

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

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

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

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

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

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

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

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

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

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

1 of enrollees enrolled through local governments.

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

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

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

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

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

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

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

20 b. The board shall establish the total health care
21 spending in the state for the base year beginning July 1,
22 2004, and shall annually determine, in collaboration with the
23 commissioner of insurance, appropriate actuarially supported
24 trend factors that reflect savings consistent with subsection
25 1 and compare rates of spending growth to the base year of
26 2004. The board shall collect on an annual basis, in
27 consultation with the commissioner, information about the
28 total cost to the state's health care providers of bad debt
29 and charity care beginning with the base year of 2004. This
30 information may be compiled through mechanisms including, but
31 not limited to, standard reporting or statistically accurate
32 surveys of providers and practitioners. The board shall
33 utilize existing data on file with state agencies or other
34 organizations to minimize duplication. The comparisons to the
35 base year shall be reported beginning April 30, 2006, and

1 annually thereafter.

2 c. Health insurance carriers and health care providers
3 shall report annually, beginning July 1, 2007, and each July 1
4 thereafter, information regarding the experience of the prior
5 twelve-month period on the efforts undertaken by the carrier
6 and provider to recover savings offset payments, as reflected
7 in reimbursement rates, through a reduction or stabilization
8 in bad debt and charity care costs as a result of the
9 operation of the HIFA health insurance program. The board
10 shall determine the appropriate format for the report and
11 utilize existing data on file with state agencies or other
12 organizations to minimize duplication. The report shall be
13 submitted to the board. Using the information submitted by
14 carriers and providers, the board shall submit a summary of
15 that information by October 1, 2007, and annually thereafter
16 to the commissioner of insurance, the governor, and the
17 general assembly.

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

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

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

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

35 3. The fund shall be separate from the general fund of the

1 state and shall not be considered part of the general fund of
2 the state. The moneys in the fund shall not be considered
3 revenue of the state, but rather shall be funds of the HIFA
4 program. The moneys deposited in the fund are not subject to
5 section 8.33 and shall not be transferred, used, obligated,
6 appropriated, or otherwise encumbered, except to provide for
7 the purposes of this chapter. Notwithstanding section 12C.7,
8 subsection 2, interest or earnings on moneys deposited in the
9 fund shall be credited to the fund.

10 4. The department shall adopt rules pursuant to chapter
11 17A to administer the fund.

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

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

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

21 2. The forum shall do all of the following:

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

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

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

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

35 e. Work collaboratively with health care providers, health

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

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

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

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

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

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

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

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

31 a. One member who is a physician.

32 b. One member who is a health care economist.

33 c. One member who is a pharmacist.

34 d. One member who represents hospitals.

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

1 Iowa college of public health.

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

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

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

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

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

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

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

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

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

21 c. Are entitled to receive reimbursement of actual
22 expenses incurred in the discharge of their duties and are
23 also eligible to receive compensation as provided in section
24 7E.6.

25 d. Shall not serve more than two consecutive terms.

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

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

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

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

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

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

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

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

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

9 (4) Conducting public hearings and meetings.

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

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

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

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

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

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

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

1 program.

2 3. The HIFA program shall submit a report to the governor
3 and the general assembly, no later than January 1, 2007,
4 outlining the patient care management protocols, procedures,
5 and delivery mechanisms used to provide patient care
6 management services to HIFA high-risk pool enrollees and the
7 assessment tool used to measure individual patient care
8 management activities. The report shall also include the
9 number of plan enrollees in the high-risk pool, the types of
10 diagnoses managed within the high-risk pool, the claims
11 experience within the high-risk pool, and the number and type
12 of claims exceeding fifty thousand dollars for enrollees in
13 the high-risk pool and for all enrollees in the HIFA health
14 insurance program.

15 4. On or before October 1, 2009, the HIFA program shall
16 evaluate the impact of HIFA health insurance on average health
17 insurance premium rates in this state and on the rate of
18 uninsured individuals in this state and compare the trends in
19 those rates to the trends in the average premium rates and
20 average rates of uninsured individuals for the states that
21 have established a statewide high-risk pool as of July 1,
22 2005. The board shall submit the evaluation of the impact of
23 HIFA health insurance in this state in comparison to states
24 with high-risk pools to the governor and the general assembly
25 by January 1, 2010. If the trend in average premium rates in
26 this state and rate of uninsured individuals exceeds the trend
27 for the average among the states with high-risk pools, the
28 board shall submit legislation on January 1, 2010, that
29 proposes to establish a statewide high-risk pool in this state
30 consistent with the characteristics of high-risk pools
31 operating in other states.

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

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

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

1 first plan shall be issued by May 2006.

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

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

8 2. a. The state health plan issued pursuant to subsection
9 1 shall establish a comprehensive, coordinated approach to the
10 development of health care facilities and resources in the
11 state based on statewide cost, quality, and access goals and
12 strategies to ensure access to affordable health care,
13 maintain a rational system of health care, and promote the
14 development of the health care workforce.

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

19 3. The plan shall do all of the following:

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

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

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

26 d. Outline strategies to do all of the following:

27 (1) Promote health systems change.

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

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

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

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

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

6 The bill provides subsidies on a sliding scale for
7 individual and employee enrollees whose income is at or below
8 300 percent of the federal poverty guidelines.

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

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

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

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

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