FEB 3 2000

COMMERCE AND REGULATION

HOUSE FILE 2144

BY MURPHY

Passed House, Date _____ Passed Senate, Date _____

Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____

Approved _____

## A BILL FOR

An Act relating to the required provider provisions under group health insurance policies and health maintenance organization contracts.

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

HF 2144

TLSB 5901HH 78

pf/cf/24

S.F. _____ H.F. 2144

Section 1. Section 509.3, subsections 5 and 6, Code Supplement 1999, are amended to read as follows:

5. A provision shall be made available to policyholders, under group policies covering vision care services or procedures, for payment of necessary medical or surgical care and treatment provided by an optometrist licensed under chapter 154 if the care and treatment are provided within the scope of the optometrist's license and if the policy would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine or surgery as licensed under chapter 148 or 150A. The provision shall also guarantee that any care or treatment provided by an optometrist shall be compensated at the same level as equivalent services provided by a person licensed in the practice of medicine and surgery under chapter 148 or 150A. The policy shall provide that the policyholder may reject the coverage or provision if the coverage or provision for services which may be provided by an optometrist is rejected for all providers of similar vision care services as licensed under chapter 148, 150A, or 154. This subsection applies to group policies delivered or issued for delivery after July 1, 1983, 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 designed only for issuance to persons for coverage under Title XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

6. 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 provision shall also guarantee that any diagnosis and treatment provided by a chiropractor shall be compensated at the same level as equivalent diagnosis and treatment provided by a person licensed in the practice of medicine and surgery under chapter 148 or 150A. 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. 2. Section 509.3, Code Supplement 1999, is amended by

adding the following new subsection:

NEW SUBSECTION. 8. A provision shall be made available to policyholders, under group policies covering hospital, medical, or surgical expenses for payment of necessary medical or surgical care and treatment, as well as drug prescriptions, provided by a person licensed to practice podiatry under chapter 149, if the care and treatment are provided within the scope of the person's license and if the policy would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery as licensed under chapter 148 or 150A. The provision shall also guarantee that any medical or surgical services provided by a podiatrist shall be compensated at the same level as equivalent services provided by ar person licensed in the practice of medicine or surgery under chapter 148 or 150A. The policy shall provide that the policyholder may reject the coverage or provision if the coverage or provision for similar services which may be provided by a podiatric physician is rejected for all providers of services as licensed under chapter 148, 149, or 150A. This subsection applies to group policies delivered or issued for delivery on or after July 1, 2000, 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 designed only for issuance to persons for coverage under Title XVIII of the federal Social Security Act, or any other similar coverage under a state or federal government plan.

Sec. 3. Section 514B.1, subsection 5, paragraphs b and c, Code Supplement 1999, are amended to read as follows:

b. The health care services available to enrollees under prepaid group plans covering vision care services or procedures, shall include a provision for payment of necessary

medical or surgical care and treatment provided by an optometrist licensed under chapter 154, if performed within the scope of the optometrist's license, and the plan would pay for the care and treatment when the care and treatment were provided by a person engaged in the practice of medicine or surgery as licensed under chapter 148 or 150A. Additionally, any optometric medical or surgical care and treatment provided shall be compensated at the same level as equivalent services provided by a person licensed in the practice of medicine or surgery under chapter 148 or 150A. The plan shall provide that the plan enrollees may reject the coverage for services which may be provided by an optometrist if the coverage is rejected for all providers of similar vision care services as licensed under chapter 148, 150A, or 154. This paragraph applies to services provided under plans made after July 1, 1983, 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.

c. 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. Additionally, any diagnosis and treatment provided by a chiropractor shall be compensated at

the same level as equivalent diagnosis and treatment provided by a person licensed in the practice of medicine or surgery under chapter 148 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. 4. Section 514B.1, subsection 5, Code Supplement 1999, is amended by adding the following new paragraph:

NEW PARAGRAPH. e. The health care services available to enrollees under prepaid group plans covering hospital, medical, or surgical expenses shall include a provision for payment of necessary medical or surgical care and treatment as well as drug prescriptions provided by a podiatric physician licensed under chapter 149, if performed within the scope of the podiatrist's license and the plan would pay for the care and treatment when the care and treatment were provided by a person engaged in the practice of medicine or surgery as

licensed under chapter 148 or 150A. Additionally, any medical or surgical service provided by a podiatrist shall be compensated at the same level as equivalent services provided by a person licensed in the practice of medicine or surgery under chapter 148, 149, or 150A. The plan shall provide that the plan enrollees may reject the coverage for services which may be provided by a podiatric physician if the coverage is rejected for all providers of similar services as licensed under chapter 148, 149, or 150A. This paragraph applies to services provided under plans made on or after July 1, 2000, 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 federal Social Security Act or any other similar coverage under a state or federal government plan.

EXPLANATION

This bill establishes the requirement under group insurance policies and health maintenance organization contracts that treatment or services provided by a person licensed under Code chapter 154 (optometrist), a person licensed under Code chapter 151 (chiropractor), or a person licensed under Code chapter 149 (podiatrist), are to be compensated at the same level as if the treatment or services were provided by a person licensed under Code chapter 148 or 150A (persons licensed to practice medicine and surgery and persons licensed to practice osteopathic medicine and surgery).

The bill establishes provisions under group insurance policies and health maintenance organization contracts to require that if the policy or available health care services currently cover or include care and treatment, as well as drug prescriptions, if provided by a person licensed to practice medicine and surgery under Code chapter 148 or a person licensed to practice osteopathic medicine and surgery under

Code chapter 150A, the plan or health care services available shall also allow for provision of the care and treatment, as well as drug prescriptions, by a podiatrist. The bill also requires that the care or treatment be within the scope of practice of the podiatrist. This requirement applies to policies delivered and issued and services provided under plans on or after July 1, 2000, and to existing plans on the latter of the anniversary, renewal, or expiration of a collective bargaining contract.