HEFFERNAN INSURANCE BROKERS
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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 example, 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 Maine's benefit, provider and person mandates for **group health insurance policies**. Please keep in mind that this summary of state insurance mandates does not address federal benefit mandates, such as those in the ACA. More information on state mandates can be found on the Maine Bureau of Insurance website. New state health insurance developments are also summarized here.

Benefit Mandates

MANDATE	DESCRIPTION
Abortion services	Policies that cover maternity services must cover abortion services. An exception is available for religious employers if this coverage conflicts with the religious employer's bona fide religious beliefs and practices. While plans may contain provisions for maximum benefits and reasonable limitations and exclusions, plans with effective dates on or after **Jan. 1, 2024**, may not impose any deductible, copayment, coinsurance, or other cost-sharing requirement for the costs of abortion services. This cost-sharing prohibition generally does not apply to policies offered for use with a health savings account (HSA), unless the requirement is permissible in a high deductible health plan (HDHP).
Abuse deterrent opioid analgesic drug product	Coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan.
AIDS	Benefits for AIDS, AIDS-Related Complex (ARC) or HIV-related diseases cannot be more restrictive than benefits for any other sickness or disabling condition. Cannot exclude benefits for AIDS, ARC or HIV-related diseases (except through an exclusion under which all sicknesses and diseases are treated the same).
Autism spectrum disorders	Coverage for the diagnosis and treatment of autism spectrum disorders for covered individuals who are **10 years of age or under**. The treatment of autism spectrum disorder includes: • Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services; • Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and • Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist. Coverage for applied behavior analysis may be limited to $36,000 per year.
Breast cancer treatment	Coverage for inpatient treatment of breast cancer for a period of time determined by the attending physician to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.
Breast reconstruction	Policies that cover mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance.
Breast reduction surgery	Insurers must make coverage available for breast reduction surgery.

MANDATE	DESCRIPTION
Mandated offer of coverage	
Cardiac rehabilitation *Mandated offer of coverage*	Insurers must offer coverage for cardiac rehabilitation to groups with **20 or more persons**. "Cardiac rehabilitation" means medically necessary treatment of persons with cardiovascular disease, including outpatient treatment initiated within 26 weeks after diagnosis and physician-recommended continuance of Phase II rehabilitation services for up to 36 sessions in a hospital or community-based setting and up to 36 Phase III sessions in a community-based setting.
Children's early intervention services	Coverage for early intervention services for children from **birth to 36 months of age** with an identified developmental disability or delay. This coverage may be limited to **$3,200 per year** for each child not to exceed $9,600 by the child's third birthday.
Chronic maintenance drugs *Mandated offer of coverage*	Coverage must be made available for an emergency supply of a chronic maintenance drug dispensed pursuant to state law, in the same manner as coverage for other drugs under the health plan. Any deductible, copayment, coinsurance or other cost-sharing requirements must be applied in the same manner as if the chronic maintenance drug were dispensed as prescribed by a provider (this generally does not apply to health plans offered for use with an HSA, unless the benefits are permissible benefits in an HDHP).
Clinical trials	Insurers cannot deny participation in an approved clinical trial to a qualified enrollee or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial.
Colorectal cancer screenings	Coverage for colorectal cancer screenings for asymptomatic individuals who are: • At average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society; or • At high risk for colorectal cancer.
Contraceptives	Policies that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives approved by the federal Food and Drug Administration (FDA) or for outpatient contraceptive services to the same extent that coverage is provided for other prescription drugs or outpatient medical services. Coverage must include coverage for "contraceptive supplies," meaning all contraceptive drugs, devices and products approved by the FDA to prevent an unwanted pregnancy. It also includes the furnishing or dispensing of prescribed contraceptive supplies intended to last for a 12-month period. Coverage must be

MANDATE	DESCRIPTION
	provided without any deductible, coinsurance, copayment or other cost-sharing requirement. Insurers may exclude this coverage for religious employers if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices.
COVID-19 health care services	Policies must cover screening, testing and immunization for COVID-19. Coverage must also be provided for any COVID-19 vaccine licensed or authorized by the FDA, that is recommended by the CDC's Prevention Advisory Committee on Immunization Practices. No deductible, copayment, coinsurance or other cost-sharing requirement may be imposed for this coverage.
Dental services for cancer patients	Coverage for medically necessary dental procedures for an enrollee who has been diagnosed with cancer. This includes fluoride treatment and dental procedures that are medically necessary to reduce the risk of infection or eliminate infection, or to treat tooth loss or decay prior to beginning cancer treatment, or that are the direct or indirect result of cancer treatment. It also includes laboratory assessments, medications and treatments.
Diabetic supplies	Coverage for the medically appropriate and necessary equipment (insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets) and the out-patient self-management training and educational services used to treat diabetes.
Donor breast milk	Plans must cover pasteurized donor breast milk provided to an infant eligible for coverage if a physician, licensed physician assistant, or licensed advanced practice registered nurse signs an order stating that: the infant is medically or physically unable to receive maternal breast milk or participate in breastfeeding, or the infant's parent is medically or physically unable to produce maternal breast milk in quantities sufficient for the infant; and the infant meets certain other criteria.
Fertility services	Coverage for fertility diagnostic care, fertility treatment if the enrollee is a fertility patient, and fertility preservation services. Plans that provide coverage for these services may include reasonable limitations to the extent they are based on an enrollee's medical history and clinical guidelines adopted by the insurer (which must be based on current guidelines developed by the American Society for Reproductive Medicine), and they **do not**: • Impose a waiting period; • Use any prior diagnosis or prior fertility treatment as a basis for excluding or otherwise limiting the availability of coverage; • Impose different limitations on coverage for, provide different benefits to or impose different requirements on a class of persons protected under state law than those of other enrollees.

MANDATE	DESCRIPTION
General anesthesia for dentistry	Coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital.
Gynecological exam	Coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations.
Hearing aids	Coverage for the purchase of a hearing aid for each hearing-impaired ear for a covered individual (without an age limit), subject to a limit of **$3,000** per hearing aid for each hearing-impaired ear every 36 months.
Home health care *Mandated offer of coverage*	Insurers must make coverage available for home health care services by a home health care provider. The number of covered visits cannot be less than 90 in any continuous period of 12 months for each person covered under the policy.
Hospice care services	Coverage for hospice care services to a person who is terminally ill.
Infant formula (medically necessary)	Coverage for amino acid-based elemental infant formula for children **two years of age and under**, regardless of the delivery method.
Leukocyte antigen testing	Coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability. This coverage may be limited to one test per lifetime.
Mammograms	Policies that cover radiologic procedures must provide coverage for screening mammograms performed at least once a year for women 40 years of age and over. Policies cannot impose any cost-sharing requirements on a screening mammogram, diagnostic breast examination or supplemental breast examination performed by a provider in accordance with this mandate (the cost-sharing prohibition generally does not apply to policies offered for use with an HSA, unless the requirements are permissible in an HDHP).
Maternity, routine newborn and postpartum care	Coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the “Guidelines for Perinatal Care,” published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. In addition, plans that provide maternity benefits must provide coverage for 12 months following childbirth for postpartum care services and support necessary to transition a patient to a healthy and stable condition that meets the recommendations of the American College of Obstetricians and Gynecologists outlined in the “Optimizing Postpartum Care” opinion published May 2018.

MANDATE	DESCRIPTION
Maternity coverage for unmarried women and minor dependents	Must provide the same maternity benefits for unmarried women certificate holders (and the minor dependents of certificate holders with dependent or family coverage) as is provided married certificate holders with maternity coverage and the wives of certificate holders with maternity coverage.
Medical food coverage for inborn error of metabolism	Coverage for metabolic formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism. Required benefits for special modified low-protein food products are limited to **$3,000 per year**.
Mental health services	Coverage for medically necessary health care for a person suffering from mental illness, subject to reasonable limitations. Medically necessary health care includes, but is not limited to, the following services for a person suffering from a mental illness: • Inpatient care; • Day treatment services; • Outpatient services; and • Home health care services. Group policies for employers with **more than 20 employees** are subject to mental health parity requirements, including coverage for the treatment and diagnosis for the following categories of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses: • Psychotic disorders, including schizophrenia; • Dissociative disorders; • Mood disorders; • Anxiety disorders; • Personality disorders; • Paraphilias; • Attention deficit and disruptive behavior disorders; • Pervasive developmental disorders; • Tic disorders; • Eating disorders, including bulimia and anorexia; and • Substance use disorders. *In addition, plans providing coverage for mental health and substance use disorder services pursuant to the mandates above must meet the requirements of the federal Mental Health Parity and Addiction Equity Act.*
Orally administered cancer treatment	Policies that cover cancer chemotherapy treatment must cover prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.
Pap tests	Coverage for screening Pap tests recommended by a physician.

MANDATE	DESCRIPTION
Prescription drugs/medical devices – off-label use; emergency use	Policies that cover prescription drugs and medical devices may not deny coverage of a prescribed drug or medical device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature. Policies must provide coverage for the furnishing or dispensing of a prescription drug in accordance with a valid prescription issued by a provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply, during a statewide state of emergency declared by the Governor. This does not apply to coverage of prescribed contraceptive supplies or coverage of opioids prescribed in accordance with applicable limits.
Prescription insulin	Policies that provide coverage for prescription insulin drugs may not impose any deductible, copayment, coinsurance or other cost-sharing requirement that results in out-of-pocket costs exceeding **$35 per prescription for a 30-day supply**, regardless of the amount of insulin needed to fill the insured's insulin prescriptions.
Prescription drugs—off-label use for cancer	Policies that cover prescription drugs may not exclude coverage of any covered drug used for the treatment of cancer for a medically accepted indication on the grounds that the drug has not been approved by the FDA for that indication, as long as that use of that drug is a medically accepted indication for the treatment of cancer.
Prescription drugs – HIV prevention drugs and off-label use for HIV or AIDS	Coverage for HIV prevention drugs that have been prescribed by a provider, with no out-of-pocket costs for laboratory testing recommended by the provider related to the ongoing treatment of an enrollee taking an HIV prevention drug. HIV prevention drugs cannot be subject to any prior authorization or step therapy requirements except in limited circumstances. Policies that cover prescription drugs may not exclude coverage of any covered drug used for the treatment of HIV or AIDS on the grounds that the drug has not been approved by the FDA for that indication, as long as that drug is recognized for the treatment of that indication in one of the standard reference compendia or in peer-reviewed medical literature.
Prescription eye drops – early refills	Coverage for one early refill of a prescription for eye drops if specific criteria are satisfied, including a requirement that the enrollee requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed.
Prostate cancer screening	Coverage for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72.
Prosthetic devices	Coverage for prosthetic devices, including repair or replacement of a prosthetic device if repair or replacement is determined appropriate by the enrollee's provider.

MANDATE	DESCRIPTION
Substance use disorder treatment	Group policies issued to employers with **more than 20 employees** must cover the treatment of substance use disorder pursuant to a treatment plan, including: • Residential treatment at a hospital or free-standing residential treatment center that is licensed, certified or approved by the state; and • Outpatient care rendered by state licensed, certified or approved providers.
Symptomatic varicose vein surgery *Mandated offer of coverage*	Insurers must make coverage available for symptomatic varicose vein surgery.
Telehealth	Insurers may not deny coverage on the basis that the coverage is provided through telehealth if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Telehealth means the use of information technology and includes synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring.

Provider Mandates

MANDATE	DESCRIPTION
Acupuncturist	Policies that cover acupuncture must provide coverage for those services when performed by a licensed acupuncturist under the same conditions that apply to the services of a licensed physician.
Chiropractor	Policies that cover therapeutic, adjustive and manipulative services must cover those services when performed by a chiropractor, to the extent that the services are within the lawful scope of practice of a licensed chiropractor. Therapeutic, adjustive and manipulative services must be covered whether performed by an allopathic, osteopathic or chiropractic doctor.
Certified registered nurse anesthetist	Coverage for health care services performed by a licensed, certified registered nurse anesthetist when those services are covered services under the health plan when performed by any other health care provider and when those services are within the lawful scope of practice of the certified registered nurse anesthetist.
Dental hygiene therapist	Policies that cover dental services must provide coverage for dental services performed by a licensed dental hygiene therapist when those services are covered under the policy and when they are within the lawful scope of practice of the dental hygiene therapist.
Dentists	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician.

MANDATE	DESCRIPTION
Independent practice dental hygienist	Policies that cover dental services must provide coverage for dental services performed by a licensed independent practice dental hygienist when those services are covered under the policy and when they are within the lawful scope of practice of the independent practice dental hygienist.
Mental health providers	Policies that provide for payment or reimbursement for services that are within the lawful scope of practice of a professional listed below must cover those services if they are performed by a physician or one of the following professionals: • A licensed psychologist; • A certified social worker licensed for the independent practice of social work; • A licensed clinical professional counselor licensed for the independent practice of counseling; • A licensed nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing; • A licensed marriage and family therapist; and • A licensed pastoral counselor. In addition, policies that provide coverage for mental health services must make coverage available for mental health services provided by licensed counselors.
Naturopathic doctor	Coverage for health care services performed by a licensed naturopathic when those services are covered services under the health plan when performed by any other health care provider and when those services are within the lawful scope of practice of the naturopathic doctor.
Nurse practitioners, midwives and nurse midwives	Coverage for services performed by a certified nurse practitioner, certified midwife or certified nurse midwife when those services are covered services and when they are within the lawful scope of practice of the certified nurse practitioner, certified midwife or certified nurse midwife.
Optometrist *Mandated offer of coverage*	Insurers must make coverage available for services performed by an optometrist if the same services would be covered if performed by a physician.
Physician assistant	Coverage for health care services performed by a licensed physician assistant when those services are covered services under the health plan when performed by any other health care provider and when those services are within the lawful scope of practice of the physician assistant.
Registered nurse first assistants	Policies that cover surgical first assisting benefits or services must provide coverage for a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications.

Person Mandates

MANDATE	DESCRIPTION
Adopted children	Policies must provide the same benefits to dependent children placed for adoption with the certificate holder or spouse of the certificate holder under the same terms and conditions as apply to natural dependent children or stepchildren of the certificate holder, irrespective of whether the adoption has become final.
Adult children *Mandated offer of coverage*	Insurers that provide dependent coverage must make that coverage available until the dependent child attains 26 years of age.
Adult children with disabilities *Mandated offer of coverage*	Policies that offer coverage for a dependent child must offer such coverage for a dependent child with a disability, regardless of age.
Children of unmarried couples	Insurers must provide unmarried women certificate holders with the option of coverage of their children from the date of birth. A certificate holder who has been adjudicated or has acknowledged the certificate holder to be the father of an illegitimate child must be given the option of coverage for that child from the date of the certificate holder's adjudication or acknowledgement of paternity. This optional coverage must be the same as that provided the children of a married certificate holder with family or dependent coverage.
Continuation coverage	Employees who were covered by the group health plan for at least six months may be eligible to elect continuation coverage if they have a temporary layoff of termination of employment due to a work-related injury or disease. Continuation coverage may last for a maximum period of one year from the last day of work.
Dependent coverage – full-time students	Policies that provide coverage for a dependent child at certain ages only if the child is a student must continue that coverage if the child is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or an accidental injury.
Domestic partners *Mandated offer of coverage*	Insurers must make coverage available for domestic partners under the same terms and conditions as benefits are provided to spouses of married certificate holders.
Newborn children	Coverage for a newly born child of the insured from the moment of birth. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. The coverage for newly born children must consist of coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the

MANDATE	DESCRIPTION
	required premium must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period.