Provided By Brown & Brown Benefit Advisors

NEW JERSEY EMPLOYMENT LAW

Health Insurance Mandates

STATE RESOURCES

New Jersey Department of Banking and Insurance website

New Jersey Department of Health website

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, effective for plan years beginning on or after Jan. 1, 2014, 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 charts outlining New Jersey's benefit, provider and person mandates for group health insurance plans (referred to as "plans" throughout this document). Please keep in mind that the following charts do not address federal benefit mandates, such as the ACA's essential health benefits mandate.

BENEFIT MANDATES

BENEFIT MANDATE	DESCRIPTION
Autism and Other Developmental Disorders	Plans must cover: • Screening for and diagnosis of autism and other developmental disabilities; • Medically necessary occupational, physical and speech therapy for an insured who is diagnosed with autism or another developmental disability; • Medically necessary behavioral interventions, without any limitations on the number of visits and provided to the same extent as any other covered medical condition, for an insured who is **under age 21** and has a primary diagnosis of autism. Coverage for these therapies may not be denied on the basis that the treatment is not restorative. The maximum benefit amount for an insured in any calendar year must be at least **$36,000** (as adjusted annually).
Cancer Treatment	Plans must offer coverage, to the same extent as any other covered illness, for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when performed by approved institutions and under certain guidelines. Benefits for this treatment must be provided
Childhood Immunizations	Plans that cover groups with **more than 50 persons** must cover all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health. These benefits must be provided to the same extent as other covered medical conditions, except that they may **not** be subject to a deductible.
Colorectal Cancer Screening	Plans must cover, to the same extent as any other covered medical condition, colorectal cancer screening at regular intervals for persons **age 50 and over** and for persons of **any age who are considered to be at high risk** for colorectal cancer.
Congenital Bleeding Disorders—Home Treatment	Plans that cover the treatment of routine bleeding episodes associated with hemophilia must cover, to the same extent as any covered sickness, blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of a state-approved hemophilia treatment center.
Contraceptives	Plans that cover outpatient prescription drugs must cover prescription female contraceptives, which include any drug or device, such as birth control pills or diaphragms, used for contraception by a female that: • Is approved by the federal FDA as a contraceptive; • Can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions. ***Effective March 15, 2018***, this coverage must include contraceptives for: • A three-month period for the first dispensing; and • A six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the plan was in effect at the time of the first dispensing (unless the six-month period would extend beyond the plan's term).

BENEFIT MANDATE	DESCRIPTION
	These benefits must be provided to the same extent as other covered outpatient prescription drugs. An exception to this mandate is available for religious employers.
Dental Treatment – Anesthesia and Hospitalization	Plans must cover the following for any insured who is **severely disabled** or a **child under age six**: • General anesthesia and hospitalization for dental services; and • Any covered medical condition that requires hospitalization or general anesthesia for dental services rendered by a dentist, regardless of where the dental services are provided. Prior authorization of hospitalization for dental services may be required in the same manner as required for other covered diseases or conditions.
Diabetes Treatment	Plans must cover, to the same extent as any other covered sickness, the following for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist: • Blood glucose monitors; • Blood glucose monitors and cartridges for the legally blind; • Test strips for glucose monitors and visual reading and urine testing strips; • Insulin; • Injection aids; • Syringes; • Insulin pumps and related accessories; • Insulin infusion devices; • Oral agents for controlling blood sugar; and • Diabetes self-management education, including information on proper diet.
Domestic Violence Injuries	Plans may not deny benefits for expenses incurred in the treatment of an injury sustained as the result of domestic violence. These benefits must be provided to the same extent as any other covered treatment.
Hearing Aids for Persons under Age 16	Plans must cover medically necessary hearing aids for an insured **under the age of 16**, as prescribed or recommended by a licensed physician or audiologist. These benefits must be provided to the same extent as any other condition but may be limited to **$1,000 per hearing aid** for each hearing-impaired ear every 24 months.
Hearing Loss Screening—Newborns and Infants	Plans that cover groups with **more than 50 persons** must cover screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss. These benefits must be provided to the same extent as any other covered medical condition, except that they may **not** be subject to a deductible.
Home Health Care	Plans that cover inpatient hospital care or skilled nursing facility care must also cover at least **60 home health care visits** in any calendar year or in any continuous period of 12 months without a separate deductible or coinsurance.

BENEFIT MANDATE	DESCRIPTION
Infertility Treatment	Plans that cover groups with **more than 50 persons** and include pregnancy-related benefits must cover medically necessary expenses incurred in the diagnosis and treatment of infertility other than infertility resulting from voluntary sterilization. This coverage must include the following services related to infertility: diagnosis and diagnostic tests; medications; surgery; in vitro fertilization; embryo transfer; artificial insemination; gamete intra fallopian transfer; zygote intra fallopian transfer; intracytoplasmic sperm injection; and four completed egg retrievals per lifetime of the covered person. However, coverage for in vitro fertilization, gamete intra fallopian transfer and zygote intra fallopian transfer may be limited to a covered person who: • Has used all reasonable, less expensive and medically appropriate treatments and is still unable to become pregnant or carry a pregnancy; • Has not reached the limit of four completed egg retrievals; and • Is 45 years of age or younger. Benefits for the diagnosis and treatment of infertility must be provided to the same extent as other covered medical or surgical benefits under the plan. Benefits for other services related to infertility must be provided to the same extent as other covered pregnancy-related procedures, except that the services must be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. An exception to this mandate is available for religious employers.
Inherited Metabolic Diseases—Food and Food Products	Plans must cover therapeutic treatment of inherited metabolic diseases, including medical foods and low protein modified food products, when diagnosed and determined to be medically necessary by the covered person's physician. These benefits must be provided to the same extent as for any other medical condition under the plan.
Lead Poisoning Screening—Children	Plans that cover groups with **more than 50 persons** must cover screening by blood lead measurement for lead poisoning for **children**, including confirmatory blood lead testing and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children. These benefits must be provided to the same extent as for any other medical condition under the plan, except that they may **not** be subject to a deductible.
Mammograms	Plans must cover mammograms as follows: • One baseline mammogram examination for women who are at least 35 but less than 40 years of age; • A mammogram examination every year for women age 40 and over; and • In the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider. Plans must also cover an ultrasound screening evaluation, a magnetic resonance imaging scan, a three-dimensional mammography or other additional testing of an entire breast or breasts after a baseline mammogram examination, if: • The mammogram demonstrates extremely dense breast tissue;

BENEFIT MANDATE	DESCRIPTION
	• The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense or extremely dense breast tissue; or • The patient has additional risk factors for breast cancer, such as family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue, or other indications as determined by the patient's health care provider. These benefits must be provided to the same extent as for any other sickness under the plan.
Mastectomy—Minimum Inpatient Stay	Plans must cover, without prior authorization and to the same extent as for any other covered sickness, a minimum of: • **72 hours** of inpatient care following a modified radical mastectomy; and • **48 hours** of inpatient care following a simple mastectomy.
Maternity Benefits (without regard to marital status)	Plans must offer coverage for maternity care without regard to marital status for expenses incurred in pregnancy and childbirth and to the same extent as the plan's hospitalization benefit for any other covered illness.
Maternity—Minimum Stay	Plans that provide maternity benefits must cover a minimum of the following for a mother and her newborn child: • **48 hours** of in-patient care following a vaginal delivery; and • **96 hours** of in-patient care following a cesarean section.
Mental Illness—Biologically Based	Plans must cover treatment of biologically-based mental illness under the same terms and conditions as any other covered sickness. "Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.
Non-standard Infant Formula	Plans that cover prescription drug must cover, to the same extent as any other covered, prescribed items, specialized non-standard infant formulas when a covered infant has been: • Diagnosed with multiple food protein intolerance for which the formula is medically necessary; or • Non-responsive to trials of standard non-cow milk-based formulas.
Off-label Drug Use	Plans that cover prescription drugs must cover a drug for a treatment for which the drug has not been approved by the FDA, if the drug is: • Recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in certain established reference compendia; or • Recommended by a clinical study or review article in a major-peer reviewed professional journal. These benefits must be provided to the same extent as other benefits under the plan for

BENEFIT MANDATE	DESCRIPTION
	drugs prescribed for treatments approved by the FDA. However, plans are **not** required to cover any experimental or investigational drug or any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed.
Oral Anticancer Medications	Plans must cover prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than the plan's coverage for intravenously administered or injected anticancer medications.
Out-of-network Services	Plans that offer a managed care plan providing for both in- and out-of-network benefits must reimburse a health care facility at the plan's full contracted rate without any penalty for the patient's selection of an out-of-network provider, in accordance with the in-network policies and cost-sharing requirements of the managed care plan, in the event that a covered person: • Is admitted by an out-of-network health care provider to an in-network health care facility for covered, medically necessary health care services; or • Receives covered, medically necessary health care services from an out-of-network health care provider while the covered person is a patient at an in-network health care facility and was admitted to the health care facility by an in-network provider.
Orthotic and Prosthetic Appliance	Plans must cover, to the same extent as any other covered medical condition, an orthotic or prosthetic appliance from any licensed orthotist or prosthetist, or any certified pedorthist, as determined medically necessary by the covered person's physician. Reimbursement must be at the same rates as provided under the federal Medicare reimbursement schedule.
Pap Smears	Plans that cover groups with **more than 50 persons** must cover pap smears to the same extent as any other covered medical condition.
Prescription Drugs – Non-opioids	Plans that cover prescription drugs must do the following on at least one occasion per year for each covered person: • Apply a prorated daily cost-sharing rate to prescription drugs that are dispensed by a network pharmacy for less than a 30 days' supply, if the prescriber or pharmacist indicates the fill or refill is in the best interest of the covered person or is for the purpose of synchronizing the covered person's chronic medications; • Provide coverage for a drug prescribed for the treatment of a chronic illness dispensed in accordance with a plan among the covered person, the prescriber and the pharmacist to synchronize the refilling of multiple prescription drugs for the covered person; and • Determine dispensing fees based exclusively on the total number of prescription drugs dispensed. This mandate does not apply to opioid drugs.
Prescription Drugs – Opioids ***Effective Jan. 16, 2018***	Plans that cover prescription drugs subject to cost-sharing requirements must apply the cost-sharing requirements to an initial prescription of an opioid drug that are either: • Proportional between the cost-sharing for a 30-day supply and the amount of drugs the patient was prescribed; or

BENEFIT MANDATE	DESCRIPTION
	• Equivalent to the cost sharing for a full 30-day opioid drug supply provided that no additional cost sharing is charged for any additional prescriptions for the remainder of the 30-day supply.
Prescription Eye Drop Refills	Plans that cover prescription eye drops must cover refills according to Medicare Part D plan guidelines, as long as: • The prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed; and • The requested refill does not exceed the number of additional quantities indicated on the original prescription.
Prostate Cancer Screening	Plans that cover groups with **more than 50 persons** must cover, to the same extent as any other covered medical condition, an annual prostate cancer screening (including, but not limited to, a digital rectal examination and a prostate-specific antigen test) for **men of ages**: • **50 and over** who are asymptomatic; and • **40 and over** who have a family history of prostate cancer or other prostate cancer risk factors.
Reconstructive Breast Surgery	Plans must cover, to the same extent as any other covered sickness, reconstructive breast surgery, surgery to restore and achieve symmetry between the two breasts, and the costs of prostheses following a mastectomy. Plans that cover outpatient x-ray or radiation therapy must also cover outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.
Second and Third Surgical Opinion	Plans that cover inpatient surgical operations must make coverage available for a second surgical opinion for elective surgical procedures that would require inpatient admission to a hospital. If a second surgical opinion does not confirm that a proposed elective surgical procedure is medically advisable, the program must cover a third surgical opinion in the same manner as the second opinion.
Sickle Cell Anemia	Plans must cover, to the same extent as any other covered medical condition, the treatment of sickle cell anemia. Plans that cover outpatient prescription drugs must also cover prescription drugs for the treatment of sickle cell anemia.
Substance Abuse Disorders	Plans must provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities, subject to certain requirements for specified treatments.
Wellness Examinations	Plans must cover expenses incurred in a health promotion program through health wellness examinations and counselling. The health promotion program must include recommended immunizations for **all covered adults** and at least the following: For **all covered persons** of **ages**: • **20 or older**: Annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level; and an annual consultation with a health care

BENEFIT MANDATE	DESCRIPTION
	provider to discuss lifestyle behaviors that promote health and well-being; • **35 or older**: A glaucoma eye test every five years; • **40 or older**: An annual stool examination for presence of blood; and • **45 or older**: A left-sided colon examination of 35 to 60 centimeters every five years. For **all covered women** of **ages**: • **20 or older**: A pap smear; and • **40 or older**: A mammogram examination. This coverage may be subject to certain annually-adjusted dollar limits.
Wilm's Tumor Treatment	Plans must cover, to the same extent as any other covered sickness, treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful, even if this treatment is deemed experimental or investigational.

PROVIDER MANDATES

PROVIDER MANDATE	DESCRIPTION
Audiologist Speech-Language Pathologist	Plans may not deny benefits for covered services when the services are: • Determined by a physician to be medically necessary; and • Provided by a licensed speech-language pathologist or licensed audiologist within the lawful scope of their licenses and practices.
Chiropractor Dentist Optometrist Psychologist	If a plan covers services that are within the lawful scope of these providers' licenses and practices, the plan must cover the services regardless of whether they are performed by a physician or one of these providers within whose scope of practice the service is performed. Equal reimbursement rates must be paid for services performed by a dentist.
Obstetrical Providers	Plans that cover maternity services must provide reimbursement in installments to an obstetrical provider licensed in New Jersey for maternity services rendered during the term of an insured person's pregnancy. Obstetrical providers covered by this mandate include: • An obstetrician/gynecologist licensed by the State Board of Medical Examiners; and • A midwife licensed by the State Board of Medical Examiners as a certified midwife or a certified nurse midwife.

PERSON MANDATES

PERSON MANDATE	DESCRIPTION
Adult Children—Coverage Extension	Plans that terminate coverage for dependent children at a specified age on or before a dependent's 30th birthday must offer to extend coverage after that specified age until a dependent's **31st birthday**.

PERSON MANDATE	DESCRIPTION
	A dependent child is eligible for this extension if he or she has no dependents of his or her own and is: • 30 or younger; • Unmarried; • A resident of New Jersey or enrolled as a full-time student at an accredited public or private institution of higher education; and • Not covered under any other health plan at the time the extended coverage begins. Certain election requirements may apply for this coverage extension. Employers are not required to pay for any part of the cost of this extended coverage.
Children	Plans that provide family coverage may not deny coverage for an insured's child because the child: • Was born out of wedlock; • Is not claimed as a dependent on the insured's federal tax return; or • Does not reside with the insured or in the issuer's service area (provided that, in the case of a managed care plan, the child complies with the terms and conditions of the plan with respect to the use of specified providers). These plans must also cover a **newly-born child** of an insured from the moment of birth.
Continuation Coverage	Plans that cover groups with **50 or fewer employees** must give covered employees and their covered spouses and dependents an opportunity to elect continuation coverage if they would otherwise lose coverage because of a "qualifying event." Qualifying events include: • The employee's termination of employment other than for cause; • The employee's reduction to less than 25 hours of employment per week; • The employee's death; • Divorce or dissolution of a civil union; • The employee's entitlement to Medicare; or • Loss of dependent child status. The maximum period of state continuation coverage is **18 months**, except that coverage may continue for up to **36 months** when the qualifying event is the employee's death, a divorce or dissolution of a civil union, or a child's loss of dependent status. Also, when an employee is determined to be disabled at the time of employment termination or at any time during the first 60 days of continuation of coverage, the maximum continuation coverage period is **29 months**.
Domestic Partners	Plans that provide family coverage must offer coverage for a covered employee's domestic partner.