STATE EMPLOYMENT LAWS

Provided By Brown & Brown Benefit Advisors

# 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, 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 a chart outlining New Jersey's benefit, provider and person mandates for group health insurance plans. Please keep in mind that the following chart does not address federal benefit mandates, such as the ACA's essential health benefits mandate.

| Benefit Mandate | Description |
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| Alcoholism Treatment | Coverage for the treatment of alcoholism when the treatment is prescribed by a doctor of medicine. These benefits must be provided to the same extent as for any other sickness under the policy. Benefits must cover:<br>• Inpatient or outpatient care in a licensed hospital;<br>• Treatment at a licensed detoxification facility; and<br>• Confinement as an inpatient or outpatient at a licensed, certified, or state-approved residential treatment facility, under a program that meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation. |
| Autism and Other Developmental Disorders | Coverage for expenses incurred in **screening and diagnosing** autism or another developmental disability.<br>When an insured's primary diagnosis is autism or another developmental disability, coverage for medically necessary **occupational therapy**, **physical therapy** and **speech therapy**, as prescribed through a treatment plan. Coverage of these therapies may not be denied on the basis that the treatment is not restorative. |

Health insurance mandates differ from state to state and often contain detailed criteria. This chart provides a general overview of health insurance mandates and is provided to you for general informational purposes only. It summarizes mandates contained in state statutes, but does not include references to other legal resources (such as supporting regulations, or formal or informal opinions of state departments of insurance), unless specifically noted. Please seek qualified and appropriate counsel for further information and/or advice regarding the application of health insurance mandates to your employee benefits plans.

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# Health Insurance Mandates

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| | For an insured who is **under age 21** and has a primary diagnosis of autism, coverage for expenses incurred for medically necessary behavioral interventions based on the principles of **applied behavioral analysis** and related structured behavioral programs, as prescribed through a treatment plan, subject to the following rules:<br>• Benefits must be provided to the same extent as for any other medical condition under the policy, but may not be subject to limits on the number of visits that an insured may make to a provider of behavioral interventions.<br>• Benefits may not be denied on the basis that the treatment is not restorative.<br>• The maximum benefit amount for an insured in any calendar year must be at least **$36,000** (adjusted for cost-of-living changes after 2011). For 2014, the adjusted maximum benefit is **$37,710**. |
| Cancer Treatment | Issuers must offer coverage for the treatment of cancer by **dose-intensive chemotherapy/autologous bone marrow transplants** and **peripheral blood stem cell transplants** when performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Benefits for this treatment must be provided to the same extent as for any other illness under the policy. |
| Childhood Immunizations | For policies that cover groups with **more than 50 persons**, coverage for all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health.<br>These benefits must be provided to the same extent as for any other medical condition under the policy, except these benefits may not be subject to a deductible. However, if the health plan is an HSA-compatible high deductible health plan (HDHP), a deductible may not be applied to any of these benefits if they are considered preventive care under federal law. |
| Colorectal Cancer Screening | Coverage for 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. Benefits for this screening must be provided to the same extent as for any other medical condition under the policy. |
| Congenital Bleeding Disorders—Home Treatment | For policies that cover the treatment of routine bleeding episodes associated with hemophilia, coverage for the purchase of 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. These benefits must be provided to the same extent as for any sickness under the policy. |
| Contraceptives | For policies that cover outpatient prescription drugs, coverage for **prescription female contraceptives**. “Prescription female contraceptives” means any drug or device used for contraception by a female that:<br>• Is approved by the federal FDA as a contraceptive;<br>• Can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions; and<br>• Includes, but is not limited to, birth control pills and diaphragms. |

# Health Insurance Mandates

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| | Benefits must be provided to the same extent as for other outpatient prescription drugs under the policy.<br>Religious employers that object to providing this coverage based on their bona fide religious beliefs and practices may qualify for an exception to this coverage mandate. |
| Dental Treatment – Anesthesia and Benefits | For any insured who is **severely disabled** or a **child under age six**, coverage for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the policy that requires hospitalization or general anesthesia for dental services rendered by a dentist, regardless of where the dental services are provided. |
| Diabetes Treatment | Coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or nurse practitioner/clinical nurse specialist:<br>• Blood glucose monitors (including those for the legally blind);<br>• Test strips for glucose monitors and visual reading and urine testing strips;<br>• Insulin;<br>• Injection aids;<br>• Cartridges for the legally blind;<br>• Syringes;<br>• Insulin pumps and related accessories;<br>• Insulin infusion devices; and<br>• Oral agents for controlling blood sugar.<br>Coverage for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet.<br>These benefits must be provided to the same extent as for any other sickness under the policy. |
| Domestic Violence Injuries | Cannot deny benefits for expenses incurred in the treatment of an injury sustained as the result of domestic violence. Benefits must be provided to the same extent as for any other treatment under the policy. |
| Hearing Aids for Persons under Age 16 | Coverage for medically necessary expenses incurred in the purchase of a hearing aid for an insured **under the age of 16**. The policy must cover the purchase of a hearing aid for each ear, when medically necessary and as prescribed or recommended by a licensed physician or audiologist. The benefit may be limited to **$1,000 per hearing aid** for each hearing-impaired ear every 24 months.<br>These benefits must be provided to the same extent as for any other condition under the policy. |
| Hearing Loss Screening—Newborns and Infants | For policies that cover groups with **more than 50 persons**, coverage for:<br>• Screening for newborn hearing loss by appropriate electrophysiologic screening measures; and<br>• Periodic monitoring of infants for delayed onset hearing loss. |

# Health Insurance Mandates

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| | These benefits must be provided to the same extent as for any other medical condition under the plan, except these benefits may not be subject to a deductible. However, if the health plan is an HSA-compatible high deductible health plan (HDHP), a deductible may not be applied to these benefits if they are considered preventive care under federal law. |
| Home Health Care | For plans that cover inpatient hospital care or skilled nursing facility care, coverage for home health care without a separate deductible or coinsurance provision. This benefit must provide coverage for at least **60 home health care visits** in any calendar year or in any continuous period of 12 months. |
| Infertility Treatment | For policies that cover groups with **more than 50 persons** and include pregnancy-related benefits, coverage for medically necessary expenses incurred in the **diagnosis and treatment of infertility**.<br><br>Coverage must be provided for 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.<br><br>Coverage for in vitro fertilization, gamete intra fallopian transfer and zygote intra fallopian transfer may be limited to a covered person who:<br>• Has used all reasonable, less expensive and medically appropriate treatments and is still unable to become pregnant or carry a pregnancy;<br>• Has not reached the limit of four completed egg retrievals; and<br>• Is 45 years of age or younger.<br><br>These benefits must be provided to the same extent as for other pregnancy-related procedures under the policy, except that these 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.<br><br>The same copayments, deductibles and benefit limits must apply to the diagnosis and treatment of infertility as those applied to other medical or surgical benefits under the policy.<br><br>Religious employers that object to providing coverage for vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection based on their bona fide religious beliefs may qualify for an exception to this coverage mandate. |
| Inherited Metabolic Diseases—Food and Food Products | Coverage for the therapeutic treatment of inherited metabolic diseases, including the purchase of **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 policy. |
| Lead Poisoning Screening | For policies that cover groups with **more than 50 persons**, coverage for 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.<br><br>These benefits must be provided to the same extent as for any other medical condition under the plan, except these benefits may not be subject to a deductible. However, if the health plan is an HSA-compatible high deductible |

# Health Insurance Mandates

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| | health plan (HDHP), a deductible may not be applied to these benefits if they are considered preventive care under federal law. |
| Mammograms | Coverage for mammograms, as follows:<br>• One baseline mammogram examination for women who are at least 35 but less than 40 years of age;<br>• A mammogram examination every year for women age 40 and over; and<br>• 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.<br>**Effective for policies issued or renewed on or after May 1, 2014**, coverage for 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:<br>• The mammogram demonstrates extremely dense breast tissue;<br>• The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense or extremely dense breast tissue; or<br>• 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.<br>These benefits must be provided to the same extent as for any other sickness under the policy. |
| Mastectomy—Minimum Inpatient Stay | Coverage for a minimum of 72 hours of inpatient care following a modified radical mastectomy, and a minimum of 48 hours of inpatient care following a simple mastectomy. These benefits must be provided to the same extent as for any other sickness under the policy. |
| Maternity Benefits (without regard to marital status) | Issuers must offer coverage for maternity care without regard to marital status for expenses incurred in pregnancy and childbirth. These benefits must be provided to the same extent as the hospitalization benefit is provided in the policy for any other covered illness. |
| Maternity—Minimum Stay | For policies that provide maternity benefits, coverage for a mother and her newborn child for a minimum of:<br>• 48 hours of in-patient care following a vaginal delivery; and<br>• 96 hours of in-patient care following a cesarean section. |
| Mental Illness—Biologically Based | Coverage for **biologically-based mental illness** under the same terms and conditions as provided for any other sickness under the policy.<br>"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 |

# Health Insurance Mandates

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| | disorder, panic disorder and pervasive developmental disorder or autism.<br><br>*The federal Mental Health Parity and Addiction Equity Act (MHPAEA) 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. Depending on a plan's design, the MHPAEA may require stricter parity requirements than state law mandates. Also, for plan years beginning on or after Jan. 1 2014, the ACA requires non-grandfathered health plans in the individual and small group markets to cover mental health and substance use disorder services and comply with the federal parity law.* |
| Non-standard Infant Formula | For policies that provide prescription drug benefits, coverage for specialized non-standard infant formulas, when:<br>• The covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined the formula to be medically necessary; and<br>• The covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.<br><br>These benefits must be provided to the same extent as for any other prescribed items under the policy. |
| Off-label Drug Use | For policies that provide prescription drug benefits, coverage for a drug prescribed for a treatment for which it has not been approved by the FDA, if the drug is:<br>• Recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in certain established reference compendia; or<br>• Recommended by a clinical study or review article in a major-peer reviewed professional journal.<br><br>Coverage is not required for 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.<br><br>These benefits must be provided to the same extent as other benefits under the policy for drugs prescribed for treatments approved by the FDA. |
| Oral Anticancer Medications | Coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than the policy provides for intravenously administered or injected anticancer medications. |
| Out-of-network Services | When an issuer offers a managed care plan that provides for both in-network and out-of-network benefits, the issuer must reimburse a health care facility at the issuer'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 in-network copayment, coinsurance or deductible requirements of the managed care plan, in the event that:<br>• 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<br>• A covered person 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 |

# Health Insurance Mandates

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| | was admitted to the health care facility by an in-network provider. |
| Orthotic and Prosthetic Appliance | Coverage for 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 rate as reimbursement for the orthotic or prosthetic appliance under the federal Medicare reimbursement schedule. These benefits must be provided to the same extent as for any other medical condition under the policy. |
| Pap Smears | For policies that cover groups with **more than 50 persons**, coverage for pap smears. This benefit must be provided to the same extent as for any other medical condition under the policy. |
| Prescription Eye Drop Refills | For policies that provide benefits for prescription eye drops, coverage for refills of prescription eye drops in accordance with the Medicare Part D plan guidelines, provided that:<br>• The prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed; and<br>• The requested refill does not exceed the number of additional quantities indicated on the original prescription. |
| Prostate Cancer Screening | For policies that cover groups with **more than 50 persons**, coverage for an annual prostate cancer screening (including, but not limited to, a digital rectal examination and a prostate-specific antigen test) for men:<br>• Age 50 and over who are asymptomatic; and<br>• Age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.<br>These benefits must be provided to the same extent as for any other medical condition under the policy. |
| Reconstructive Breast Surgery | Following a mastectomy on one breast or both breasts, coverage for reconstructive breast surgery, surgery to restore and achieve symmetry between the two breasts and the costs of prostheses. These benefits must be provided to the same extent as for any other sickness under the policy. |
| Second Surgical Opinion | Issuers that provide coverage for inpatient surgical operations must make coverage available for a second surgical opinion program for elective surgical procedures that would require inpatient admission to a hospital. |
| Sickle Cell Anemia | Coverage for the treatment of sickle cell anemia. If the policy provides benefits for outpatient prescription drugs, coverage for prescription drugs for the treatment of sickle cell anemia. These benefits must be provided to the same extent as for any other medical condition under the policy. |
| Wellness Examinations | Coverage for expenses incurred in a health promotion program through health wellness examinations and counseling. The health promotion program must include, but is not limited to, the following tests and services:<br>• For all persons 20 years of age and 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;<br>• For all persons 35 years of age or older, a glaucoma eye test every |

# Health Insurance Mandates

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| | five years;<br>• For all persons 40 years of age or older, an annual stool examination for presence of blood;<br>• For all persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years;<br>• For all women 20 years of age or older, a pap smear;<br>• For all women 40 years of age or older, a mammogram examination;<br>• For all adults, recommended immunizations; and<br>• For all persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.<br>This coverage must provide the following benefits (subject to annual cost-of living adjustments):<br>• $125 a year for each person between the ages of 20 to 39, inclusive;<br>• $145 a year for each man age 40 and over; and<br>• $235 a year for each woman age 40 and over. For persons 45 years of age or older, the cost of a left-sided colon examination is not included in this amount. Benefits for a left-sided colon examination may be limited to $150. |
| Wilm’s Tumor Treatment | Coverage for the 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.<br>These benefits must be provided to the same extent as for any other sickness under the policy. |

| Provider Mandate | Description |
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| Audiologist | Cannot deny benefits for eligible services when the services are determined by a physician to be medically necessary and are provided by a licensed audiologist within the scope of practice. Nondiscrimination mandate.<br>*Nondiscrimination mandates require coverage if the health plan reimburses services within the scope of the health care professional’s practice.* |
| Chiropractor | For policies that cover any service within the lawful scope of practice of a licensed chiropractor, coverage must be provided when the service is performed by a licensed chiropractor. Nondiscrimination mandate. |
| Dentist | For policies that cover any service within the lawful scope of practice of a licensed dentist, coverage must be provided for the service regardless of whether the service is performed by a licensed physician or licensed dentist. Equal reimbursement rates must also apply. Nondiscrimination mandate. |
| Obstetrical Providers | For policies that provide benefits for maternity services, issuers must provide for reimbursement in installments to an obstetrical provider licensed in New |

# Health Insurance Mandates

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| | Jersey for maternity services rendered during the term of an insured's pregnancy. Obstetrical providers covered by this mandate include:<br>• An obstetrician/gynecologist licensed by the State Board of Medical Examiners; or<br>• A midwife licensed by the State Board of Medical Examiners as a certified midwife or a certified nurse midwife. |
| Optometrist | For policies that cover any optometric service within the lawful scope of practice of a licensed optometrist, coverage must be provided for the service regardless of whether the service is performed by a physician or licensed optometrist. Nondiscrimination mandate. |
| Psychologist | For policies that cover any service within the lawful scope of practice of a licensed practicing psychologist, coverage must be provided for the service regardless of whether the service is performed by a physician or licensed practicing psychologist. Nondiscrimination mandate. |
| Speech-Language Pathologist | Cannot deny benefits for eligible services when the services are determined by a physician to be medically necessary and are provided by a licensed speech-language pathologist within the scope of practice. Nondiscrimination mandate. |

| Person Mandate | Description |
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| Adult Children—Coverage Extension | Policies that terminate coverage for dependent children at a specific age on or before the dependent's 30th birthday must offer to extend coverage after that specific age, until the dependent's 31st birthday. A dependent child is eligible for this extension if he or she:<br>• Is 30 years of age or younger;<br>• Is unmarried;<br>• Has no dependents of his or her own;<br>• Is a resident of New Jersey or is enrolled as a full-time student at an accredited public or private institution of higher education; and<br>• Is not actually provided coverage under any other health plan at the time the extended coverage begins.<br>Certain election requirements apply for this coverage extension. Employers are not required to pay for all or part of the cost of this extended coverage. |
| Children | Policies that provide family coverage may not deny coverage for an insured's child because the child:<br>• Was born out of wedlock;<br>• Is not claimed as a dependent on the insured's federal tax return; or<br>• 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 policy with respect to the use of specified providers). |
| Continuation Coverage | Issuers that cover groups with **50 or fewer employees** must provide insured employees and dependents (spouses and children) who would lose |

# Health Insurance Mandates

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| | coverage under a group health plan because of a qualifying event with the opportunity to elect continuation coverage.<br>"Qualifying event" includes:<br>• A termination of employment for a reason other than for cause;<br>• A reduction in an employee's hours of employment to less than 25 hours;<br>• The employee's death;<br>• Divorce (or dissolution of a civil union);<br>• The employee's entitlement to Medicare; or<br>• A child's loss of dependent child status.<br>A "spouse" includes a same-sex spouse, a civil union partner and a domestic partner if the employer elected to include coverage for domestic partners.<br>The maximum period of state continuation coverage is **18 months**, except coverage may continue for a maximum period of **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 termination of employment or at any time during the first 60 days of continuation of coverage, the maximum continuation coverage period is **29 months**. |
| Disabled Children | Policies that have an age limit for dependent children must extend eligibility past the limiting age for an unmarried dependent child who is:<br>• Covered by the policy prior to attaining age 19;<br>• Incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to reaching age 19; and<br>• Chiefly dependent upon the employee for support and maintenance. |
| Domestic Partners | Issuers of family coverage policies must offer coverage to employers for domestic partners (in accordance with the state's domestic partnership law). Employers may decide whether to provide coverage for their employees' domestic partners. |
| Same-sex Spouses and Civil Union Couples | Due to New Jersey's same-sex marriage and civil union laws, health insurance coverage for same-sex spouses and civil union couples must be provided on the same basis as for opposite-sex spouses. |

**While many of the mandates described in the above chart are applicable to managed care plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), managed care plans may be subject to additional requirements under New Jersey statutes and regulations that are not specifically addressed in the above chart. In addition, the chart focuses on mandates applicable to health insurance plans sponsored by private employers, and does not address mandates specifically applicable to the health benefits provided by government employers.*

**Additional Resources:**

New Jersey statutes

New Jersey Department of Banking & Insurance