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# TEXAS EMPLOYMENT LAW 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 example, in addition to many other federal mandates, the health care reform law requires non-grandfathered health plans to cover certain preventive services without any cost-sharing. Health plan sponsors and issuers should work with their advisors to determine how to comply with applicable federal and state mandates.

This Law Summary contains charts outlining Texas's benefit, provider and person mandates for **group health insurance plans** (referred to as "**plans**" in this document). Please keep in mind that the charts do **not** address federal benefit mandates, such as the federal health care reform mandates.

Also, while many of the mandates described in these charts are applicable to health maintenance organizations (HMOs) and preferred provider plans (PPPs), HMOs and PPPs may be subject to additional requirements under Texas statutes and regulations that are **not** specifically addressed in this document. Similarly, this document focuses on mandates applicable to health insurance plans sponsored by **private employers**, and does **not** address mandates specifically applicable to health benefits provided by government employers.

Finally, Texas law allows issuers to offer consumer choice plans that are not required to comply with all of the health insurance mandates described below. Consumer choice plans are required to provide members with a disclosure statement and a list of the benefits that are not covered.

## STATE RESOURCES

**Texas Department of Insurance website**

**Mental Health and Substance Abuse Parity**
The Texas Department of Insurance provides information about mental health and substance abuse parity requirements here.

**Consumer Choice Plans**
The Texas Department of Insurance provides information about consumer choice plans here.

## BENEFIT MANDATES

| BENEFIT MANDATE | DESCRIPTION |
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| Acquired Brain Injury | Plans must cover treatment of an acquired brain injury, subject to the same payment limitations and cost-sharing factors as those that apply to other similar coverage. This coverage must include benefits for cognitive rehabilitation and communication therapy, neurofeedback therapy, post-acute transition services and community reintegration services. |
| Alzheimer's Disease | Plans that cover Alzheimer's disease and require demonstrable proof of organic disease or other proof before authorizing payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a licensed physician, including a history, physical, neurological and psychological or psychiatric evaluations and laboratory studies. |
| Amino Acid-Based Elemental Formulas | Plans must cover medically necessary amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:<br>• Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;<br>• Severe food protein-induced enterocolitis syndrome;<br>• Eosinophilic disorders, as evidenced by the results of a biopsy; and<br>• Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.<br>This coverage must include benefits for any medically necessary services associated with the administration of the formula. This coverage must also be:<br>• No less favorable than a plan's coverage for prescription drugs and other medications and related services; and<br>• Provided to the same extent as a plan's coverage for drugs that are available only on the orders of a physician. |
| Autism Spectrum Disorder | Plans must cover an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis through **age nine** for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.<br>Covered services may include:<br>• Evaluation and assessment services;<br>• Applied behavior analysis;<br>• Behavior training and behavior management;<br>• Speech therapy;<br>• Occupational therapy;<br>• Physical therapy; or<br>• Medications or nutritional supplements used to address symptoms of autism spectrum disorder. |

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| | These benefits may be subject to annual deductibles and other cost-sharing that is consistent with those required for other coverage under the plan. |
| Breast Cancer Surgery – Inpatient Care | Plans that cover breast cancer treatment must cover inpatient care for a minimum of:<br>• **48 hours** following a mastectomy; and<br>• **24 hours** following a lymph node dissection for the treatment of breast cancer.<br>This length of inpatient care is not required if an insured and his or her attending physician determine that a shorter period is appropriate.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Cancer Clinical Trials – Routine Patient Care | Plans must cover routine patient care costs incurred in connection with a phase I, phase II, phase III or phase IV clinical trial, if the clinical trial receives appropriate approval and relates to prevention, detection or treatment of a life-threatening disease or condition. This coverage may be subject to cost-sharing requirements comparable to those that apply to other benefits under a plan. |
| Cancer Treatments – Orally-Administered Anti-Cancer Drugs | Plans that cover cancer treatment must cover a prescribed, orally-administered anti-cancer medication that is used to kill or slow the growth of cancerous cells. This coverage must be no less favorable than a plan's coverage for intravenously administered or injected cancer medications. The cost to an insured for an orally-administered drug may not exceed the coinsurance or copayment that would be applied to a chemotherapy or other cancer treatment visit. |
| Cardiovascular Disease – Early Detection Tests | Plans that cover screening medical procedures must cover up to **$200** for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function **every five years**:<br>• Computed tomography (CT) scanning measuring coronary artery calcification; or<br>• Ultrasonography measuring carotid intima-media thickness and plaque.<br>This coverage must be provided to males between the **ages of 46 and 75** and females between the **ages of 56 and 75** who are diabetic or at risk of developing coronary heart disease. |
| Cervical Cancer Screening | Plans that cover diagnostic medical procedures must cover an annual examination for the early detection of cervical cancer for women **age 18 or older**. |
| Chemical Dependency Treatment | Plans must cover necessary care and treatment of chemical dependency. This coverage may be limited to a lifetime maximum of **three separate treatment series** for each insured. Coverage for treatment in a chemical dependency treatment center must be the same as if the care and treatment were provided in a hospital.<br>This coverage may **not** be less favorable than a plan's coverage for physical illness in general, except to the extent that different dollar or durational limits are sufficient to provide appropriate care and treatment under guidelines issued by the Texas Department of Insurance. |
| Childhood Immunizations | Plans that provide family coverage must cover immunizations for each covered child from **birth through age 6**, without any cost-sharing requirements. |

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| | This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Colon Cancer Screenings | Plans that cover screening medical procedures must cover colon cancer screenings for enrolled individuals who are **age 50 or older** and at normal risk for developing colon cancer. This coverage must include benefits for:<br>• An annual fecal occult blood test;<br>• A flexible sigmoidoscopy every five years; or<br>• A colonoscopy every 10 years.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Contraceptive Coverage | Plans that cover prescription drugs or devices must also cover to the same extent:<br>• Prescription contraceptive drugs or devices approved by the U.S. Food and Drug Administration (FDA); and<br>• Outpatient contraceptive services.<br>This mandate does **not** require plans to cover any drug or device that terminates a pregnancy. An exception to this mandate is available for religious employers, except when a prescription contraceptive is necessary to preserve the life or health of an insured. |
| Craniofacial Abnormalities - Children | Plans that provide family coverage must cover reconstructive surgery for craniofacial abnormalities and must define this terms as surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease for a child who is younger than **18 years of age**.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Development Delays – Children | Plans must offer to cover the following for a child:<br>• Occupational therapy evaluations and services;<br>• Physical therapy evaluations and services;<br>• Speech therapy evaluations and services; and<br>• Dietary or nutritional evaluations.<br>These therapies may not be applied to a plan's annual or lifetime maximum benefit.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Diabetes | Plans must cover diabetes equipment, supplies and self-management training, on the same basis as similar coverage under a plan. Covered equipment and supplies must include::<br>• Blood glucose monitors, including those designed to be used by or adapted for the legally blind;<br>• Test strips specified for use with a corresponding glucose monitor; |

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| | • Lancets and lancet devices;<br>• Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;<br>• Insulin and insulin analog preparations;<br>• Injection aids, including devices used to assist with insulin injection and needleless systems;<br>• Insulin syringes;<br>• Biohazard disposal containers; and<br>• Insulin pumps, both external and implantable, and associated appurtenances.<br>Diabetes self-management training must be covered when:<br>• Diabetes is initially diagnosed;<br>• A significant change in the symptoms or condition of the insured requires changes in the insured's self-management regime; or<br>• Periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Emergency Care | Plans must cover emergency health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility. Benefits for out-of-network emergency services may not be subject to different cost-sharing requirements than those that apply to in-network services if:<br>• A medical screening examination or other evaluation required by state or federal law is needed to determine whether a medical emergency condition exists;<br>• The services are necessary to treat and stabilize an emergency medical condition; or<br>• The services originated in an emergency facility following treatment or stabilization of an emergency medical condition. |
| Fertility Treatment – In Vitro Fertilization | Plans that include pregnancy-related benefits must offer to cover in vitro fertilization procedures to the same extent as other pregnancy-related procedures. This coverage may limited to circumstances under which:<br>• The fertilization or attempted fertilization of a patient's oocytes is made only with the sperm of the patient's spouse;<br>• The patient and the patient's spouse have a history of infertility for at least five continuous years or the patient's infertility is associated with endometriosis, exposure in utero to diethylstilbestrol (DES), blockage of or surgical removal of one or both fallopian tubes or oligospermia;<br>• The patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which plan coverage is available; and<br>• The in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards adopted by the American Society for Reproductive Medicine.<br>An exception to this mandate is available for certain religious employers. |

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| Hearing Tests for Children | Plans that provide family coverage must include coverage, without cost-sharing, for the following:<br>• A screening test for hearing loss from **birth to 30 days of age**; and<br>• Necessary diagnostic follow-up care related to the screening test from **birth to 24 months of age**.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| HIV, AIDS or HIV-Related Illnesses | Plans must cover treatment and care of human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or an HIV-related illness. |
| Home Health Care | Plans must offer to cover home health services provided by a home health agency on the same basis as a plan's coverage for hospital services. This coverage may be subject to:<br>• A limit of 60 or more visits per year;<br>• An exclusion for custodial care;<br>• An exclusion for services provided by an individual who resides in the insured'd home or is a member of the insured's family; and<br>• Services provided to an insured who is eligible for Medicare coverage. |
| Mammograms | Plans must cover annual breast cancer screenings, to the same extent as a plan's coverage for other radiological examinations, for insured women who are **35 years of age or older**. This coverage must include benefits for all forms of low-dose mammography, including two views for each breast, and digital mammography or breast tomosynthesis. |
| Mastectomy – Reconstructive Surgery | Plans that cover mastectomy must also cover the following, consistent with other coverage and without dollar limits other than the lifetime maximum benefits under a plan:<br>• Reconstruction of the breast on which the mastectomy has been performed;<br>• Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and<br>• Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. |
| Maternity – Inpatient Stay and Post-Delivery Care | Plans that include maternity and childbirth benefits must cover inpatient care in a health care facility for a woman and her newborn child for at least:<br>• **48 hours** after an uncomplicated vaginal delivery; and<br>• **96 hours** after an uncomplicated delivery by cesarean section.<br>If a woman or her newborn child are discharged from inpatient care earlier, a plan must cover timely post-delivery care. |
| Medically Necessary Foods and Formulas | Plans must cover formulas necessary to treat **phenylketonuria** or a **heritable disease** to the same extent as any covered drugs that are available only on the orders of a physician. |
| Mental Health – Alternative Treatment Benefits | Plans that cover hospital treatment of mental or emotional illness or disorder must also cover treatment in a **residential treatment center for children and adolescents** or a **crisis stabilization unit** to the same extent as a plan's coverage for inpatient psychiatric |

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| | treatment. For purposes of determining plan benefits and maximums, each two days of treatment in a residential treatment center or in a crisis stabilization unit is the equivalent of one day in a hospital or inpatient program. |
| Mental Health – Psychiatric Day Treatment Facility | Plans must offer to cover treatment of mental or emotional illness or disorder when in a hospital or psychiatric day treatment facility. The psychiatric day treatment facility coverage may not be less favorable than the hospital coverage and must be subject to the same durational limits, deductibles, and coinsurance factors. |
| Mental Health – Serious Mental Illness | Plans sponsored by **employers with 51 or more employees** must cover (and small-employer plans must offer to cover) a minimum of the following treatments for **serious mental illness** in each calendar year, to the same extent as a plan's coverage for physical illness:<br>• **45 days** of inpatient treatment; and<br>• **60 visits** for outpatient treatment, including group and individual outpatient treatment.<br>This coverage may not be subject to a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment.<br>This mandate does **not** require coverage for treatment of:<br>• Addiction to a controlled substance or marijuana used in violation of law; or<br>• Mental illness resulting from the use of a controlled substance or marijuana in violation of law. |
| Osteoporosis | Plans must cover medically accepted bone mass measurements to detect low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis for qualified enrollees. Qualified enrollees include:<br>• A postmenopausal woman who is not receiving estrogen replacement therapy;<br>• An individual with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or<br>• An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. |
| Prescription Drugs | Plans that cover drugs must cover any drug prescribed to treat an insured for a chronic, disabling or life-threatening illness covered under a plan. This mandate applies only for drugs that are:<br>• FDA-approved for at least one indication; and<br>• Recognized by certain medical compendium or literature for treatment of the condition for which the drug is prescribed.<br>This coverage must also include medically necessary services associated with the administration of the drug. Plans may not deny this coverage based on a "medical necessity" requirement unless the reason for the denial is unrelated to the legal status of the drug use.<br>This mandate does **not r**equire a plan to cover:<br>• Experimental drugs that are not FDA-approved; |

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| | • Any disease or condition that is excluded from coverage under the plan; or<br>• A drug that the FDA has determined to be contraindicated for treatment of the current indication.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Prostate Cancer Screenings | Plans that cover diagnostic medical procedures must cover an annual examination for the detection of prostate cancer, including a physical examination and a prostate-specific antigen test used for the detection of prostate cancer for each male who is at least:<br>• **50 years of age** and is asymptomatic; or<br>• **40 years of age** and has a family history of prostate cancer or another prostate cancer risk factor.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Prosthetics and Orthotic Devices | Plans must cover prosthetic devices, orthotic devices and professional services related to the fitting and use of those devices on a basis equivalent to the coverage provided under the Medicare program. This coverage may **not** be subject to annual dollar limits. |
| Speech or Hearing – Loss or Impairment | Plans must offer to cover necessary care and treatment of loss or impairment of speech or hearing on the same basis as covered physical illness in general. |
| Telemedicine/Telehealth | Plans may not exclude a covered health care service or procedure because it is provided through telemedicine or a telehealth service rather than through an in-person consultation. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |
| Temporomandibular Joint (TMJ) | Plans that cover medically necessary diagnostic and surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint (TMJ), if the treatment is medically necessary as a result of:<br>• An accident or trauma;<br>• A congenital defect;<br>• A developmental defect; or<br>• A pathology.<br>This coverage may be subject to any provision plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. This mandate does **not** require coverage for dental services if dental services are not otherwise scheduled or provided as part of the plan's coverage.<br>This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. |

## PROVIDER MANDATES

| PROVIDER MANDATE | | DESCRIPTION |
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| Acupuncturist | Occupational Therapist | 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. |
| Advanced Practice Nurse | Optometrist | |
| Audiologist | Physical Therapist | |
| Chemical Dependency Counselor | Physician Assistant | |
| Clinical Social Worker | Podiatrist | |
| Chiropractor | Professional Counselor | |
| Dentist | Psychological Associate | |
| Dietician | Psychologist | |
| Hearing Instrument Fitter and Dispenser | Speech-Language Pathologist | |
| Marriage and Family Therapist | Surgical Assistant | |
| Nurse First Assistant | | Nondiscrimination mandate: An insured may select a nurse first assistant to provide the services scheduled in a plan that are within the scope of the nurse's license and requested by the physician whom the nurse is assisting. |

## PERSON MANDATES

| PERSON MANDATE | DESCRIPTION |
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| Adopted Children | Plans that provide family coverage may not exclude or limit coverage of a child solely because the child is adopted. |
| Child of Spouse | Plans that provide family coverage may not exclude or limit coverage of a child solely because the child is the natural or adopted child of the insured's spouse. |
| Continuation Coverage | Plans must offer continuation coverage to insured employees and dependents if:<br>• Coverage would otherwise be terminated for any reason other than the employee's involuntary termination for cause; and<br>• The individual has been continuously insured under the plan for at least **three consecutive months** before termination.<br>The maximum continuation period is **nine months**, or, if the individual is eligible for federal COBRA coverage, **six additional months** following any period of COBRA coverage. If a family member or dependent's coverage would end because of severance of the family |

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| | relationship or the insured employee's retirement or death, the continuation coverage may be elected for a maximum period of **three years** as long as the family member or dependent has been insured under the plan for a least **one year** or is an infant under one year of age. |
| Conversion Coverage | Plans that are terminating may offer a conversion policy to each insured employee, member or dependent. |
| Dependent - Adult Child Coverage | Plans that provide family coverage must cover:<br>• An unmarried child who is younger than **25 years** of age; and<br>• A child who is a full-time student, younger than 25 years of age and financially dependent on the parent. |
| Dependent – Disability Extension | Plans that have an age limit for dependent coverage must provide that a child's attainment of that age does not terminate coverage while the child is:<br>• Incapable of self-sustaining employment because of mental retardation or physical disability; and<br>• Chiefly dependent on the insured for support and maintenance. |
| Grandchildren | Plans that provides family coverage must cover a grandchild of an insured if the grandchild is:<br>• Unmarried;<br>• Younger than **age 25**; and<br>• A dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.<br>Coverage for a grandchild may not be terminated solely because the covered grandchild is no longer a dependent of the insured for federal income tax purposes. |
| Newborn Children | Plans may not limit or exclude initial coverage of a newborn child of a covered employee but may require notice of the birth and payment of any additional premium for coverage starting on the 32nd day after the child's birth. Plans that are sponsored by employers with 51 or more employees and do not provide family coverage may terminate a newborn child's coverage as of the 32nd day after the child's birth. |