CHAPTER 1180

PAYMENT FOR CHIROPRACTIC HEALTH SERVICES

H.F. 2219

AN ACT providing for optional payment by corporations subject to chapters 509, 514, and 514B for services performed by chiropractors, making corporations organized by chiropractors for establishing, maintaining, and operating a health care service plan subject to chapter 514 and requiring chapter 514 corporations and physician providers to establish utilization review programs for purposes of health care cost control.

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

Section 1. Section 145.3, subsection 3, paragraph h, Code Supplement 1985, is amended to read as follows:

h. The commissioner of insurance and the commissioner of public health require the collection of physicians billing information from third-party payers and self insurers as specified by the health data commission by July 1, 1986. This billing information shall be collected for physicians as defined by section 135.1. The collection, correlation, and development of this data shall include, but not be limited to, information and reports covering the physician designations as defined in section 135.1 and shall be made available annually.

Sec. 2. Section 509.3, Code 1985, is amended by adding the following new subsection:

NEW SUBSECTION. 7. A provision shall be made available to policyholders under group policies covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis or treatment provided by a chiropractor licensed under chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor's license and if the policy would pay or reimburse for the diagnosis or treatment by a person licensed under chapter 148, 150, or 150A of the human ailment, irrespective of and disregarding variances in terminology employed by the various licensed professions in describing the human ailment or its diagnosis or its treatment. The policy shall provide that the policyholder may reject the coverage or provision if the coverage or provision for diagnosis or treatment of a human ailment by a chiropractor is rejected for all providers of diagnosis or treatment for similar human ailments licensed under chapter 148, 150, 150A, or 151. A policy of group health insurance may limit or make optional the payment or reimbursement for lawful diagnostic or treatment service by all licensees under chapters 148, 150, 150A, and 151 on any rational basis which is not solely related to the license under or the practices authorized by chapter 151 or is not dependent upon a method of classification, categorization, or description based directly or indirectly upon differences in terminology used by different licensees in describing human ailments or their diagnosis or treatment. This subsection applies to group policies delivered or issued for delivery after July 1, 1986, and to existing group policies on their next anniversary or renewal date, or upon expiration of the applicable collective bargaining contract, if any, whichever is later. This subsection does not apply to blanket, short-term travel, accident-only, limited or specified disease, or individual or group conversion policies, or policies under Title XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

Sec. 3. Section 514.1, Code 1985, is amended to read as follows:

514.1 APPLICABILITY — DEFINITIONS.

A corporation ~~hereafter~~ organized under chapter 504 or chapter 504A for the purpose of establishing, maintaining, and operating a nonprofit hospital service plan, whereby hospital service may be provided by the corporation or by a hospital with which it has a contract for service, to the public who become subscribers to this plan under a contract which entitles each

subscriber to hospital service; or a corporation organized for the purpose of establishing, maintaining, and operating a plan whereby ~~medical and surgical~~ health care service may be provided at the expense of this corporation, by ~~duly~~ licensed physicians and surgeons, dentists, podiatrists, osteopathic physicians, ~~or~~ osteopathic physicians and surgeons or chiropractors, to subscribers under contract, entitling each subscriber to ~~medical and surgical~~ health care service, as provided in the contract; or ~~any~~ a corporation organized for the purpose of establishing, maintaining, and operating a nonprofit pharmaceutical service plan or optometric service plan, whereby pharmaceutical or optometric service may be provided by this corporation or by a licensed pharmacy with which it has a contract for service, to the public who become subscribers to this plan under a contract which entitles each subscriber to pharmaceutical or optometric service; shall be governed by this chapter and is exempt from all other provisions of the insurance laws of this state, unless specifically designated ~~herein~~ in this chapter, not only in governmental relations with the state but for every other purpose, and additions ~~hereafter~~ enacted after the effective date of this chapter shall not apply to these corporations unless they ~~be~~ are expressly designated ~~therein~~ in the additions.

PARAGRAPH DIVIDED. For the purposes of this chapter, "subscriber" means an individual who enters into a contract for health care services with a corporation subject to this chapter and includes ~~any~~ a person eligible for medical assistance or additional medical assistance as defined under chapter 249A, with respect to whom the department of human services has entered into a contract with ~~any~~ a firm operating under chapter 514. For purposes of this chapter, "provider" ~~shall mean~~ means a person as defined in section 4.1, subsection 13, which is licensed or ~~otherwise~~ authorized in this state to furnish health care services. "Health care" ~~shall mean~~ means that care necessary for the purpose of preventing, alleviating, curing, or healing human physical or mental illness, injury, or disability.

Sec. 4. Section 514.5, unnumbered paragraph 2, Code 1985, is amended to read as follows:

~~Any~~ A medical service corporation organized under ~~the provisions of~~ this chapter may enter into contracts with subscribers to furnish ~~medical and surgical~~ health care service through physicians and surgeons, dentists, podiatrists, osteopathic physicians, ~~or~~ osteopathic physicians and surgeons, or chiropractors.

Sec. 5. Section 514.7, Code 1985, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. A provision shall be made available in approved contracts with hospital and medical subscribers under group subscriber contracts or plans covering diagnosis and treatment of human ailments, for payment or reimbursement for necessary diagnosis or treatment provided by a chiropractor licensed under chapter 151 if the diagnosis or treatment is provided within the scope of the chiropractor's license and if the subscriber contract would pay or reimburse for the diagnosis or treatment of the human ailment, irrespective of and disregarding variances in terminology employed by the various licensed professions in describing the human ailment or their diagnosis or treatment, if it were provided by a person licensed under chapter 148, 150, or 150A. The subscriber contract shall also provide that the subscriber may reject the coverage or provision if the coverage or provision for diagnosis or treatment of a human ailment by a chiropractor is rejected for all providers of diagnosis or treatment for similar human ailments licensed under chapter 148, 150, 150A or 151. A group subscriber contract may limit or make optional the payment or reimbursement for lawful diagnostic or treatment service by all licensees under chapters 148, 150, 150A, and 151 on any rational basis which is not solely related to the license under or the practices authorized by chapter 151 or is not dependent upon a method of classification, categorization, or description based upon differences in terminology used by different licensees in describing human ailments or their diagnosis or treatment. This paragraph applies to group

subscriber contracts delivered after July 1, 1986, and to group subscriber contracts on their anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This paragraph does not apply to contracts designed only for issuance to subscribers eligible for coverage under Title XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

Sec. 6. Section 514.23, Code Supplement 1985, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. A corporation organized and governed by this chapter which becomes a mutual insurer under this section shall continue as a mutual insurer to be governed by the provisions of section 514.7 and shall also be governed by section 509.3, subsection 7.

Sec. 7. Section 514B.1, subsection 2, Code 1985, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. The health care services available to enrollees under prepaid group plans covering diagnosis and treatment of human ailments, shall include a provision for payment of necessary diagnosis or treatment provided by a chiropractor licensed under chapter 151 if the diagnosis or treatment is provided within the scope of the chiropractor's license and if the plan would pay or reimburse for the diagnosis or treatment of human ailment, irrespective of and disregarding variances in terminology employed by the various licensed professions in describing the human ailment or its diagnosis or its treatment, if it were provided by a person licensed under chapter 148, 150, or 150A. The plan shall also provide that the plan enrollees may reject the coverage for diagnosis or treatment of a human ailment by a chiropractor if the coverage is rejected for all providers of diagnosis or treatment for similar human ailments licensed under chapter 148, 150, 150A, or 151. A prepaid group plan of health care services may limit or make optional the payment or reimbursement for lawful diagnostic or treatment service by all licensees under chapters 148, 150, 150A, and 151 on any rational basis which is not solely related to the license under or the practices authorized by chapter 151 or is not dependent upon a method of classification, categorization, or description based upon differences in terminology used by different licensees in describing human ailments or their diagnosis or treatment. This paragraph applies to services provided under plans made after July 1, 1986, and to existing group plans on their next anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This paragraph does not apply to enrollees eligible for coverage under Title XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

Sec. 8. Section 514B.7, Code 1985, is amended to read as follows:

514B.7 GOVERNING BODY.

The governing body of ~~any~~ a health maintenance organization ~~shall be a legal entity separate from the governing body of any other legal entity and~~ may include providers, other individuals, or both, but it shall establish a mechanism to allow a reasonable representation of enrollees to participate in matters of policy and operation ~~as members of the governing body~~. The commissioner shall establish guidelines to implement this section.

Sec. 9. NEW SECTION. 514.21 UTILIZATION REVIEW PROGRAM.

Utilization review program shall be established for purposes of health care cost control, according to usual and customary third-party insurance payment or reimbursement procedures, by a corporation subject to this chapter and by physician providers as defined in section 135.1. This utilization review program shall not be used directly or indirectly to circumvent the provisions for payment or reimbursement to providers of health care services as provided in section 509.3, subsection 7 and section 514.7.

Sec. 10. Chapter 514B, Code 1985, is amended by adding the following new sections:

NEW SECTION. 514B.33 UTILIZATION AND COST CONTROL REVIEW COMMITTEES.

The boards of examiners under chapters 148, 150, 150A, 151, and 153 shall establish utilization and cost control review committees of licensees under the respective chapters, selected from licensees who have practiced in Iowa for at least the previous five years, or shall accredit and designate other utilization and cost control organizations as utilization and cost control committees under this section, for the purposes of utilization review of the appropriateness of levels of treatment and of giving opinions as to the reasonableness of charges for diagnostic or treatment services of licensees. Persons governed by the various chapters of Title XX of the Code and self insurers for health care benefits to employees may utilize the services of the utilization and cost control review committees upon the payment of a reasonable fee for the services, to be determined by the respective boards of examiners. The respective boards of examiners under chapters 148, 150, 151, and 153 shall adopt rules necessary and proper for the implementation of this section pursuant to chapter 17A. It is the intent of this general assembly that conduct of the utilization and cost control review committees authorized under this section shall be exempt from challenge under federal or state antitrust laws or other similar laws in regulation of trade or commerce.

NEW SECTION. 514B.34 UTILIZATION AND COST CONTROL.

Nothing contained in the chapters of Title XX of the Code shall be construed to prohibit or discourage insurers, nonprofit service corporations, health maintenance organizations, or self insurers for health care benefits to employees from providing payments of benefits or providing care and treatment under capitated payment systems, prospective reimbursement rate systems, utilization control systems, incentive systems for the use of least restrictive and least costly levels of care, preferred provider contracts limiting choice of specific provider, or other systems, methods or organizations designed to contain costs without sacrificing care or treatment outcome, provided these systems do not limit or make optional payment or reimbursement for health care services on a basis solely related to the license under or the practices authorized by chapter 151 or on a basis that is dependent upon a method of classification, categorization, or description based upon differences in terminology used by different licensees under the chapters of Title VIII of the Code in describing human ailments or their diagnosis or treatment.

Approved May 5, 1986

CHAPTER 1181

PUBLIC WATER SUPPLY SYSTEMS

H.F. 2303

AN ACT relating to the contamination of public water supply systems by providing for a testing program, authorizing the use of ground water funds for grants to eliminate or abate contamination, and dedicating part of the ground water fund to such grants.

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

Section 1. Each public water supply system regulated under chapter 455B which serves a city under chapter 362 or serves a state-owned facility regularly housing two hundred or more persons, each benefited water district created under chapter 357 and each rural water district created under chapter 357A shall test the finished water of that water supply for presence of synthetic organic chemicals and pesticides. The department of water, air and waste management shall adopt rules under chapter 17A governing the testing under this Act. The rules