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 Virginia's benefit, provider and person mandates for insured group health plans. Please keep in mind that the following charts do not address federal benefit mandates, such as those in the ACA.

In addition, Virginia law allows small employers (50 or fewer employees) to purchase "basic health insurance coverage" for their employees. This coverage is not required to include all of the benefit mandates described below. It is, however, required to include the benefit mandates for mammograms, pap smears, prostate-specific antigen testing and colorectal cancer screenings. These small employer plans are also subject to certain provider nondiscrimination mandates.

State Resources

- Virginia State Corporation Commission website
- Virginia Statutes

Benefit Mandates

MANDATE	DESCRIPTION
Autism spectrum disorder	Plans must cover the diagnosis and treatment of autism spectrum disorder in individuals of **any age**. Diagnosis includes medically necessary assessments, evaluations or tests to diagnose whether an individual has an autism spectrum disorder. Treatment for autism spectrum disorder includes the following medically necessary care: • Behavioral health treatment; • Pharmacy care; • Psychiatric care and psychological care; • Therapeutic care (services provided speech therapists, occupational therapists, physical therapists or clinical social workers); and • Applied behavior analysis when provided or supervised by a board-certified behavior analyst who is licensed by the Virginia Board of Medicine. Coverage for treatment of autism spectrum disorder may be subject to an annual maximum benefit of no less than **$35,000** but may not be subject to any visit limits or be different or separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors and benefit year maximum for cost-sharing factors.
Bones and joints of the head, neck, face or jaw	Plans that cover diagnostic and surgical treatment involving any bone or joint of the skeletal structure may not exclude medically necessary diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw. This coverage may not be subject to limits that are more restrictive than those applicable to the coverage for any bone or joint of the skeletal structure.
Cancer clinical trials – patient costs	Plans must cover patient costs incurred during participation in qualifying clinical trials for treatment studies on cancer. This coverage must have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.
Child wellness services	Plans must offer coverage for child health supervision services, which include periodic review of a covered child's physical and emotional status by a licensed and qualified physician or pursuant to a physician's supervision. This coverage may not be subject to any copayment, coinsurance, deductible or other dollar limit.
Childhood immunizations	Plans must cover all routine and necessary immunizations for newborn children from **birth to 36 months of age**. This mandate does not apply to plans that include optional coverage for child wellness services.
Colorectal cancer screening	Plans must cover colorectal cancer screening in accordance with the guidelines established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in these recommendations. This coverage may not be more restrictive than or separate

MANDATE	DESCRIPTION
	from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors and benefit year maximum for cost-sharing factors.
Contraceptive drugs and devices	Plans that cover prescription drugs on an outpatient basis must offer coverage for any prescribed drug or device approved by the U.S. Food and Drug Administration (FDA) for use as a contraceptive. This coverage may not be subject to any copayment, coinsurance or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level receiving benefits for prescription drugs. These plans must also: • Cover up to a 12-month supply of hormonal contraceptives when dispensed or furnished at one time by a provider or pharmacy or at a location licensed or otherwise authorized to dispense drugs or supplies; and • In the absence of clinical contraindications, not impose utilization controls or other forms of medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished to an amount that is less than a 12-month supply.
Dental procedures – general anesthesia and hospitalization	Plans must cover medically necessary general anesthesia and hospitalization or facility charges for dental care provided to a covered person who: • Is under age five; • Is severely disabled; or • Has a medical condition and requires general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care.
Diabetes	Plans must cover treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes. This coverage must include benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy. This coverage may not be subject to any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category nor to any annual dollar or durational benefit limitations or maximums.
Early intervention services	Plans must cover medically necessary early intervention services, which include speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices, for dependents **from birth to age three** who are certified as eligible. This coverage may be subject to a maximum annual benefit of **$5,000** per insured, but may not be subject to dollar limits, deductibles and coinsurance factors that are less favorable than those that apply for physical illness generally.
Formula and enteral nutrition products	Plans must cover medically necessary formula and enteral nutrition products on the same terms and subject to the same conditions imposed on other covered medicines. This coverage must:

MANDATE	DESCRIPTION
	• Apply to the partial or exclusive feeding of a covered individual by means of oral intake or enteral feeding by tube; • Include coverage for any medical equipment, supplies and services that are required to administer the covered formula or enteral nutrition products; • Apply only when the formula and enteral products are furnished pursuant to a prescription or order for the management of an inherited metabolic disorder, and used under medical supervision (which may include a home setting); and • Not apply to nutritional supplements taken electively. Effective March 31, 2023, these provisions do not apply to plans issued in the small group market.
Hearing aids and related services	Plans issued or renewed on or after **Jan. 1, 2024**, must cover hearing aids and related services for children 18 years of age or younger, which must include payment of the cost of one hearing aid per hearing-impaired ear every 24 months, up to $1,500 per hearing aid. Coverage must be available only for services and equipment recommended by an otolaryngologist.
Hemophilia and congenital bleeding disorders	Plans must cover treatment of hemophilia and congenital bleeding disorders.
Hospice care	Plans must cover hospice services, including palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.
Hysterectomy	Plans must cover laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy. This coverage must include benefits for a minimum hospital stay of not less than: • **23 hours** for a laparoscopy-assisted vaginal hysterectomy; and • **48 hours** for a vaginal hysterectomy.
Infant hearing screening	Plans must cover infant hearing screenings and all necessary audiological examinations for newborn children, including any follow-up examinations to confirm the existence or absence of hearing loss.
Lymphedema	Plans must cover treatment of lymphedema, including prescribed equipment, supplies, complex decongestive therapy and outpatient self-management training and education. This coverage may not be subject to any copayment, fee, annual or durational benefit limitation or maximum for benefits or services that is not equally imposed upon all individuals in the same benefit category.
Mammograms	Plans must cover low-dose screening mammograms for determining the presence of occult breast cancer based on the following schedule: • One mammogram for persons **age 35-39**; • One mammogram every two years for persons **age 40-49**;

MANDATE	DESCRIPTION
	• One mammogram annually for persons **age 50 and over**. This benefit may be limited to $50 per mammogram subject to dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally.
Mastectomy – inpatient stay	Plans must cover a minimum stay in the hospital of not less than: • **48 hours** following a radical or modified radical mastectomy for the treatment of breast cancer; and • **24 hours** following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.
Mastectomy - reconstructive breast surgery	Plans must cover reconstructive breast surgery performed coincident with or following a mastectomy and following a mastectomy to reestablish symmetry between the two breasts. This mandate also includes coverage for prostheses and physical complications of mastectomy, including medically necessary treatment of lymphedemas. This coverage may not be subject to durational limits, dollar limits, deductibles and coinsurance factors that are less favorable than for physical illness generally.
Mental health and substance abuse – small employers	Plans must cover mental health and substance use disorder benefits, which must include **mobile crisis response services** and **support and stabilization services provided in a residential crisis stabilization unit** to the extent that such services are covered in other settings or modalities, regardless of any difference in billing codes. Plans must cover **inpatient** and **partial hospitalization** mental health and substance abuse services as follows: • Treatment for an adult (**19 years of age and older**) as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of **20 days** per year; and • Treatment for a child or adolescent (**under age 19**) as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of **25 days** per year. Up to 10 days of the inpatient benefit may be converted, when medically necessary, to a partial hospitalization benefit applying a formula which is no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. Except as described above, the benefits for inpatient and partial hospitalization may not be more restrictive than those that apply for any other illness. Plans must also cover a minimum of **20 visits** per year for **outpatient treatment** of an adult, child or adolescent. The limits on these outpatient benefits may not be more restrictive than the limits applicable to physical illness, except the coinsurance factor applicable to any outpatient visit beyond the first five covered visits in any year must be at least 50 percent.

MANDATE	DESCRIPTION
	Medication management visits must also be covered in the same manner as treatment of physical illness and may not be counted as an outpatient treatment visit. This mandate does not apply to biologically-based mental illnesses. *This state benefit mandate does not apply to large employers (**more than 50 employees**). These employers are subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which creates additional parity requirements for employers with more than 50 employees that offer mental health or substance use disorder benefits in their group health plans.*
Morbid obesity treatment	Plans must offer coverage for the treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. This coverage may not be subject to duration limits, dollar limits or cost-sharing requirements that are less favorable than those that apply for physical illness generally.
Obstetrical and gynecological care – direct access	Plans that cover obstetrical or gynecological services must allow any covered female who is **age 13 or older** to have direct access to the health care services of a participating obstetrician-gynecologist. An annual examination and related routine health care services rendered during an annual visit may be performed without prior authorization from the primary care physician. However, additional health care services may be subject to consultation and/or authorization requirements.
Obstetrical benefits	Plans must offer coverage for inpatient obstetrical services in a general hospital, and the reimbursement for obstetrical services by a physician must be determined according to the same formula that applies to other medical and surgical procedures. This coverage may not have durational limits, dollar limits, deductibles and coinsurance factors that are less favorable than for physical illness generally.
Obstetrical benefits – limits and cost-sharing	Plans that cover obstetrical hospital inpatient services or obstetrical services by a physician may not impose durational limits or cost-sharing requirements that are less favorable than those that apply for physical illness generally.
Obstetrical benefits – postpartum care	Plans that cover obstetrical services must cover postpartum services, including inpatient care and one or more home visits, based on certain medical criteria.
Orally administered cancer chemotherapy drugs	Plans that cover cancer chemotherapy drugs administered orally and intravenously or by injection must provide that the cost-sharing criteria for these drugs must be consistently applied within the same plan.
Organ, eye or tissue transplant	Plans that include coverage for services related to organ, eye or tissue transplantation cannot deny, reduce or limit coverage to a covered person solely on the basis of the person's disability, or deny a person eligibility or continued eligibility to enroll in or to renew coverage for the purpose of avoiding applicable nondiscrimination requirements.

MANDATE	DESCRIPTION
Pap smears	Plans must cover annual pap smears performed by any FDA-approved gynecologic cytology screening technologies.
Prescription drugs – length of time since FDA approval	Plans that cover prescription drugs may not exclude any drug based solely on the length of time since the drug obtained FDA approval.
Prescription drugs - off-label drug use	Plans that cover prescription drugs may not deny coverage or benefits for any: • Drug prescribed to treat a covered indication, as long as the drug is FDA-approved for at least one indication and is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or • FDA-approved cancer treatment drug on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which it was prescribed, as long as the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia. This coverage must also include medically necessary services associated with the administration of the drug.
Prescription drugs – medication synchronization	Plans that cover prescription drugs must permit (and apply) a prorated daily cost-sharing rate to prescriptions that are dispensed by a network pharmacy for a partial supply if the prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the enrollee and the enrollee requests or agrees to a partial supply for the purpose of synchronizing the enrollee's medications, provided that this proration for any prescription cannot occur more frequently than annually.
Prescription drugs – treatment of cancer pain	Plans that cover prescription drugs may not deny benefits for any drug approved by the FDA for treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with state law for a patient with intractable cancer pain.
Prostate-specific antigen (PSA) testing	Plans must cover one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines, for: • Persons age **50 and over**; and • Persons **age 40 and over who are at high risk** for prostate cancer.
Prosthetic devices	Plans must offer coverage for medically necessary prosthetic devices, their repair, fitting, replacement and components. These benefits may be subject to certain limits on annual or lifetime dollar maximums and cost-sharing.

MANDATE	DESCRIPTION
Proton radiation	Plans that cover cancer therapy may not hold proton radiation therapy to a higher standard of clinical evidence for decisions regarding coverage under the plan than is applied for decisions regarding coverage of other types of radiation therapy treatment.
Standing referrals for cancer patients	Plans must have a procedure in place to permit any covered individual who has been diagnosed with cancer to have a standing referral to a board-certified physician in pain management or oncologist who is authorized to provide services under the plan and has been selected by the cancer patient.
Standing referrals to specialists	Plans must have a procedure in place to permit a covered individual with a special condition to receive a standing referral to a participating specialist for the treatment of the condition. “Special condition” means a condition or disease that is life-threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.
Telemedicine services	Plans must cover the cost of health care services provided through telemedicine services. “Telemedicine services” as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment. “Telemedicine services” does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

Provider Mandates

MANDATE	DESCRIPTION
Acupuncturist	Nondiscrimination mandate: If a plan covers any service that may be legally performed by these licensed providers, benefits may not be denied because the service is rendered by the licensed provider (provided that, for services performed by an athletic trainer, such service is performed in an office setting).
Athletic trainer	
Audiologist	
Certified nurse midwife or other advanced practice registered nurse	
Chiropractor	
Clinical nurse specialist	
Clinical social worker	
Marriage and family therapist	
Nurse practitioner	

MANDATE	DESCRIPTION
Optician	
Optometrist	
Physical therapist	
Podiatrist	
Professional counselor	
Psychologist	
Speech pathologist	
Dentist	A plan's use of the word "physician" or "doctor" must be construed to include a dentist performing covered services within the scope of his or her professional license.
Pharmacies – freedom of choice	Insurers of either preferred provider policies or exclusive provider policies may not prohibit any person receiving pharmacy benefits (including specialty pharmacy benefits) from selecting, without limitation, the pharmacy of his or her choice to furnish such benefits.
Pharmacist	If a plan covers any service that may be legally performed by a licensed pharmacist, benefits under the plan may not be denied because the service is rendered by the licensed pharmacist provided that: • The service is performed under the terms of a collaborative agreement; • The service is for the administration of vaccines for immunization; or • The service is provided in accordance with the Virginia Insurance Code relating to initiating of treatment with, and dispensing and administering of, controlled substances by pharmacists.

Person Mandates

MANDATE	DESCRIPTION
Adopted children	Plans that provide family coverage must cover adopted children of the insured in the same manner and to the same extent as the plan's coverage for other children.
Continuation coverage	If a person's eligibility for coverage ends before he or she becomes eligible for Medicare or Medicaid benefits and the employee or member has been insured under the plan for at least three months, he or she, and his or her eligible dependents, may elect to continue coverage for up to 12 months. This option is not applicable if federal continuation coverage (COBRA) is required to be offered.
Disabled children	Plans that terminate a dependent's coverage at a specified age must provide that attainment of the specified age will not terminate coverage while a dependent child is and continues to be both:

MANDATE	DESCRIPTION
	• Incapable of self-sustaining employment by reason of intellectual or physical disability; and • Chiefly dependent upon the employee for support and maintenance.
Newborn children	Plans that provide family coverage must cover a newly born child of the insured from the moment of birth. This coverage must be identical to the coverage provided to the insured, except that coverage must also be provided for: • Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and • Inpatient and outpatient dental, oral surgical and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia.
Victims of rape or incest	Plans that provide benefits as a result of an “accident” or “accidental injury” must be construed to include benefits for pregnancy following an act of rape of an insured that was reported to the police within a specified period of time.