

ASSEMBLY, No. 659

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

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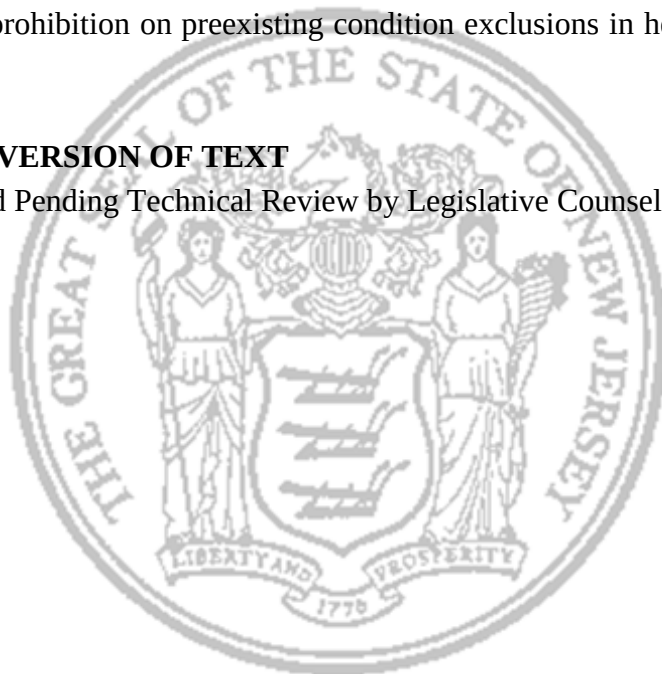
Assemblyman Johnson, Assemblywoman Murphy, Assemblymen McKeon, Bramnick, Assemblywoman Reynolds-Jackson, Assemblyman Caputo and Assemblywoman N.Munoz

SYNOPSIS

Clarifies prohibition on preexisting condition exclusions in health insurance policies.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



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

3

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

6

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

9 a. Notwithstanding any other provision of law to the contrary,
10 no group health insurance contract issued by a hospital service
11 corporation pursuant to the provisions of P.L.1938, c.366 (C.17:48-
12 1 et seq.), shall contain any provision which denies benefits for a
13 preexisting condition to any person becoming a member of that
14 group **【if: (1) during the period immediately preceding the person's**
15 becoming a member of the group the person was enrolled as a
16 member under another group contract issued by the corporation;
17 and (2) the corporation paid benefits for the condition under the
18 group contract in which the person was previously insured**】**.

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

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

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

26

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

29 a. Notwithstanding any other provision of law to the contrary,
30 no group health insurance contract issued by a medical service
31 corporation pursuant to the provisions of P.L.1940, c.74 (C.17:48A-
32 1 et seq.), shall contain any provision which denies benefits for a
33 preexisting condition to any person becoming a member of that
34 group **【if: (1) during the period immediately preceding the person's**
35 becoming a member of the group the person was enrolled as a
36 member under another group contract issued by the corporation;
37 and (2) the corporation paid benefits for the condition under the
38 group contract in which the person was previously insured**】**.

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

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

45 (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 thus is new matter.

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

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

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

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

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

21

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

24 15. A health insurer **【may】** shall not impose a preexisting
25 condition exclusion in its group health plan **【only if:**

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

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

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

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

37

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

40 6. The commissioner shall approve the policy and contract
41 forms and benefit levels to be made available by all carriers for the
42 health benefits plans required to be issued pursuant to section 3 of
43 P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications
44 to one or more plans as the board determines are necessary to make
45 available a "high deductible health plan" or plans consistent with
46 section 301 of Title III of the "Health Insurance Portability and
47 Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220),
48 regarding tax-deductible medical savings accounts, within 60 days

1 after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The
2 commissioner shall provide the board with an informational filing
3 of the policy and contract forms and benefit levels it approves.

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

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

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

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

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

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

42 e. Effective immediately for an individual health benefits plan
43 issued on or after the effective date of P.L.2005, c.248 (C.17:48E-
44 35.27 et al.) and effective on the first 12-month anniversary date of
45 an individual health benefits plan in effect on the effective date of
46 P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health
47 benefits plans required pursuant to section 3 of P.L.1992, c.161
48 (C.17B:27A-4), including any plan offered by a federally qualified

1 health maintenance organization, shall contain benefits for expenses
2 incurred in the following:

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

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

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

24 The benefits provided pursuant to this subsection shall be
25 provided to the same extent as for any other medical condition
26 under the health benefits plan, except that a deductible shall not be
27 applied for benefits provided pursuant to this subsection; however,
28 with respect to a health benefits plan that qualifies as a high
29 deductible health plan for which qualified medical expenses are
30 paid using a health savings account established pursuant to section
31 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223),
32 a deductible shall not be applied for any benefits provided pursuant
33 to this subsection that represent preventive care as permitted by that
34 federal law, and shall not be applied as provided pursuant to section
35 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall
36 apply to all individual health benefits plans in which the carrier has
37 reserved the right to change the premium.

38 f. Effective immediately for a health benefits plan issued on or
39 after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and
40 effective on the first 12-month anniversary date of a health benefits
41 plan in effect on the effective date of P.L.2001, c.361 (C.17:48-
42 6z et al.), the health benefits plans required pursuant to section 3 of
43 P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses
44 incurred in the purchase of prescription drugs shall provide benefits
45 for expenses incurred in the purchase of specialized non-standard
46 infant formulas, when the covered infant's physician has diagnosed
47 the infant as having multiple food protein intolerance and has
48 determined such formula to be medically necessary, and when the

1 covered infant has not been responsive to trials of standard non-cow
2 milk-based formulas, including soybean and goat milk. The
3 coverage may be subject to utilization review, including periodic
4 review, of the continued medical necessity of the specialized infant
5 formula.

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

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

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

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

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

31
32 6. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to
33 read as follows:

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

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

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

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

22 c. **【**A health benefits plan shall not impose a preexisting
23 condition exclusion for the following:

24 (1) A newborn child who, as of the last date of the 60-day
25 period beginning with the date of birth, is covered under creditable
26 coverage;

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

33 (3) Pregnancy as a preexisting condition. **】** (Deleted by
34 amendment, P.L. , c.) (pending before the Legislature as this
35 bill)

36 (cf: P.L.2017, c.361, s.10)

37

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

40

41 8. This act shall take effect immediately.

42

43

44

STATEMENT

45

46 This bill clarifies that a health insurer shall not impose, or include
47 in its insurance policies, any provision excluding coverage for a

1 preexisting condition. While the federal Affordable Care Act
2 mandates that health insurers, except in certain grandfathered plans,
3 may not include an exclusion for a preexisting condition in any
4 insurance policy, New Jersey law was never changed to conform to the
5 federal law. This bill revises the New Jersey law concerning group
6 health insurance, the Individual Health Coverage Program, the Small
7 Employer Health Benefits Program, and certain hospital, medical, and
8 health service corporation plans to conform to the federal law
9 regarding preexisting conditions.