514C.19 Prescription contraceptive coverage.

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 shall not do either of the following:

a. Exclude or restrict benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and which are approved by the United States food and drug administration, or generic equivalents approved as substitutable by the United States food and drug administration, if such policy or contract provides benefits for other outpatient prescription drugs or devices.

b. Exclude or restrict benefits for outpatient contraceptive services which are provided for the purpose of preventing conception if such policy or contract provides benefits for other outpatient services provided by a health care professional.

2. A person who provides a group policy or contract providing for third-party payment or prepayment of health or medical expenses which is subject to subsection 1 shall not do any of the following:

a. Deny to an individual eligibility, or continued eligibility, to enroll in or to renew coverage under the terms of the policy or contract because of the individual's use or potential use of such prescription contraceptive drugs or devices, or use or potential use of outpatient contraceptive services.

b. Provide a monetary payment or rebate to a covered individual to encourage such individual to accept less than the minimum benefits provided for under subsection 1.

c. Penalize or otherwise reduce or limit the reimbursement of a health care professional because such professional prescribes contraceptive drugs or devices, or provides contraceptive services.

d. Provide incentives, monetary or otherwise, to a health care professional to induce such professional to withhold from a covered individual contraceptive drugs or devices, or contraceptive services.

3. This section shall not be construed to prevent a third-party payor from including deductibles, coinsurance, or copayments under the policy or contract, as follows:

a. A deductible, coinsurance, or copayment for benefits for prescription contraceptive drugs shall not be greater than such deductible, coinsurance, or copayment for any outpatient prescription drug for which coverage under the policy or contract is provided.

b. A deductible, coinsurance, or copayment for benefits for prescription contraceptive devices shall not be greater than such deductible, coinsurance, or copayment for any outpatient prescription device for which coverage under the policy or contract is provided.

c. A deductible, coinsurance, or copayment for benefits for outpatient contraceptive services shall not be greater than such deductible, coinsurance, or copayment for any outpatient health care services for which coverage under the policy or contract is provided.

4. This section shall not be construed to require a third-party payor under a policy or contract to provide benefits for experimental or investigational contraceptive drugs or devices, or experimental or investigational contraceptive services, except to the extent that such policy or contract provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

5. This section shall not be construed to limit or otherwise discourage the use of generic equivalent drugs approved by the United States food and drug administration, whenever available and appropriate. This section, when a brand name drug is requested by a covered individual and a suitable generic equivalent is available and appropriate, shall not be construed to prohibit a third-party payor from requiring the covered individual to pay a deductible, coinsurance, or copayment consistent with subsection 3, in addition to the difference of the cost of the brand name drug less the maximum covered amount for a generic equivalent.

6. A person who provides an individual policy or contract providing for third-party payment or prepayment of health or medical expenses shall make available a coverage provision that satisfies the requirements in subsections 1 through 5 in the same manner as

such requirements are applicable to a group policy or contract under those subsections. The policy or contract shall provide that the individual policyholder may reject the coverage provision at the option of the policyholder.

7. *a.* This section applies to the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2000:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to chapter 509A for public employees.

b. 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.

2000 Acts, ch 1120, §1; 2017 Acts, ch 148, §72