HEFFERNAN INSURANCE BROKERS
Because You're Different

Health Insurance Mandates

State 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 example, the Affordable Care Act (ACA) requires non-grandfathered health plans in the small group and individual markets to provide coverage for certain 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 Florida's benefit, provider and person mandates for **group health insurance policies** (referred to as "plans" throughout this document). More information can be found on the Florida Office of Insurance Regulation website. Text of Florida's laws is also available here.

Benefit Mandates

MANDATE	DESCRIPTION
Advanced practice registered nurse services	Plans cannot require an insured to receive services from an advanced practice registered nurse in place of a physician.
Air ambulance services	Plans must require an insurer to provide reasonable reimbursement to an air ambulance service for covered nonemergency and emergency services to an insured in accordance with policy coverage terms. Such reasonable reimbursement may be reduced only by applicable copayments, coinsurance and deductibles. Payment in full by the insured of the applicable copayment, coinsurance or deductible constitutes an accord and satisfaction of, and a release of, any claim for additional moneys owed.
Autism spectrum disorders	Plans must provide coverage to insureds who are **under age 18** (or age 18 and older, if they are in high school and were **diagnosed with a developmental disability at age 8 or younger**) for: • Well-baby and well-child screening for diagnosing autism spectrum disorder; and • Treatment of autism spectrum disorder and Down syndrome through speech therapy, occupational therapy, physical therapy and applied behavior analysis. This coverage may be limited to $36,000 annually and $200,000 in total lifetime benefits (subject to adjustments for inflation) but may not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable than those that apply to covered physical illnesses under the plan. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
Bone marrow transplant procedures	Plans that cover cancer treatment may not exclude coverage for bone marrow transplant procedures recommended by a referring physician and a treating physician under an exclusion for experimental, clinical investigative, educational or similar procedures, if the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental (based on rules issued by the Florida Agency of Health Care Administration). Covered bone marrow transplant procedures must include costs associated with the donor-patient to the same extent, except that the reasonable costs of searching for the donor may be limited to immediate family members and the National Bone Marrow Donor Program.

Breast cancer	Plans may not include any exceptions or exclusions solely because an insured has: • Been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition to developing breast cancer; • A family history related to breast cancer; or • Any combination of these factors. This mandate does **not** apply if a condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer. In addition, plans may not except or exclude benefits solely due to breast cancer if an insured has been free from breast cancer for more than two years before a request for health insurance coverage.
Cancer treatment drugs – off label use	Plans that cover cancer treatment may not exclude coverage for any drug prescribed for the treatment of cancer on the basis that the drug is not approved by the U.S. Food and Drug Administration (FDA) for a particular indication, if that drug is recognized for treatment of the indication in a standard reference compendium or recommended in the medical literature. A plan's coverage must also include the medically necessary services associated with administration of the drug.
Cancer treatment medication – orally administered	Plans that cover cancer treatment medications must also cover prescribed, orally administered cancer treatment medications without any cost-sharing requirements that are less favorable to an insured than those that apply for intravenous or injected cancer treatment medications. However, if the cost-sharing for intravenous or injected cancer treatment medications is less than $50 per month, the cost-sharing for orally administered cancer treatment medications may be up to $50 per month.
Cleft lip/cleft palate	Plans that cover children **under age 18** must cover treatment of cleft lip and cleft palate for these children. This coverage must include medical, dental, speech therapy, audiology and nutrition services, if the services are prescribed by a treating physician or surgeon and the physician or surgeon certifies that the services are medically necessary and result from treatment of the cleft lip or cleft palate. This coverage may be subject to terms and conditions applicable to other benefits.
Dental treatment – general anesthesia and hospitalization	Plans that cover general anesthesia and hospitalization services must cover these services when necessary to assure the safe delivery of necessary dental care provided to a covered person who: • Is **under age 8** and requires, as determined by a licensed dentist and the child's licensed physician, necessary dental treatment in a

	hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven to be ineffective; or • Has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center. All terms and conditions of insured's coverage apply to the services. This mandate does not require coverage for the diagnosis or treatment of dental disease.
Diabetes treatment	Plans must cover all medically appropriate and necessary equipment, supplies and diabetes outpatient self-management training and educational services used to treat diabetes, if a patient's treating physician or a physician who specializes in the treatment of diabetes certifies that the services are necessary.
Emergency services – non-participating providers	Plans must cover emergency services provided to an insured, subject to any copayments, coinsurance and deductibles that apply to services furnished by participating providers, even if the emergency services are furnished by a nonparticipating provider. These services may not be subject to prior authorization requirements. In addition, plans must cover nonemergency services furnished by a nonparticipating provider, subject to any cost-sharing applicable for participating providers, if the services are provided: • In a facility that has a contract for the nonemergency services with the insurer; and • When the insured does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the insured.
Enteral formulas	Insurers must offer coverage (for an additional premium) for prescription and nonprescription enteral formulas for home use, if prescribed by a physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism, or malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited diseases of amino acids and organic acids must include food products modified to be low protein, in an amount of up to **$2,500** annually for any insured through the **age of 24**.

Home health services	Plans must cover home health care by a licensed home health care agency. This coverage may be subject to a maximum length of care for any policy year, but may not be limited to less than **$1,000** per year.
Jaw or facial procedures	Plans that cover any diagnostic or surgical procedure involving bones or joints of the skeleton must cover any similar diagnostic or surgical procedure involving bones or joints of the jaw and facial region, if the procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease or injury.
Mammograms	Plans must cover mammograms as follows: • A **baseline mammogram** for any woman who is 35 years of age or older, but younger than 40 years of age; • A mammogram **every 2 years** for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendation; • A mammogram **every year** for any woman who is 50 years of age or older; and • **One or more mammograms a year**, based upon a physician's recommendation, for any woman who is at risk for breast cancer.
Mastectomy – prosthetic devices and reconstructive surgery	Plans that cover mastectomies must also cover prosthetic devices and breast reconstructive surgery incident to a mastectomy.
Mastectomy – inpatient stay and postsurgical care	Plans that cover breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by a treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient. Plans that cover mastectomies must also cover outpatient postsurgical follow-up. A treating physician, after consultation with an insured patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center or home of the insured patient. These benefits may be subject to the same cost-sharing requirements as those that apply to other benefits.
Maternity care	Plans that cover hospitalization for maternity and newborns may not limit coverage for the length of a maternity and newborn stay in a hospital or for follow-up care outside of a hospital to any time period that is less than that determined to be medically necessary by a treating obstetrical care provider or pediatric care provider. These plans must also cover post-delivery care for a mother and her newborn infant, including a postpartum assessment and newborn assessment,

	which may be provided at the hospital, at an attending physician's office, at an outpatient maternity center or in an insured's home by a qualified licensed health care professional trained in mother and baby care. These services must include physical assessment of a newborn and mother and any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.
Mental health	Insurers must offer coverage (for an appropriate additional premium) for the necessary care and treatment of mental and nervous disorders, as follows: • Inpatient benefits may be limited to not less than **30 days per year**; • Outpatient benefits may be limited to **$1,000** for consultations with a licensed physician, a licensed psychologist, a licensed mental health counselor, a licensed marriage and family therapist and a licensed clinical social worker; • Partial hospitalization benefits must be provided under the direction of a licensed physician; • In any benefit year, if partial hospitalization services (or a combination of inpatient and partial hospitalization services) are utilized, the total benefits paid for these services may not exceed the cost of **30 days** after inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered; and • Inpatient hospital benefits, partial hospitalization benefits and outpatient benefits consisting of durational limits, dollar amounts, deductibles and coinsurance factors may not be less favorable than for physical illness generally, except to the extent that a plan provides benefits in excess of the minimum limits described above.
Opioids	Plans that cover abuse-deterrent opioid analgesic drug products may impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if they impose the same requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim. In addition, these plans may not require use of an opioid analgesic drug product without an abuse-deterrence labeling claim before authorizing the use of an abuse-deterrent opioid analgesic drug product.
Organ transplants	Plans that provide coverage for organ transplants on an expense-incurred basis may not deny coverage for an organ transplant solely on the basis of an insured's disability.

Osteoporosis	Plans must cover medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to individuals who: • Are estrogen-deficient and at clinical risk for osteoporosis; • Have vertebral abnormalities; • Are receiving long-term glucocorticoid (steroid) therapy; • Have primary hyperparathyroidism; or • Have a family history of osteoporosis.
Out-of-hospital benefits	Plans must cover treatment performed outside of a hospital for any accident or illness, if the treatment: • Would be covered on an inpatient basis; • Is furnished by a health care provider whose services would be covered if the treatment were performed in a hospital; and • Is medically necessary and is provided as an alternative to inpatient treatment in a hospital. These benefits may not be subject to any deductible or coinsurance.
Prescription drugs - Synchronization	Plans that cover prescription drugs must offer medication synchronization to allow an insured to align the refill dates for covered prescription drugs at least once in a plan year.
Step-therapy protocol for prescription drugs	Insurers cannot require a step-therapy protocol for a covered prescription drug requested by an insured if: • The insured has previously been approved to receive the prescription drug through the completion of a step-therapy protocol required by a separate health plan; and • The insured provides documentation from the health plan that approved the prescription drug, indicating that the health plan paid for the drug on the insured's behalf during the 90 days immediately before the request. Insurers must publish on their websites and provide insureds with a written procedure for requesting a protocol exemption or appealing the denial of a protocol exemption request.
Substance abuse	Insurers must offer coverage for necessary care and treatment of substance abuse impaired persons. Inpatient or outpatient benefits must consist of an intensive program for the treatment of substance abuse impaired persons, subject to the following: • A minimum lifetime benefit of **$2,000**; • A maximum of **44** outpatient visits; and

	• A maximum benefit of **$35** for an outpatient visit. Detoxification is not considered a benefit under an outpatient program.
Telehealth services – reimbursement	A contract between an insurer and a telehealth provider must be voluntary and must establish mutually acceptable payment rates or payment methodologies for services provided through telehealth. Any contract provision that distinguishes between payment rates or payment methodologies for services provided through telehealth and the same services provided without the use of telehealth must be initialed by the telehealth provider.
Well child care	Plans that provide family coverage must cover child health supervision services from the moment of **birth to age 16 years**. These services may not be subject to a deductible. Child health supervision services must include periodic visits involving a history, physical examination, developmental assessment and anticipatory guidance and appropriate immunizations and laboratory tests.

Provider Mandates

MANDATE	DESCRIPTION
Acupuncturist	Plans that cover procedures that are within the scope of these providers' professional licenses or certifications must cover the services when furnished by these providers within their licenses or certifications.
Chiropractor	
Dentist	
Optometrist	
Podiatrist	
Ambulatory surgical center	Plans must cover any service performed in an ambulatory surgical center if the service would have been covered as an eligible inpatient service.
Home health care provider	Under the home health services benefit mandate, services may be performed by a registered graduate nurse, licensed practical nurse, physical therapist, speech therapist, occupational therapist or home health aide.
Massage therapists	Plans that cover massage must cover the services of persons licensed to practice massage therapy where the massage therapy has been prescribed by a licensed physician as being medically necessary and the prescription specifies the number of treatments.

Midwives, nurse-midwives and birth centers	Plans that cover maternity care must cover the services of certified nurse-midwives and licensed midwives and the services of licensed birth centers.
Physician	Any limitation or condition placed upon payment to or upon services of any licensed physician must apply equally to all licensed physicians without discrimination to the usual and customary treatment procedures of any class of physicians.
Physician's assistant or registered nurse first assistant	Plans that cover surgical first assisting services must cover these services when performed by a registered nurse first assistant or a physician's assistant within the scope of their professional licenses. This nondiscrimination mandate applies only if reimbursement for a licensed assisting physician would be covered and a physician assistant or a registered nurse first assistant who performs the services is used as a substitute.

Person Mandates

MANDATE	DESCRIPTION
Adopted/foster children and children in court-ordered custody	Plans that provide family coverage must cover an adopted child or a foster child of an insured from the moment of placement in the insured's residence. If an insured enters a written agreement to adopt a child prior to the child's birth, plans must cover the child from the moment of birth regardless of whether the agreement is enforceable. This mandate also applies to a child who is placed in an insured's custody under a court order.
Adult dependent children	Plans that provide family coverage must cover a dependent child until at least the end of the calendar year in which the child reaches the **age of 25**, if the child is: • Dependent upon the insured for support; and • Living in the insured's household or is a full-time or part-time student. • In addition, an insured must be offered the option to insure his or her child until at least the end of the calendar year in which the child reaches the age of 30, if the child is: • Unmarried and does not have a dependent of his or her own; • A resident of this state or a full-time or part-time student; and • Not entitled to benefits under Medicare or covered under any other health benefit plan.

Continuation coverage	Plans sponsored by employers with **fewer than 20 employees** must allow each qualified beneficiary who would lose coverage under the plan because of a qualifying event to elect continuation coverage without evidence of insurability. A **qualified beneficiary** is any individual who is covered under a plan as an employee, a spouse or a dependent child on the day before a qualifying event. A **qualifying event** is any of the following which, but for the election of continuation coverage, would result in a loss of coverage to a qualified beneficiary: • Employee's death; • Employee's termination of employment (except for termination due to gross misconduct) or reduction in hours; • Divorce or legal separation from the employee's spouse; • Employee's entitlement to Medicare benefits; • Dependent child's ceasing to qualify as a dependent under the plan's terms; or • A retiree or the spouse or child of a retiree losing coverage within one year before or after the employer's commencement of a federal bankruptcy proceeding. The maximum period of state continuation coverage is **18 months** (or **29 months** if the qualified beneficiary is eligible for an 11-month disability extension). Special continuation coverage rules apply to employees in the military Reserves or National Guard.
Disabled children	Plans that provide family coverage and have an age limit for dependent eligibility must provide that attaining the limiting age does not terminate a child's coverage while the child continues to be both: • **Incapable of self-sustaining employment** by reason of mental retardation or physical handicap; and • **Chiefly dependent** upon the employee or member for support and maintenance.
Newborn children	Plans that provide family coverage must cover a newborn child of an insured from the moment of birth. Newborn coverage must include benefits for: • Injury or sickness, including necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity; • Transportation of a newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition if the transportation is certified by an attending physician as necessary to protect the health and safety of the

	newborn child. This transportation coverage may be limited to usual and customary charges of up to **$1,000**.