

**514C.22 Biologically based mental illness coverage.**

1. Notwithstanding the uniformity of treatment requirements of [section 514C.6](#), a group policy, contract, or plan providing for third-party payment or prepayment of health, medical, and surgical coverage benefits issued by a carrier, as defined in [section 513B.2](#), shall provide coverage benefits for treatment of a biologically based mental illness if either of the following is satisfied:

a. The policy, contract, or plan 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, contract, or plan is issued to a small employer as defined in [section 513B.2](#), and such policy, contract, or plan provides coverage benefits for the treatment of mental illness.

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 for treatment of a biologically based mental illness.

3. For purposes of [this section](#), "biologically based mental illness" means the following psychiatric illnesses:

- a. Schizophrenia.
- b. Bipolar disorders.
- c. Major depressive disorders.
- d. Schizo-affective disorders.
- e. Obsessive-compulsive disorders.
- f. Pervasive developmental disorders.
- g. Autistic disorders.

4. The commissioner, by rule, shall define the biologically based mental illnesses identified in [subsection 3](#). Definitions established by the commissioner shall be consistent with definitions provided in the most recent edition of the American psychiatric association's diagnostic and statistical manual of mental disorders, as such 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, contract, or plan covered under [this section](#) shall not impose an aggregate annual or lifetime limit on biologically based mental illness coverage benefits unless the policy, contract, or plan imposes an aggregate annual or lifetime limit on substantially all health, medical, and surgical coverage benefits.

b. A group policy, contract, or plan covered under [this section](#) that imposes an aggregate annual or lifetime limit on substantially all health, medical, and surgical coverage benefits shall not impose an aggregate annual or lifetime limit on biologically based mental illness coverage benefits that is less than the aggregate annual or lifetime limit imposed on substantially all health, medical, and surgical coverage benefits.

8. A group policy, contract, or plan covered under [this section](#) shall at a minimum allow for thirty inpatient days and fifty-two outpatient visits annually. The policy, contract, or plan may also include deductibles, coinsurance, or copayments, provided the amounts and extent of such deductibles, coinsurance, or copayments applicable to other health, medical, or surgical services coverage under the policy, contract, or plan are the same. It is not a violation of [this section](#) if the policy, contract, or plan excludes entirely from coverage benefits for the cost of providing the following:

- a. Marital, family, educational, developmental, or training services.
- b. Care that is substantially custodial in nature.
- c. Services and supplies that are not medically necessary or clinically appropriate.
- d. Experimental treatments.

9. [This section](#) applies to third-party payment provider policies or contracts and to plans established pursuant to [chapter 509A](#) that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2006.

[2005 Acts, ch 91, §1](#); [2017 Acts, ch 148, §75, 76](#)

Referred to in [§135H.3, 514C.28](#)