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 a chart outlining Tennessee'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 the ACA's mandates.

More information can be found on the Tennessee Department of Commerce and Insurance website. Links to the Tennessee Code can be found on the Tennessee General Assembly website.

Benefit Mandates

MANDATE	DESCRIPTION
Autism spectrum disorders	Policies that provide benefits for neurological disorders must provide benefits and coverage for treatment of autism spectrum disorders that are at least as comprehensive as those provided for other neurological disorders. These benefits and coverage for treatment must be provided to any person less than 12 years of age.
Bone mass measurement	Issuers must offer coverage for scientifically proven bone mass measurement (bone density testing) for the diagnosis and treatment of osteoporosis.
Cancer treatments	If coverage for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants is provided for patients or enrollees included in the TennCare program, then group policies must offer and make available this coverage. The coverage may be offered at an additional cost but the health care service may not be subject to any greater deductible than any other health care service under the policy.
Chemical dependency	Issuers must offer coverage for the necessary care and treatment of alcohol and other drug dependency that is not less favorable than the coverage for physical illness generally and is subject to the same durational limits, dollar limits, deductibles and coinsurance factors. A policyholder may reject this offered coverage and select an alternative level of benefits. Any benefits provided must be determined as if necessary care and treatment in an alcohol or other drug dependency treatment center were care and treatment in a hospital. In addition, coverage must be offered for outpatient expenses at a community mental health center for up to 30 visits per year for the care and treatment of mental, emotional or nervous disorders, alcoholism, drug dependence or the medical complication of mental illness or intellectual disability. If this coverage is provided, the benefits cannot be subject to deductibles and coinsurance factors that are less favorable than those for physical illness generally.
Chlamydia screening	Required coverage offering for one annual chlamydia screening test in conjunction with an annual pap smear for covered females who are not more than 29 years of age, if the screening test is determined to be medically necessary.
Clinical trials – routine patient care	For an enrollee diagnosed with cancer and accepted into a Phase I, Phase II, Phase III or Phase IV clinical trial for cancer, coverage for all routine patient care costs related to the clinical trial, if the enrollee's treating physician recommends participation in the clinical trial after determining that it has a meaningful potential benefit to the enrollee.
Colorectal cancer screenings	Must provide or offer coverage for colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines or federal Preventive

MANDATE	DESCRIPTION
	Services Task Force guidelines for colorectal cancer screening of asymptomatic individuals.
Diabetes	Coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition counseling, when prescribed by a physician as medically necessary for the treatment of diabetes.
Emergency services	Coverage for emergency services if the symptoms presented by an enrollee and recorded by the attending provider indicate that an emergency medical condition could exist, regardless of the final diagnosis of the symptoms, whether or not prior authorization was obtained to provide those services and regardless of whether or not the provider furnishing the services has a contractual agreement with the health benefit plan for the provision of the services to the enrollee.
Hearing aids for children	Coverage of up to $1,000 per individual hearing aid per ear, every three years, for every child (person under age 18) covered by the policy.
Hospital dental procedures	Coverage for anesthesia expenses, hospital expenses and physician expenses associated with any inpatient/outpatient hospital dental procedure where: • The expense is covered under the policy; and • The procedure is performed on a child who is 8 years of age or younger and cannot be safely performed in a dental office setting.
Infant hearing screening	Coverage for infant hearing screening tests in accordance with current hearing screening standards established by a nationally recognized organization such as the Joint Committee on Infant Hearing Screening of the American Academy of Pediatrics.
Mammograms	Policies that provide coverage for imaging services for screening mammography must cover a patient for low-dose mammography according to the following guidelines: • A baseline mammogram for women 35 to 40 years of age; • A yearly mammogram for women 35 to 40 years of age if they are at high risk based upon personal family medical history, dense breast tissue, or additional factors that may increase the individual's risk of breast cancer; and • A yearly mammogram for a woman 40 years of age or older based on the recommendation of the woman's physician. Plans that cover a screening mammogram must provide coverage for diagnostic imaging and supplemental breast screening without imposing a cost sharing requirement (but high deductible health plans may impose a deductible if permitted by federal law and required to remain compatible with health savings accounts).
Medication counseling	Issuers must offer coverage for medication counseling from a pharmacist. An insured who uses six or more types of medication may be entitled to receive two medication

MANDATE	DESCRIPTION
	counseling sessions during the first year the patient begins the sessions, with a licensed doctor of pharmacy who has received additional clinical training in the areas of medication management and counseling.
Mental health, alcoholism or drug dependency services	Coverage for mental health or alcoholism or drug dependency services in compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations.
Organ transplants	Plans that provide coverage for transplantation to individuals or groups on an expense-incurred basis cannot deny coverage for transplantation solely on the basis of the covered person's disability.
Pediatric nursery care for newborns	Policies that provide maternity benefits must make available benefits for pediatric nursery care of newborn children. The additional benefit must be for a specified number of nursery care days and maximum dollar limits as elected by the group policyholder.
Phenylkentonuria treatment	Coverage for the treatment of phenylketonuria. This coverage includes licensed professional medical services under the supervision of a physician and those special dietary formulas that are medically necessary for the therapeutic treatment of phenylketonuria.
Prescription drugs – off-label use	Policies that provide drug coverage may not exclude coverage of any covered drug for a particular indication on the basis of off-label use, if the drug is recognized for treatment of the indication in standard reference compendia or certain medical literature.
Prescription eye drops	Polices that cover prescription eye drops must cover a refill of a prescription that is a covered benefit under the policy and is otherwise eligible for a refill if: • The renewal is requested by the insured for a 30-day supply of the drug at least 23 days from: the original date the prescription was dispensed to the insured; or the date the most recent refill was dispensed to the insured; • The renewal is requested by the insured for a 60-day supply of the drug at least 45 days from: the original date the prescription was dispensed to the insured; or the date the most recent refill was dispensed to the insured; or • The renewal is requested by the insured for a 90-day supply of the drug at least 68 days from: the original date the prescription was dispensed to the insured; or the date the most recent refill was dispensed to the insured.
Prostate cancer screenings	Coverage for the early detection of prostate cancer, upon a physician's recommendation, for men 50 years of age and older and other men if a physician determines that early detection for prostate cancer is medically necessary.

MANDATE	DESCRIPTION
Reconstructive breast surgery	Policies that provide coverage for mastectomy surgery must provide coverage for all stages of reconstructive breast surgery on the diseased breast as a result of a mastectomy, but not including a lumpectomy, as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the patient and physician.
Repairs of complex rehabilitation technology and manual wheelchairs	Plans that offer coverage of complex rehabilitation technology or manual wheelchairs cannot require prior authorization for repairs of such technology or equipment unless they are covered under a manufacturer's warranty, the cost of repairs exceeds the cost of replacement, or because the age of the technology or equipment exceeds, or is within one year of the expiration of, its recommended lifespan.
Speech or hearing disorders	Must offer to provide benefits for expenses arising from conditions or disorders of hearing or conditions or disorders of speech, voice or language, so long as such conditions or disorders receive treatment from duly licensed audiologists or speech pathologists.
Step therapy exceptions	Plans that deny coverage of a prescription drug for the treatment of a medical condition through the use of a step therapy protocol must provide access to a clear, readily accessible and convenient process for a patient or prescribing practitioner to request a step therapy exception. Plans must grant a step therapy exception if certain requirements are satisfied.
Sterilization procedures	Policies that provide coverage for sterilization operations or procedures may not impose any disclaimer, restriction on, or limitation of coverage with respect to the insured's reason for sterilization.

Provider Mandates

MANDATE	DESCRIPTION
Advanced practice nurse	If a policy provides for reimbursement of any service that is within the lawful scope of practice of a nurse in advanced practice, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the services, whether the services are performed by a duly licensed physician or a licensed nurse in advanced practice. Nondiscrimination mandate. (A nondiscrimination mandate requires coverage if the health plan reimburses services within the scope of the health care professional's practice.)
Audiologists	Policies must offer to provide benefits for expenses arising from conditions or disorders of hearing or conditions or disorders of speech, voice or language, so long as such

MANDATE	DESCRIPTION
	conditions or disorders receive treatment from licensed audiologists or speech pathologists.
Chiropractor	If a policy provides for reimbursement for any service that is within the lawful scope of practice of a licensed chiropractor, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the services, whether the services are performed by a licensed medical physician or by a licensed chiropractor. Nondiscrimination mandate. A health insurance entity offering employer-based plans must offer at least one plan option in which the copayment and coinsurance amounts for services rendered during an office visit to a licensed chiropractic physician or to a licensed physical therapist or occupational therapist are no greater than the copayment and coinsurance amounts for the services rendered during an office visit to a licensed primary care physician. Nondiscrimination mandate.
Dentist	If a policy provides for reimbursement or payment for surgical procedures or other medical or health care services that are within the scope of practice of dentistry, coverage must include a licensed dentist who performs the specified procedures or services. Nondiscrimination mandate.
Marital and family therapist	If a policy provides for reimbursement for any service that is within the lawful scope of practice of a licensed marital and family therapist, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the therapist's services. Nondiscrimination mandate.
Nurse midwife	If a policy provides for reimbursement of any service that is within the lawful scope of practice of a nurse midwife, duly licensed by the state board of nursing as a registered nurse and also duly certified as a nurse midwife by the American College of Nurse-Midwives, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the midwife's services. Nondiscrimination mandate.
Optometrist	If a policy provides for reimbursement for any service that is within the lawful scope of practice of a licensed optometrist, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the optometrist's services. Nondiscrimination mandate.
Pharmacy	Issuers must apply the same coinsurance, copayment, deductible and quantity limit factors within the same employee group and other plan-sponsored groups to all drug prescriptions filled by any licensed pharmacy provider, whether by a retail provider or a mail service provider, provided that all pharmacy providers comply with the same terms and conditions.

MANDATE	DESCRIPTION
Physical and occupational therapists	A health insurance entity offering employer-based plans must offer at least one plan option in which the copayment and coinsurance amounts for services rendered during an office visit to a licensed chiropractic physician or to a licensed physical therapist or occupational therapist are no greater than the copayment and coinsurance amounts for the services rendered during an office visit to a licensed primary care physician. Nondiscrimination mandate.
Physician assistant	A policy cannot impose a copayment or coinsurance amount for services rendered during an office visit to a licensed physician assistant who is contracted or authorized as a primary care practitioner by that health insurance entity, that is greater than the copayment or coinsurance amount for the services rendered during an office visit to a licensed physician. Nondiscrimination mandate.
Podiatrist	If a policy provides for reimbursement for any service that is within the lawful scope of practice of a licensed podiatrist, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the podiatrist's services. Nondiscrimination mandate.
Professional counselor	If a policy provides for reimbursement for any service that is within the lawful scope of practice of a licensed professional counselor, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the counselor's services. Nondiscrimination mandate.
Providers without operative facilities	Policies may not exclude or deny coverage to an insured undergoing care and treatment in a facility for the care and treatment of persons with mental illness or intellectual disability on the basis that the facility does not have organized facilities for operative surgery, if the facility has a bona fide arrangement with an accredited hospital to perform the surgical procedures.
Psychologist	If a policy provides for reimbursement for any service that is within the lawful scope of practice of a licensed psychologist designated as a health service provider, a licensed psychological examiner supervised, a certified psychological assistant supervised or a licensed senior psychological examiner, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the provider's services.
Social worker	If a policy provides for reimbursement for any service that is within the lawful scope of practice of a person licensed to engage in independent practice as a licensed clinical social worker, the insured or other person entitled to benefits under the policy must be entitled to reimbursement for the social worker's services.
Speech pathologist	Policies must offer to provide benefits for expenses arising from conditions or disorders of hearing or conditions or disorders of speech, voice or language, so long as such

MANDATE	DESCRIPTION
	conditions or disorders receive treatment from duly licensed audiologists or speech pathologists.

Person Mandates

MANDATE	DESCRIPTION
Adopted child	Must provide the same coverage to adopted children (under 18 years of age) as of the date of placement for adoption or adoption as for natural children, regardless of whether the adoption has become final.
Continuation coverage	An employee whose insurance under the group policy has been terminated for any reason, except discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy for at least three months immediately prior to termination, is eligible to elect continuation coverage. The continuation coverage may last for the fractional policy month remaining at termination, plus three additional months. In addition, individuals who are terminated from group coverage because of divorce or because of the death of the insured spouse are eligible for continuation coverage for the fractional policy month remaining at termination plus 15 additional months. Individuals whose group coverage is terminated during pregnancy are eligible to have their coverage continued under the group policy for the fractional month remaining at termination plus a period of not less than six months after the pregnancy ends and not more than the end of the second three-month period following the three-month period within which the pregnancy ends.
Children – court-ordered custody	Coverage for minor children who are by court order in the custody of a guardian who is a resident of Tennessee covered under the policy or plan issued to or on behalf of the guardian, unless the policy or plan specifically excludes or reduces the benefits.
Dependent coverage	If a policy provides that dependent coverage terminates at a specific age, it must provide that the limiting age not be earlier than 24 years for those dependent children who are unmarried and dependent on the insured for support and maintenance.
Disabled dependent	If a policy provides that dependent coverage terminates at a specific age, it must provide that attainment of the limiting age does not operate to terminate the coverage of the child while the child is and continues to be both: • Incapable of self-sustaining employment by reason of intellectual or physical disability; and • Chiefly dependent upon the policyholder for support and maintenance.
Newborn child	A policy that provides dependent child coverage must also provide that the health insurance benefits applicable to children, if any, must be payable with respect to a

MANDATE	DESCRIPTION
	newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children must, in addition to coverage for infants placed in the well-child care unit, consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
Non-custodial parent	Cannot deny coverage to a child because the child was born out of wedlock, was not claimed as a dependent on the parent's income tax return, or does not reside with the parent or in the service area of the entity providing health insurance or coverage.