514C.27 Mental illness and substance abuse treatment coverage for veterans.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a group policy or contract providing for third-party payment or prepayment of health or medical expenses issued by a carrier, as defined in section 513B.2, shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse if either of the following is satisfied:

a. The policy or contract is issued to an employer who on at least fifty percent of the employer's working days during the preceding calendar year employed more than fifty full-time equivalent employees. In determining the number of full-time equivalent employees of an employer, employers who are affiliated or who are able to file a consolidated tax return for purposes of state taxation shall be considered one employer.

b. The policy or contract is issued to a small employer as defined in section 513B.2, and such policy or contract provides coverage benefits for the treatment of mental illness and substance abuse.

2. Notwithstanding the uniformity of treatment requirements of section 514C.6, a plan established pursuant to chapter 509A for public employees shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse as defined in subsection 3.

3. For purposes of this section:

a. *"Mental illness"* means mental disorders as defined by the commissioner by rule.

b. *"Substance abuse"* means a pattern of pathological use of alcohol or a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when the alcohol or drug is withdrawn.

c. *"Veteran"* means the same as defined in section 35.1.

4. The commissioner, by rule, shall define *"mental illness"* consistent with definitions provided in the most recent edition of the American psychiatric association's diagnostic and statistical manual of mental disorders, as the definitions may be amended from time to time. The commissioner may adopt the definitions provided in such manual by reference.

5. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance, or individual accident and sickness policies issued to individuals or to individual members of a member association.

6. A carrier or plan established pursuant to chapter 509A may manage the benefits provided through common methods, including but not limited to providing payment of benefits or providing care and treatment under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system for the use of least restrictive and least costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

7. *a.* A group policy or contract or plan covered under this section shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits unless the policy or contract or plan imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits.

b. A group policy or contract or plan covered under this section that imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits which is less than the aggregate annual or lifetime limit imposed on substantially all medical and surgical coverage benefits.

8. A group policy or contract or plan covered under this section shall at a minimum allow for thirty inpatient days and fifty-two outpatient visits annually. The policy or contract or plan may also include deductibles, coinsurance, or copayments, provided the amounts

and extent of such deductibles, coinsurance, or copayments applicable to other medical or surgical services coverage under the policy or contract or plan are the same. It is not a violation of this section if the policy or contract or plan excludes entirely from coverage benefits for the cost of providing the following:

a. Care that is substantially custodial in nature.

b. Services and supplies that are not medically necessary or clinically appropriate.

c. Experimental treatments.

9. This section applies to third-party payment provider policies or contracts and plans established pursuant to chapter 509A delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011.

2010 Acts, ch 1121, §15; 2014 Acts, ch 1026, §143; 2016 Acts, ch 1011, §95; 2017 Acts, ch 148, §79, 80