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 only require issuers to *offer coverage* to employers for 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 Indiana's benefit, provider and person mandates for employer-sponsored, insured group health plans (referred to as "plans" throughout this document). Please keep in mind that the following charts do not address federal benefit mandates, such as those in the ACA.

State Resources

- Indiana Department of Insurance (IDOI) website
- Insurance Rules and Bulletins from the IDOI

Benefit Mandates

MANDATE	DESCRIPTION
Anatomical gifts and transplantation	Plans cannot deny coverage for anatomical gifts, transplantation, or related health care services based solely on the disability of the covered individual.
Autism spectrum disorder	Plans must cover treatment of autism spectrum disorder to the same extent as physical illness in general. This mandate is limited to treatment prescribed by an insured's treating physician in accordance with a treatment plan. Plans may not deny, restrict or refuse to provide coverage for an individual solely because he or she is diagnosed with a pervasive developmental disorder.
Breast cancer screening	Plans must cover, to the same extent as physical illness in general, breast cancer screening mammography as follows: • One baseline mammography for women **35-49 years of age**; • One screening mammography every year for women **younger than age 40** who are **at risk of developing breast cancer**; and • One screening mammography every year for women who are **age 40 or older**. Plans must also cover any additional mammography views that are required for proper evaluation and medically necessary ultrasound services. This coverage is required in addition to any specific benefits for x-rays, laboratory testing or wellness examinations.
Cancer chemotherapy drugs – off-label use	Plans that cover drugs may **not** exclude coverage of a drug or biologic that is used in an anticancer chemotherapeutic regimen on the grounds that the drug has not been approved by the federal Food and Drug Administration (FDA) for the particular indication, if the drug is: • Recognized for treatment of the indication in at least one standard reference compendium; or • Recommended for that particular type of cancer and found to be safe and effective in certain clinical studies.
Cancer chemotherapy – orally administered	Plans must cover orally administered cancer chemotherapy to the same extent as cancer chemotherapy administered intravenously or by injection.
Cardioverter defibrillators	Effective **July 1, 2023**, plans must cover wearable cardioverter defibrillators, including the cost of the defibrillator, any necessary accessory, and ongoing monitoring services, in accordance with a local or national coverage determination. This coverage cannot be subject to an annual or lifetime limitation.
Chronic pain management	Plans must cover medically necessary chronic pain management prescribed by an insured's treating practitioner. This coverage cannot be subject to annual or lifetime limitation, deductible, copayment or coinsurance provisions that are more restrictive than those that apply generally under the plan.

MANDATE	DESCRIPTION
	"Chronic pain management" means evidence-based health care products and services intended to relieve chronic pain that has lasted for at least three months. It includes prescription drugs, physical therapy, occupational therapy, chiropractic care, osteopathic manipulative treatment and athletic trainer services.
Cleft lip/cleft palate	Plans that provide family coverage must cover inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of cleft lip and cleft palate for covered children.
Clinical trials – routine patient care	Plans must cover routine care costs that are incurred in the course of a qualifying Phase I, II, III or IV cancer clinical trial, if they would cover the same routine care costs not incurred in a clinical trial.
Colorectal cancer screenings	Plans must cover colorectal cancer examinations and laboratory tests for any non-symptomatic insured. An insured who is **at least 45 years of age** or **younger than 45 years of age** and **at high risk for colorectal cancer** may not be required to pay a greater deductible or coinsurance amount for a colorectal cancer examination/testing than those that apply to similar benefits.
Dental care – anesthesia and hospital charges	Plans must cover anesthesia and hospital charges for dental care for an insured child who is **younger than age 19** or an insured with a disability, if the mental or physical condition requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center.
Diabetes	Plans must cover medically necessary **treatment of diabetes**, including supplies and equipment as ordered in writing by a licensed physician, podiatrist, advanced practice registered nurse or physician assistant, to the same extent as similar covered conditions. Plans must also cover **diabetes self-management training**, which may be limited to one or more visits: • After receiving a diagnosis of diabetes; • After receiving a diagnosis by a physician or podiatrist that represents a significant change in the insured's symptoms or condition and makes changes in the insured's self-management medically necessary; and • For reeducation or refresher training.
Early intervention services – first steps program	Plans that cover early intervention services must reimburse the First Steps Program a monthly fee established by the Indiana Division of Disability & Rehabilitative Services instead of processing individual claims (with a limited exception). The reimbursement may not be applied to any annual or aggregate lifetime limits on a child's coverage, but any cost-sharing payments made by the First Steps Program must be applied to the plan's deductibles, copayments or other out-of-pocket expenses.
Emergency medical services	Plans that cover emergency medical services must provide reimbursement for those services that are: rendered by an emergency medical services provider

MANDATE	DESCRIPTION
	organization; within the organization's scope of practice; performed or provided as advanced life support services; and performed or provided during a response initiated through the 911 system, regardless of whether the patient is transported. Reimbursement for basic and advanced life support services must be provided on an equal basis regardless of whether the services involve transportation of the patient by ambulance. Plans that cover emergency medical services must also provide reimbursement for: • Emergency ambulance services provided by an emergency medical services provider organization; • Specialty care transport provided by an emergency medical services provider organization.
Inherited metabolic diseases	Plans must cover medical food that is medically necessary and prescribed by a covered individual's treating physician for treatment of an inherited metabolic disease. "Medical food" means a formula that is: • Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and • Formulated to be consumed or administered internally under the direction of a physician. This coverage may not be subject to dollar limits, coinsurance or deductibles that are less favorable to the insured than those that apply to coverage for: • Prescription drugs generally, if prescription drugs are covered; or • Physical illness generally, if prescription drugs are not covered.
Mastectomies	Plans that cover a mastectomy must provide the coverage required under the federal Women's Health and Cancer Rights Act, including coverage for: • Prosthetic devices; and • Reconstructive surgery incident to a mastectomy including all stages of reconstruction of the breast on which the mastectomy has been performed and surgery and reconstruction of the other breast to produce symmetry. In addition, coverage must be provided for custom fabricated breast prosthesis and one additional breast prosthesis per affected breast. This coverage may be subject to the deductible and coinsurance provisions applicable to a mastectomy and all other terms and conditions applicable to other benefits.
Maternity benefits/newborn exams and tests	Plans that provide maternity benefits must cover a postpartum hospital stay for an insured mother and her newborn that is consistent with the stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. A shorter period of inpatient stay is permissible if certain conditions are met, such as coverage for an at-home

MANDATE	DESCRIPTION
	post-delivery care visit. These plans must also cover certain newborn child exams and tests required under state law.
Mental health benefits – parity requirements	Plans sponsored by employers with **more than 50 full-time employees** may not apply treatment limitations or financial requirements on coverage of services for a mental illness, if similar limitations or requirements are not imposed on coverage of services for other medical or surgical conditions. For this purpose, "mental illness" does not include substance abuse or chemical dependency. However, plans that cover treatment of substance abuse/chemical dependency when the services are required in the treatment of a mental illness must offer to provide this coverage without treatment limitations or financial requirements, if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.
Morbid obesity treatment	Plans must offer coverage for non-experimental, surgical treatment of morbid obesity that has persisted for at least five years and for which nonsurgical treatment supervised by a physician has been unsuccessful for at least six consecutive months. This coverage may **not** include surgical treatment of morbid obesity for an insured who is **younger than 21 years of age** unless two physicians determine that the surgery is necessary to either save the life of the insured or restore the insured's ability to maintain a major life activity.
Pediatric neuropsychiatric disorders	Plans must cover the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), as well as treatment of pediatric acute-onset neuropsychiatric syndrome (PANS), including treatment with intravenous immunoglobulin therapy. This coverage may not be subject to annual or lifetime limitation, deductible, copayment, or coinsurance provisions that are more restrictive than those that apply generally under the policy.
Prescription drugs for chronic illness	Plans that cover prescription drugs may not deny coverage for the refill of any drug prescribed for the treatment of a chronic illness that is made in accordance with a plan between the covered individual and a pharmacist to synchronize the refilling of multiple prescriptions for the covered individual.
Prescription drug costs	A pharmacy or pharmacist has the right to provide an insured with information concerning the amount of the insured's cost-share for a prescription drug. Neither a pharmacy nor a pharmacist can be prevented by an insurer from discussing this information or from selling to the insured a more affordable alternative if an affordable alternative is available. In addition, plans that cover prescription drugs may not require an insured to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of: • the contracted copayment amount; or • The amount of total approved charges by the insurer at the point of sale.

MANDATE	DESCRIPTION
	A pharmacy or pharmacist cannot be required to collect a higher copayment for a prescription drug from an insured than the insurer or pharmacy benefit manager allows them to retain.
Prescription eye drops	Plans must cover a refill of prescription eye drops if: • For a 30-day supply, the insured requests the refill no earlier than 25 days after the prescription eye drops were last dispensed; or • For a 90-day supply, the insured requests the refill no earlier than 75 days after the prescription eye drops were last dispensed; and • The prescribing practitioner has indicated on the prescription that the prescription eye drops are refillable and the refill requested by the insured does not exceed the refillable amount remaining on the prescription. This coverage required may not be subject to dollar limits, copayments, deductibles, or coinsurance provisions that are less favorable to an insured than those that apply to coverage for prescription drugs generally.
Prostate cancer screenings	Plans must cover at least one prostate specific antigen test annually for an insured who is: • At **least 50 years of age**; and • **Younger than age 50 years of age and at high risk for prostate cancer** according to the American Cancer Society guidelines. Dollar limits, deductibles, copayments or coinsurance for this coverage may not be less favorable than those that apply to similar benefits under the plan. This coverage is in addition to any specific benefits for x-rays, laboratory testing or wellness examinations.
Prosthetic and orthotic devices	Plans must cover orthotic devices and prosthetic devices, including repairs or replacements, that are: • Medically necessary to restore or maintain an insured's ability to perform activities of daily living or essential job-related activities; and • Not solely for comfort or convenience. This coverage and reimbursement amounts must be equal to what Medicare would cover for the same device, repair or replacement, unless a different reimbursement rate is negotiated. The coverage may **not** be subject to provisions that are more restrictive or less favorable to the insured than those that apply to other plan benefits, including deductibles, copayment or coinsurance provisions. Any lifetime maximum benefit that applies to this coverage must not be included in and equal to the lifetime maximum benefit that applies to all other covered items and services.
Substance abuse or chemical dependency treatment	Plans that cover substance abuse or chemical dependency treatment must cover treatment rendered by an addiction counselor, a clinical addiction counselor or a marriage and family therapist, when the provider is appropriately licensed and the treatment is within the scope of practice of the counselor or therapist.

MANDATE	DESCRIPTION
Telehealth	Plans must cover telehealth services in accordance with the same clinical criteria that applies to coverage for the same health care services delivered in person. Plans may not require a separate consent for these services. If a plan provides coverage for telehealth services via secure videoconferencing, store and forward technology, or remote patient monitoring technology between a provider in one location and a patient in another location, the plan cannot require the use of a specific information technology application for those services.

Provider Mandates

MANDATE		DESCRIPTION
Athletic trainer	**Optometrist**	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.
Certified registered nurse anesthetist	**Osteopath**	
Chiropractor	**Podiatrist**	
Dentist	**Psychologist**	
Mental illness/substance abuse providers		Plans that cover inpatient services for treatment of mental illness and/or substance abuse may **not** exclude coverage for these services when they are provided by a community mental health center or by any psychiatric hospital licensed by the Indiana Department of Health or the Division of Mental Health and Addiction to offer those services.

Person Mandates

MANDATE	DESCRIPTION
Adopted children	Plans must cover newly adopted children of an insured or enrollee to the same extent as other dependents.
Dependent child – age	Upon request, plans must cover of a child of an insured **up to age 26**.
Disabled dependents	Plans that contain a limiting age for dependent coverage must provide that a child's attainment of the limiting age does not terminate his or her coverage while the child is: • Incapable of self-sustaining employment because of intellectual disability or mental or physical disability; and • Chiefly dependent upon the insured for support and maintenance.
Newborns	Plans must provide that the benefits applicable for an insured or family member are payable with respect to a newly born child of the insured. Newborn child coverage must include: necessary care and treatment of medically diagnosed congenital

	defects and birth abnormalities; and inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.