House Study Bill 161

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Section 1. NEW SECTION. 514C.23 ENTERAL FORMULAS == COVERAGE.

1. Except as provided in subsections 4 and 5, and notwithstanding the uniformity of treatment requirements of section 514C.6, a contract, policy, or plan providing for third=party payment or prepayment of health or medical expenses shall not exclude or restrict benefits for enteral formulas for home use for which a practitioner licensed by law to prescribe and administer prescription drugs has issued a written order, if such contract, policy, or plan provides benefits for other outpatient prescription drugs or devices. Such written order must state that the enteral formula is medically necessary for the patient.

2. For purposes of this section, "enteral formula" means enteral formulas which have been proven effective for the treatment of inborn errors of metabolism with a dietary restriction, which if left untreated will cause malnourishment, chronic physical disability, mental retardation, or death. "Enteral formula" includes low=protein medical food and metabolic formula prescribed for persons diagnosed with inborn errors of metabolism with a dietary restriction. The commissioner, by rule, shall further define enteral formula.

3. a. This section applies to the following classes of third=party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2008:

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

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

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

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

(5) An organized delivery system licensed by the director of public health.

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.

4. An individual or group contract, policy, or plan subject to the requirements of this section shall not impose an annual deductible on enteral formula coverage benefits that is greater than two thousand five hundred dollars per year for each family covered and shall not impose an aggregate annual limit for enteral formula coverage benefits that is less than twelve thousand five hundred dollars per year for each family covered.

5. An individual or group contract, policy, or plan subject to the requirements of this section shall provide, at a minimum, enteral formula coverage benefits to each male insured until that individual reaches the age of twenty=one years old or until that individual ceases to be enrolled as a full=time student, as defined in section 261.102, whichever occurs later, and shall provide, at a minimum, enteral formula coverage benefits to each female insured until that individual reaches the age of forty=five years old.

Sec. 2. NEW SECTION. 514C.24 AUDIOLOGICAL SERVICES AND HEARING AIDS FOR CHILDREN == COVERAGE.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a contract, policy, or plan providing for third=party payment or prepayment of health or medical expenses shall provide minimum coverage benefits for audiological services and hearing aids for children, including but not limited to the following classes of third=party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or

after January 1, 2008:

a. Individual or group accident and sickness insurance providing coverage on an expense=incurred basis.

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

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. A plan established pursuant to chapter 509A for public employees.

2. This section shall not apply to accident=only, specified disease, short=term hospital or medical, hospital confinement indemnity, credit, dental, vision, 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.

3. As used in this section, "minimum coverage for audiological services and hearing aids for children" means coverage that includes at a minimum both of the following:

a. Coverage for hearing aids that are prescribed, filled and dispensed by a licensed audiologist for children up to eighteen years of age.

b. Coverage for an ear mold and a hearing aid for each hearing=impaired ear payable every twenty=four months for children up to eighteen years of age and coverage for up to four additional ear molds per year for children up to three years of age.

4. The commissioner of insurance shall adopt rules pursuant to chapter 17A as necessary to administer this section.

Sec. 3. NEW SECTION. 514C.25 HUMAN PAPILLOMA VIRUS VACCINATIONS == COVERAGE.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a contract, policy, or plan providing for third=party payment or prepayment of health or medical expenses that provides coverage benefits for any vaccination or immunization shall provide coverage benefits for vaccinations for the human papilloma virus, to each female insured who is nine years of age or older until that individual reaches twenty=six years of age, including but not limited to the following classes of third=party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2008:

a. Individual or group accident and sickness insurance providing coverage on an expense=incurred basis.

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

c. An individual or group health maintenance organization contract regulated under chapter 514B.

d. An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

e. A plan established pursuant to chapter 509A for public employees.

2. This section shall not apply to accident only, specified disease, short=term hospital or medical, hospital confinement indemnity, credit, dental, vision, 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.

3. As used in this section, "human papilloma virus" means the human papilloma virus as defined by the centers for disease control and prevention of the United States department of health and human services.

4. The commissioner of insurance shall adopt rules pursuant to chapter 17A as necessary to administer this section.

EXPLANATION

This bill requires insurers offering certain individual or group health insurance contracts, policies, or plans in the state to provide coverage for certain enteral formulas, audiological services and hearing aids for children, and vaccinations for human papilloma virus.

The provisions of the bill are applicable to third=party

payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2008.

The commissioner of insurance is required to adopt rules under Code chapter 17A to administer the provisions of the bill.

ENTERAL FORMULAS. New Code section 514C.23 requires specified individual and group health insurance contracts, policies, or plans that provide coverage for outpatient prescription drugs or devices to also provide coverage for certain enteral formulas that have been prescribed by a licensed medical practitioner for the treatment of inborn errors of metabolism with a dietary restriction which if left untreated will cause malnourishment, chronic physical disability, mental retardation, or death.

The bill prohibits imposition of an annual deductible on enteral formula coverage benefits that exceeds $2,500 per year for each family covered or an aggregate annual limit for such benefits that is less than $12,500 per year for each family.

The bill requires that the benefits must be provided, at a minimum, to each male insured until that individual reaches 21 years of age or ceases to be enrolled as a full=time student, whichever occurs later, and to each female insured until that individual reaches the age of 45.

AUDIOLOGICAL SERVICES AND HEARING AIDS FOR CHILDREN. New Code section 514C.24 requires specified individual and group health insurance contracts, policies, or plans that provide coverage for third=party payment or prepayment of health or medical expenses to provide minimum coverage for audiological services and hearing aids for children.

The bill provides that "minimum coverage for audiological services and hearing aids for children" must include, at a minimum, coverage for hearing aids that are prescribed, filled, and dispensed by a licensed audiologist for children up to 18 years of age, coverage for an ear mold and a hearing aid for each hearing=impaired ear payable every 24 months for children up to 18 years of age, and coverage for up to four additional ear molds per year for children up to three years of age.

HUMAN PAPILLOMA VIRUS VACCINATIONS. New Code section 514C.25 requires specified individual and group health insurance contracts, policies, or plans that provide coverage of any vaccinations or immunizations to provide coverage of vaccinations for the human papilloma virus to each female insured who is nine years of age until that individual reaches 26 years of age.

The bill defines "human papilloma virus" to mean the human papilloma virus as defined by the centers for disease control and prevention of the United States department of health and human services.

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