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.
- ✓ **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 North Carolina's benefit, provider and person mandates for insured group health plans issued in the state. Please keep in mind that the following chart does not address federal benefit mandates, such as those in the ACA. More information can be obtained from the North Carolina Department of Insurance.

Benefit Mandates

MANDATE	DESCRIPTION
Autism spectrum disorder	Plans must cover screenings for, diagnosis of and treatment of autism spectrum disorder, to the same (or a greater) extent as substantially all other covered medical services. For an insured diagnosed with autism spectrum disorder, this coverage must include the following, when medically necessary and ordered by a licensed physician or psychologist: • Adaptive behavior treatment; • Pharmacy care; • Psychiatric care; • Psychological care; and • Therapeutic care. A plan's coverage for **adaptive behavior treatment** may be: • Subject to a maximum benefit of **up to $40,000 per year** (as adjusted for inflation); and • Limited to insureds who are **18 years of age or younger**. Plans may not deny coverage for treatment of autism spectrum disorder on the basis that the treatment is habilitative or educational in nature.
Bone mass measurement	Plans must cover, on the same basis as similar covered services, bone mass measurements for the diagnosis and evaluation of osteoporosis or low bone mass for qualified individuals. Plans may limit these measurements to once every **23 months**, except when more frequent measurements are medically necessary. For this mandate, a qualified individual means an individual who: • Is estrogen-deficient and at clinical risk of osteoporosis or low bone mass; • Has radiographic osteopenia anywhere in the skeleton; • Is receiving long-term glucocorticoid (steroid) therapy; • Has primary hyperparathyroidism; • Is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies; • Has a history of low-trauma fractures; or • Has other conditions or is on medical therapies known to cause osteoporosis or low bone mass.

MANDATE	DESCRIPTION
Bones or joints of jaw, face or head	Plans that cover diagnostic, therapeutic or surgical procedures involving bones or joints of the human skeletal structure must provide the same coverage for procedures involving any bone or joint of the jaw, face or head, as long as: • The procedures are medically necessary to treat a condition that prevents normal functioning of the particular bone or joint involved; and • The condition is caused by congenital deformity, disease or traumatic injury. For the treatment of temporomandibular joint (TMJ), authorized therapeutic procedures must include splinting and use of intraoral prosthetic appliances to reposition the bones. Payment for these, and for procedures involved in any other nonsurgical treatment of TMJ dysfunction, may be subject to a reasonable lifetime maximum dollar amount. This mandate does not require plans to cover orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants or root canals.
Cancer treatment drugs (off-label use)	Plans that cover prescription drugs to treat certain types of cancer may not exclude coverage of any drug on the basis that the drug has been prescribed to treat a type of cancer for which the drug has not been FDA-approved. However, this mandate requires coverage only if a drug is: • FDA-approved; and • Proven effective and accepted to treat the specific type of cancer for which it has been prescribed. Plans are **not** required to cover any experimental or investigational drugs, **nor** any drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.
Cervical cancer screening	Plans must cover, on the same basis as similar covered services, examinations and laboratory tests to screen for cervical cancer, including conventional PAP smear screening, liquid-based cytology, and human papilloma virus detection methods, in accordance with certain guidelines.
Chemical dependency	Plans must offer to cover, on the same basis as any other covered physical illness, all necessary care and treatment of chemical dependency. Plans that include this coverage and provide total annual benefits for all illnesses in excess of $8,000 must provide minimum chemical dependency benefits of: • **$8,000** for each 12-month period; and • **$16,000** over the plan lifetime.

MANDATE	DESCRIPTION
	In addition, plans sponsored by employers with **50 or more employees** must comply with all applicable requirements of the federal Mental Health Parity and Addiction Equity Act (MHPAEA).
Clinical trials	Plans must cover an insured's participation in phase II, phase III and phase IV clinical trials if the insured meets protocol requirements and provides informed consent. The required coverage is limited to medically necessary services associated with a covered clinical trial, including: • Services typically provided absent a clinical trial; • Diagnosis and treatment of complications; and • Medically necessary monitoring. This mandate does not require plans to cover non-FDA approved drugs after a clinical trial is discontinued.
Colorectal cancer screenings	Plans must cover, on the same basis as similar covered services, colorectal cancer examinations and laboratory tests to screen for colorectal cancer, in accordance with certain guidelines, for any non-symptomatic, covered individual who is: • **50 years of age or older**; or • Younger than 50 years of age and at **high risk** for colorectal cancer.
Contraceptives	Plans that cover prescription drugs or devices must cover contraceptive drugs or devices to the same extent. This coverage must include benefits for the insertion or removal of and any medically necessary examination associated with the use of a prescribed contraceptive drug or device. In addition, plans that cover outpatient services provided by a health care professional must also cover outpatient contraceptive services to the same extent. An exception to this mandate is available for religious employers.
Dental procedures	Plans must cover, on the same basis as physical illnesses in general, anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for: • Children under **age nine**; • Any insured with a **serious mental or physical condition**; and • Any insured with a **significant behavioral problem**.

MANDATE	DESCRIPTION
	Plans may condition this coverage on a provider's certification that a patient's age, condition or problem makes hospitalization or general anesthesia necessary in order to safely and effectively perform the procedures.
Diabetes	Plans must cover, on the same basis as similar covered services, medically appropriate and necessary services to treat diabetes, including: • Outpatient self-management training; • Educational services and equipment; • Supplies; • Medications; and • Laboratory procedures.
Emergency services	Plans must cover emergency services necessary to screen and stabilize an insured individual. This coverage may be subject to cost-sharing as long as it is the same for both in-network and out-of-network emergency services. In addition, plans may not: • Require prior authorization for any emergency services, if a prudent layperson acting reasonably would have believed that an emergency medical condition existed; or • Deny coverage of out-of-network emergency services, if a prudent layperson acting reasonably would have believed that a delay would worsen the emergency or if the insured did not use a network provider because of circumstances beyond his or her control.
Hearing aids for children	Plans must cover, on the same basis as similar covered services, one new hearing aid per hearing-impaired ear, up to **$2,500** per hearing aid, every **36 months** for covered individuals under the **age of 22**. This coverage must include all medically necessary hearing aids and services ordered by a physician or audiologist, including: • Initial and replacement hearing aids; • A new hearing aid when alterations to an existing one cannot adequately meet the covered individual's needs; and • Services, including the initial hearing aid evaluation, fitting, adjustments and supplies.
Intoxicants and narcotics	Plans may **not** limit or exclude benefits because the nature of a loss is due to an insured being under the influence of drugs or alcohol.

MANDATE	DESCRIPTION
Lymphedema	Plans must cover, on the same basis as similar covered services, the diagnosis, evaluation and treatment of lymphedema. This coverage must include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments and self-management training and education, if the treatment is determined to be medically necessary and is provided by a licensed occupational or physical therapist, licensed nurse who has experience providing this treatment, or other licensed health care professional when the treatment of lymphedema is within the professional's scope of practice.
Mammograms	Plans must cover, on the same basis as similar covered services, low-dose screening mammography, as follows: • One or more mammograms per year as recommended by a physician, for any woman who is **at risk for breast cancer**; • One baseline mammogram for women **ages 35-39**; • A mammogram every two years, or annually with a doctor's recommendation, for women **ages 40-49**; and • An annual mammogram for women **ages 50 and older**.
Mastectomy: breast reconstruction after surgery	Plans that cover mastectomies must also cover, on the same basis as similar covered services, reconstructive breast surgery following a mastectomy. This coverage must include benefits for: • All stages and revisions of reconstructive breast surgery performed on a non-diseased breast to establish symmetry, if reconstructive surgery on a diseased breast is performed; and • Prostheses and physical complications in all stages of mastectomy, including lymphedemas.
Mastectomy: inpatient care	Plans that cover mastectomies and post-mastectomy inpatient care must ensure that a decision to discharge a patient following mastectomy is made by the attending physician in consultation with the patient and that the length of post-mastectomy hospital stay is based on the patient's unique characteristics.
Maternity care	Plans that include maternity benefits must cover necessary care and treatment related to maternity on the same basis as other covered physical illnesses.
Maternity – care following delivery	Plans that include maternity and childbirth benefits must cover a minimum of the following, without provider authorization, for a mother and her newborn child:

MANDATE	DESCRIPTION
	• **48 hours** of inpatient care following a normal vaginal delivery; and • **96 hours** of inpatient care following a cesarean delivery. Under this mandate, a decision to discharge a mother and her newborn child before the end of a 48- or 96-hour period may be made by the attending provider in consultation with the mother. If an early discharge occurs, plans must cover timely post-delivery care.
Mental illness	Plans must cover necessary care and treatment of mental illness to the same as physical illnesses in general. Subject to exceptions, a plan may apply different durational limits than those that apply to physical illnesses, as long as the coverage includes at least: • **30 combined inpatient and outpatient days** per year; and • **30 office visits** per year. However, durational limits for the following must be the same as those that apply for any covered physical illness: • Bipolar disorder; • Major depressive disorder; • Obsessive compulsive disorder; • Paranoid and other psychotic disorder; • Schizoaffective disorder; • Schizophrenia; • Post-traumatic stress disorder; • Anorexia nervosa; and • Bulimia. In addition, plans sponsored by employers with **50 or more employees** must comply with all applicable requirements of the MHPAEA.
Newborn hearing screenings	Plans must cover newborn hearing screenings ordered by a covered newborn's attending physician on the same basis as similar covered services.
Organ transplants	Plans that provide coverage for anatomical gifts, organ transplants, or treatment and services related to these cannot: • Deny coverage to an insured solely on the basis of that individual's disability; • Deny eligibility, or continued eligibility, to enroll or to renew coverage solely for the purpose of avoiding the requirements of this mandate;

MANDATE	DESCRIPTION
	• Attempt to induce a health care provider to provide care to an insured in a manner inconsistent with this mandate by either penalizing, or otherwise reducing or limiting the reimbursement of the provider, or by providing monetary or nonmonetary incentives to the provider. • Reduce or limit benefits to an insured for any services related to medically necessary organ transplantation performed.
Ovarian cancer screenings	Plans must cover, on the same basis as similar covered services, annual ovarian cancer screenings using transvaginal ultrasound and rectovaginal pelvic examinations for women **age 25 and older**.
Prescription drugs – non-formulary and restricted access drugs	If a plan: (i) maintains one or more closed formularies for or restricts access to covered prescription drugs, devices or (ii) requires an insured with an open or closed formulary to use a prescription drug or sequence of prescription drugs, other than the drug the health care provider recommends, before providing coverage for the recommended prescription drug, the insurer must meet certain requirements. In addition, there must be a process by which an insured, or the insured's prescribing provider acting on their behalf, is allowed to obtain coverage for a specific nonformulary drug or device or the drug requested by the prescribing provider, if it is determined to be medically necessary and the prescription drug is covered under the current plan. This coverage must be without penalty or additional cost-sharing beyond that provided for in the plan.
Prostate cancer screenings	Plans must cover, on the same basis as similar covered services, prostate-specific antigen or equivalent tests for the presence of prostate cancer, when recommended by a physician.

Provider Mandates

MANDATE		DESCRIPTION
• Advanced practice registered nurse • Chiropractor • Clinical social worker • Clinical mental health counselor • Dentist • Marriage counselor • Certified fee-based practicing pastoral counselor	• Occupational therapist • Optometrist • Pharmacist • Physician assistant • Physical therapist • Podiatrist • Psychologist • Registered nurse • Substance abuse counselor	***Nondiscrimination mandates:*** If a plan covers services within the scope of these providers' licenses and practices, the plan must cover the services when performed by these providers within their scopes.

Person Mandates

MANDATE	DESCRIPTION
Adopted and foster children	Plans that cover minor children must cover foster and adopted children, on the same basis as newborn infants, upon placement in the foster home or for adoption (regardless of whether an adoption is final), subject to certain premium and enrollment requirements. This coverage must include benefits for all necessary treatment and care of congenital defects or anomalies, including cleft lip or cleft palate.
Children	Plans may not deny a child for enrollment on the bases that the child: • Was born out of wedlock; • Is not claimed as a dependent on a covered parent's federal income tax return; or • Does not reside with the covered parent or in the insurer's service area.
Continuation coverage	Plans must provide an insured employee and his or her covered dependents with an opportunity to elect to continue their coverage if: • The coverage would otherwise end due to termination of employment or loss of eligibility; and

	• The employee was continuously covered under the plan for **at least three consecutive months** immediately before the loss of eligibility. The maximum continuation period is **18 months**.
Dependent - disabled	Plans must offer continued coverage for a dependent child after he or she attains the plan's limiting age, if the child is and continues to be: • Incapable of self-sustaining employment because of a physical or intellectual disability; and • Chiefly dependent on the policyholder for support and maintenance.
Dependent – medically necessary leave of absence from school	Plans that terminate a dependent child's coverage upon a change in enrollment in a postsecondary educational institution must provide for the continued eligibility of a dependent child during a medically necessary leave of absence from a postsecondary educational institution in accordance with the federal law known as Michelle's law.
Newborns	Plans that cover minor children must cover a newborn from the moment of birth, subject to certain premium and enrollment requirements. This coverage must include all necessary treatment and care for congenital defects or anomalies, including cleft lip or cleft palate.