71. Carry out other duties required by law and duties assigned pursuant to section 331.323.

Sec. 8. Section 331.756, subsection 85, Code Supplement 1985, is amended to read as follows:

85. Perform other duties required by ~~state~~ law and duties assigned pursuant to section 331.323.

Sec. 9. This Act, being deemed of immediate importance, takes effect from and after its publication in the Bellevue Herald-Leader, a newspaper published in Bellevue, Iowa, and in The Jefferson Bee, a newspaper published in Jefferson, Iowa.

Approved April 28, 1986

Pursuant to the authority vested in the undersigned Secretary of State of the State of Iowa, under the provisions of Section 3.9, Code of Iowa, 1985, there being no newspaper by the name of the Bellevue Herald-Leader, published in Bellevue, Iowa, I hereby designate that House File 2370 be published in The Bellevue Herald-Leader, a newspaper published in Bellevue, Iowa.

MARY JANE ODELL, *Secretary of State*

I hereby certify that the foregoing Act, House File 2370, was published in The Bellevue Herald-Leader, Bellevue, Iowa, on May 8, 1986 and in The Jefferson Bee, Jefferson, Iowa, on May 13, 1986.

MARY JANE ODELL, *Secretary of State*

CHAPTER 1156

IOWA COMPREHENSIVE HEALTH ASSOCIATION

H.F. 2181

AN ACT establishing the Iowa comprehensive health association, providing for a plan of operation, establishing financial procedures, providing eligible expenses, excluding certain requirements, and relating to other provisions of health insurance coverage and providing an appropriation.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. NEW SECTION. 514E.1 DEFINITIONS.

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

1. "Association" means the Iowa comprehensive health association established by section 514E.2.

2. "Association policy" means an individual policy issued by the association that provides the coverage specified in section 514E.4.

3. "Carrier" means an insurer providing accident and sickness insurance under chapter 509, 514 or 514A and includes a health maintenance organization established under chapter 514B if payments received by the health maintenance organization are considered premiums pursuant to section 514B.31 and are taxed under chapter 432. "Carrier" also includes a corporation which becomes a mutual insurer pursuant to section 514.23 and any other person as defined in section 4.1, subsection 13, who is or may become liable for the tax imposed by chapter 432.

4. "Commissioner" means the commissioner of insurance.

5. "Eligible expenses" means the usual, customary and reasonable charges for the health care services specified in section 514E.4.

6. "Health care facility" means a health care facility as defined in section 135C.1, subsection 4, a hospital as defined in section 135B.1, subsection 1, or a community mental health center established under chapter 230A.

7. "Health care services" means services, the coverage of which is authorized under chapter 509, chapter 514, chapter 514A, or chapter 514B as limited by sections 514E.4 and 514E.5, and

includes services for the purposes of preventing, alleviating, curing, or healing human illness, injury or physical disability.

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

9. "Health insurance trust fund" means the fund created in section 514E.3.

10. "Insured" means an individual who is provided qualified comprehensive health insurance under an association policy, which policy may include dependents and other covered persons.

11. "Medicaid" means the federal-state assistance program established under Title XIX of the federal Social Security Act.

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

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

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

Sec. 2. NEW SECTION. 514E.2 IOWA COMPREHENSIVE HEALTH ASSOCIATION.

1. There is established a nonprofit corporation known as the Iowa comprehensive health insurance association which shall assure that health insurance, as limited by sections 514E.4 and 514E.5, is made available to each eligible Iowa resident applying to the association for coverage. All carriers as defined in section 514E.1, subsection 3, providing health insurance or health care services in Iowa shall be members of the association. The association shall operate under a plan of operation established and approved under subsection 3 and shall exercise its powers through a board of directors established under this section.

2. The board of directors of the association shall consist of not less than four nor more than eight members selected by the members of the association, subject to approval by the commissioner and a public member selected by the commissioner.

In order to select the initial board of directors and organize the association, the commissioner shall give notice to all carriers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each carrier member is entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after the organizational meeting, the commissioner shall appoint the initial board. In approving or selecting members of the board, the commissioner shall consider whether all carriers are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not be otherwise compensated by the association for their services.

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

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

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

c. Regular times and places for meeting of the board of directors.

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

e. Procedures for selecting the board of directors and submitting the selections to the commissioner for approval.

f. Establishing, in cooperation with the commissioner of insurance and the state comptroller, procedures for the determination and payment to the association from the health insurance trust fund of amounts which represent the net loss for the preceding calendar year to the association. The amount of the payment shall be based upon the amount of funds deposited in the health insurance trust fund and the amount of net loss of the association. If funds deposited in the health insurance trust fund are insufficient to pay all of the losses, the state comptroller shall notify the commissioner of insurance and the association of the amount of the deficiency.

g. The periodic advertising of the general availability of health insurance coverage from the association.

h. Additional provisions necessary or proper for the execution of the powers and duties of the association.

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

5. The association has the general powers and authority enumerated by this subsection and executed in accordance with the plan of operation approved by the commissioner under subsection 3. The association has the general powers and authority granted under the laws of this state to carriers licensed to issue health insurance. In addition, the association may do any of the following:

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

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

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

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

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

f. Pool risks among members.

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

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

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

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

k. Hire independent consultants as necessary.

l. Develop a method of advising applicants of the availability of other coverages outside the association, and shall promulgate a list of health conditions the existence of which would make an applicant eligible without demonstrating a rejection of coverage by one carrier.

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

6. Rates for coverages issued by the association shall not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing coverage. Separate scales of rates based on age may apply for individual risks. Rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification shall not be more than one hundred fifty percent of the average premium or payment rate for that classification charged by the five carriers with the largest health insurance premium or payment volume in the state during the preceding calendar year. In determining the average rate of the five largest carriers, the rates or payments charged by the carriers shall be actuarially adjusted to determine the rate or payment that would have been charged for benefits similar to those issued by the association.

7. Following the close of each calendar year, the association shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the association for the year. The association shall certify the amount of any net loss for the preceding calendar year to the commissioner of insurance and state comptroller who shall make payment to the association according to procedures established under subsection 3, paragraph "f". Any remaining loss, after payment to the association from the health insurance trust fund, shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year or on any other equitable basis as provided in the plan of operation. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the next calendar year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums.

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

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

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

11. The association shall not issue an association policy to an individual who, on the effective date of the coverage applied for, has not been rejected for, already has, or will have coverage similar to an association policy, as an insured or covered dependent.

12. The association shall pay an agent's referral fee of twenty-five dollars to each insurance agent who refers an applicant to the association if that applicant is accepted.

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

14. A member who, after July 1, 1986, has paid one or more assessments levied under this chapter may take a credit against the premium taxes, or similar taxes, upon revenues or income of the member that are imposed by the state on health insurance premiums pursuant to chapter 432 or payments subject to taxation under section 514B.31, up to the amount of twenty percent of those taxes due, for each of the five calendar years following the year for which an assessment was paid, or until the aggregate of those assessments has been offset by credits against those taxes if this occurs first. If a member ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

Sec. 3. NEW SECTION. 514E.3 HEALTH INSURANCE TRUST FUND — DEPOSIT OF MONEYS.

A health insurance trust fund is created within the state treasury. Commencing July 1, 1987, and annually thereafter, there shall be deposited in the health insurance trust fund twenty-five percent of the moneys set aside pursuant to 1985 Iowa Acts, chapter 239, section 8. The moneys in the health insurance trust fund and any income to the fund shall be used to make the payments provided for in section 514E.2, subsection 3, paragraph "f". If after making a payment, there is a balance remaining in the health insurance trust fund, the balance shall be retained in the fund together with any interest or earnings that is earned on the balance and may be used to cover future expenses of the association. However, if the balance of the health insurance trust fund after the payments provided for in section 514E.2, subsection 3, paragraph "f" exceeds ten million dollars, then the amount of the funds in excess of the ten million dollars shall be transferred to the separate account established in 1985 Iowa Acts, chapter 239, section 8.

Moneys deposited in the health insurance trust fund may be invested by the treasurer of state in the same manner as moneys in the general fund.

Sec. 4. NEW SECTION. 514E.4 ASSOCIATION POLICY — COVERAGE AND BENEFIT REQUIREMENTS — ELIGIBLE EXPENSES.

The association policy shall pay only the usual, customary and reasonable charges for medically necessary eligible health care services which exceed the deductible and coinsurance amounts applicable under section 514E.6. Eligible expenses are the charges for the following health care services furnished by a health care provider in an emergency situation or furnished or prescribed by a health care provider:

1. Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty days in a calendar year.

2. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered nurses, licensed practical nurses, or other health care providers.

3. The first twenty professional visits for the diagnosis or treatment of one or more mental conditions, rendered during a calendar year by one or more health care providers, or at their direction, by their staff of registered nurses, licensed practical nurses, or other health care providers.

4. Drugs and contraceptive devices requiring a prescription.

5. Services of a skilled nursing facility as defined in section 135C.1, subsection 3, or services in an intermediate care facility as defined in section 135C.1, subsection 2, to the same extent as the services would be paid in a skilled nursing facility, for not more than one hundred eighty days in a calendar year.

6. Homemaker-home health services up to one hundred eighty days of service in a calendar year.

7. Use of radium or other radioactive material.

8. Oxygen.

9. Anesthetics.

10. Prostheses, other than dental.

11. Rental of durable medical equipment, other than eye glasses and hearing aids, which have no personal use in the absence of the condition for which prescribed.

12. Diagnostic X rays and laboratory tests.

13. Oral surgery for any of the following:

a. Excision of partially or completely erupted impacted teeth.

b. Excision of a tooth root without the extraction of the entire tooth.

c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

14. Services of a physical therapist and services of a speech therapist.

15. Professional ambulance services to the nearest health care facility qualified to treat the illness, injury, or condition.

16. Processing of blood, including but not limited to, collecting, testing, fractionating, and distributing blood.

Sec. 5. NEW SECTION. 514E.5 EXPENSES EXCLUDED.

Eligible expenses shall not include an expense for any of the following:

1. Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of a patient to pay.

2. Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service-connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States.

3. Benefits which would duplicate the provision of services or payment of charges for any care for an injury, disease, or condition for which either of the following applies:

a. It arises out of and in the course of an employment subject to a workers' compensation or similar law.

b. Benefits for it are payable without regard to fault under a coverage required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance. However, this does not authorize exclusion of charges that exceed the benefits payable under the applicable workers' compensation or no-fault coverage.

4. Care which is primarily for a custodial or domiciliary purpose.

5. Cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure.

6. Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

7. That part of any charge for services or articles rendered or prescribed by a health care provider which exceeds the prevailing charge in the locality where the service is provided, or a charge for services or articles not medically necessary.

8. Services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred.

9. Routine physical examinations including examinations to determine the need for eye glasses and hearing aids.

10. Illness or injury due to an act of war.

11. Service of a blood donor and any fee for failure to replace the first three pints of blood provided to an eligible person each calendar year.

12. Personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

13. Experimental services or supplies. Experimental means a service or supply not recognized by the appropriate medical board as normal mode of treatment for the illness or injury involved.

14. Eye surgery if corrective lenses would alleviate the problem.

The coverage and benefit requirements of this section for association policies shall not be altered by any other state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits which, in the opinion of the board of directors, may be of benefit to the citizens of the state.

Sec. 6. NEW SECTION. 514E.6 POLICIES, DEDUCTIBLE AND COINSURANCE REQUIREMENTS — LIMITATIONS — LIFETIME BENEFIT LIMIT.

1. Except as provided in subsection 3, an association policy offered in accordance with this chapter shall include a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall be offered. The board may authorize deductibles in other amounts. The deductibles must be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

2. Except as provided in subsection 3, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.

3. The maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance shall not exceed in a policy year:

a. One thousand five hundred dollars for an individual five-hundred-dollar deductible policy.

b. Two thousand dollars for an individual one-thousand-dollar deductible policy.

c. Three thousand dollars for a family five-hundred-dollar deductible policy.

d. Four thousand dollars for a family one-thousand-dollar deductible policy.

e. An amount authorized by the board for any other deductible policy.

4. For a family policy, the maximum annual deductible under the policy shall be the deductible chosen for a maximum of two individuals under the policy.

5. Eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

6. The lifetime benefit per covered person is two hundred fifty thousand dollars.

7. The association shall, in addition to other policies, offer Medicare supplement policies designed to supplement Medicare and provide coverage of at least fifty percent of the deductible and eighty percent of the covered expenses in section 514E.4. Medicare supplement plans are subject to the same limitations on premiums, deductibility, and annual out-of-pocket expenses as other association policies.

Sec. 7. NEW SECTION. 514E.7 POLICIES — ELIGIBLE PERSONS — DEPENDENT COVERAGE — PREEXISTING CONDITIONS.

1. A person is not eligible for an association policy if the person, at the effective date of coverage, has or will have coverage under any insurance plan that has coverage equivalent to an association policy. Only residents of this state are eligible for an association policy. Coverage under an association policy is in excess of, and shall not duplicate, coverage under any other form of health insurance.

2. A person is eligible to apply for an association policy only if that person has been rejected for similar health insurance coverage or is only offered health insurance coverage at a rate exceeding the association rate.

3. An association policy shall provide that coverage of a dependent unmarried person terminates when the person becomes nineteen years of age or, if the person is enrolled full time in an accredited educational institution, terminates at twenty-five years of age. The policy shall

also provide in substance that attainment of the limiting age does not operate to terminate coverage when the person is and continues to be both of the following:

a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap.

b. Primarily dependent for support and maintenance upon the person in whose name the contract is issued.

Proof of incapacity and dependency must be furnished to the carrier within one hundred twenty days of the person's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two-year period following the person's attainment of the limiting age.

4. An association policy that provides coverage for a family member of the person in whose name the contract is issued shall also provide, as to the family member's coverage, that the health insurance benefits applicable for children include the coverage required under section 514C.1.

5. An association policy may contain provisions under which coverage is excluded during a period of six months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as either of the following exist:

a. The condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis or treatment.

b. Medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

These preexisting condition exclusions shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage which was involuntarily terminated, if the application for pool coverage is made not later than thirty days following the involuntary termination. In that case, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

This subsection does not prohibit preexisting conditions coverage in an association policy that is more favorable to the insured than that specified in this subsection.

6. An individual is not eligible for coverage by the association if any of the following apply:

a. The individual is at the time of application eligible for health care benefits under chapter 249A.

b. The individual has terminated coverage by the association within the past twelve months.

c. The individual is an inmate of a public institution or is eligible for public programs for which medical care is provided.

Sec. 8. NEW SECTION. 514E.8 POLICIES – RENEWAL PROVISIONS – ELECTION TO CONTINUE COVERAGE UPON DEATH OF POLICYHOLDER.

1. An association policy shall contain provisions under which the association is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the durational requirements of this subsection. However, when the individual in whose name the contract is issued becomes eligible for Medicare coverage, the person shall be eligible for the Medicare supplement plan offered by the association.

2. The association shall not change the rates for association policies except on a class basis with a clear disclosure in the policy of the association's right to do so.

3. An association policy shall provide that upon the death of the individual in whose name the policy is issued, every other individual then covered under the contract may elect, within a period specified in the policy, to continue coverage under the same or a different policy until such time as the person would have ceased to be entitled to coverage had the individual in whose name the policy was issued lived.

Sec. 9. NEW SECTION. 514E.9 RULES.

Pursuant to chapter 17A, the commissioner shall adopt rules to provide for disclosure by carriers of the availability of insurance coverage from the association, and to otherwise implement this chapter.

Sec. 10. NEW SECTION. 514E.10 COLLECTIVE ACTION.

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

Sec. 11. NEW SECTION. 514E.11 NOTICE OF ASSOCIATION POLICY.

Commencing July 1, 1986, every carrier, including a health maintenance organization subject to chapter 514B, authorized to provide health care insurance or coverage for health care services in Iowa, shall provide a notice and an application for coverage by the association to any person who receives a rejection of coverage for health insurance or health care services, or a notice to any person who is informed that a rate for health insurance or coverage for health care services will exceed the rate of an association policy, that effective January 1, 1987, that person is eligible to apply for health insurance provided by the association. Application for the health insurance shall be on forms prescribed by the board and made available to the carriers.

Sec. 12. There is appropriated from the general fund of the state on January 1, 1987 for the period January 1, 1987 to July 1, 1987, to the Iowa comprehensive health association the sum of twenty-five thousand (25,000) dollars or as much thereof as necessary for salaries and expenses.

Sec. 13. Health insurance coverage provided under this Act shall not be effective until January 1 following the effective date of this Act.

Approved April 28, 1986

CHAPTER 1157

WHEELCHAIR LIFT REGULATION

H.F. 2417

AN ACT relating to the regulation of stairway chair lifts and wheelchair lifts, and making penalties applicable.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. Section 104.1, subsection 1, Code 1985, is amended to read as follows:

1. "Facility" means ~~any~~ an elevator, dumbwaiter, escalator, moving walk, ~~or~~ lift, or inclined or vertical wheelchair lift subject to regulation under ~~the provisions of~~ this chapter, and includes hoistways, rails, guides, and all other related mechanical and electrical equipment.

Sec. 2. Section 104.1, Code 1985, is amended by adding the following new subsection:

NEW SUBSECTION. 18. "Inclined or vertical wheelchair lift" means a lift used as part of an accessible route in or at a public building as specified in the American national standard safety code for elevators and escalators, A17.1.

Sec. 3. Section 104.3, Code 1985, is amended by adding the following new subsection:

NEW SUBSECTION. 5. The commissioner may adopt rules permitting inclined or vertical wheelchair lifts in churches and houses of worship to service more than one floor.

Approved April 28, 1986