ASSEMBLY, No. 1733

STATE OF NEW JERSEY

218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:
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SYNOPSIS

Clarifies prohibition on preexisting condition exclusions in health insurance policies.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

(Sponsorship Updated As Of: 1/29/2019)

AN ACT concerning health insurance and revising various parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.1989, c.63 (C.17:48-6e) is amended to read as follows:

a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a hospital service corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group **[**if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group contract issued by the corporation; and (2) the corporation paid benefits for the condition under the group contract in which the person was previously insured**]**.

b. Nothing in this section shall be construed to operate to add any benefit, to increase the scope of any benefit, or to increase any benefit level under any group contract.

c. This section shall apply to every group contract or policy in which the corporation or insurer has the right to change the premium.

(cf: P.L.1989, c.63, s.2)

2. Section 1 of P.L.1989, c.63 (C.17:48A-7d) is amended to read as follows:

a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a medical service corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group **[**if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group contract issued by the corporation; and (2) the corporation paid benefits for the condition under the group contract in which the person was previously insured**]**.

b. Nothing in this section shall be construed to operate to add any benefit, to increase the scope of any benefit, or to increase any benefit level under any group contract.

c. This section shall apply to every group contract or policy in which the corporation or insurer has the right to change the premium.

(cf: P.L.1989, c.63, s.1)

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

3. Section 3 of P.L.1989, c.63 (C.17:48E-35.2) is amended to read as follows:

a. Notwithstanding any other provision of law to the contrary, no group health insurance contract issued by a health service corporation pursuant to the provisions of P.L.1985, c.236 (C.17:48E-1 et seq.), shall contain any provision which denies benefits for a preexisting condition to any person becoming a member of that group **[**if: (1) during the period immediately preceding the person's becoming a member of the group the person was enrolled as a member under another group contract issued by the corporation; and (2) the corporation paid benefits for the condition under the group contract in which the person was previously insured**]**.

b. Nothing in this section shall be construed to operate to add any benefit, to increase the scope of any benefit, or to increase any benefit level under any group contract.

c. This section shall apply to every group contract or policy in which the corporation or insurer has the right to change the premium.

(cf: P.L.1989, c.63, s.3)

4. Section 15 of P.L.1997, c.146 (C.17B:27-55) is amended to read as follows:

15. A health insurer **[**may**]** shall not impose a preexisting condition exclusion in its group health plan **[**only if:

a. the exclusion relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date of the participant or beneficiary;

b. the exclusion extends for a period of not more than 12 months, or 18 months for a late enrollee, after the enrollment date of the participant or beneficiary; and

c. the period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date**]**.

(cf: P.L.1997, c.146, s.15)

5. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to read as follows:

6. The commissioner shall approve the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220),

regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The commissioner shall provide the board with an informational filing of the policy and contract forms and benefit levels it approves.

a. The individual health benefits plans established by the board may include cost containment measures such as, but not limited to: utilization review of health care services, including review of medical necessity of hospital and physician services; case management benefit alternatives; selective contracting with hospitals, physicians, and other health care providers; and reasonable benefit differentials applicable to participating and nonparticipating providers; and other managed care provisions.

b. **[**An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no more than 12 months on coverage for preexisting conditions.**]** An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting condition limitation of any period **[**under the following circumstances:

(1) to an individual who has, under creditable coverage, with no intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or

(2) to a federally defined eligible individual who applies for an individual health benefits plan within 63 days of termination of the prior coverage**]**.

c. In addition to the standard individual health benefits plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board may develop up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of P.L.1992, c.161 (C.17B:27A-9).

d. After the board's establishment of the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier shall file the policy or contract forms with the commissioner and certify to the commissioner that the health benefits plans to be used by the carrier are in substantial compliance with the provisions in the corresponding approved plans. The certification shall be signed by the chief executive officer of the carrier. Upon receipt by the commissioner of the certification, the certified plans may be used until the commissioner, after notice and hearing, disapproves their continued use.

e. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161

(C.17B:27A-4), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

(1) Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

(2) All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall notify its insureds, in writing, of any change in the health care services provided with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this subsection that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has

determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

The benefits shall be provided to the same extent as for any other prescribed items under the health benefits plan.

This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

g. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically necessary benefits provided in-network which represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection. This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2012, c.17, s.57)

6. Section 10 of P.L.1994, c.11 (C.17B:27A-19.1) is amended to read as follows:

10. a. A carrier shall not deliver or issue for delivery a hospital confinement or other supplemental limited benefit insurance plan unless the applicant for such coverage signs a statement on the application form that confirms that the applicant is already covered under a health benefits plan contract or policy. The application form shall be filed with the board on an informational basis.

b. A hospital confinement plan or other supplemental limited benefit insurance plan issued to a small employer or other group health benefits plan provider or to individual employees of a small employer or other group health benefits provider **[**:

(1)**]** shall be subject to the same rating requirements that apply to health benefits plans issued pursuant to paragraph (2) of subsection a. of section 9 of P.L.1992, c.162 (C.17B:27A-25), except that a hospital confinement plan and supplemental limited

benefit insurance plan shall be subject to the commissioner's exclusive review and regulation with regard to loss ratios, medical underwriting and eligibility requirements, and form approval[; and

(2) may include preexisting condition exclusions].

c. A health benefits plan shall not coordinate benefits against any hospital confinement or other supplemental limited benefit insurance plan.

(cf: P.L.1994, c.11, s.10)

7. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to read as follows:

6. a. No health benefits plan subject to this act shall include any provision excluding coverage for a preexisting condition regardless of the cause of the condition [, provided that a preexisting condition provision may apply to a late enrollee or to any group of two to five persons if such provision excludes coverage for a period of no more than 180 days following the effective date of coverage of such enrollee, and relates only to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of such enrollee and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; provided that, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition provision shall apply to any such enrollee].

b. [In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefits plans shall credit the time that person was covered under creditable coverage if the creditable coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan. A carrier shall provide credit pursuant to this provision in one of the following methods:

(1) A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period; or

(2) A carrier shall count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in federal regulation rather than the method provided in paragraph (1) of this subsection. This election shall be made on a uniform basis for all covered persons. Under this election, a carrier shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within that class or category. A carrier which elects to provide credit pursuant to this provision shall comply with all federal notice requirements.] (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill)

c. [A health benefits plan shall not impose a preexisting condition exclusion for the following:

(1) A newborn child who, as of the last date of the 30-day period beginning with the date of birth, is covered under creditable coverage;

(2) A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of the adoption or placement for adoption; or

(3) Pregnancy as a preexisting condition.] (Deleted by amendment, P.L. , c.) (pending before the Legislature as this bill)

(cf: P.L.1997, c.146, s.9)

8. Sections 16 through 19 of P.L.1997, c.146 (C.17B:27-56 through 17B:27-59) are repealed.

9. This act shall take effect immediately.

STATEMENT

This bill clarifies that a health insurer shall not impose, or include in its insurance policies, any provision excluding coverage for a preexisting condition. While the federal Affordable Care Act mandates that health insurers, except in certain grandfathered plans, may not include an exclusion for a preexisting condition in any insurance policy, New Jersey law was never changed to conform to the federal law. This bill revises the New Jersey law concerning group health insurance, the Individual Health Coverage Program, the Small Employer Health Benefits Program, hospital confinement plans, and certain hospital, medical, and health service corporation plans to conform to the federal law regarding preexisting conditions.

It is the sponsor's intent that, if the Affordable Care Act is ever amended or repealed, the prohibition on insurers excluding coverage for preexisting conditions or putting certain waiting periods on coverage, would continue to be prohibited in New Jersey.