HEFFERNAN INSURANCE BROKERS
Because You're Different

Health Insurance Mandates

State health insurance mandates are laws regulating the terms of coverage for insured health plans. Mandates can affect various parts of health insurance plans as follows:

- **Benefit mandates** require health insurance plans to cover specific treatments, services or procedures. In some cases, however, benefit mandates require issuers to offer coverage for specific treatments, services or procedures to employers for purchase.
- **Provider mandates** require health insurance plans to pay for services provided by specific health care professionals. Often, provider mandates are in the form of nondiscrimination mandates that require coverage only if the health plan already reimburses services within the scope of the health care professional's practice.
- **Person mandates** require health insurance plans to cover specific categories of people.

Additional mandates for health plans exist at the federal level. For instance, the Affordable Care Act (ACA) requires non-grandfathered plans in the small group and individual markets to provide coverage for items and services designated as "essential health benefits." Health plan sponsors and issuers should work with their advisors to determine how to comply with applicable federal and state mandates.

This Employment Law Summary contains charts outlining Iowa's benefit, provider and person mandates for insured group health plans issued in the state (referred to as "plans" throughout this document). Please keep in mind that the following chart does not address federal benefit mandates, such as the ACA's mandates. The Iowa Insurance Division website and the Iowa Department of Public Health website provides more information on state law mandates.

Benefit Mandates

BENEFIT MANDATE	DESCRIPTION
Applied behavior analysis (autism spectrum disorder)	Plans sponsored by employers with **more than 50 full-time equivalent employees** must cover benefits for **applied behavior analysis** provided to covered individuals under **19 years of age** for the treatment of autism spectrum disorder. This coverage may provide an annual maximum benefit of not less than the following: • For an individual through age six, $36,000 per year • For an individual age seven through age 13, $25,000 per year • For an individual age 14 through age 18, $12,500 per year This coverage may be subject to dollar limits, deductibles, copayments or coinsurance provisions that apply to other medical and surgical services under the plan. Also, this coverage may be subject to the plan's care management provisions, including prior authorization, prior approval and limits on the number of visits a covered individual may make for applied behavior analysis.
Cancer clinical trial – routine care	Plans must cover cancer clinical trial treatment consistent with coverage for treatment of any other sickness, injury, disease or condition.
Cancer medication (oral)	Plans may not discriminate between coverage benefits for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells and covered intravenously administered or injected cancer medications, regardless of formulation or benefit category determination by plan.
Contraceptive drugs and devices	Plans that cover prescription drugs or devices must also cover prescription contraceptive drugs and devices. This coverage may be subject to cost-sharing that is no greater than that imposed on other covered prescription drugs or devices. Coverage for experimental or investigational contraceptive drugs, devices or services must be covered only to the extent that the plan provides coverage for other experimental or investigational outpatient prescription drugs, devices or services.
Diabetes self-management	Plans must cover medically necessary treatment for diabetes, including medically necessary supplies and equipment as certified by the licensed physician or licensed physician assistant managing the individual's diabetic condition. Coverage for diabetes self-management training and education program certified by the department of health and human services and includes: • At least 10 hours of initial outpatient self-management training within a continuous 12-month period; and • Up to 2 hours of follow-up training for each subsequent year.
Emergency medical services	Plans that cover emergency services must pay all charges for emergency services provided to a covered individual, including services furnished outside any contractual provider network or preferred provider network. These plans may not require prior authorization for the emergency services.

BENEFIT MANDATE	DESCRIPTION
Dental procedures—general anesthesia and hospitalization	Plans must cover the administration of general anesthesia and hospital or ambulatory surgical center charges related to dental care services provided to a covered individual who either: • Is a child under five years of age; or • Has a medical condition that would create a medical risk if the dental treatment or surgery were not performed in a hospital or ambulatory surgical center. Prior authorization of hospitalization or ambulatory surgical center may be required in the same manner as required for other hospitalization coverages.
HPV vaccination	Plans that cover any vaccination or immunization must also cover a human papilloma virus (HPV) vaccination.
Mammograms	Plans must cover minimum mammography examination, including: • One baseline mammogram for individuals **age 35-39**; • A mammogram every two years for individuals **age 40-49**; and • An annual mammogram every year for individuals **age 50 or older**. More frequently scheduled mammograms will be covered if recommended by the insured's physician.
Maternity care	Plans that provide maternity benefits, not limited to complications of pregnancy, or newborn care benefits, may not terminate inpatient benefits or require discharge of a mother or the newborn from a hospital following delivery earlier than determined to be medically appropriate by the attending physician. In addition, these plans must cover maternity services rendered by a licensed midwife, regardless of the site of services, in accordance with state guidelines—these services cannot be subject to any greater copayment, deductible or coinsurance than is applicable to any other similar benefits provided by the plan. Standard postpartum hospital stays range from a **minimum of 48 hours for a vaginal delivery to a minimum of 96 hours for a cesarean birth**, excluding the day of delivery. If mother or newborn is discharged earlier, a follow-up visit must be provided to the mother and newborn by health care provider competent in postpartum care and newborn assessment. Plans may not require preauthorization or precertification for a hospital stay or post-discharge follow-up visit. If the covered person is in her second or third trimester experiences an involuntary change in health plans, she may request that the new plan cover the cost of her health care provider, even it that provider is not in the new plan. This coverage must continue through postpartum care.
Mental disorders	Plans sponsored by employers with 50 or more full-time employees and plans sponsored by small employers that cover treatment of mental illness must also cover treatment of biologically-based mental illnesses, including:

BENEFIT MANDATE	DESCRIPTION
	• Schizophrenia; • Bipolar disorders, • Major depressive disorders, • Schizoaffective disorders, Obsessive-compulsive disorders, • Pervasive developmental disorders and • Autistic disorders. This coverage must include **30 inpatient days and 52 outpatient visits annually** but may exclude marital, family, educational, developmental or training services, custodial care, non-medical services and supplies and experimental treatments. Plans may not apply treatment limitations or financial requirements on mental illness coverage unless similar limitations or requirements are imposed on coverage of services for other medical or surgical conditions. Cost-sharing may apply to these services to the same extent that they apply to other medical or surgical services.
Mental illness and substance use disorder treatment for veterans	Plans sponsored by employers with 50 or more full-time employees and plans sponsored by small employers that cover treatment of mental illness must cover treatment of mental illness and substance use disorder for veterans. “Mental illness” means mental disorders as defined in the American Psychiatric Association’s diagnostic and statistical manual. “Substance use disorder” means a pattern of alcohol or drug use that causes impairment in social or occupational functioning, or that produces physiological dependency. This coverage must include **30 inpatient days and 52 outpatient visits annually** but may exclude marital, family, educational, developmental or training services, custodial care, non-medical services and supplies and experimental treatments. Plans may not apply treatment limitations or financial requirements on mental illness coverage unless similar limitations or requirements are imposed on coverage of services for other medical or surgical conditions. Cost-sharing may apply to these services to the same extent that they apply to other medical or surgical services.
Nursing home or skilled nursing facility care	Plans that cover skilled nursing care must also cover this care received in a hospital or health care facility not designated to provide this care, if: • A hospitalized individual is reclassified from acute care to skilled nursing care; and • A bed is not available in a designated skilled nursing care facility with a 30-mile radius of the hospital.
Prescription drugs	Plans that cover prescription drugs may not require an insured individual to fill a covered prescription through a mail order pharmacy. Coverage for prescription drugs must be the same regardless if filled through a mail order service or a retail pharmacy.
Prosthetic devices	Plans must cover prosthetic devices prescribed by a licensed physician or a licensed physician assistant. “Prosthetic device” means an artificial limb device to replace, in whole or in part, an arm or leg.

BENEFIT MANDATE	DESCRIPTION
Telehealth services	Plans cannot discriminate between coverage benefits for health care services that are provided in-person and the same health care services that are delivered through telehealth. "Telehealth" means the delivery of health care services through the use of real-time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the covered person are each located. "Telehealth" does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message or facsimile transmission. In addition, insurers must reimburse telehealth services provided to a covered person for a mental health condition, illness, injury or disease on the same basis and at the same rate as would apply to the same in-person services. They also cannot exclude a health care professional that provides these services who is physically located out-of-state from participating as a provider under the plan via telehealth, if certain requirements are met.

Provider Mandates

PROVIDER MANDATE	DESCRIPTION
Chiropractor	Plans that cover health or medical benefits may not impose copayment or coinsurance amounts for services provided by a chiropractor within the chiropractor's scope of practice that are greater than those imposed for services provided by a physician for the same or a similar diagnosed condition.
Dentist	Plans that cover dental services must cover the services regardless of whether they are provided by a licensed dentist or a physician.
Non-physician providers	Plans may not refuse to pay for health care services provided by a licensed physician assistant or an advanced registered nurse practitioner if the services are covered by the plan and the professional is licensed to provide the services. A plan is not required to cover services unless the physician assistant or registered nurse practitioner provides the service under the supervision of a medical professional under contract with the plan.
Optometrist	Plans that cover vision care services or procedures must cover services provided by a licensed optometrist within the scope of the practice of optometry if they would be covered when provided by another health care provider. This mandate does not prevent insurers from excluding all vision care services or procedures from coverage.
Other providers	Plans must include a provision for the payment of necessary behavioral health services provided by any of the following: • A licensed master social worker who provides services under the supervision of an independent licensed social worker;

	• A licensed mental health counselor or licensed marital and family therapist who holds a temporary license to practice mental health counseling or marital and family therapy and who provides services under the supervision of a qualified supervisor; and • A person who holds a provisional license to practice psychology and who practices under the supervision of a supervisor who meets the qualifications determined by the Board of Psychology.
Therapists	Plans cannot impose a copayment or coinsurance amount on an insured for services provided by a licensed physical therapist, a licensed occupational therapist or a licensed speech pathologist that is greater than the copayment or coinsurance amount imposed on the insured for services provided by a physician for the same or a similar diagnosed condition.

Person Mandates

PERSON MANDATE	DESCRIPTION
Continuation coverage	Employees who have been continuously covered by the group policy during the entire three-month period immediately before the qualifying event, and their eligible dependents, may continue coverage following a qualifying event. A qualifying event includes: • A termination of employment or membership (all qualified beneficiaries); • A permanent or temporary layoff (all qualified beneficiaries); • An approved leave of absence (all qualified beneficiaries); • A divorce or annulment of marriage (spouse and dependent children); and • The death of the covered employee (spouse and dependent children). The maximum continuation period is nine months.
Dependent coverage for young adults	Family coverage policies must offer dependent coverage for an adult child of the insured if the child is under the **age of 26**. Coverage for a **disabled dependent** must continue past the policy's limiting age while the dependent is and continues to be: • Unmarried; • Incapable of self-sustaining employment by reason of an intellectual disability or physical disability; and • Primarily dependent on the employee for support and maintenance.
Newborn and adopted children	Coverage is required for a newborn child of the insured from the moment of birth. In the case of a newly adopted child, coverage is provided from the date of placement, the date custody is granted, or the date of adoption, whichever occurs earlier. Congenial defects and birth abnormalities of the newborn must be considered as an injury or sickness under the policy.

	The plan may require notification of the child's birth within 60 days after the birth. If the coverage for the newborn results in a premium increase, payment can also be required within 60 days after the birth. The same notification and premium payment requirements may apply to a newly adopted or placed child.