# SENATE, No. 626

# STATE OF NEW JERSEY

## 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION


**Sponsored by:**
**Senator JOSEPH F. VITALE**
**District 19 (Middlesex)**
**Senator PATRICK J. DIEGNAN, JR.**
**District 18 (Middlesex)**

**Co-Sponsored by:**
**Senator Gordon**



**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: 5/28/2019)**

**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**]**. A hospital service corporation shall not include a preexisting condition as a factor in calculating the premium.

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**]**. A medical service corporation shall not include a preexisting condition as a factor in calculating the premium.

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.

**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 thus is new matter.**

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)

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]. A health service corporation shall not include a preexisting condition as a factor in calculating the premium.

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] and shall not include a preexisting condition as a factor in calculating the premium.

(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:

1 6. The commissioner shall approve the policy and contract
2 forms and benefit levels to be made available by all carriers for the
3 health benefits plans required to be issued pursuant to section 3 of
4 P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications
5 to one or more plans as the board determines are necessary to make
6 available a "high deductible health plan" or plans consistent with
7 section 301 of Title III of the "Health Insurance Portability and
8 Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220),
9 regarding tax-deductible medical savings accounts, within 60 days
10 after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The
11 commissioner shall provide the board with an informational filing
12 of the policy and contract forms and benefit levels it approves.
13 a. The individual health benefits plans established by the board
14 may include cost containment measures such as, but not limited to:
15 utilization review of health care services, including review of
16 medical necessity of hospital and physician services; case
17 management benefit alternatives; selective contracting with
18 hospitals, physicians, and other health care providers; and
19 reasonable benefit differentials applicable to participating and
20 nonparticipating providers; and other managed care provisions.
21 b. ⟦An individual health benefits plan offered pursuant to
22 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a
23 limitation of no more than 12 months on coverage for preexisting
24 conditions.⟧ An individual health benefits plan offered pursuant to
25 section 3 of P.L.1992, c.161 (C.17B:27A-4) shall not contain a
26 preexisting condition limitation of any period ⟦under the following
27 circumstances:
28 (1) to an individual who has, under creditable coverage, with no
29 intervening lapse in coverage of more than 31 days, been treated or
30 diagnosed by a physician for a condition under that plan or satisfied
31 a 12-month preexisting condition limitation; or
32 (2) to a federally defined eligible individual who applies for an
33 individual health benefits plan within 63 days of termination of the
34 prior coverage⟧ <u>and shall not include a preexisting condition as a</u>
35 <u>factor in calculating the premium</u>.
36 c. In addition to the standard individual health benefits plans
37 provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the
38 board may develop up to five rider packages. Premium rates for the
39 rider packages shall be determined in accordance with section 8 of
40 P.L.1992, c.161 (C.17B:27A-9).
41 d. After the board's establishment of the individual health
42 benefits plans required pursuant to section 3 of P.L.1992, c.161
43 (C.17B:27A-4), and notwithstanding any law to the contrary, a
44 carrier shall file the policy or contract forms with the commissioner
45 and certify to the commissioner that the health benefits plans to be
46 used by the carrier are in substantial compliance with the provisions
47 in the corresponding approved plans. The certification shall be
48 signed by the chief executive officer of the carrier. Upon receipt by

1 the commissioner of the certification, the certified plans may be
2 used until the commissioner, after notice and hearing, disapproves
3 their continued use.
4 e. Effective immediately for an individual health benefits plan
5 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
6 35.27 et al.) and effective on the first 12-month anniversary date of
7 an individual health benefits plan in effect on the effective date of
8 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health
9 benefits plans required pursuant to section 3 of P.L.1992, c.161
10 (C.17B:27A-4), including any plan offered by a federally qualified
11 health maintenance organization, shall contain benefits for expenses
12 incurred in the following:
13 (1) Screening by blood lead measurement for lead poisoning for
14 children, including confirmatory blood lead testing as specified by
15 the Department of Health pursuant to section 7 of P.L.1995, c.316
16 (C.26:2-137.1); and medical evaluation and any necessary medical
17 follow-up and treatment for lead poisoned children.
18 (2) All childhood immunizations as recommended by the
19 Advisory Committee on Immunization Practices of the United
20 States Public Health Service and the Department of Health pursuant
21 to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall
22 notify its insureds, in writing, of any change in the health care
23 services provided with respect to childhood immunizations and any
24 related changes in premium. Such notification shall be in a form
25 and manner to be determined by the Commissioner of Banking and
26 Insurance.
27 (3) Screening for newborn hearing loss by appropriate
28 electrophysiologic screening measures and periodic monitoring of
29 infants for delayed onset hearing loss, pursuant to P.L.2001, c.373
30 (C.26:2-103.1 et al.). Payment for this screening service shall be
31 separate and distinct from payment for routine new baby care in the
32 form of a newborn hearing screening fee as negotiated with the
33 provider and facility.
34 The benefits provided pursuant to this subsection shall be
35 provided to the same extent as for any other medical condition
36 under the health benefits plan, except that a deductible shall not be
37 applied for benefits provided pursuant to this subsection; however,
38 with respect to a health benefits plan that qualifies as a high
39 deductible health plan for which qualified medical expenses are
40 paid using a health savings account established pursuant to section
41 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),
42 a deductible shall not be applied for any benefits provided pursuant
43 to this subsection that represent preventive care as permitted by that
44 federal law, and shall not be applied as provided pursuant to section
45 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall
46 apply to all individual health benefits plans in which the carrier has
47 reserved the right to change the premium.

1 f. Effective immediately for a health benefits plan issued on or
2 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
3 effective on the first 12-month anniversary date of a health benefits
4 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z
5 et al.), the health benefits plans required pursuant to section 3 of
6 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses
7 incurred in the purchase of prescription drugs shall provide benefits
8 for expenses incurred in the purchase of specialized non-standard
9 infant formulas, when the covered infant's physician has diagnosed
10 the infant as having multiple food protein intolerance and has
11 determined such formula to be medically necessary, and when the
12 covered infant has not been responsive to trials of standard non-cow
13 milk-based formulas, including soybean and goat milk. The
14 coverage may be subject to utilization review, including periodic
15 review, of the continued medical necessity of the specialized infant
16 formula.
17 The benefits shall be provided to the same extent as for any other
18 prescribed items under the health benefits plan.
19 This subsection shall apply to all individual health benefits plans
20 in which the carrier has reserved the right to change the premium.
21 g. Effective immediately for an individual health benefits plan
22 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
23 35.27 et al.) and effective on the first 12-month anniversary date of
24 an individual health benefits plan in effect on the effective date of
25 P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans
26 required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4)
27 that qualify as high deductible health plans for which qualified
28 medical expenses are paid using a health savings account
29 established pursuant to section 223 of the federal Internal Revenue
30 Code of 1986 (26 U.S.C. s.223), including any plan offered by a
31 federally qualified health maintenance organization, shall contain
32 benefits for expenses incurred in connection with any medically
33 necessary benefits provided in-network which represent preventive
34 care as permitted by that federal law.
35 The benefits provided pursuant to this subsection shall be
36 provided to the same extent as for any other medical condition
37 under the health benefits plan, except that a deductible shall not be
38 applied for benefits provided pursuant to this subsection. This
39 subsection shall apply to all individual health benefits plans in
40 which the carrier has reserved the right to change the premium.
41 (cf: P.L.2012, c.17, s.57)
42
43 6. Section 10 of P.L.1994, c.11 (C.17B:27A-19.1) is amended
44 to read as follows:
45 10. a. A carrier shall not deliver or issue for delivery a hospital
46 confinement or other supplemental limited benefit insurance plan
47 unless the applicant for such coverage signs a statement on the
48 application form that confirms that the applicant is already covered

1 under a health benefits plan contract or policy. The application
2 form shall be filed with the board on an informational basis.
3 b. A hospital confinement plan or other supplemental limited
4 benefit insurance plan issued to a small employer or other group
5 health benefits plan provider or to individual employees of a small
6 employer or other group health benefits provider [:
7 (1)] shall be subject to the same rating requirements that apply
8 to health benefits plans issued pursuant to paragraph (2) of
9 subsection a. of section 9 of P.L.1992, c.162 (C.17B:27A-25),
10 except that a hospital confinement plan and supplemental limited
11 benefit insurance plan shall be subject to the commissioner's
12 exclusive review and regulation with regard to loss ratios, medical
13 underwriting and eligibility requirements, and form approval[; and
14 (2) may include preexisting condition exclusions].
15 c. A health benefits plan shall not coordinate benefits against
16 any hospital confinement or other supplemental limited benefit
17 insurance plan.
18 (cf: P.L.1994, c.11, s.10)
19
20 7. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to
21 read as follows:
22 6. a. No health benefits plan subject to this act shall <u>include a</u>
23 <u>preexisting condition as a factor in calculating the premium or</u>
24 include any provision excluding coverage for a preexisting
25 condition regardless of the cause of the condition [, provided that a
26 preexisting condition provision may apply to a late enrollee or to
27 any group of two to five persons if such provision excludes
28 coverage for a period of no more than 180 days following the
29 effective date of coverage of such enrollee, and relates only to
30 conditions, whether physical or mental, manifesting themselves
31 during the six months immediately preceding the enrollment date of
32 such enrollee and for which medical advice, diagnosis, care, or
33 treatment was recommended or received during the six months
34 immediately preceding the effective date of coverage; provided that,
35 if 10 or more late enrollees request enrollment during any 30-day
36 enrollment period, then no preexisting condition provision shall
37 apply to any such enrollee].
38 b. [In determining whether a preexisting condition provision
39 applies to an eligible employee or dependent, all health benefits
40 plans shall credit the time that person was covered under creditable
41 coverage if the creditable coverage was continuous to a date not
42 more than 90 days prior to the effective date of the new coverage,
43 exclusive of any applicable waiting period under such plan. A
44 carrier shall provide credit pursuant to this provision in one of the
45 following methods:
46 (1) A carrier shall count a period of creditable coverage without
47 regard to the specific benefits covered during the period; or

1 (2) A carrier shall count a period of creditable coverage based
2 on coverage of benefits within each of several classes or categories
3 of benefits specified in federal regulation rather than the method
4 provided in paragraph (1) of this subsection. This election shall be
5 made on a uniform basis for all covered persons. Under this
6 election, a carrier shall count a period of creditable coverage with
7 respect to any class or category of benefits if any level of benefits is
8 covered within that class or category. A carrier which elects to
9 provide credit pursuant to this provision shall comply with all
10 federal notice requirements.】 (Deleted by amendment, P.L. , c. )
11 (pending before the Legislature as this bill)
12 c. 【A health benefits plan shall not impose a preexisting
13 condition exclusion for the following:
14 (1) A newborn child who, as of the last date of the 30-day
15 period beginning with the date of birth, is covered under creditable
16 coverage;
17 (2) A child who is adopted or placed for adoption before
18 attaining 18 years of age and who, as of the last day of the 30-day
19 period beginning on the date of the adoption or placement for
20 adoption, is covered under creditable coverage. This provision
21 shall not apply to coverage before the date of the adoption or
22 placement for adoption; or
23 (3) Pregnancy as a preexisting condition.】 (Deleted by
24 amendment, P.L. , c. ) (pending before the Legislature as this
25 bill)
26 (cf: P.L.1997, c.146, s.9)
27
28 8. Sections 16 through 19 of P.L.1997, c.146 (C.17B:27-56
29 through 17B:27-59) are repealed.
30
31 9. This act shall take effect immediately.
32
33
34 STATEMENT
35
36 This bill clarifies that a health insurer shall not impose, or
37 include in its insurance policies, any provision excluding coverage
38 for a preexisting condition. The bill also provides that an insurer
39 shall not include any preexisting condition as a factor in calculating
40 the premium. While the federal Affordable Care Act mandates that
41 health insurers, except in certain grandfathered plans, may not
42 include an exclusion for a preexisting condition in any insurance
43 policy, New Jersey law was never changed to conform to the federal
44 law. This bill revises the New Jersey law concerning group health
45 insurance, the Individual Health Coverage Program, the Small
46 Employer Health Benefits Program, hospital confinement plans, and
47 certain hospital, medical, and health service corporation plans to
48 conform to the federal law regarding preexisting conditions.

1 It is the sponsor's intent that, if the Affordable Care Act is ever
2 amended or repealed, the prohibition on insurers excluding
3 coverage for preexisting conditions, putting certain waiting periods
4 on coverage, or using a preexisting condition as a factor in setting
5 premiums, would continue to be prohibited in New Jersey.