514C.31 Applied behavior analysis for treatment of autism spectrum disorder — 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 shall provide coverage benefits for applied behavior analysis provided by a practitioner to covered individuals for the treatment of autism spectrum disorder pursuant to a treatment plan if the policy, contract, or plan is either of the following:

a. A policy, contract, or plan issued by a carrier, as defined in section 513B.2, 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. A plan established pursuant to chapter 509A for public employees other than employees of the state.

2. As used in this section, unless the context otherwise requires:

a. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

b. "Autism spectrum disorder" means the same as defined in section 514C.28, subsection 2.

c. "Practitioner" means any of the following:

(1) A physician licensed pursuant to chapter 148.

(2) A psychologist licensed pursuant to chapter 154B.

(3) A behavior analyst licensed pursuant to chapter 154D.

d. "Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a licensed physician or licensed psychologist after a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American academy of pediatrics. *"Treatment plan"* includes supervisory services, subject to the provisions of subsection 4.

3. Coverage required pursuant to this section may be subject to deductibles, copayments, or coinsurance provisions that apply to other medical and surgical services under the policy, contract, or plan.

4. Coverage required pursuant to this section may be subject to care management provisions of the applicable policy, contract, or plan, including prior authorization and prior approval.

5. A carrier or plan may request a review of a treatment plan for a covered individual not more than once every three months during the first year of the treatment plan and not more than once every six months during every year thereafter, unless the carrier or plan and the covered individual's treating physician or psychologist execute an agreement that a more frequent review is necessary. An agreement giving a carrier or plan the right to review the treatment plan of a covered individual more frequently applies only to a particular covered individual receiving applied behavior analysis and does not apply to other individuals receiving applied behavior analysis from a practitioner. The cost of conducting a review under this section shall be paid by the carrier or plan. A carrier or plan shall not change the provisions of a treatment plan until the completion of a review of the treatment plan.

6. This section shall not be construed to limit benefits which are otherwise available to an individual under a group policy, contract, or plan.

7. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

8. 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.

9. This section applies to third-party provider payment contracts, policies, or plans specified in subsection 1, paragraph "*a*" or to plans established pursuant to chapter 509A for public employees other than employees of the state, that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2018.

2017 Acts, ch 18, §4; 2017 Acts, ch 148, §103; 2018 Acts, ch 1106, §13, 14; 2022 Acts, ch 1026, §7, 8; 2025 Acts, ch 162, §7 – 10

Referred to in §225D.1, 225D.2, 514C.22

2022 amendment to subsection 2, paragraphs b and d applies to third-party provider payment contracts, policies, or plans specified in subsection 1, paragraph a, or to plans established pursuant to chapter 509A for public employees other than employees of the state, that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2023; 2022 Acts, ch 1026, §8

2025 amendments to section apply to third-party provider payment contracts, policies, or plans specified in subsection 1, paragraph a, or to plans established pursuant to chapter 509A for public employees other than employees of the state, that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2026; Acts, ch 162, §102025 Acts, ch 162, §10

Subsection 1, unnumbered paragraph 1 amended

Subsection 3 stricken

Former subsections 4 and 5 amended and renumbered as 3 and 4

Former subsections 6 – 10 renumbered as 5 – 9