Senate File 188 - Introduced

SENATE FILE 188
BY PETERSEN, DONAHUE, BISIGNANO, TRONE GARRIOTT, TOWNSEND, STAED, QUIRMBACH, WINCKLER, WEINER, DOTZLER, BLAKE, and BENNETT

A BILL FOR

An Act relating to health insurance coverage for contraceptive devices, drugs, and services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

TLSB 1188XS (7) 91
nls/ko

Section 1. NEW SECTION. **514C.19A Contraceptive drugs, devices, and services.**

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

a. "*Contraceptive device*" means any device or non-drug product that has been approved as a contraceptive by the United States food and drug administration.

b. "*Contraceptive drug*" means any drug approved as a contraceptive by the United States food and drug administration.

c. "*Medical need*" means considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive drug or contraceptive device, or an ability to adhere to the appropriate use of such drug or device, as determined by a health care professional.

d. "*Therapeutically equivalent version*" means a drug or device that has the same clinical effect and safety profile as another drug or device and that meets the criteria for therapeutic equivalence as determined by the United States food and drug administration.

2. Notwithstanding the uniformity of treatment requirements of section 514C.6, a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses, and that provides coverage for prescription drugs, shall not do any of the following:

a. Exclude or restrict benefits for contraceptive drugs, contraceptive devices, or generic equivalents approved as substitutable by the United States food and drug administration, if such policy, contract, or plan provides benefits for other noncontraceptive 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, contract, or plan provides benefits for other outpatient services provided by a health care professional.

c. Deny to an individual eligibility, or continued

eligibility, to enroll in or to renew coverage under the terms of the policy, contract, or plan because of the individual's use or potential use of contraceptive drugs, contraceptive devices, or outpatient contraceptive services.

d. Provide a monetary payment or rebate to a covered individual to encourage such individual to accept less than the minimum benefits provided under this section.

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

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

g. Impose upon any covered individual receiving benefits pursuant to this section any deductible, coinsurance, or copayment for benefits for contraceptive drugs, contraceptive devices, or contraceptive services.

3. Notwithstanding subsection 2, paragraph "*g*", a policy, contract, or plan that provides coverage for more than one therapeutically equivalent version of a contraceptive drug or contraceptive device may impose cost-sharing on any therapeutically equivalent version, provided that at least one therapeutically equivalent version of the contraceptive drug or contraceptive device is available without cost-sharing. However, if a covered individual's health care professional recommends a particular contraceptive drug or contraceptive device based on a determination of medical need, coverage shall be provided for the recommended contraceptive drug or contraceptive device without cost-sharing.

4. This section shall not be construed to do any of the following:

a. Limit or otherwise discourage the use of generic equivalent drugs approved by the United States food and drug

administration, whenever available and appropriate.

b. Prohibit a third-party payor from requiring a covered individual to pay a deductible, coinsurance, or copayment consistent with this section, in addition to the difference of the cost of a brand-name drug less the maximum covered amount for a generic equivalent, when a brand-name drug is requested by a covered individual and a suitable generic equivalent is available and appropriate.

c. Require a third-party payor under a policy, contract, or plan to provide coverage for an experimental or investigational contraceptive drug or contraceptive device, or an experimental or investigational contraceptive service, except to the extent that such policy, contract, or plan provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

5. A policy, contract, or plan to which this section applies shall not impose any burdensome restrictions or delays on the coverage required by this section and shall provide clear, written, and complete information on its internet site, and by mail at the request of a current or potential covered individual, about the contraceptive coverage included and excluded from the plans offered by the policy, contract, or plan.

6. A policy, contract, or plan to which this section applies shall include a coverage provision that satisfies subsections 2 through 5, and shall provide that the policyholder may reject the coverage provision at the option of the policyholder.

7. *a.* This section applies to the following classes of policies, contracts, and plans providing for third-party payment or prepayment of health or medical expenses, and that provide coverage for prescription drugs, provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2026:

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

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 of insurance, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

Sec. 2. REPEAL. Section 514C.19, Code 2025, is repealed.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to health insurance coverage for contraceptive devices, drugs, and services.

The bill prohibits a policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses (policy), and that provides coverage for prescription drugs, from excluding or restricting benefits for contraceptive drugs, contraceptive devices (contraceptives), or generic equivalents, if the policy provides benefits for other prescription drugs or devices. "Contraceptive device" and "contraceptive drug" are defined in the bill. The bill also prohibits a policy from excluding or restricting benefits for outpatient contraceptive services that are provided for the purpose of preventing conception if the policy provides benefits for other outpatient services provided by a health care professional (professional).

A policy is prohibited from denying to an individual eligibility, or continued eligibility, to enroll in or renew coverage under the terms of the policy because of the

individual's use or potential use of contraceptives or outpatient contraceptive services; providing a monetary payment or rebate to a covered individual to encourage such individual to accept less than the minimum benefits provided for under the bill; penalizing, reducing, or limiting the reimbursement to a professional because such professional prescribes contraceptives or provides contraceptive services; and from providing incentives to a professional to induce such professional to withhold from a covered individual contraceptives or contraceptive services. The bill also prohibits a policy from imposing upon any covered individual any deductible, coinsurance, or copayment for benefits for contraceptives or contraceptive services.

Under the bill, a policy that provides coverage for more than one therapeutically equivalent version of a contraceptive may impose cost-sharing requirements, provided that at least one therapeutically equivalent version of the contraceptive is available without cost-sharing. If a covered individual's professional recommends a particular contraceptive based on a determination of medical need, a policy shall provide coverage for the recommended contraceptive without cost-sharing.

The bill does not limit or otherwise discourage the use of generic equivalent drugs approved by the United States food and drug administration, whenever available and appropriate. When a brand-name drug is requested by a covered individual and a suitable generic equivalent is available and appropriate, the bill does not prohibit a third-party payor from requiring the covered individual to pay a deductible, coinsurance, or copayment, in addition to the difference of the cost of the brand-name drug less the maximum covered amount for a generic equivalent. The bill does not require a third-party payor under a policy to provide benefits for experimental or investigational contraceptives, or experimental or investigational contraceptive services, except to the extent that such policy provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient

health care services.

A policy shall not impose any burdensome restrictions or delays on the coverage required by the bill and shall provide clear, written, and complete information on its internet site, and by mail upon request, about the contraceptive coverage included and excluded from the offered plans.

A policy shall include a coverage provision. The policy shall provide that the policyholder may reject the coverage provision at the option of the policyholder.

The bill applies to third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state, on or after January 1, 2026, by the third-party payment providers enumerated in the bill. The bill specifies the types of specialized health-related insurance not subject to the bill.