Senate Study Bill 1009

SENATE FILE _____
BY (PROPOSED COMMITTEE ON COMMERCE BILL BY CHAIRPERSON ANGELO)

Passed Senate, Date _____ Passed House, 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:

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Section 1. Section 509.3, subsections 5, 6, and 7, Code 2003, 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 care or treatment provided by a chiropractor 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 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.

7. A provision shall be made available to policyholders, under group policies covering hospital, medical, or surgical expenses, for payment of covered services determined to be medically necessary provided by registered nurses certified by a national certifying organization, which organization shall be identified by the Iowa board of nursing pursuant to rules adopted by the board, if the services are within the practice of the profession of a registered nurse as that practice is defined in section 152.1, under terms and conditions agreed upon between the insurer and the policyholder, subject to utilization controls. The provision shall also guarantee that any care or treatment provided by registered nurses 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. This subsection shall not require payment for nursing services provided by a certified nurse practicing in a hospital, nursing facility, health care institution, physician's office, or other noninstitutional setting if the certified nurse is an employee of the hospital, nursing facility, health care institution, physician, or other health care facility or health care provider. This subsection applies to group policies delivered or issued for delivery in this state on or after July 1, 1989, and to existing group policies on their next anniversary or renewal dates, 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, policies rated on a community basis, or policies designed only for issuance to persons for eligible coverage under Title XVIII of the federal Social Security Act, or any other similar coverage under a state or federal government plan.

Sec. 2. Section 509.3, Code 2003, 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 a 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, 2003, 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 509.3, unnumbered paragraph 1, Code 2003, is amended to read as follows:

In addition to the provisions required in subsections 1 through ~~7~~ 8, the commissioner shall require provisions through the adoption of rules implementing the federal Health

Insurance Portability and Accountability Act, Pub. L. No. 104-191.

Sec. 4. Section 514B.1, subsection 5, paragraphs b, c, and d, Code 2003, 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 services 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.

d. The health care services available to enrollees under prepaid group plans covering hospital, medical, or surgical expenses, may include, at the option of the employer purchaser, a provision for payment of covered services determined to be medically necessary provided by a certified registered nurse certified by a national certifying organization, which organization shall be identified by the Iowa board of nursing pursuant to rules adopted by the board, if the services are within the practice of the profession of a registered nurse as that practice is defined in section 152.1, under terms and conditions agreed upon between the employer purchaser and the health maintenance organization, subject to utilization controls. Additionally, any covered services provided by a registered nurse 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. This paragraph shall not require payment for nursing services provided by a certified registered nurse practicing in a hospital, nursing facility, health care institution, a physician's office, or other noninstitutional setting if the certified registered nurse is an employee of the hospital, nursing facility, health care institution, physician, or other health care facility or health care provider. This paragraph applies to services provided under plans within this state made on or after July 1, 1989, 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 later. This paragraph does not apply to enrollees eligible for coverage under an individual contract or coverage designed only for issuance to enrollees eligible for coverage under Title XVIII of the federal Social Security Act, or under coverage which is rated on a community basis, or any other similar coverage under a state or federal government plan.

Sec. 5. Section 514B.1, subsection 5, Code 2003, 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, 2003, 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), a person licensed under Code chapter 152 (nursing), 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 (allopathic and osteopathic physicians).

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 podiatric physician. The bill also requires that the care or treatment be within the scope of practice of the podiatric physician. This requirement applies to policies delivered and issued and services provided under plans on or after July 1, 2003, and to existing plans on the latter of the anniversary, renewal, or expiration of a collective bargaining contract.

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